Policy

Policy Guideline

Transfer of Individuals between Public Health Services and Residential Aged Care Services

Objective file number: eA814059
Policy developed by: System Performance Division
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Next review due: 31 December 2018

Summary
The Transfer of Individuals between Public Health Services and Residential Aged Care Services Policy Guideline has been developed to guide the transfer of individuals between public health services and residential aged care services in a manner that ensures optimal continuity of care, patient safety and the effective engagement and support of relevant stakeholders.

Keywords
Transfer, residential care, care awaiting placement, aged care, policy guideline

Policy history
Is this a new policy? Y
Does this policy amend or update an existing policy? N
Does this policy replace an existing policy? N
If so, which policies?

Applies to
All Stakeholders
All Department for Health and Ageing Divisions
CALHN, SALHN, NALHN, CHSALHN
Residential Aged Care Services

Staff impact
Management, Admin,
All Clinical, Medical, Nursing, Allied Health, Allied Health

PDS reference
G0135

Version control and change history

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1. Objective

At any time, there are a significant number of South Australians who transfer between public health services and residential aged care services\(^1\). There are approximately 260 residential aged care services in South Australia and over 17,000 residential aged care beds\(^2\).

Approximately 70% of individuals living permanently in residential aged care services have transitioned from public and private hospitals\(^3\). The transfer of individuals takes place in both directions, as approximately 25% of individuals are likely to take leave from residential aged care to receive hospital treatment\(^4\).

Unsurprisingly given the preference for individuals to remain at home as long as possible and increased access to home based care, the ageing profile of residential aged care has gradually increased as reflected in the proportion of people aged over 85 accessing residential aged care having grown from 50% to 57% between 2001 and 2011\(^5\). With an ageing population, there is increasing likelihood of growth in numbers of older individuals experiencing complex health needs and frailty.

It is known that transferring between these services can be stressful and complex for individuals. It is also recognised that there are different types of transfers, as well as different reasons behind the transfer for each individual.

This policy guideline seeks to ensure that individuals are able to make this transfer in a dignified, safe, timely and appropriate manner. It is to be administered with compassion and to be supportive of the needs and wishes of each individual/family/carer (throughout this policy guideline, carer is inclusive of a substitute decision maker/s).

The objective of the policy guideline is to:

- Support the safe and timely transfer of individuals across the public health service-residential aged care interface
- Ensure continuity of care and a consistent, high quality approach to guide the transfer of individuals across public health and residential aged care

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1. Commonwealth Department of Health and Ageing  
3. AIHW, Movement from Hospital to Residential Aged Care, Data Linkage Series No 6 Cat No CSI 6 Canberra 2008  
2. **Scope**

This policy guideline is relevant for staff across public health services and residential aged care services who are directly involved in the care and discharge of individuals transferring between these services.

As the policy guideline applies to the transfer of any individual between a public health service and a residential aged care service, it is assumed the individual has been assessed as being eligible for residential aged care by an Aged Care Assessment Team (ACAT).

It is also assumed the individual has medical clearance for discharge and there is acceptance of admission by the residential aged care service after having been fully informed of the care needs of the individual. A transfer from hospital to an aged care facility should take place when the individual is medically stable, to reduce the potential of a re-admission due to a too-early discharge.

This policy guideline also applies to individuals in public health services who have been clinically assessed as likely to require discharge to a residential aged care service, but have yet to undergo an aged care assessment. They do not apply if the subsequent assessment does not deem the individual as eligible for residential aged care services.

*Note:* This policy guideline applies to individuals who have knowingly agreed to a transfer (inclusive of consent from a substitute decision maker(s)).

3. **Principles**

Principles underpinning this policy guideline include:

- Early and proactive planning of transfer of individuals between public health services and residential aged care services
- Effective involvement of the individual/family/carer in all aspects of preparing and enacting transfer arrangements
- Valued partnership between public health services and residential aged care services that support effective communication and information sharing
- Governance and leadership across public health services and the aged care sector to ensure appropriate systems and processes are in place that enhance safe and timely transfer arrangements

4. **Detail**

This Policy Guideline addresses the transfer of the individual from a public health service to a residential aged care service and from a residential aged care service to a public health service.

**Transfer from Public Health Service to Residential Aged Care Service**

4.1 **Early Preparations for Transfer**

Preparing the transfer of an individual to a residential aged care service should be part of standard discharge planning practice. Discharge planning typically should begin at the earliest phase of the in-patient admission, and involve as early as possible the individual/family/carer/residential aged care service in discussions about the transfer.
Where possible, the General Practitioner should be involved in discharge planning (ensure General Practitioner details are current). The aim is to maximise the support of the General Practitioner in the transfer and follow up care.

Planning for the transfer of the individual need not be delayed by the timing of an ACAT assessment. Note: The relevant discharge planning/support team (these teams focus on supporting the discharge of individuals with complex needs) in the public health service is responsible for guiding the transfer as soon as the clinical assessment by the treating clinical acute/subacute team indicates the transfer can proceed. Staff who are to have a significant role with transfers should have knowledge and sensitivity about the needs of older individuals and provide an educative, support and advisory role for other staff members. Good knowledge of local residential aged care services, including information about the standard of accommodation and specific areas of expertise (e.g. dementia specific accommodation), is also helpful.

4.2 Communication to support the transfer

Public health services are a common pathway to residential aged care services for individuals who are to undergo their initial transfer to a long term placement. Often there are precipitating complex and life altering circumstances that necessitate the transfer. The individual may be experiencing grief and struggling to accept that a return to their previous accommodation is no longer viable.

Communication should reflect awareness and compassion of the varying circumstances of all individuals transferring to a residential aged care service, whether the individual is undergoing an initial or subsequent transfer.

Communication with the individual/family/carer should explain the types of supports can be provided and address any specific concerns but also determine if additional assistance is needed for individuals undergoing an initial transfer. Any significant care, guardianship, lifestyle and financial matters should be addressed to support the individual, in both the case of an initial or subsequent transfer.

It is important that the individual/family/carer understand all aspects of the transfer. There should be consideration about the cultural context of the individual and if any additional services (e.g. interpreter services) are required.

The family/carer are to be provided with contact details of the designated contact person from the discharge planning/support team.

4.3 Recognising and responding to the different types of transfer

The circumstances and challenges for each individual undergoing a transfer should be respected at all times. In planning the transfer it is important to understand there are different types of transfers and that the purpose for transfer may vary for each individual.

Initial Transfer

In the case of an individual who is to transfer for a long term residential aged care placement, as outlined in 4.2, supports that may assist the individual to adjust to their circumstances and that ease the transfer, should be considered.

The may be a need to identify a long term placement, assuming a placement has not been previously identified. The family/carer may often look for a residential aged care placement that will best suit the individual and the family/carer. Selecting a residential aged care provider can be stressful and is a critical aspect of an effective transfer. The
The discharge planning/support team should consult with the individual/family/carer about their preferences or need for support with seeking a placement.

Where support is needed to identify a prospective residential aged care service, the discharge planning/support team is to consider undertaking the following actions, as relevant:

- Proactive, early and comprehensive engagement with the individual/family/carer to determine preferences and needs.
- Provide relevant brochures and useful information about local aged care services, including information from accreditation agencies and Seniors Information Services to the individual/family/carer (relevant staff should consider visiting local services to understand the type of services provided).
- Encourage the family/carer to visit prospective residential aged care services.
- Consider accessing the new Commonwealth Aged Care Gateway (‘My Gateway’ is accessible via - http://www.myagedcare.gov.au/) for assistance with navigating the aged care system, and/or advise the family/carer about this resource.

The discharge planning/support team is to initiate discussion with prospective residential aged care services as early as possible to identify suitable accommodation.

In circumstances in which an individual/family/carer preference is not able to be realised and there is little likelihood of a vacancy arising in the short term, then the individual/family/carer is responsible for finding a suitable alternative for either, respite until a permanent vacancy at the preferred residential aged care service is available or a permanent placement at an alternative residential aged care service.

As a general requirement, where the individual is deemed clinically suitable for transfer, and has undergone an ACAT assessment, the individual should not remain in a public health service for longer than it is necessary to organise the required preparations for their transfer.

Following agreement about the discharge destination (in consideration of the wishes of the individual or the substitute decision maker/s), a designated health professional from the discharge planning/support team will liaise with the residential aged care service about the transfer. It is preferred that a single designated contact person is identified by the residential aged care service to liaise with the public health service discharge planning/support team (it is acknowledged this may not always be practical particularly in rural and/or smaller locations).

**Subsequent Transfers**

As indicated, 25% of individuals residing in residential aged care are likely to take leave to receive treatment in a public health service⁶.

As the circumstances of the individual may have changed since their initial or previous admission to residential aged care, there should be consideration about whether there have been changes that impact on care, guardianship, lifestyle and financial matters. Any significant developments are to be addressed as part of the safe transfer of the individual.

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In support of this, communication should also take place with the relevant residential aged care service, given their existing role in providing care for the individual and their knowledge of the overall circumstances of the individual.

Before the individual is discharged, it is important the relevant residential aged care service is informed about the current circumstances of the individual and of any issues that may impact on continuity of care (see 4.4).

**Short term transfers – Respite Care and Transition Care**

There are a significant number of individuals who transfer from a public health service to a residential aged care service to receive short term support.

This includes the transfer to receive residential respite care. The most recent indications are that over half of all admissions to residential aged care are for respite care."7"

Residential respite care provided in residential aged care services is governed by the *Aged Care Act 1997* and the relevant policy guidelines can be found in the Commonwealth *Residential Care Manual* available on the Commonwealth Department of Social Services website. Residential respite care can be accessed on a planned or emergency basis, and is subject to ACAT approval.

Short term transfers also take place as part of the Transition Care program. Transition Care supports older people by improving their independence after their hospital stay. Transition Care is also subject to ACAT approval.

Up to 60% of individuals participating in a Transition Care program transfer to residential aged care where they receive therapeutic and personal care support to optimise their independence (via a Residential Transition Care program). Program specifications are outlined in the *National Transition Care Guidelines*, also available on the Commonwealth Department of Social Services website.

The principles and actions for planning a transfer as outlined are to apply to short term interventions where relevant in conjunction with the specific program guidelines. It is important however, that the different purpose of the short term transfer - the remedial and rehabilitative focus - is reflected in the discharge plan or transfer communication.

**4.4 The safe transfer of individuals with complex circumstances**

To support the residential aged care service to provide an appropriate care environment for the individual, the public health service is to advise of any complex circumstances regarding the individual.

All relevant information regarding the individual is to be provided, along with notification of the following circumstances of the individual, where these apply:

- Allergies
- Mobility and mobility aids
- Continence status and any appropriate aids that are used
- Usual diet or nutrition/malnutrition risks
- Issues regarding the weight of the patient (BMI) i.e. underweight or bariatric needs

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7 Australian Institute of Health and Welfare – Residential Aged Care in Australia 2010-2011
• Reduced skin integrity/ wounds/ pressure sores/injuries that may require complex care (include current wound care plan)
• Complex, multiple medical pathologies
• Smoking/drug dependency/addiction
• Dental/oral health
• Difficulties with swallowing
• Respiratory support inclusive of tracheostomy tubes
• Infectious conditions including any multi-resistant organisms such as MRSA and VRE
• Specific equipment requirements (this is to include any cytotoxic medicines, IDC/SPC/Peg tubes/Peritoneal Dialysis, PICC lines etc.)
• Cognitive status and known effective individual calming strategies
• Active behaviours of concern and triggers/methods for intervention
• History of falls
• Psychogeriatric circumstances/diagnosis
• Mental health disorders
• If relevant, advise re the status of: Advance Care Directives including Enduring Power of Guardianship, Medical Power of Attorney, Anticipatory Directive, Guardianship Order, or Section 32 Order from the Guardianship Board.
• Resuscitation status
• Palliative Care needs
• Disabilities (intellectual and/or physical)
• Complex communication impairments including use of communication aids
• Complex medication regimes
• History of Code Black events and likely triggers for escalation and de-escalation of challenging behaviours.

The residential aged care service is also to be consulted about any ongoing care needs including any potential occupational health and safety matters associated with manual handling issues (relevant to individuals with bariatric or mobility concerns), and to advise of potential triggers for escalation or de-escalation in the case of challenging behaviours and/or generally behaviours that may pose a security risk.

Planning the transfer should determine if there is any significant impact on levels of nursing support, personal care, medical support, and whether additional supports are needed. It should also be recognised that residential aged care services need sufficient time to prepare accommodation that meets the needs of the individual. In cases of individuals with highly complex needs, for instance, a period of days may be needed to make the necessary preparations.

Planning for the transfer should also ensure all risks have been addressed.

4.5 Transfer of Individual and Medical Information

After agreement about where the individual is to be transferred, and consideration about circumstances of the individual as outlined in 4.4, arrangements for the transfer can take place, including determining the date and time of the transfer and means of travel. Transport arrangements are to be confirmed at least the day before discharge.

Within metropolitan Adelaide, the transfer is to generally take place in normal operating hours. For transfers outside of normal hours, prior arrangements need to be made with the designated contact person, or the Residential Care Manager or Director of Nursing. As it is not always feasible for the transfer to take place during normal office hours, an agreed time for the transfer is to be negotiated to avoid individuals being transferred at inappropriate times, and to avoid individuals remaining in the public health service for a prolonged period after the standard discharge time.
Within country South Australia, every effort is to be made for transfers to a residential aged care service to take place during normal operating hours. However, where the timing of transfers is dependent on the availability of ambulance transport, including aeromedical transfers (generally via RFDS), consultation with the residential aged care service will be underlined by the importance of allowing flexibility in arrival time.

Whenever practical, the designated contact persons of the public health service and the residential aged care service are to oversee the transfer.

The following information, where relevant, is to be transferred with the individual:

- Discharge Plan (including OPD appointments/referrals and clinical diagnosis)
- Medical Summary
- Nursing Summary
- Relevant Clinical Information/record
- Allied Health professionals summary (including Speech Pathology report and any oral eating and drinking care plan)
- Relevant observation notes
- Advance Care Directive/Advance Care Plan/Resuscitation Plan
- Medication list/drug charts
- Mobility maintenance requirements
- Details regarding End of Life Care

Where it may be helpful, consider developing an Action Management Plan for individuals with complex needs before the transfer takes place. The plan should outline any current and ongoing issues, treatment and management plans and expected outcomes.

Planning should also take into account the transfer of equipment for the individual (e.g. wheelchair) and the return of equipment to the public health service.

Staff should ensure discharge information is to be high quality, legible and easy to negotiate. The transfer of the individual and appropriate information is to be confirmed in the appropriate clinical notes by the public health service and the residential aged care service.

**Transfer from Residential Aged Care Service to Public Health Service**

4.6 **Is the transfer avoidable?**

Where appropriate, actions that can avoid transfer to a public hospital should be considered, particularly in the case of predictable medical requirements, and where there are known alternatives to hospitalisation (e.g. where there are pathways to ‘in reach’ services inclusive of General Practitioner visitation, or rapid response services – see Appendices for contact details of hospital avoidance programs across public health services).

This does not apply to situations assessed as acute risk or any situation in which transfer to a public health service is considered necessary, and where there are no other alternative and appropriate ‘in reach’ options.

Where the circumstances may be appropriate, the wishes of the individual as expressed in advance care directives (and by the substitute decision maker/s in their advance care plan) and resuscitation plan are to be considered, and expected to be understood and implemented within existing legal constraints.
4.7 Key steps for a safe transfer

In the event the transfer of the individual is planned or unplanned, the aim is to enable a high quality transfer that minimises preventable adverse outcomes. Relevant actions for both planned and unplanned admissions may include:

**Planned Transfer**

In planning a transfer, the admission should be negotiated with the nearest public health service as clinically appropriate (unless a specific public health service has previously been designated as the site for transfer).

Clinical advice will consider issues around optimal continuity of care as part of identifying which public health service the individual is to be transferred to. This may not necessarily be the public health service nearest to the referring residential aged care service. This circumstance may be less relevant where the General Practitioner is responsible for the care of the individual across both residential aged care and the local public health service (this is more likely the case in rural and remote settings).

Where practical, liaison could take place with the designated contact person (or with an alternative clinician if the designated contact person is not available) of the discharge planning/support team to seek advice about appropriate admission and whether transfer to an Emergency Department is avoidable.

Where there is a prior arrangement for the transfer of the individual (e.g. scheduled surgery), communication is to take place with the relevant public health service contact person to confirm transfer arrangements.

In most instances, the transfer will involve the South Australian Ambulance Service (SAAS). Where possible, advice should be sought from SAAS about transport options and the timing of the transfer, to optimally meet the needs of the individual.

**Unplanned Admission**

An unplanned admission usually involves an emergency or an unanticipated event.

These transfers are likely to involve the emergency intervention (as distinct from the planned intervention) of SAAS. In these instances, it is likely SAAS may determine which public health service the individual will be transferred to.

Given there may be uncertainty about the destination of the individual, where practical, the residential aged care service is to contact SAAS (or the relevant public health service if the destination site is known) to determine the destination and the contact person at the site of transfer. Ensure the notifying letter that is transferred with the individual advises the public health service as to who the contact person is for the residential aged care service.

It is important that relevant SAAS and/or public health service staff are advised if the individual to be transferred may present with any behaviours of concern.

**Standard Transfer Requirements**

Whether the transfer of the individual is planned or unplanned, the residential aged care service is to fully inform the public health service (and SAAS when relevant) about the care circumstances of the individual.
The quality of transfer could be enhanced by ensuring the following information is provided by the residential aged care service, as relevant:

- Information outlining the reason for the transfer and sought outcome(s)
- Any documents outlined in Section 4.5 that aged care services use that are relevant to the circumstances of the individual
- Any information relevant to the individual as outlined in Section 4.4
- Any information that may have involved consultation with the relevant General Practitioner prior to the transfer of the individual

The appropriate documents are to be placed in the transfer envelope (preferably the yellow envelope – it is preferred that the yellow envelope is adopted consistently across relevant sites if practical) and sent with the individual. It is important that the information sent remains with the Emergency Department (or any other point of admission) and is not separated from the individual by sending it, for instance, to hospital administration.

The family/carer and the General Practitioner are to be contacted by the residential aged care service and provided updated information (also ensure that the family/carer are provided with key details of the designated contact person from the residential aged care service). The public health service is to contact the residential aged care service to confirm that the transfer has been effective.

In an unplanned transfer, where it has not been possible to organise information to transfer with the individual, the information is to be transferred to the relevant public health service as soon as practical. Clinical handover via telephone should also take place if this may enhance continuity of care.

It is also important that the public health service is advised of individuals who have complex needs or behaviours of concern relating to dementia (e.g. challenging behaviour, potential wanderers) and any other complex presentation (e.g. mental health conditions). Any relevant information about the routines and general needs of the individual with dementia that may assist with avoiding the occurrence of code black events should be outlined in the individual’s medical or nursing summary/care plan.

The transfer of information should include details of the contact person from the residential aged care service, the General Practitioner and family/carer contact details.

Ensure effective arrangements for the transfer of any relevant equipment and assistive technology devices.

Information transferred to the public health service is to be high quality, legible and easy to navigate.

**Medication Management**

The continuity of medication management is a critical concern for individuals transferring between public health services and residential aged care services.

To enhance continuity, the residential aged care service is to be advised about medication needs of the individual, including:

- medication review
- prescriptions
- ongoing medication requirements

The above listed requirements are to be negotiated and agreed between relevant staff of the public health service and the residential aged care service.
As part of the discharge of the individual, the residential aged care service is to be supplied with an appropriate medication chart (Supportive Care Chart) that is aligned with requirements of the Pharmaceutical Benefits Scheme.

Medication should also be properly packaged in Webster or Sachet packaging. Communication between the public health service and the residential aged care service may be needed to determine arrangements for the packaging of ongoing and new and changed medication.

In cases of individuals who transfer to a public health service for elective purposes along with their medication, it is expected that any unused medication is returned with the individual and any newly prescribed medication, upon their discharge to the residential aged care service.

Also in the case of individuals who transfer to a public health service, it is important that staff from the residential aged care service provide relevant information about the medication regime and medication needs of the individual and packaging requirements.

Note also in the case of the discharge of the individual from a public health service, there should also be consideration about any issues relevant to the ongoing availability of specific drugs and administering medications. For instance, any drugs that are not readily available on the Pharmaceutical Benefits Scheme should be organised and prepared to follow the individual before the discharge takes place. This may include drugs for special treatment regime e.g. specialist and hospital pharmacy ensures the individual has sufficient supply of medicines until next appointment e.g. HIV antivirals, drugs for renal dialysis etc.

5. Roles and Responsibilities

The Department for Health and Ageing is responsible for the overall administration and oversight of the Guideline and for any measures relevant to its evaluation.

Chief Executive Officers, Local Health Networks are responsible for implementing the Guideline across their respective acute hospital sites including ensuring that relevant discharge planning/support teams are familiar with the Guideline and seek to apply the Guideline as part of their daily work routines.

Residential Aged Care Services are responsible for ensuring key staff are familiar with the Guideline and seek to apply the Guideline as part of their daily work routines. This includes key staff such as contractors where relevant.

6. Reporting (if applicable)

Not applicable.

7. EPAS Considerations

Not applicable.

8. Associated Policy Directives / Policy Guidelines (if applicable)

South Australia's Strategic Plan

Transfer of Individuals between Public Health Services and Residential Aged Care Services Policy Guideline
9. References, Resources and Related Documents

1. Commonwealth National Transition Care Program Guidelines

2. Commonwealth Residential Care Manual

3. Checklist for convenient application of the Guideline is being finalised.
10. National Safety and Quality Health Service Standards (if applicable)

This Policy Guideline, while not directly aligned to any National Safety and Quality Health Service Standards, its application can be considered in the context of the following:

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<td>Patient Identification &amp; Procedure Matching</td>
<td>Clinical Handover</td>
<td>Blood and Blood Products</td>
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11. Other

The risks associated with non-compliance with this policy guideline are:

- Individuals deemed eligible for residential aged care who remain in acute care for inappropriate extended time may be at risk of functional decline
- Acute beds are occupied with individuals who no longer require acute care while individuals who are in need of such care are refused due to limited capacity
- Residential aged care services do not receive critical information such as medication charts/medication leading to poor quality care and possible adverse outcomes
- Poor transfer resulting in unnecessary stress and anxiety for the individual/family/carer
- Individuals are unnecessarily readmitted to public hospitals due to poor quality and incomplete transfer arrangements.

12. Evaluation

Evaluation will include monitoring and review of the following key indices:

- Improved integration and continuity of care and overall outcomes for individuals (surveys of individuals)
- Reduced Length of Stay for individuals in the public health service
- Decrease in Emergency Department and hospital admissions from residential aged care services within the first 28 days of discharge
- Decrease in incidents of public health services returning individuals to residential aged care services with inadequate clinical and handover information

13. Attachments

Attachment 1: Services supporting hospital avoidance and discharge/emergency department liaison information.
14. Definitions

In the context of this document:

- **transfer** means: Transfer for the purpose of this document is meant as – the planned or unplanned movement of individuals between public health services and residential aged care services for the purpose of receiving care intervention from the respective services.

- **A public health service means**: a public hospital inclusive of the range of clinical acute and sub-acute services.
Attachment 1

Services Supporting Hospital Avoidance and Discharge/Emergency Department Liaison Information

SA Health has developed a range of programs to support hospital avoidance and appropriate discharge from hospital. The programs include:

- Hospital and Health Care at Home
- Country Home Link
- End of Life Choice
- Community Nursing Program for:
  - Extended Community Care
  - Palliative Care
- Transition Care Program
- SAAS Extended Care Paramedics
- Older Persons Mental Health Service

Metropolitan Referral Unit
The Metropolitan Referral Unit (MRU) is a single point of contact for referrals from hospitals, clinicians, GPs, Residential Aged Care and community to access a range of services supporting immediate hospital avoidance and early supported discharge. The team of clinicians in the MRU review and assess referrals to admit individuals to the most appropriate SA Health program. The MRU is the access point for admission to community based SA Health programs to support SA Public Hospitals patient flow and bed capacity. The MRU is open seven days a week from 8am-8pm including public holidays.

MRU Contact Details are:
Telephone: 1300 110 600  Fax: (08) 8201 7822

A referral form can be obtained from health site intranets on: www.sahealth.sa.gov.au/MRU or by calling the MRU on 1300 110 600.

Program Options

Hospital and Health Care @ Home
Hospital and Health Care @ Home (HHC@H) is a service that provides short term support for people in their homes (inclusive of residential care facilities) to help:

- Avoid unnecessary presentations to a metropolitan public emergency department and / or an admission to a metropolitan public hospital.
- Be able to be discharged from a public metropolitan hospital earlier than otherwise may have been possible in a safe and supportive manner

HHC@H delivers clinical services in the metropolitan area 7 days a week.

What type of clinical and personal care can be provided by HHC@H?
Short term clinical and personal services to support hospital avoidance or early supported discharge are matched to meet the individual needs of the patient. Services can include:

- Nursing/Midwifery care
- Personal Care
- Allied Health

Transfer of Individuals between Public Health Services and Residential Aged Care Services Policy Guideline
• End of Life Care
• Equipment
• Short term overnight supported accommodation – post procedure only (HHC@H only)

Country Home Link (CHL)
Country Home Link is a service for country patients who are in metropolitan public hospitals and require support in order to facilitate discharge back to their community. Country Home Link is utilised when the local country community service is not able to provide an immediate response. The service provides short term clinical services to support patients to leave hospital earlier than otherwise may have been possible, in a safe and supportive environment. Country Home Link delivers services in rural areas.

What type of clinical and personal care can be provided CHL?
Short term clinical and personal services to support hospital avoidance or early supported discharge are matched to meet the individual needs of the patient. Services can include:
• Nursing/Midwifery care
• Personal care
• Allied health
• Equipment
• Short term overnight supported accommodation – post procedure only (HHC@H only)

Community Nursing Program
SA Health provides options for specialised nursing services to support identified populations to remain supported in the community. Accessed via the Metropolitan Referral Unit. This program is accessed via the Metropolitan Referral unit and can support patients requiring additional support due to individual circumstances and/or medical conditions:
• Palliative Care
• Extended Community Care (ECC)

Palliative Care
Provision of community general palliative care nursing in the home to assist with direct care related to medication management and symptom management.

Extended Community Care
The ECC nursing program provides nursing care to assist patients with a long term community nursing need that is not met by any other service or programs.

Other Program Options Available include:

Transition Care Program
The Transition Care Program (TCP) provides a range flexible care options for older people who would otherwise require ongoing care following discharge from hospital for up to a maximum of 12 weeks. Transition Care provides goal orientated, restorative care to eligible patients to improve their overall functioning following hospitalisation. Specific services include:
• Care coordination
• Nursing
• Personal care
• Allied Health and Therapy (physiotherapy, occupational therapy, speech pathology, dietetics, social work)
• Continence aids
• Equipment
• Home safety assessments
Transition Care Program services can be provided in a residential setting or at the patient’s own home if appropriate. Many TCP type services are provided in both settings – commencing in residential setting before moving the care to the person’s own home.

**Eligibility Criteria:**
- In hospital and nearing the end of their stay
- Able to benefit from a program to improve recovery and restore independence as much as possible
- Assessed by Aged Care Assessment Team as being eligible

Early discharge planning is essential to ensure that options are maximised to support transition back into the community

**Local Health Network (LHN) TCP Coordinator Contacts: (Monday to Friday – 9am – 5pm):**

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<tr>
<td>Central Adelaide LHN TCP</td>
<td>TCP Co-ordinators</td>
<td>Telephone: (08) 8243 5469 Mobile: 0423 294 410</td>
</tr>
<tr>
<td>Northern Adelaide LHN TCP</td>
<td>TCP Co-ordinators</td>
<td>Telephone: (08) 73214001 Mobile: 0402 973 604</td>
</tr>
<tr>
<td>Southern Adelaide LHN TCP</td>
<td>TCP Co-ordinators</td>
<td>Telephone: (08) 8201 7875 Mobile: 0429 440 313</td>
</tr>
<tr>
<td>Country Health SA LHN TCP</td>
<td>TCP Co-ordinators</td>
<td>Telephone: (08) 86832702 Mobile: 0407390818</td>
</tr>
</tbody>
</table>

**Extended Care Paramedics**
The extended care paramedic (ECP) service allows patients to be treated at home or in their home surrounds, without being transported to a hospital emergency department if it is not necessary.

An ECP is an SA Ambulance Service intensive care paramedic who has undergone intensive skills enhancement and training. ECPs can treat patients for a range of common medical issues and refer patients to other health providers such as GPs if needed.

With this service, an ECP assesses the patient’s requirements through phone consultation and dispatches an ECP single responder in an ambulance response vehicle as opposed to a traditional stretcher-carrying ambulance.

**For more information**
SA Ambulance Service  
GPO Box 3  
Adelaide SA 5001  
Telephone: 1300 13 62 72  

**Older Persons Mental Health Services**
Mental health services for older persons in South Australia include:

**Adelaide Metropolitan Community Mental Health Teams**
Older Persons community teams operate during business hours from Monday to Friday and provide:
• initial mental health assessment
• treatment
• care planning
• short term follow-up for people aged 65 years and over, Indigenous consumers aged 45 years and over, or younger people who do not fall within this aged care criteria but who have an illness related to mental health and ageing with challenging behaviours.

These services are geared specifically towards the care needs of older persons. The nature of the intervention is similar to those offered by general community mental health services.

In addition, the service provides in-reach support to residential aged care facilities to assist in ensuring residents quality of life.

• Eastern team
  (relocating to 367 Magill Road, St Morris later in 2013)
  398A Payneham Road, Glynde
  Telephone: (08) 8336 7301
• Northern team
  30 Gawler Street, Salisbury
  Telephone: (08) 8282 2500
• Southern team
  Springbank House
  1020 South Road, Edwardstown
  Telephone: (08) 8374 5800
• Western team
  308-320 Grange Road, Kidman Park
  Telephone: (08) 8426 0600

Older persons transitional service
The older person’s transitional service operates seven days a week to provide a consultancy service. It ensures consumers are linked to support services that meet their needs and prevent unnecessary admission to hospitals or nursing homes. The team manages immediate needs as well as addressing long-term issues.

Contact:
Transitional Care Consultant
Oakden Campus, 200 Fosters Road, Oakden
Telephone (08) 8282 0444 (Monday to Friday during business hours)

Country older persons mental health services
Mental health services are jointly delivered to older people living in country regions by the local mental health team and a consultation liaison service based at the Glenside Campus. Services are available through the local mental health team during business hours.

Out-of-hours services are available 24 hours a day, seven days a week through the Emergency Triage Liaison Service (ETLS) on telephone 13 14 65.

Country liaison service
Telephone: (08) 8303 1110 (Monday to Friday during business hours)

Consultation Liaison Service
The consultation liaison service offers a visiting and remote service with direct assessments of consumers as well as education, advice and support for service
providers. The consultation liaison service offers a distance consultation and video conferencing service.

**Also consider:**
Health Direct Phone Line – 1800 022 222
Dementia Behaviour Management Advisory Service – 1800 699 799

**Public Hospital and LHN Contacts**
The following list outlines individuals employed across metropolitan public hospitals. Some of these roles are involved in discharge planning and assisting in timely transition of care. The key enablers at each site can assist in the transition of care. The following are some of the contact points.

<table>
<thead>
<tr>
<th>Local Health Network</th>
<th>Public Hospital</th>
<th>Contact Persons</th>
<th>Phone No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southern Adelaide Local Health Network</td>
<td>FMC, RGH, NHS</td>
<td>Aged Care Liaison Community Flow Coordinator – CPC</td>
<td>(08) 8201 7964 or 0408411361</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nursing role to assist in transition of care RACF and acute sites for clinical issues. Working in partnership with MRU. Coordinator of Substitute Services (facilitates Residentia Care/Community Aged Care Forums)</td>
<td>0407 248 440</td>
</tr>
<tr>
<td>Northern Adelaide Local Health Network</td>
<td>Modbury Hospital</td>
<td>ED Liaison Nurse</td>
<td>(08) 8161 2000 Pager 127</td>
</tr>
<tr>
<td></td>
<td>Lyell McEwin Hospital</td>
<td>ED Liaison Nurse Home link coordinators</td>
<td>(08) 8182 9000 0401 692 646 (available 7 days per week, 365 days per year from 0700-1530 hours and 1530-2000hours via after hours phone support.</td>
</tr>
<tr>
<td>Central Adelaide Local Health Network</td>
<td>RAH</td>
<td>ED Liaison Nurse</td>
<td>(08) 8222 4000 pager 1229</td>
</tr>
<tr>
<td></td>
<td>TQEH</td>
<td>RAH and TQEH Aged Care Liaison Nurse</td>
<td>(08) 8222 6000 Pager 6747</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ED Liaison Nurse. Also undertake GP Liaison as part of the role. They work across 7 days.</td>
<td></td>
</tr>
</tbody>
</table>