Policy Directive: compliance is mandatory

Care Awaiting Placement Program Policy Directive.

Objective file number: eA922848
Document classification: For Official Use Only -I2-A2
Document developed by: System Performance and Service Delivery
Approved at Portfolio Executive on: 30 June 2016
Next review due: 30 June 2017

Summary
The Care Awaiting Placement Program Policy Directive details the Care Awaiting Placement (CAP) Program for elderly in-patients of metropolitan public hospitals who are occupying a hospital bed whilst awaiting permanent Residential Aged Care placement. The CAP program is short term (maximum 21 day) maintenance care program for patients who have completed their acute or sub-acute episode of care and are medically fit for discharge.

Keywords
Care Awaiting Placement, CAP, elderly/older/aged in-patients, maintenance care, acute or sub-acute episode of care, permanent Residential Aged Care placement, hospital discharge, transfer, Care Awaiting Placement Program Policy Directive.

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
CALHN, SALHN, NALHN

Staff impacted
All Clinical, Medical, Nursing, Allied Health,

EPAS compatible
Yes

Registered with Divisional Policy
Yes

Contact Officer

Policy doc reference no.
D0418

Version control and change history

<table>
<thead>
<tr>
<th>Version</th>
<th>Date from</th>
<th>Date to</th>
<th>Amendment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>30/06/2016</td>
<td>30/06/2017</td>
<td>Original version</td>
</tr>
</tbody>
</table>

© Department for Health and Ageing, Government of South Australia. All rights reserved.
Care Awaiting Placement Program Policy Directive

30 June 2016
### Document control information

| Document owner                                                                 | Executive Director  
|                                                                             | Operational Service Improvement and Demand Management  
|                                                                             | System Performance and Service Delivery  
| Contributors                                                                | Community Systems Service Improvement  
| Document location                                                            | SA Health internet – ‘policies page’  
| Document Classification                                                       | For Official Use Only-l2-A2  
| Reference                                                                    | eA922848  
| Valid from                                                                   | 30 June 2016  
| Anticipated Date of Review                                                   | June 2017  

### Document history

<table>
<thead>
<tr>
<th>Date</th>
<th>Version</th>
<th>Who approved New/Revised Version</th>
<th>Reason for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>30/06/2016</td>
<td>V1</td>
<td>Chief Executive, SA Health</td>
<td>Strengthening of KPIs, reporting responsibilities and implementation plans.</td>
</tr>
</tbody>
</table>
1. Objective

To provide Local Health Networks (LHN) with a policy to guide the implementation and management of the Care Awaiting Placement (CAP) program developed for elderly patients who are in-patients of a metropolitan public hospital, and are occupying a hospital bed whilst awaiting permanent placement in a suitable Residential Aged Care Facility (RACF).

The CAP program is a state funded, short term (maximum 21 day) maintenance care program for patients who have completed their acute or sub-acute episode of care and are medically fit for discharge.

The LHN Chief Executive Officer is required to submit an implementation plan to the Chief Executive, SA Health confirming the number of hospital beds closed (in alignment with the Transforming Health bed closures for each LHN) including the hospital and ward location prior to creating a virtual ward for CAP eligible patients and purchasing CAP program beds for a period of 12 months with a Non-Government Organisation, which may be extended with further approvals.

If there are delays in a patient accepting a permanent placement offer whilst in the CAP program, the escalation process detailed in this Policy Directive is to be initiated. If the patient requires more than 21 days in the program, the LHN Chief Executive Officer is required to give approval to extend past the 21 days to a maximum of 28 days.

2. Scope

This policy directive supports patients who:

- Are over 65 years of age (50 and over for Aboriginal and Torres Strait Islanders).
- Are an in-patient of a metropolitan public hospital and;
  - Are no longer acute
  - Are medically stable (and categorised as a maintenance care patient).
- Have been assessed by the hospital treating team as requiring permanent placement in a RACF and:
  - Have been assessed by an ACAT as being eligible for a permanent RAC placement (only in circumstances when believed that a patient will move through the CAP program within the maximum 21 day length of stay can they be transferred prior to receiving their ACAT approval)
  - Have a confirmed RAC placement that will become available within 21 days.
- Are not eligible for the Transition Care Program due to functional decline.
- May be at risk of a delayed discharge from hospital to a RACF and therefore at risk of a prolonged hospital stay.
- Have care needs that can be provided in a CAP facility.
- Are not a Country Health patient who is able to return to an aged care country hospital bed whilst awaiting permanent RAC placement.

3. Principles

The principles for managing patients who will receive ongoing care under the CAP program prior to discharge to permanent placement in a RACF include:

- Transfer of the patient to the CAP program results in the continuation of their ongoing maintenance care being provided in a RACF for a maximum of 21 days. If the patient
requires more than 21 days in the program, the LHN Chief Executive Officer is required to give approval to extend past the 21 days.

- Medical care provided to the patient in the CAP facility will be coordinated by the existing hospital team, whilst Activities of Daily Living will be provided by RACF staff.
- Patients in the CAP program are admitted to a 'virtual' hospital ward and are counted as receiving maintenance care. Where appropriate, patients must be charged the Long Stay Nursing Home Type patient fee to support funding the CAP program.
- SA Health will provide the following support services to patients in the CAP program:
  - Nursing and/or Allied Health support to provide ongoing coordination to a permanent RACF placement
  - Medical assessment by hospital treating team in the RACF
  - The supply of pharmaceuticals and equipment if required by the patient.
- Metropolitan public hospital patients are able to access CAP facility beds (unlicensed residential aged care beds) outside of the LHN perimeter in which they have been admitted.
- Delays in patient discharge to a permanent RAC placement will be escalated to Hospital Executive to address prior to day 21 on the CAP Program.

4. Detail

4.1 CAP PROGRAM OVERVIEW

- Early communication by the hospital team with the patient/family/carer/guardian should detail that once the patient is medically fit for hospital discharge, they will be transferred to a CAP facility whilst awaiting a permanent RACF placement. Transfer of the patient to the CAP facility will require patient/family/carer/guardian agreement.
- The CAP program is short term with a length of stay usually between 10 – 18 days, and a maximum 21 days.
- The aim of the CAP program is to:
  - Assist the transition to permanent RACF placement.
  - Ensure that metropolitan public hospital beds are available to those who require acute or sub-acute care.
  - Minimise avoidable extended hospital stays.
- The hospital team will negotiate with CAP facilities to ensure they are able to deliver the required level of care for the patient.
- The referring metropolitan public hospital retains governance of the patient (the patient remains admitted to a virtual ward bed) and provides appropriate resources to support the ongoing planning to achieve discharge to a permanent RAC placement.
- A weekly case management meeting should occur at each site involving representatives from the referring hospital, the CAP facility and the patient/family/carer/guardian.
- Once several preferred RACFs have been identified by the patient/family/carer/guardian and an appropriate permanent vacancy has arisen, the patient is discharged and all hospital equipment returned to the referring hospital.
- In the event that a patient experiences an acute episode and returns to hospital, regular processes for readmission apply including a patient risk assessment and review of patient eligibility for the CAP program.
- If the patient requires readmission to hospital, admission is negotiated with the nearest hospital as clinically appropriate. Alternatively, if clinically appropriate, the patient may be referred to a hospital that can provide optimal continuity of acute or sub-acute care, which may or may not be the hospital nearest to the patient’s accommodation.

4.2 METROPOLITAN PUBLIC HOSPITAL RESPONSIBILITY

It is the responsibility of the referring metropolitan public hospital to ensure that:

- The patient/family/carer/guardian has identified and is waitlisted for several suitable RACFs for permanent placement.
- The permanent placement process has been planned and is initiated prior to the patient transferring to the CAP facility.
• The patient/family/carer/guardian has been provided with an information sheet outlining the processes for their transfer to a CAP facility and their rights and responsibilities. This information sheet is supplemented to existing hospital information provided to the patient/family/carer/guardian.

• The patient/family/carer/guardian is clearly informed of the time limitation of the CAP program and is advised of any fees or charges, including charges for ambulance transportation, as per the SA Health Fees and Charges Manual.

• A detailed handover is given to the CAP facility by the hospital team, including the care requirements of the patient as well as any family issues of concern. This should include outstanding outpatient and medical appointments.

• The following information, where relevant, is to be transferred with the patient:
  o Discharge plan (including outpatient department appointments).
  o Relevant clinical information including medication list/drug charts, medical, nursing, and allied health summaries (speech pathology report, oral eating/drinking plan, and mobility requirements).
  o Advance care directive, Resuscitation plan and End of Life care plan.

• Planning should also take into account the transfer of equipment for the patient (e.g. wheelchair) and the return of equipment to the referring hospital.

• Ongoing assistance by hospital staff is provided to the patient/family/carer/guardian to secure a permanent placement in a RACF.

• Attachment 1 - CAP Program Pathway Flowchart details the decision making processes and actions to be undertaken by LHN staff to identify patient eligibility for the CAP program and the steps required to prepare patients for CAP program placement.

4.3 ESCALATION PLANNING

• Whilst the patient is in a short term placement within a CAP facility, delays in locating or accepting a permanent RAC placement should be escalated to the Hospital Executive.

• Each CAP program patient will be formally reviewed at 10 days to ensure that they are on track to achieve permanent RAC placement. At the 10 day period, if there is no identified permanent RAC placement, the case must be escalated to the Divisional Director of the referring hospital to meet with the patient/family/carer/guardian to discuss placement options.

• If there is no further progress at 15 days, the case is to be further escalated to the LHN Chief Operating Officer to review the management plan and develop further strategies to address delays.

• If the patient remains in a CAP placement at 21 days, the LHN Chief Operating Office is required to develop an exit strategy. However if there is evidence that the patient has a date for transfer to a permanent RAC placement, then a 7 day extension can be authorised by the LHN Chief Operating Officer (to a maximum of 28 days).

• If there is any further delay past the 28 days, the LHN Chief Executive Officer is required to approve the extension.

• Additionally the LHN Chief Executive Officer is required to provide a report of the number of patients in the CAP program who had extensions past 28 day with clarification of how delays are being managed at the monthly Department for Health and Ageing and LHN Contract Performance Meeting chaired by the Chief Executive, SA Health.

• Attachment 2 – CAP Program Escalation Process Flowchart further details this process.

4.4 MANAGING COMPLAINTS

• Complaints relating to a patient’s stay in hospital or their transfer to the CAP facility should be managed by the referring hospital.

• Complaints regarding the CAP facility should be initially directed to the CAP facility with intervention from the referring hospital if the complaint cannot be resolved by the CAP facility.

• If the dispute is unable to be resolved in a timely fashion, consideration may be given to escalating the complaint to Divisional Director within the referring hospital.
5. Roles and Responsibilities

The Deputy Chief Executive, System Performance and Service Delivery is responsible for the maintenance, monitoring and evaluation of this policy directive.

LHN Chief Executive Officers are responsible for ensuring that all staff involved in the provision of the Care Awaiting Placement program implement this policy directive. In addition LHN Chief Executive Officers are responsible for approving the implementation plan prior to commencing the CAP program, including identifying and confirming acute beds are closed and a reduction in full time equivalent staffing (in alignment with the Transforming Health bed closures for each LHN) are identified, implemented and maintained.

LHN Executive Directors, Directors and Senior Managers are responsible for providing leadership and support to hospital staff to support the development, implementation and monitoring of consistent protocols to ensure that the CAP program patients are identified, treated and managed in accordance with this directive.

Appropriate hospital treating teams are responsible for adhering to the principles and details within this directive and acknowledging that early intervention and planning is critical to the success of the CAP program.

6. Reporting

LHNs are required to report to the Department for Health and Ageing, Operational Service Improvement and Demand Management division on a weekly basis on the following, and these reports will be collated and discussed at bi-monthly management meetings with LHN representatives:

- The length of stay of patients in the CAP program; measured from transfer to the Virtual Ward (commencement in the CAP program) to hospital discharge to a permanent RAC placement (i.e. licenced bed)
- The reason for patient delays and actions taken to address delays
- The number of readmissions and reason for readmission to an acute hospital bed whilst in the CAP program
- The number of referrals to the CAP program (for each referring hospital)
- The number of patients awaiting CAP program placement

In addition as per section 4.3 Escalation Planning the LHN Chief Executive Officer is required to provide a report of the number of patients in the CAP program who had extensions past 28 day with clarification of how delays are being managed at the monthly Department for Health and Ageing and LHN Contract Performance Meeting, chaired by the Chief Executive, SA Health.

7. EPAS

Not Applicable

8. Exemption

Not Applicable

9. Associated Policy Directives / Policy Guidelines

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

- Decision making pathways when experiencing delays in the transfer of patients requiring Residential Aged Care placement
- Patient Information Sheet - Residential Aged Care Placement
- Clinical Process Document - The transfer of patients from a metropolitan hospital to a peri-urban hospital before discharge to a Residential Aged Care Facility

11. Other

Not Applicable

12. National Safety & Quality Health Service Standards

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Governance for Safety and Quality in Health Care</td>
<td>Partnering with Consumers</td>
<td>Preventing &amp; Controlling Healthcare associated infections</td>
<td>Medication Safety</td>
<td>Patient Identification &amp; Procedure Matching</td>
<td>Clinical Handover</td>
<td>Blood and Blood Products</td>
<td>Preventing &amp; Managing Pressure Injuries</td>
<td>Recognising &amp; Responding to Clinical Deterioration</td>
<td>Preventing Falls &amp; Harm from Falls</td>
</tr>
<tr>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

13. Risk Management

The risks associated with non-compliance of this policy directive are:
- Hospital teams do not engage with the patient/family/carer/guardian in a timely manner, therefore reducing the ability to successfully transfer patients to the CAP program.
- Planning for a permanent RAC placement is not commenced early in the patient’s in-patient journey, therefore increasing the potential for avoidable delayed discharge from a CAP facility to a permanent RAC placement.

14. Evaluation

Ongoing evaluation will include monitoring and review of the following key indices:
- Number of CAP places purchased and their location within the RAC sector.
- CAP program occupancy.

15. Attachments

Attachment 1: CAP Program Pathway Flowchart
Attachment 2: CAP Program Escalation Process Flowchart
Attachment 3: 2.2 Patient Information Sheet - Care Awaiting Placement Program

16. Definitions

Not Applicable
Attachment 1: CAP Program Pathway Flowchart

A risk assessment is to be undertaken where possible within the first 24 hours of the patient's hospital admission to determine if RAC placement will be required.

Discussions and information about available RACFs, ongoing services, including assistance with registering with My Aged Care to occur with patient and family/carer/guardian.

If permanent placement is likely, CAP Program check list to be used to identify patients eligibility for CAP Program.

Patient is eligible for CAP Program and can be discharged within 21 days?

Yes

Other options to be explored e.g. Transition Care Program, peri-urban transfer, respite or other community supports.

No

Family conference, case management, discharge planning and the development of a management plan to be undertaken while work continues to identify available RACF.

Patient is medically stable?

Yes

Continue to work with the patient and family/carer/guardian to identify a suitable RACF until patient is identified by treating team as medically stable and ready for an ACAT assessment.

No

Referral for ACAT assessment submitted?

Yes

Organise ACAT assessment referral and submit.

No

Placement in a RACF identified that will become available within 21 days?

Yes

Management plan in place?

Yes

Management plan to be developed in consultation with patient and family/carer/guardian.

No

Family concerns raised?

Yes

No
Attachment 1: CAP Program Pathway Flowchart continued

Family concerns raised?

Yes

Can these concerns be resolved in a timely manner?

Yes

No

Patient not eligible for CAP Program, other options to be explored.

Appropriate CAP Program placement identified and available?

Yes

No

Patient waitlisted for CAP Program and/or other options explored.

Referring hospital bed closed and maintenance care funding converted to pay for CAP facility bed and any other associated costs.

Patient transferred on Patient Administration System to CAP Program virtual ward.

Hospital staff to provide detailed handover to CAP facility (as per policy directive) including management plan.

Weekly case management meetings undertaken to ensure patients progress remains aligned with management plan.

Has the patient’s progress deviated from management plan and planned discharge date?

Yes

No

Discharge to permanent RACF.

Undertake more regular case management meetings until the reason for deviation from management plan and related issues are mitigated. Delays are to be escalated as per the policy directive.

Case management occurrence and any deviation from management plan to be recorded by referring hospital.

If the patient experiences an acute episode whilst in the CAP facility, the patient is discharged from the CAP Program virtual ward and admitted to the nearest clinically appropriate hospital. This may not be the referring hospital.

When the patient is discharged to a permanent RACF appropriate clinical handover from CAP facility to RACF is to be undertaken with equipment returned to referring hospital. Referring hospital to administratively discharge the patient from the CAP Program virtual ward.
Attachment 2: CAP Program Escalation Process Flowchart

Patient remains in the CAP Program at day 10: Division Director notified - Formal review undertaken

- Is the patient on track as per management plan?
  - Yes
  - Check reporting from weekly case management meetings. Work in consultation with patient/family/carer/guardian to maintain management plan and planned discharge date.
  - No

- Referring hospital to record escalation compliance and outcomes.
  - Yes
  - Has RACF been identified and is placement scheduled within program max 21 day LOS?
    - Yes
    - No
    - Division Director to meet with patient and family/carer/guardian and discuss placement options and remind family of program LOS reiterating the need to accept first reasonable offer.

- No
  - Check reporting from weekly case management meetings. Work in consultation with patient/family/carer/guardian to maintain management plan and planned discharge date.

Patient remains in the CAP Program at day 15: Chief Operating Officer notified - Formal review undertaken

- Is the patient on track as per management plan?
  - Yes
  - Check reporting from weekly case management meetings. Work in consultation with patient/family/carer/guardian to maintain management plan and planned discharge date.
  - No

- Referring hospital to record escalation compliance and outcomes.
  - Yes
  - Has RACF been identified and is placement scheduled within program max 21 day LOS?
    - Yes
    - No
    - Chief Operating Officer oversee of management plan, and development of further strategies to address delays.

- No
  - Has RACF been identified and is placement scheduled within 7 days?
    - Yes
    - No
    - Chief Operating Officer to develop exit strategies.

Patient remains in the CAP Program at day 21: Chief Operating Officer notified

- Has RACF been identified and is placement scheduled within 7 days?
  - Yes
  - Authorisation is required from the LHN Chief Operating Officer for an extension to a maximum 7 days (28 CAP program days in total).
  - No

- Referring hospital to record escalation compliance, outcomes and extension approval.

Patient remains in the CAP Program at day 28:

- CEO approval required for further extension provision. This is to be used in extreme cases and only if exit strategies have been devised.
  - Yes
  - Referring hospital to record escalation compliance, outcomes and extension approval and report to the Department.
Care Awaiting Placement Program

The Care Awaiting Placement Program has been designed for older people who are currently in a metropolitan public hospital and are awaiting permanent placement in a residential aged care facility.

The Care Awaiting Placement Program allows you to move to a more appropriate setting within the community at the end of your acute hospital stay to receive the care that you need whilst preparing for your move to ongoing accommodation.

General Information

During your hospital stay, staff will have discussed with you and your family that once you are medically fit for discharge, you may be transferred to a more appropriate setting within the community to receive support whilst securing a permanent placement within a residential aged care facility.

The aim of the Care Awaiting Placement Program is to assist you in your transition to permanent residential aged care.

What will the Care Awaiting Placement Program provide?

The Care Awaiting Placement Program is a short term program delivered in a residential aged care facility for a period of up to 21 days. Appropriate nursing support and personal care will be provided to you by residential aged care facility staff and medical care provided by the hospital team. The hospital team will also provide appropriate resources to support you and your family in the ongoing planning for your move to a permanent placement within a residential aged care facility.

What can I do to assist during my short term stay?

Prior to your transition to a Care Awaiting Placement facility, the hospital team will have listed you for a vacancy at all of your preferred residential aged care facilities. We understand that this can be a busy time for you, and your family however, we will appreciate if you and your family are contactable by phone and available to view vacancies at short notice.

We encourage you and your family to contact the facilities you have waitlisted for on a regular basis and ask that you please notify the hospital staff caring for you when you are offered any permanent placements. Every endeavour will be made to assist you to arrange a placement in your first preferred facility. However, there may be times when other options will need to be considered, for example, when other preferences on your list have a current room available. If this situation occurs it is considered to be fair that you accept the first appropriate placement offered to you, keeping in mind that you have the ability to move to your first preferred facility at a later date.
What happens if I require acute care whilst in a Care Awaiting Placement facility?

In the event that you become unwell and need to return to hospital, your admission will be to the nearest hospital able to provide you with the best care.

This may or may not be the hospital nearest to your current place of accommodation. If you require transportation by way of ambulance, you may be charged a fee, if you do not have ambulance insurance.

Following your readmission to hospital, your needs may be reassessed and you may be transferred again to a Care Awaiting Placement facility for a short term period, once you are medically fit.

If a suitable permanent placement within a residential aged care facility has not been secured within 35 days of your admission to hospital, the hospital is required to charge you a fee whilst occupying your short term placement within a Care Awaiting Placement facility. This fee is comparable to the daily fee charged by a residential aged care facility and is standard practice for the hospital.

Who can I contact if I have any questions or concerns?

The hospital staff providing your ongoing support will be available to speak with you and your family to answer any questions you may have about the process. Concerns relating to your stay in hospital or your transfer to the Care Awaiting Placement facility will also be managed by the hospital staff.

If you or your family have any concerns relating to the Care Awaiting Placement facility you have been placed in, we encourage you to direct these to the facility staff in the first instance.

Where can I find out more about residential aged care placement?

There is a lot of information available to you and your family about Aged Care Services. Please ask hospital staff for this assistance.

Additionally, the Commonwealth Government has developed the My Aged Care website [www.myagedcare.gov.au](http://www.myagedcare.gov.au) which has resources to assist in your decision making. A helpline is also available to you and can be contacted on 1800 200 422.