SESLHD PROCEDURE COVER SHEET

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EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Director Allied Health SESLHD
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FUNCTIONAL GROUP(S)	Aged Care and Rehabilitation
KEY TERMS	Residential Aged Care Facility, Accommodation
SUMMARY	The policy aims to guide the process when permanent accommodation in a Residential Aged Care Facility (RACF) from hospital is being considered for a patient of South Eastern Sydney Local Health District (SESLHD).

Feedback about this document can be sent to SESLHD-Policy@health.nsw.gov.au

1. POLICY STATEMENT

The policy aims to guide the process when accommodation in a Residential Aged Care Facility (RACF) from hospital is being considered. It is acknowledged that this is a major life event for patients and their families/carers. The process should thus occur in a timely and sensitive manner with full consideration given to the patient's and/or family's wishes. Actions by the health care team should be based on a comprehensive assessment of the patient's specific health care needs. This is described in more detail in the section following.

Specific Principles:

1.1 It is important that patients who may require residential accommodation are identified as early as possible following hospital admission. Where possible, screening and/or identification during pre-hospital admission is encouraged with action initiated outside the hospital environment.

1.2 To determine if accommodation in a RACF is appropriate, all necessary assessments must be completed by the multidisciplinary team. This may include medical, nursing, social work, physiotherapy, and occupational therapy assessment. Other assessments from relevant professionals may also be required, as per the recommendations of the treating team. At every stage of this process, the patient and family/carer need to be central to communication about options for future care, and consent obtained before proceeding with an assessment for RACF.

1.3 If RACF accommodation is considered to be the appropriate discharge option, the medical team should discuss this with the patient/family/carer and document this in the patient's medical notes. In many instances, it will be necessary for a multidisciplinary / family case conference to take place. Social Work services are required to assist the patient and/or carer/family with emotional, social and practical issues that may arise. It is important for appropriate cultural consideration when working with clients and their families/carers who identify as Aboriginal and/or Torres Strait Island. A referral to the Aboriginal Hospital Liaison Officer or appropriate Aboriginal identified role is to be explored and made as per the patient's and family/carers wishes. It is important to acknowledge the impact that placement in a RACF may have in regards to past trauma, discrimination, lack of cultural safety and distance from home and family. It is important to ensure that culturally appropriate RACFs are located to meet the needs of the community.

1.4 If the patient is not able to participate in the decision making process due to diminished capacity, consent must be sought from a substitute decision-maker. If there is conflict over the discharge plan, it may be necessary to make an application to the Guardianship Tribunal to appoint a guardian, with the authority to make decisions on the patient's behalf. Please refer to local business rules for additional information.

1.5 To assist with the optimal management of the patient throughout this process, a clear escalation plan is required. Minimum requirements for a local procedure are outlined in APPENDIX 1.

1.6 Where a recommendation for Residential care has been made and the patient is medically stable, referral to the Aged Care Assessment Team (ACAT) should occur. Additional consideration is required for residential care approvals for people under 65 years of age and 50 years and under for people of Aboriginal and Torres Strait Island origins, as per the My Aged Care Assessment Manual version 1.1 (June 2018).

1.7 It is noted that an ACAT assessment must be independent from acute care management.

1.8 The patient or person responsible or appointed substitute decision-maker must provide consent for the ACAT assessment. Patients and their carers should be advised that they are not compelled to enter an aged care facility once eligibility has been determined. In some instances guardianship may need to be considered if the patient lacks capacity to make this decision and/or there is disagreement regarding the discharge plan.

1.9 Once a patient is assessed by ACAT and approved as eligible for Residential Aged Care, and medically stable, social work services should liaise with the patient/carers regarding suitable options for accommodation, information about the process and general information about the costs of care.

1.10 It is anticipated that the first appropriate vacancy offered is accepted by the patient/family. The local escalation procedures / business rules should be followed if there is a delay with accepting a vacancy or a dispute as to the discharge plan or process.

1.11 As per NSW Health policy, all patients who have exceeded 35 days and no longermeet the requirements of an Acute Aged Care Certificate must be charged fees as per the NSW Health Guidelines.

1.12 The Social Worker should be informed when a vacancy is accepted by a patient. Themultidisciplinary team should be informed and details recorded in the patient's medical record. The discharge process will then include:

1. Ward communication with the RACF regarding the patients care needs
2. Negotiation regarding the discharge date and transport arrangements of the patient to the RACF. This involves advising the patient and carer/family of these arrangements and recording this in the patient's medical record.
3. Medical discharge summary.
4. Nursing discharge summary.
5. Medication required e.g. Webster pack arranged through liaison with the

community pharmacy that services the RACF.

6. Any other relevant discharge information from the multidisciplinary team.

Please refer to local discharge planning procedures /business rules for additional information.

2. AIMS

This policy aims to guide the process when accommodation in a Residential Aged Care Facility (RACF) from hospital is being considered for a patient of South Eastern Sydney Local Health (SESLHD).

3. TARGET AUDIENCE

Staff responsible for arranging accommodation for patients to RACFs.

4. RESPONSIBILITIES

All relevant clinical and management staff across SESLHD including geriatric services, Aged Care Assessment Teams and other aged care services, medical, nursing and allied health personnel. Specialist Mental Health services for older people may also be involved.

5. DEFINITIONS

National Screening and Assessment Form (NSAF) – is used by the Aged Care Assessment Service to determine a client's aged care needs and assist in developing a support plan.

Support Plan – is developed by the Aged Care Assessment Service with the client. It is used by service providers to identify the client's needs, goals and recommendation for services.

Residential Care – is within a facility accredited under the Aged Care Quality and Safety Commission (Australian Government).

6. DOCUMENTATION

N/A

7. REFERENCES

7.1 Legislation:

Commonwealth of Australia *Aged Care Act* 1997
NSW Government *Guardianship Act* 1987 (NSW)

7.2 External References

My Aged Care Assessment Manual, June 2018, Department of Health

Aged Care Assessment Program Guidelines, May 2015, Department of Social Services
NSW Health, 2007, Fees Procedures Manual for Public Health Organisations
NSW Health GL2005_057: *End of Life Care and Decision Making Guidelines*
NSW Health, The Guardianship Application Process for Adult Inpatient of NSW Health Facilities GL2017_013

7.3 Internal References

SHN Pol-Clin Gov-06: ACAT Assessment and Residential Aged Care Placements

Aged Care - Guideline for Weekend Discharges to Residential Facilities, TSH (TSH CLIN085)

Aged Care- Residential Aged Care Facility Placement and Escalation Process – TSH (TSH CLIN389)

TSH 'Moving into residential aged care: information for patients and carers'

SGH 'Residential Care Information Pack'

http://seslhnweb.lan.sesahs.nsw.gov.au/SGSHHS/Business_Rules/Clinical/documents/A/CLIN001_SGH_Discharge_Escalation_process_for_RACF.pdf

Existing procedures/business rules across SESLHD were utilised to inform the development of the policy.

8. REVISION & APPROVAL HISTORY

Date	Revision No.	Author and Approval
October 2007	0	Patricia Bradd, Area Director Allied Health and SESIH Area Residential Care Policy Review Committee. Approved by SESIH Clinical Council and Area Executive Committee 23 October 2007.
September 2009	1	Patricia Bradd, Area Director Allied Health and SESIH Area Residential Care Policy Review Committee. Approved by SESIH Clinical Council September 2009.
April 2013	2	Glenn Power, Stream Manager Aged Care & Rehabilitation Services
August 2015	3	Julia Capper, Acting Director Allied Health and Kimberly Thomsett Clinical Stream Nurse Manager – Aged Care, Rehabilitation & Medicine District Access, Redesign and Clinical Services.
September 2015	3	Posted on Draft for Comment until 9 October 2015
November 2015	3	Approved by C&QC on 11 November 2015 for publishing

April 2021	4	Minor review. Updated age requirements and consideration to people of ATSI origin; simplification of section 1.11; updated definitions and references - Patrick Dunn, SESLHD Social Work Advisor.
May 2021	4	Approved by Executive Sponsor.

APPENDIX 1

ESCALATION PLAN FOR DIFFICULT OR COMPLEX DISCHARGES

This plan is to ensure that complex cases are identified early and escalated to appropriate staff at a senior level in South Eastern Sydney Local Health District hospitals SESLHD.

Prior to any escalation the following need to have been completed and documented as this is standard practice for all patients

As per NSW Health policy directive for discharge planning PD2007_092

- Admission and Discharge Risk Assessment form completed by nursing staff within 24 hours of admission to ward
- Risks identified from the admission assessment to be referred to other allied health professionals for further assessment e.g. change in mobility, functional status or cognition
- Patient and family have been informed by Estimated Date of Discharge (EDD) and EDD documented in notes/admission form
- Intended/proposed discharge plan discussed with patient/ family. Plan and discussion are documented in notes
- Issues with capacity of patient to make decisions identified early
- Correct person responsible details are recorded on front sheet
- If multiple relatives/friends involved, one person is nominated as the contact person

For some patients, the Guardianship Tribunal may need to be engaged to appoint a guardian with the authority to make decisions on the patient's behalf.

All of the above needs to be clearly documented in the patients' notes.

Triggers/flags for early identification of potential delays or complex discharges:

Stage 1 applies to all cases.
Stage 2 is divided into two scenarios:

- Aged care and residential placement
- Cases other than the above

STAGE 1
Issues:

- Unable to contact family
- No family or family not available
- Family not attending scheduled meetings/alternatives, e-mail contacts
- Frequent changes to discharge plan, either by family or treating team
- Lack of flexibility by family in which facility patient may be placed
- Lack of suitable options for patient due to highly complex needs

- Requirement for particularly culturally sensitive discharge plan or placement
- Patients with a history of frequent admissions (greater than 4 admissions in 6 months) **with same or similar diagnostic related group** and services offered **and refused**.
- Approaching EDD with no discharge plan in place
- Identified complex **internal** home environment
- Difficulty accessing equipment or arranging services
- Multiple patient moves through wards that creates a communication gap
- Delay in progress toward discharge due to staffing

Note: Specific arrangements may need to be considered for patients placed under Guardianship arrangements.

Staff response to these triggers

- Inform senior ward staff
- Inform relevant Senior Nurse Manager Patient Access (or equivalent senior staff at the facility)
- Consult with senior staff- social work, occupational therapy, physiotherapy and nursing and notify by e-mail and document in notes that they are involved
- Person who will be co-coordinating/case managing the patients' needs to be identified inthe notes with proposed discharge plan and the role of the coordinator.
- Develop plan to manage situation with a timeframe for outcome to be reached or for escalation to Stage 2
- Document the following in the notes – senior staff member notified, contact details given

STAGE 2

Escalation plan

An escalation plan should be actioned if Stage 1 has been completed and the discharge continues to be delayed or likely to be delayed.

Aged Care and residential placements:

- Patient is medically appropriate for discharge
- Allocated Social Worker has discussed discharge plan with patient/family
- Case conference held where the Nursing Unit Manager (NUM), Clinical (Care) Coordinator, Social Worker, Discharge Clinical Nurse Consultant (CNC) or Occupational Therapist, Physiotherapist, Medical Officer present as appropriate for the patient's situation at the facility.
- Case Conference documented to support the decisions for placement
  - ✓ Patient/family aware that alternate/residential accommodation is appropriate for care needs and patient is no longer acute
  - ✓ Patient/family aware of the financial issues and process
  - ✓ Transfer to Residential Aged Care Facility information pack including suitable accommodation across the district, is given to the patient/relatives
  - ✓ **One** designated contact person for family with contact details, mobile phone

etc. documented in notes
- ✓ Social Worker ensure contact person is aware of requirement to visit available homes within 24 hours of being notified of a vacancy

- If no return call after this 24 hour period from contact person, Social Worker to immediately initiate follow up contact and if no response or significant delay by family alert NUM/(or equivalent at facility) to situation.
- Patient/family given information by NUM on the procedure to transfer to another facility at any time if they are not happy.
- The patient/family informed by NUM of above they will not be able to stay in the acute hospital.
- If patient/family refuse to discharge patient to appropriate facility and services cannot provide suitable care at home due to patients care needs, then the family to be informed NUM or by Nursing Co-Director (or equivalent at facility) with other as appropriate, that the only option is for them to take the patient home. Family will be provided with information on private services. **At this stage there is no need for another review of the case unless the patient's condition has improved.**
- Appraise Nursing Co-Director (or equivalent) for relevant clinical area and Head of Social Work and other as indicated.
- Appraise Director of Nursing (DON) for relevant site for action and involvement of Director Clinical Services (DCS) (or equivalent at facility) if required.

Other

- Patient is medically appropriate for discharge to appropriate destination, such as home/friend/relative.
- Case conference held where the Nursing Unit Manager, Clinical (Care) Coordinator, Social Worker, CNC, Occupational Therapist, Physiotherapist, Medical Officer (or equivalent for facility) present as appropriate.
- Recommendations from Allied Health made including services, modifications and equipment.
- Risks identified and explained to patient/relatives and documented in the notes
- The patient/relatives informed they will not be able to stay in the acute sector.
- If refusal to accept recommendations, appraise Allied Health Head of Discipline, Nursing Co-Director (or equivalent for facility) for clinical area.
- Appraise DON for relevant site for action and involvement of DCS (or equivalent for facility) if required.

At this stage the co-directors, DCS or DON (or equivalent senior managers of facility) need to take over management of this case.

Prior to escalation case manager needs to summarise events and actions taken in patients' clinical notes and to who they have escalated the issue. Outcome of escalation is discharge within an agreed timeframe.