

## section 4.2.2: discharge to Residential Aged Care Facilities

### essential components of transfers from acute care facilities include:

#### negotiation of timing of transfer

Staff at the Residential Aged Care Facility (RACF) should be notified of impending discharge so that arrangements that suit all parties can be negotiated. Transfers to RACF's must occur within their normal working hours, which may be different to the hospital departure time – transfers after 3 pm weekdays and after 12 midday Fridays are not suitable due to lack of staff, especially Registered Nurses, and create difficulties in care.

#### communication of accurate, timely information to the RACF staff

Timely communication of information facilitates appropriate care planning, suitable staffing levels and the ability to access essential supplies that may be necessary following transfer.

Key issues to be considered include:

- **identification of a key person in both facilities** so that communication happens with the right person at the right time and that negotiation and care planning occurs with the right person. Other key staff are likely to include:
  - Nursing Home Liaison Nurse
  - General Practitioner Liaison Nurse
  - Palliative Care Liaison Nurse
  - Appropriate staff member from the RACF (Director of Nursing, Care Coordinator or Clinical Nurse)
- accurate and current clinical status summary required which includes:
  - current medication orders signed by a Medical Officer which can be continued at the RACF without transcription
  - synopsis of the patient's status, care and interventions that have been initiated during admission
  - nursing interventions that have made a positive difference
  - any introduction or modification to feeding regimes, with details from the speech therapist/dietician
  - advance notice, supplies and details of any artificial feeding to enable the RACF to obtain further supplies
  - a copy of any current advance care directive
  - a copy of any Aged Care Assessment Team (ACAT) assessment form completed or reviewed during admission
- the residential facility be included in the list of consumers requiring a copy of the discharge summary so that this can be easily communicated to the relevant clerical staff

- questions or difficulties in care planning during the planning stage or after discharge should be directed to the Acute Care Nursing Home Liaison or the hospital Discharge Planner, depending on the staffing of the acute facility. Contact details to be included in discharge summary.

## **inclusion of the General Practitioner in the discharge plan**

- GP notification via phone is essential, in addition to a written discharge letter
- This is of particular importance when
  - there has been a change in the GP
  - when there have been significant changes to the patient's status and management during admission
  - when the management plan is to keep the resident at the facility for end of life care and symptoms are likely to become difficult. Involving the specialist palliative care team in helping to develop this plan may be of great value.

## **communication with the patient and family**

Family meetings or case conferences are a valuable means of providing the patient and family with clear information about the patient's status and an opportunity to clarify expectations.

Topics covered can include:

What are the family's expectations for future care – are they clear and realistic?

- identify the patient's current palliative phase of illness – stable, unstable etc
- clarify the role and function of respite admissions to RACF's
  - limited or no ability to access resources required for rehabilitation
  - Will the specialist palliative care team have an ongoing role with the patient? Will their role be one of acting when required, with exacerbation of symptoms or assisting with particularly difficult discussions regarding future care?

Exploration of practical issues

- eg avoiding the loss of the patient's clothing in the RACF's general laundry system. This issue gives rise to significant distress for family particularly in the initial weeks of settling in and can be avoided either by the family clearly naming clothing themselves or utilising the aged care facilities sewing service (if available and at the family's cost)

## **an awareness of the limited availability of nursing staff, particularly Registered Nurses**

Levels of staffing in residential care facilities are much lower than those provided in acute facilities and may significantly restrict flexibility of care offered due to limited skill mix.

This reality has the following effects:

- gives even further weighting to the need to plan timing of transfers, to consider the complexity of the patient's needs and the ability of the facility to match these needs
- discharge to hostels requires specific consideration as staffing allocation may be limited to qualified care workers.

## medications

- where possible send a completed medication chart with the patient to the RACF, or the "7-day chart"
- if prescribed medications are difficult to obtain, more than 3 days supply may be required
- if oxygen is required, is there a medical order and how will the oxygen be sourced?
- consider the financial position of the patient, ie Are the medications prescribed listed on the Pharmaceutical Benefits Schedule?

## additional special supplies

- essential supplies must be provided for 48 hrs. These include:
  - PEG feeds
  - wound dressings
- hostels may not have access to hospital beds as part of their normal practice – should this be required by the patient, check with the particular facility as negotiation with the hostel manager to arrange for hiring of a bed may need to occur prior to discharge.

## ACAT Status

- frequently residents from RACF's require a review of the status due to increasing care needs
- acute hospitals currently provide an extremely valuable role in facilitating this review which is greatly appreciated by RACF staff

## related resources and information

### **Guidelines for a Palliative Approach in Residential Care**

Comprehensive description of implementing a palliative approach  
see [www.pallcare.org.au](http://www.pallcare.org.au)

### **Aged Care Self Directed Learning Package**

Training resources for use by staff in Residential Aged Care Facilities or for use by trainers as a basis for education provision  
see [www.pallcare.org.au](http://www.pallcare.org.au)