Government of **Western Australia**
Department of **Health**

Western Australia

Transition Care Program

OPERATIONAL GUIDELINES 2022

Aged Care Programs and Planning Team

January 2022

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Contents

This document has been created in collaboration between the TCP Central Coordinators (NMHS, SMHS and EMHS).

Document Control

Version	Primary Author(s)	Description of Version	Date Completed
3.0	ACCD, WA TCP Central Coordinators (NMHS & SMHS)	Final	November 2013
4.0	PCU, WA TCP Central Coordinators (NMHS, EMHS & SMHS)	Final	June 2018
5.0	SPIGR, WA TCP Central Coordinators (NMHS & EMHS & SMHS)	Final	January 2022

Chapter 1: Introduction

The Western Australian (WA) Transition Care Program (TCP) Operational Guidelines are intended to provide guidance and assistance for parties involved in the referral process and the delivery of the program. The Guidelines are written for:

- TCP Providers; and
- Hospital Staff

The WA TCP Operational Guidelines should be read in conjunction with the Australian Government Department of Health TCP Guidelines that give a broader overview of the program.

The national TCP Guidelines can be found on the Australian Government's Department of Health website at:

https://www.health.gov.au/resources/publications/transition-care-programme-guidelines

The WA TCP Operational Guidelines are intended to supplement the national TCP Guidelines in setting out the parameters of the program as it operates in WA.

1.1 Transition Care Program in brief

TCP provides short-term care that seeks to optimise the functioning and independence of older people after a hospital stay.

TCP is goal-oriented and time-limited. The aim of the program is to provide older people with an option to improve their functional independence and enable them to either return home if possible (the restorative pathway), or provide support to secure permanent aged residential care whilst maximising their abilities (residential pathway).

The program facilitates a continuum of care for older people who have completed their hospital episode, including acute and subacute care (e.g. rehabilitation, geriatric evaluation and management), and who need more time and support to make a decision on their longer term aged care options.

Transition care can be delivered in either:

- a facility-based residential setting (e.g. a residential aged care home); or
- a community setting (e.g. a person's own home); or
- a mixture of both.

Services provided through TCP

TCP provides older people with a package of services that includes low intensity therapeutic interventions such as physiotherapy and occupational therapy, as well as social work, nursing support or personal care. TCP must be provided in accordance with *Schedule 1: Specified care and services for transition care services* in the national TCP Guidelines, available at: https://www.health.gov.au/resources/publications/transition-care-programme-guidelines

The services provided as part of TCP are designed to meet a client's daily care needs and provide additional therapeutic care to enable the client to maintain or improve their physical, cognitive and psychosocial functioning.

TCP in the Perth metropolitan area is provided in both residential aged care settings or in the community if the patient is to be based at home (TCP Community) depending on which will best meet the client's needs. TCP Providers are located across the metropolitan area and are all accredited and experienced Aged Care Providers, as recognised by the Australian Government.

There are three rural areas in which TCP services are delivered; the Great Southern, the Midwest and the South West, all are community TCP services.

1.2 Access to TCP

Assessment and approval by an Aged Care Assessment Team (ACAT) is necessary before a patient can enter TCP. A hospital inpatient is not eligible for ACAT assessment until they are medically stable and ready for discharge.

TCP eligibility requirements are stated in Part 2.3, Section 21-4 of the Act and Part 2 Section 8 *Approval of Care Recipients Principles 2014.*

People may be eligible for TCP if they:

- Aged 65 years and over or 50 years and over for Aboriginal and Torres Strait Islander people; **and**
- Are an inpatient in a public or private hospital; **and**
- Would otherwise be eligible for aged residential care; **and**
- Have completed their acute or subacute hospital care, including rehabilitation; **but**
- Need more time in a non-hospital environment to:
    - Complete their restorative process;
    - Optimise their functional capacity **and/or**
    - Finalise and access their longer-term aged care arrangements.

Referrals to TCP Residential are managed by the TCP Central Coordinators (Central Coordinators) who are senior clinicians with experience in patient-flow management and aged care employed by Area Health Services within WA Health. Please refer to **Chapter 3** of these guidelines for further information on the Central Coordination process, including the referral of a patient to TCP Residential and requirements for TCP providers.

Referrals to TCP Community are made directly to the TCP Community Provider in both the Perth metropolitan area and in the rural areas where TCP is available.

All referrals and handovers should be of a high standard and include **all** relevant clinical information to ensure that the patient's care is well-maintained following discharge to TCP.

For Transition Care delivered in a residential care setting, the person is required to enter care immediately (within 24 hours) on discharge from hospital. Where Transition Care is to be delivered in a home setting (Community TCP), the person needs to enter Transition Care service within 48 hours from their date of discharge from hospital. In this situation, it remains the discharging hospital's responsibility to ensure safe discharge practices are followed and as such, to be confident that the discharging patient will be adequately supported for the period prior to entry into home-based (Community) TCP.

1.2.1 Existing recipients of residential or community aged care in TCP

If a patient is an existing permanent resident of an aged care facility and would not benefit from an episode of Transition Care to complete their restorative process and optimise their functional capacity, then the first discharge option should be return to the facility from which they came.

If the patient would benefit from an episode of Transition Care, then discharge to TCP should be considered, with the plan to return to their place of residence at the conclusion of TCP. In all cases, the recommendation to the patient and/or their family/carer/guardian should be **not** to give up their existing place at the facility.

Existing recipients of Australian Government funded residential or home care services, including recipients of Home Care Packages (HCP) or the Commonwealth Home Support Programme (CHSP), may be able to access transition care following an episode of hospital care, are able to access transition care if they are assessed as eligible. The Australian Government has created a category of leave to enable this to occur. An existing recipient of residential aged care and/or Home Care Package (HCP) can be on leave for the purposes of Transition Care, as long as they are in receipt of Transition Care.

The Australian Government subsidy continues to be paid to the original aged care provider during periods of leave for TCP.

The Transition Care Service Provider should notify the residential aged care provider or HCP service provider when existing recipients of such services enter Transition Care.

For those clients who are existing residents of a residential facility, and once the client's care needs have been met, the expected discharge pathway is to return to the facility from which they came. For further information, please refer to **Appendix A**.

1.2.2 Palliative Care

Patients who are in the advanced or end-stages of a terminal or life-limiting condition and on a pathway to residential care should not be referred to TCP.

This is due to the fact that TCP cannot:

- Substitute for subacute palliative care;
- Optimise the functional capacity of a person who is rapidly deteriorating due to being in the end-stages of a terminal condition;
- Provide a restorative process to this cohort.

To be considered for TCP, referring hospitals should be able to demonstrate that the patient is likely to be able to maintain or improve their functioning for the duration of TCP.

Due to the frailty and age of the TCP population there will be occasions when the death of a TCP client is unavoidable. Please refer to **Appendix B** for more information.

1.2.3 Older Adult Mental Health (OAMH)

Patients from OAMH units are eligible for TCP if they meet the eligibility criteria for entry to the program. A number of TCP Residential places are provided for OAMH patients. There is a specific Model of Care for this group of patients that details the agreed process for identification, referral to, and care in TCP.

Occasionally, the Hospital Social Worker may wish to consider accessing mainstream TCP for an OAMH patient who is no longer in need of OAMH services. The OAMH TCP Coordinator is to

discuss with the relevant Central Coordinator why mainstream TCP services would be more appropriate before referral will be considered.

Please refer to **Appendix C** for more information.

1.3 Patients who decline TCP

It is expected that all public inpatients on a pathway to permanent residential aged care will be discharged to TCP if they cannot access their preferred permanent option from hospital.

This is because:

- Hospitals are not safe places for people, particularly frail older people, who no longer require acute or subacute admitted care. Rates of infections, falls, medication problems and delirium all increase significantly with increased hospital length of stay;
- TCP is a better environment than hospital for frail older people on a pathway to Australian Government-funded aged care because TCP is designed to meet the specific care needs of this group;
- Hospitals face increasing demand pressures for inpatient services. The aim should be to minimise the amount of time patients spent in hospital when they no longer require acute or subacute admitted care to reduce the risk of negative outcome.

The hospital treating team should:

- Discuss TCP with the patient, their family or caregiver as a realistic discharge option, based on the above reasons;
- Ensure the Social Worker has access to current, accurate and relevant clinical information regarding the patient's care needs in order to complete TCP documentation. The Social Worker will discuss all essential aspects of the TCP pathway with patient and/or carers, including fees supported by provision of the TCP Fact Sheet to the patient/carer.
- Be clear that the level of care provided at TCP is not hospital level care, so that staff may assist patients and families to understand that the same intensity of therapy will not be provided at TCP as it would in subacute rehabilitation. Realistic expectations of the type of care, environment and timelines for TCP should be communicated to the patient and/or carer by all members of the team.
- Provide a realistic understanding of the location of TCP Residential facilities. Acceptance of the first available vacancy which meets the patient's care needs should be sensitively encouraged. As patients must agree to enter TCP, the hospital treating team should be prepared to manage the discharge of those who refuse.
- The hospital treating team should also manage the discharge of those patients who are declined by TCP due to ineligibility.

Chapter 2: Roles and responsibilities

2.1 Australian Government

The Australian Government's roles and responsibilities in relation to the Transition Care Program are to:

- Develop and implement national policies to meet the objectives of the Transition Care Program in partnership with the state and territory governments;
- Administer the Transition Care Program in partnership with the state and territory governments;
- Allocate Transition Care places under the *Aged Care Act 1997* (the Act);
- Provide subsidy under the Act per occupied Transition Care place for care and services;
- Collaborate with state and territory governments in the evaluation of the Program and reporting of Transition Care data;
- Provide strategic direction.

2.2 WA Government

The WA Government, via the Aged Care Programs and Planning Team, WA Department of Health, has the responsibility to:

- In partnership with the Australian Government, develop and implement policies;
- As the Approved Provider under the Act, maintain responsibility for of the overall system-wide management of the Transition Care Program;
- Ensure quality care is provided in accordance with the **Transition Care Program Quality Improvement Framework** (refer to the national TCP Guidelines at https://www.health.gov.au/resources/publications/transition-care-programme-guidelines
- Manage complaints, and where necessary cooperate with the Aged Care Quality and Safety Commissioner to resolve complaints;
- Collaborate with the Australian Government in the national evaluation of the Transition Care Program;
- Ensure that Transition Care data are collected and reported to the Australian Government;
- Provide proportionate funding towards the operation of the Transition Care Program;
- Establish mechanisms to ensure that the Transition Care Program Guidelines and the Australian Government's conditions for managing the Transition Care Program are met, including monitoring the performance and the quality of service delivery of the Transition Care Service Providers;
- As the Approved Provider under the Act, ensure that Transition Care Service Providers comply with the provisions of the Transition Care Payment Agreement and any Transition Care Recipient Agreements.

2.3 TCP Central Coordinators

The Central Coordinators are senior clinical representatives from North Metropolitan Health Services (NMHS), South Metropolitan Health Services (SMHS) and East Metropolitan Health Services (EMHS) who have experience in hospital patient-flow management, aged care and interim care services.

The role of the Central Coordinators is to:

- Manage metropolitan-wide referrals and admissions to TCP facilities;
- Manage, plan and develop Transition Care services pertaining to the referral and admission process with the allocated TCP facilities and hospital sites for their respective metropolitan Health Service Providers;
- Provide support and guidance to TC Site Coordinators in their area
- Represent their Area Health service in liaison with DoH regarding Transition Care issues.

Patients from all public and private hospitals for admission to metropolitan residential TCP facilities are to be referred to the Central Coordinators for inclusion on a centralised waitlist. As the primary managers of TCP vacancy allocation within the health system, Central Coordinators review referrals and determine if patients are suitable for the program and for identified vacancies.

Referrals for patients from an OAMH Unit are made to the OAMH TCP Coordinator.

Please see Chapter 3 for details of the Central Coordination process.

2.4 Hospital TCP Site Coordinators

The Site Coordinators are usually senior Social Workers whose role is to:

- Monitor the management of patients awaiting Transition Care and other aged care services at their site;
- Review patient eligibility for TCP;
- Ensure referral details are complete and accurate;
- Assign the referral to the relevant Central Coordinators within the Transition Care Program and Aged Care Services (TACS) online referral system, or by forwarding to the Central Coordinator by email to: TCPCentralCoordinators@health.wa.gov.au if from a private, country or interstate hospital;
- Oversee and educate regarding site-related TCP issues, and liaise with the relevant Central Coordinator regarding the operation of TCP referrals at site level.

In the unusual situation where there is no dedicated Site TCP Coordinator, referrals may be assigned or forwarded directly by the Hospital Social Worker, but a nominated Senior Social Worker will be the site contact for liaison with the relevant Central Coordinator.

2.5 Hospitals

Hospital staff are required to comply with the processes and policies set down in the:

- National TCP Guidelines https://www.health.gov.au/resources/publications/transition-care-programme-guidelines;
- WA TCP Operational Guidelines; and
- WA Transition Care Program Policy (*due for release in early 2022 and replacing Operational Directive 0290/10*).

Hospital staff are expected to work with their patients to:

- Facilitate a smooth discharge to TCP by ensuring ACAT referrals for TCP approval are timely and appropriate and providing clear information about TCP to patients, managing expectations in a sensitive and transparent manner;
- Minimise inappropriate hospital length of stay to reduce risk of harm to the patient and to the health system;
- Manage health system requirements with respect to hospital bed capacity;
- Provide the relevant clinical handover to ensure that the patient's care is as seamless as possible.

2.6 TCP Providers – Residential & Community

TCP Providers are required to comply with the processes and policies set down in the national TCP Programme Guidelines and the WA TCP Operational Guidelines.

TCP Residential Providers must:

- Ensure that referred client information is reviewed ensure eligibility and support appropriate care planning for the anticipated vacancy;
- Ensure that the WA TCP database portal is kept current to provide up-to-date information on occupancy, planned discharges and client leave entitlements to Central Coordinators on a daily basis;
- Respond to formal referral from Central Coordinators in a timely way with the aim of facilitating same day admission where possible;
- Once the TCP client's goals have been achieved, aim to discharge by midday of the date of discharge;
- Aim to admit new clients on the same working day as discharges to minimise length of time a place remains vacant. Admissions of new clients need to be formally agreed between the TCP Provider, the Central Coordinator and the discharging hospital, and comply with patient safety requirements. Admissions that meet these criteria should occur between 9 am and 5 pm, Monday to Friday, and between 9 am and 12 pm on Saturday, whilst aiming to admit patients as early as possible to facilitate a smooth transfer for the patient, carers and TCP facility staff;
- Regularly liaise with Central Coordinators regarding admissions, discharges and transfers between TCP services, and management of TCP operational issues, including site visits. Once the referral has been accepted, liaise with the relevant hospital TCP Site Coordinator and the treating team to ensure good clinical handover prior to TCP admission;
- If the referral is for a complex case, consider reviewing the patient in hospital before accepting to determine whether the patient can be managed in TCP. This should be in discussion with the Central Coordinator who will advise the TCP Site Coordinator to negotiate a suitable time for the review. The TCP facility representative is to advise the Central Coordinator of the outcome of the review by the next working day if not sooner. No discussion regarding the vacancy or the outcome of the assessment will be undertaken by the TCP representative with the patient, carers or hospital staff;
- Inform Central Coordinators of any Emergency Department presentation or hospital admission of a TCP client within the same day. Information on the client's remaining leave days should be included, as well as being entered on the TCP Database Portal. Where this occurs outside regular business hours, Providers should contact Emergency Department staff directly. TCP Providers must also complete the "TCP Readmission to

Acute Care" form to accompany the client and email to the Central Coordinators. Refer to **Appendix D** for the relevant proforma; and

- All communication regarding referrals and admissions to TCP will be directly to the Central Coordinators. Once the patient is accepted to TCP, direct liaison between the TCP Provider and the referring health site may occur.

All TCP Providers based in the Perth metropolitan area should participate in the:

- Regular TCP Management meetings;
- Regular TCP Model of Care meetings;
- Regular TCP Open Days and education sessions for WA Health staff facilitated by Central Coordinators;
- Regular education and networking sessions for TCP Social Workers ("Social Workers in Transition Care Network").

Chapter 3: TCP Processes

3.1 Central Coordination Process

All public and private hospital patients for admission to the TCP Residential mainstream (non-OAMH) program will be allocated to a central waitlist managed by the Health Service Provider's Central Coordinators. Refer to Appendix H for TCP Central Coordination Process Flowchart.

Referrals for patients from an OAMH Unit are made to the relevant area OAMH TCP Coordinator. For further information regarding OAMH TCP, please refer to the OAMH TCP Model of Care (see **Appendix C**).

All admissions to mainstream residential TCP in the metropolitan area are managed by the Central Coordinators using a centralised waitlist model.

Patients should be waitlisted for all suitable TCP facilities, and be counselled that they will be expected to accept the first allocated TCP vacancy, in accordance with **the Transition Care Program Policy** (due for release early 2022). Where there are exceptional circumstances, the referring Social Worker may present a case for limited waitlisting for consideration by the Central Coordinators. This should first be assessed by the relevant Site Coordinator.

Patients from all metropolitan Health Services may be referred to all metropolitan TCP Residential facilities, including those coordinated by the other Health Services. TCP referrals for patients of private hospitals are also managed by the Central Coordinators. In the first instance, Site Coordinators will liaise with the relevant Central Coordinator regarding any operational TCP issues.

The Central Coordinators will coordinate patient flow for this patient cohort from the following Health Services and into the following TCP facilities:

HOSPITALS

EMHS	NMHS	SMHS
Armadale Health Service (non OAMH)	Joondalup Health Campus	Fiona Stanley Hospital
Bentley Health Service	Osborne Park Hospital	Fremantle Hospital
Royal Perth Hospital	Sir Charles Gairdner Hospital	Peel Health Campus
St John of God Midland	Graylands Hospital	Murray District Hospital
St John of God Mt Lawley (Restorative Unit)	King Edward Memorial Hospital	Rockingham General Hospital
Kalamunda Hospital		

TRANSITION CARE FACILITIES

EMHS	NMHS	SMHS
Amana Living Bullcreek	Aegis Ascot	Aegis Bankia Park
Carinya of Bicton	Brightwater Birralee	Amana Living Mosman Park
Juniper Charles Jenkins	Brightwater Kingsley	

3.1.1 Referral to TCP for public hospital patients

Patients can be waitlisted for TCP when they meet the following criteria:

- Medically stable and ready for discharge;
- Current ACAT approval for Transition Care. Eligible patients will often also be approved for other Commonwealth aged care services, depending on the ACAT's assessment of their needs. A copy of the ACAT Support Plan from the Commonwealth My Aged Care Client Record is to be attached to the referral;
- Patients on the pathway to residential aged care (RAC) must have commenced the process of securing suitable RAC and have reviewed and submitted any requirements related to the aged care service costs (e.g. means tested care fee and accommodation costs). Further information on residential aged care costs can also be found on the Services Australia Government Website:

  https://www.servicesaustralia.gov.au/understanding-aged-care-costs-to-get-aged-care-services?context=60049
- Where the patient is considered by the Central Coordinator to be 'complex' (e.g.limited discharge options), they should also be confirmed as wait-listed for at least one realistic RAC facility. Patients on the restorative pathway (including those who aim to return home) but are also approved for permanent RAC, should also have reviewed and submitted any requirements related to the aged care service costs unless clinically contra-indicated by the referring Social Worker (also see Services Australia website above) ;
- Those patients who require Guardianship and/or Administration orders and who may require TCP post-discharge from hospital should have the State Administration Tribunal (SAT) application completed and lodged as soon as this need is identified. Central Coordinators will liaise with Site Coordinators to assess the impact of any application for Guardianship and/or Administration on the timeline for discharge planning, Decisions regarding when patients undergoing this process may transfer to Transition Care will be at the discretion of the Central Coordinators. This decision will consider both the need to discharge patients as soon as viable from hospital and maintaining a realistic exit plan with the Transition Care timeframe.
- Non-Australian residents and older people from overseas can access the programme if they are ACAT assessed and approved as eligible using the same criteria as other clients. Importantly, people who are not permanent residents of Australia may not be eligible for the PBS and Medicare and would thus be responsible for meeting their own medical and

pharmaceutical expenses while in transition care. There are several countries, however, with which Australia has reciprocal health agreements, and people from these countries may be eligible for Medicare and PBS medicines. Further information is available on the Services Australia website: Reciprocal Health Care Agreements - Services Australia.

- To facilitate acceptance of referred patients, all information regarding clinical care needs should be included at the point of referral. Where specialised or complex care needs are evident, the Central Coordinators will assess and negotiate whether the patient is suitable for Transition Care. Advance planning may also be required to facilitate this where consumables, training or additional resources are required e.g. wound care, equipment and oxygen. Where relevant, behaviour management plans and wound care plans should also be included. Where the referred patient has behavioural challenges, information on the nature of the patient's behaviour should be included. The Central Coordinator will assess whether this is manageable in a TCP environment i.e. not a threat to self, staff or residents.
- All referrals must include a completed 'Covid-19 & Influenza Screening Tool' (Appendix P) to ensure safety for patients and staff.
- The following patients are NOT eligible for Transition Care:
    - Those requiring sub-acute care, including those with a palliative diagnosis and unable to maintain or improve their functioning;
    - Those requiring intra-venous fluids/medications;
    - Those seeking respite care upon discharge from hospital;
    - Those needing an intensive rehabilitation program;
    - Those requiring naso-gastric feeding, Total Parenteral Nutrition (TPN) or tracheostomy care;
    - Those requiring ongoing intervention from the Hospital in the Home service (HITH).

If the patient meets the above TCP eligibility criteria, the Hospital Social Worker should:

- Following consultation with the treating team, discuss TCP with the patient and/or the patient's family, carer or guardian, depending on the patient's decision-making capacity;
- Provide the relevant TCP documentation, encouraging realistic expectations of the type of care delivered, including the TCP Fact Sheet (Refer to **Appendix G**).
- Reiterate that TCP does not provide the same intensity of therapy as they would receive in subacute rehabilitation;
- Provide a realistic understanding of the location of TCP Residential services, and discuss waitlisting for all relevant facilities, **as supported by the Transition Care Program Policy** (due for release early 2022). Where there are barriers to following this policy, Social Workers will discuss with their Site Coordinator in the first instance, who will assess whether the situation is exceptional and may then present to the Central Coordinator for consideration. Acceptance of the first available vacancy should be sensitively encouraged;
- Once agreed, initiate referral to the ACAT for an assessment or via existing inpatient referral service. Referrals to ACAT may be completed on line by visiting the My Aged Care Website: https://www.myagedcare.gov.au/health-professionals;
- If they are a Social Worker at a WA public or public/private hospital with access, register the patient in 'Transition Care Program and Aged Care Services' (TACS), a WA health web application found at: https://transitioncare.hdwa.health.wa.gov.au/Login; Once approved for TCP by ACAT, complete referral to TCP;

    - For referrals to TCP Community services, the Hospital Social Worker should liaise directly with the service coordinator. The following process is applicable to all referrals for residential TCP
- In the Perth metropolitan area:
    - Referrals to TCP Residential from public hospitals are made using the WA Health web application, 'Transition Care Program and Aged Care Services' (TACS)
    - Referrals to TCP Residential from private hospitals are made using the TCP Private Country & Interstate Hospital form (refer to 3.1.2, and **Appendix H**);
    - All referrals to TCP Residential should include the Support Plan from the NSAF
    - Referrals to TCP Residential will be allocated by the Central Coordinators according to the TCP Patient Flow Principles, balancing the needs of the patient and the health system (**Appendix I**)

Hospital Social Workers maintain responsibility for ensuring that the patient and/or carers are fully informed of the Transition Care referral process, services and fees prior to agreement to be waitlisted for Transition Care and are supported during this process. Where the patient/carer expresses concern regarding TCP fees, the social work may assist them to assess eligibility for a reduction in TCP fees and include this with the referral to TCP. This tool indicates the financial concerns of the patient being referred, and will contribute to the assessment by Providers to determine eligibility for fee reductions. See **Appendix J** for the WA Fee Reduction Assessment Tool.

3.1.2 Referral to TCP for private hospital patients

Private hospital patients will be considered for TCP placement if there are no suitable public hospital patients awaiting Transition Care at that time.

To ensure continuity of care, patients from private hospitals must meet the TCP referral criteria and the following is to be provided at the point of initial referral:

- Comprehensive and legible medical discharge summary, including clinical findings where relevant e.g. blood results;
- Comprehensive medication profile;
- Detailed post TCP discharge plan

As with referrals from within the public sector, a TCP bed will be offered where the vacancy occurs and specific site requests cannot be guaranteed. Please refer to **Appendix H.**

3.1.3 Waitlist

Patients are waitlisted according to TCP Patient Flow Principles, with consideration given to length of time on the waitlist, matching the patient's suitability with the vacancy and patient flow demands.

If the patient no longer requires TCP, the Site Coordinator is required to notify the Central Coordinator of the change in status as soon as possible so that they will not be considered for vacancies. The Central Coordinators monitor suitable vacancies in liaison with TCP Providers, and communicate directly with facilities when referring the next suitable patient.

Allocation of all TCP vacanciess remains the responsibility of the Central Coordinators.

3.1.4 Handover

Allied Health reports are to be provided to the allocated TCP facility where there is current active or relevant intervention by a hospital treating team allied health professional. Where information is contained in the National Screening and Assessment Form (NSAF), it is not necessary to duplicate this in the TCP referral form.

The TCP facility can also view details/information on the NSAF found on the client record in the My Aged Care Portal.

A brief Social Work report from the Hospital Social Worker regarding progress with planning residential care or community support services, or other information which was not included in the ACAT Support Plan should be provided at the point of referral. For referrals using TACS, this should be included in the Hospital Social Work report. Where complex psychosocial issues prevail, a verbal or written handover to the TCP facility Social Worker is also requested prior to transfer.

Medical and nursing handovers are to be provided with the patient, including the provision of a nursing handover to the specified contact at the TCP facility at the point of discharge. Where there are complex clinical care requirements, further direct liaison with the treating team may occur prior to transfer, once the discharge to TCP has been confirmed by the Central Coordinator.

Where there is a Guardianship and/or Administration Order application pending at the time of patient transfer, the Hospital Social Worker must notify the Guardianship and Administration Board in writing of the handover and provide a copy of documentation to the facility Social Worker. Where Hospital Social Workers are the Applicant, they maintain responsibility for any Applicant attendance requested at SAT Hearings.

3.2 Entry to TCP facilities

A TCP client can only enter Transition Care directly upon discharge from hospital with a valid ACAT approval for TCP.

TCP clients are expected to contribute to the cost of their care while in TCP. Please refer to **Appendix K** for the WA TCP Fees Policy. Where there are concerns about meeting this financial commitment, the patient/carer can apply for a reduction in fees. No patient should be denied entry to TCP based on their inability to pay and the process for assessment should be simple and unobtrusive. Please refer to **Appendix J** for the WA Fee Reduction Assessment (FRA) Tool.

The TCP Provider must offer and remain ready at all times to enter into a formal agreement with the care recipient or their representative. The Transition Care Recipient Agreement maps out how the care will be provided while the client is in TCP, and the roles and responsibilities of each party. Please refer to **Appendix E** for an example.

If a care recipient does not want to formally acknowledge a Transition Care Recipient Agreement, the TCP Provider is still required to observe its responsibilities to negotiate and deliver the level and type of care each care recipient needs. It is important in these circumstances that the TCP

Provider documents in writing the reasons for not having a signed agreement with the care recipient and the basis on which agreed care is delivered.

3.2.1 Duration of care

The average length of stay is usually about seven (7) weeks, but if required, clients can receive care for up to twelve (12) weeks on the program. For the small number of clients who require more time in TCP, one extension of up to six (6) additional weeks may be possible if approved by an ACAT.

To ensure that the limited resources benefit as many clients as possible, there should not be an assumption that the program is a 'twelve-week program' for every client. Care should be provided based on each client's care needs.

3.2.2 Extensions beyond 18 weeks

WA Department of Health will only state-fund clients who are not able to be discharged within 18 weeks as a last resort.

The circumstances in which a client can be extended past the 126 days are as follows:

- All efforts to identify a discharge option have been exhausted by the TCP Provider.
- The TCP Provider has followed the TCP discharge planning process per **Attachment M**.
- The reasons for the inability to identify a discharge option are outside the TCP Provider's OR the TCP client's control (eg complex financial/legal or citizenship situation).

Approval is required by the Manager, Aged Care Programs and Planning (WA Department of Health) before any place can be state-funded.

Providers are required to:

1. enter new client details within 24 hours of admission
2. continue to update the Portal as required
3. enter discharge information within 24 hours of discharge

3.2.3 Care and discharge planning

As TCP is time-limited, discharge planning should start as soon as the TCP client enters the service. Please refer to **Appendix M** for further information on TCP discharge planning.

Care planning by the TCP Provider is based on:

- Input from the client and/or their family, caregivers or guardian;
- A review of the Support Plan of the NSAF, TCP referral and clinical handover from the discharging hospital;
- Clinical assessment of the client by the relevant members of the TCP multidisciplinary team. The TCP team typically includes Geriatricians; General Practitioners; Registered and Enrolled Nurses; Physiotherapists; Occupational Therapists, Social Workers; Therapy Assistants and Carers, although other clinical staff will be organised as needed.

Additional Geriatrician support is provided to TCP clients. This support is to:

- Provide a specialist medical overview for care recipients;
- Support the General Practitioner and Transition Care staff in care delivery and planning; and
- Facilitate the interface with acute/subacute medical services, general practitioners and other medical specialists for care recipients.

For further detail on what services are provided in TCP, and the Quality Standards that apply to the program, please see the Australian Government's Department of Health TCP Guidelines at:https://www.health.gov.au/resources/publications/transition-care-programme-guidelines
Please note that services will be tailored to meet the individual client needs identified in the Care Plan.

3.2.4 Extra 48 hours to commence TCP episode (for community placements only)

Recipients entering community TCP can take up to 48 hours to commence their TCP episode after discharging from hospital.

3.3 Taking leave from TCP

3.3.1 Seven (7) day leave rule

TCP clients can take up to 7 days leave within a TCP episode for social or medical reasons, including a hospital stay.

If the number of days leave a client has had goes over seven (7) days, a valid ACAT approval will be necessary and the patient must be re-referred to commence a new Transition Care episode.

The seven days is cumulative and includes both social leave and hospital leave, so hospital staff should consult with team Social Workers regarding remaining leave entitlements. Social Workers will confirm with Site and Central Coordinators how much leave the client has already taken. ata on leave days is recorded on the WA TCP Database Portal by TCP facilities and is accessed by the Central Coordinators.

The 7 days can be split up in blocks or taken as individual days within the TCP episodes. If the client has an approved extension, they do not get more leave days.

For more information, refer to **Appendix N** or contact the Central Coordinator.

3.3.2 Acute Readmission to Hospital

In accordance with Australian Government regulations, the patient's TCP bed will be held if it is anticipated that they will return from hospital before they have used their remaining leave days (see '7 day leave rule' above). Where the patient remains in hospital for a period which exceeds their available leave, the patient will be discharged from TCP and given priority to return once they are again ready for discharge. A new ACAT approval, Support Plan/NSAF and TCP Referral is not required if the patient returns to the TCP facility within the above timeframe. A new ACAT approval, Support Plan/NSAF and referral to Transition Care is required if the 28 day TCP

approval has expired. Hospital Social Workers are to advise the Site Coordinator of the patient's progress and discharge plans, with the option to cease the Transition Care episode where the patient will definitely not be returning to TCP within the remaining leave timeframe.

The Transition Care Provider must inform the appropriate Central Coordinator when a patient is admitted to hospital during business hours and to the admitting Emergency Department after hours. A completed copy of the 'Acute Re-admission to Hospital' form is to accompany the patient to hospital and a copy is to be emailed to the Central Coordinators.

Chapter 4: Complaints

4.1 Complaints Process

As with any other service, people have a right to raise a concern or complaint about TCP. There are different options to discuss a concern or complaint depending on the relevant part of the TCP process that is under question.

For more information about the Complaints Process, please refer to **Appendix O**.

Chapter 5: Reporting of Serious Incidents

5.1 Serious Incidents

As with any other service, people have a right to raise a concern or complaint about TCP. There are different options to discuss a concern or complaint depending on the relevant part of the TCP process that is under question.

For more information about the Complaints Process, please refer to **Appendix O**.

This fact sheet clarifies the steps that Transition Care Program (TCP) Service Providers should follow when reporting serious incidents. Providers can now meet their Commonwealth and State requirements by making one report under the new Serious Incident Response Scheme (SIRS).

New Reporting requirements under SIRS

The Commonwealth Department of Health has expanded mandatory reporting requirements.

From 1 April 2021, providers of residential care and flexible care in a residential setting must have an effective incident management system in place and are required to report all 'Priority 1 incidents within 24 hours of becoming aware of the incident.

From 1 October 2021, providers will also be required to report all Priority 2 incidents within 30 days of becoming aware of the incident.

From 1 July 2022, the reporting requirements will be extended to providers of aged care delivered in a community/home setting.

WA Department of Health, as the Approved Provider, is required to report incidents that occur at TCP Service Providers facilities under the Serious Incident Response Scheme (SIRS).

Reportable incidents under the Scheme include:

- Unreasonable use of force – *for example, hitting, pushing, shoving, or rough handling*.
- Unlawful sexual contact or inappropriate sexual conduct – *such as sexual threats or stalking, or sexual activities without consent*.
- Psychological or emotional abuse – *such as yelling, name calling, ignoring a consumer, threatening gestures, or refusing a consumer access to care or services as a means of punishment*.
- Unexpected death – *in the event of a fall, untreated pressure injury, or the actions of a consumer result in the death of another consumer*.
- Stealing or financial coercion by a staff member – *for example, if a staff member coerces a consumer to change their will to their advantage, or steals valuables from the consumer*.
- Neglect – *includes withholding personal care, untreated wounds, or insufficient assistance during meals*.
- Inappropriate physical or chemical restraint – *for example, where physical or chemical restraint is used without prior consent or without notifying the consumer's representative as soon as practicable; where physical restraint is used in a non-emergency situation; or when a provider issues a drug to a consumer to influence their behaviour as a form of chemical restraint*.
- Unexplained absence from care – *this occurs when the consumer is absent from the service, it is unexplained and has been reported to the police.*

Reporting timeframes

'Priority 1' incidents must be reported **within 24 hours** of becoming aware of the incident. This is a reportable incident where the incident has caused, or could reasonably have caused, a care recipient physical or psychological injury or discomfort that requires medical or psychological treatment to resolve, or where there are reasonable grounds to report the incident to police. Instances of unexplained absence from care and any unexpected death of a consumer are always to be regarded as Priority 1 reportable incidents.

'Priority 2' incidents must be reported **within 30 days** of becoming aware of the incident. This includes all other reportable incidents that do not meet the criteria for a 'Priority 1' incident.

Reporting Steps to follow

- Step 1
    - **Take immediate action** when a serious incident occurs to ensure the client receives appropriate management/treatment
- Step 2
    - **Report the incident internally,** following your facility's own policies for incident reporting
- Step 3
    - **Initial Notice of the Incident Form:** Complete the SIRS Incident Report Form on the My Aged Care TCP Provider Portal. A "Decision Support Tool" has been developed to support whether an incident must be reported to the Commission. Reportable SIRS must be reported within 24 hours for a Priority 1 incident or within 30 days for a Priority 2 incident.
- Step 4
    - If you do not have access to the **My Aged Care TCP Provider Portal** you must email a copy of the completed SIRS Incident Report Form to the WA DOH TCP inbox: TCP@health.wa.gov.au within the specified time frames for Priority 1 and 2 incidents. **WA DOH will report the SIRS incident** via the My Aged Care TCP Provider Portal on your service TCP Outlet. NB: To set up access to the My Aged Care TCP Provider Portal to support mandatory SIRS reporting email the request to the WA TCP inbox: TCP@health.wa.gov.au.
- Step 5
    - **Notice of Additional Information (Priority 1 or 2) Form (if required**) If further information becomes available after you report a Priority 1 or 2 incident complete this form or as advised by the Commission within 5 days of the initial notice. Once completed, send this notice and any supporting documents to SIRS@agedcarequality.gov.au
- Step 6
    - **Notice of Significant New Information Form (if required)** If, after you have given initial notice, you become aware of significant new information in relation to any reportable incident complete this form and send this notice and any supporting documents to SIRS@agedcarequality.gov.au.

- Step 7
    - **Final Report on Reportable Incident Form (if required)** Where the Commission requires you to undertake an internal investigation of an incident, a final report must be provided with 84 days of submitting initial notice to the Commission and/or TCP@health.wa.gov.au

If you are providing an initial notice in respect of a Priority 1 or 2 reportable incident, then you are only required to provide the information that is known to you at that time.

A second notice can be provided within five days including any of the information described above that was not known at the time of the initial notice, along with any further information required by the Commission.

If you later become aware of significant new information after making a notification, you must as soon as practicable make a (further) notification.

Guidelines, Resources, Forms

SIRS provider resources can be found on the Aged care Quality and Safety Commission Website with some relevant links are as follows:

- Serious Incident Response Scheme Guidelines
- Full range of SIRS resources
- Notice of Additional Information (Priority 1) Form
- SIRS – Notice of additional information form (Priority 2) | Aged Care Quality and Safety Commission
- Notice of Significant New Information Form
- Final Report on Reportable Incident Form

Appendices

Appendix A: Security of Tenure

Security of Tenure for WA TCP clients who are also existing permanent residents of an aged care facility

What is Security of Tenure?

The Australian Government administers the Aged Care Act 1997 including the performance of aged care service providers via the Department of Health. The Act clearly defines the obligations of aged care providers to their permanent residents in relation to Security of Tenure. These obligations include the requirement that aged care providers ensure that appropriate alternative accommodation is available for an existing permanent resident before that resident can be required to leave the aged care service. All rights and responsibilities for exiting residents are in Division 2 of the User Rights Principles 2014.

Security of Tenure applies even if the resident's ongoing care needs have changed, including requiring a higher or more complex level of care than the provider can routinely administer using its normal care provision model, while a more appropriate alternative is developed or ongoing care at the required level is maintained. **Please note that hospital or TCP are not considered to be appropriate alternative accommodation options for an existing resident who is waiting for another aged care facility.**

Some hospital patients who are existing permanent aged care residents require more time and support in a non-hospital environment to complete their restorative process and/or optimise their functional capacity. Admission to TCP is appropriate for this group of people if all other eligibility criteria are met. On occasion, a TCP client may start their restorative process but because their functioning is unable to be improved they will require the residential pathway. **When this occurs, TCP providers should ensure that:**

- **The client, family and existing aged care provider are made aware of the changed TCP goals, especially that the TCP discharge plan is now for return of the client to the existing aged care facility as soon as possible;**
- **The client's care plan is amended to reflect the aim to return the client to the existing aged care facility as soon as possible;**
- **The client's care needs are communicated clearly to the existing aged care provider to allow for any changed care needs to be met post-TCP discharge;**
- **Negotiations with the existing aged care facility commence to ensure the discharge occurs in a safe and timely way.**

While the Security of Tenure Principle states that the responsibility of an existing aged care provider is to care for the resident until longer-term care arrangements are put in place. **In all cases, the needs of the TCP client are paramount, and no discharge should occur until it is safe for the client to do so.**

Contacts

Please direct any queries from patients, their carers or families to the Older Persons Advocacy Network (contact number below) in the first instance.

For queries regarding Security of Tenure, the User Right's Principles or the Aged Care Act 1997, contact:

> The Commonwealth Government's Older Person's Advocacy Network (OPAN) on: **(Freecall) 1800 700 600**

For concerns regarding an Aged Care Service Facility, please contact:

> The Aged Care Quality and Safety Commission on: **(Freecall) 1800 951 822**

For queries regarding the operationalisation of this protocol, please contact:

> WA Department of Health Aged Care Programs and Planning Team on: **(08) 9222 4074**

Appendix B: TCP and End of Life

Referrals for patients who are on an end-of-life trajectory

This policy is intended to provide direction on the process of TCP referrals for a patient who has been diagnosed with a life-limiting illness or whose death is expected, and the management of TCP clients who develop a terminal condition.

The policy should be read in conjunction with the WA Health End-of-Life Framework.

TCP and palliative care

TCP cannot be used as a substitute for subacute palliative care[1]. The aims of the program include assisting clients to:

- Complete their restorative process;
- Optimise their functional capacity; and
- Finalise and access their longer term care arrangements.[2]

A person who is rapidly deteriorating due to being in the end stages of a terminal condition is not suitable to be referred to TCP. This is because the program aims of completing the restorative process, optimising functional capacity and finalising longer-term care arrangements do not fit someone with these care needs.

A referral to TCP, therefore, should not be accepted if it is reasonable to expect that the person will not survive to progress to their longer-term care arrangements.

It can be very difficult for clinicians to accurately predict a patient's prognosis during the end-of-life phase. The *WA Health End-of-Life Framework* can assist clinicians in this process:

Figure 1: The *End-of-Life Framework*

Stages*			Triggers	Action
1	*Would you be surprised if the patient died in the next 6-12 months?*	**Advancing disease**	* Known advanced cancer or chronic disease * Evidence of disease progression and/or symptoms * Patient/family expresses concern about the future * Would you be surprised if the patient died in the next 6-12 months?	**Consider:** * Advance Care Planning * Palliative Care consultation

[1] Transition Care Programme Guidelines, Commonwealth Department of Social Services, June 2015, p. 6.
[2] Ibid, p. 12

2	*Would you be surprised if the patient died this admission or in the next month?*	**Increasing decline**	**As for Stage 1 plus:** * Increasing frailty * Increasing symptom burden * Increasing psychosocial support needs * Not responding to treatment or non-adherence with treatment * For hospital inpatients, would you be surprised if the patient died this admission?	**Consider:** * Referral to palliative care for ongoing care or * palliative care consultation and/or * shared care partnerships with palliative care
3	*Irreversible clinical deterioration, life expectancy one week or less*	**Last days of life**	* Irreversible clinical deterioration * Team decision of diagnosis of dying.	**Commence:** * Best practice care of the dying, e.g. *Care Plan for the Dying Person*
4		**Death and bereavement**	* Death of patient	**Consider:** * Bereavement follow-up needs

*** The stages are provided as a guide and are not intended to be prescriptive – each patient's circumstances will be different and care should be provided accordingly.**[3]

Using the stages detailed above, referrals to TCP should therefore only be accepted for patients in stage 1.

Existing TCP clients on an end-of-life trajectory

Due to the frailty and age of the TCP population, there will be occasions when the death of a TCP client is unavoidable.

In many cases, it may be more appropriate for the existing TCP client to avoid going to hospital if clinically indicated. The decision of how to manage the TCP client's death should be based on:

- A clinical assessment of the client's needs. Consider referring to the Metropolitan Palliative Care Consultancy Service (MPaCCS) if required and available in your area;
- The client's wishes, including any prior decision-making expressed via Advance Care Planning;
- The wishes of the client's advocate or next-of-kin;
- Agreed goals of care, including avoidance or prevention of unnecessary or long-term hospital admissions or readmissions.

Further guidance can be sought from the *Guidelines for a Palliative Approach in Residential Aged Care*[4].

[3] The End-of-Life Framework, WA Cancer and Palliative Care Network, WA Department of Health, 2016, p.6
[4] National Health and Medical Research Council, Australian Government, 2006

Appendix C: Older Adult Mental Health Model of Care

Transition Care provides short-term support and active management for older people at the interface of the acute/sub-acute and residential aged care sectors. It is goal oriented, time-limited and targets older people at the conclusion of a hospital episode who require more time and support in a non-hospital environment to complete their restorative process, optimise their functional capacity and finalise and access their longer term care arrangements.

The potential for further recovery will vary according to the individual. Therefore, the services provided will vary from individual to individual, ranging from those that further improve physical, cognitive and psycho-social functioning thereby improving the person's capacity for independent living, to those that actively maintain the individual's functioning while assisting them and their family and carers make appropriate long-term care arrangements.

An outcome of Transition Care is that inappropriate extended hospital lengths of stay and premature admission to residential aged care are minimised. However, it should be stressed that Transition Care's primary function is therapeutic, rather than administrative[5].

These Guidelines and the Transition Care Program Policy (due for release early 2022) provide a standardised foundation for all transition options in Western Australia. This foundation remains for elderly mental health patients. It is acknowledged however, that some additional needs require consideration for a mental health model, especially follow-up care and care management should exacerbation of mental health symptoms occur whilst a person is in Transition Care.

Principles and Minimum Standards

The following principles and minimum standards apply in caring for Older Adult Mental Health (OAMH) patients who are eligible for a TCP service:

- The processes and policies take into account the individual needs of the patient and their carer or family;
- The patient and their carer or family are provided with sufficient information in a form that fosters understanding and awareness of expected stages of care. This includes information on the alternate pathways of residential care planning if returning home is no longer an option, or accessing community support services where the plan is to return to their usual place of residence;
- Patients and their carer or family have unencumbered access to appropriate staff, including Social Workers, to assist them through the process of arranging appropriate long-term care;
- The patient and their carer or family understand and are able to assert their right to complain and to have their complaints dealt with promptly and impartially;
- A clearly defined Care Pathway is available for use and reference by hospitals staff at all points in the continuum of care. The Care Pathway is the foundation for information delivery to all stakeholders in the care of the patient

[5] Commonwealth Government Department of Health: Transition Care Program Program Guidelines, 2015. https://www.dss.gov.au/sites/default/files/documents/08_2015/transition-care-programme-guidelines-june-2015.pdf

MODEL OF CARE

OAMH TCP is a joint State and Commonwealth funded program designed to provide time limited accommodation and care for older mental health patients who are inpatients in a psychogeriatric or OAMH unit and who are waiting for some form of Commonwealth Aged Care service, including permanent residential placement or Home Care Package for people returning to their own homes. This does not include inpatients who are approved for Residential Respite only.

Underlying Philosophy

To provide time limited, goal oriented care for OAMH patients who would benefit from time in a non-hospital environment to complete their restorative process and organise their longer-term care arrangements. This will allow acute beds to be available in an OAMH unit for other patients requiring acute or subacute hospital intervention.

Provider of Care

OAMH TCP will be provided in a dedicated secure section of a residential aged care facility, appropriate for the care needs of the client group. This facility is licensed and accredited under Commonwealth Aged Care Standards. The service will be provided by an Approved Provider of Aged Care under the *Aged Care Act 1997.* Where the full capacity of the OAMH TCP service is not met by demand from OAMH inpatients, empty beds will be available for access by appropriate public hospital non-OAMH inpatients awaiting Commonwealth aged care services.

OAMH TCP Care and Services

The OAMH TCP service will provide a mix of staff and services to address the individual needs of the patient. Staff will have appropriate training and skills to manage the care of older mental health patients.

A case management approach to patient care will be undertaken. The patient will receive higher level of care on admission, to support adjustment to the new environment, with care and support reducing over time to the level provided by mainstream residential or community aged care services as required.

The OAMH TCP Provider will liaise directly with the Health Service Provider and TCP OAMH Coordinators regarding referrals, admission and discharges from the service.

A Social Worker will be employed to assist the patient and their family and carers prepare, locate and move to appropriate permanent residential care.

A general practitioner (GP) will manage the patient care. This can be the patient's usual GP or a GP facilitated by the Provider.

The purchase of Psychogeriatrician consultation by the provider is encouraged.

Management of the Program

The OAMH TCP service is a metropolitan wide service which will accommodate inpatients referred from metropolitan Older Adult Mental Health Inpatient Units and are awaiting for Commonwealth aged care services.

Access priority

Access priority to OAMH TCP residential beds is dependent on bed availability and at the discretion of the OAMH TCP Coordinators. The service is metropolitan wide. It is a Commonwealth requirement that TCP can only be accessed on discharge from hospital. All referrals will be directed to the relevant OAMH TCP Coordinator.

Patient profile

The older patient:

- Assessed and approved as eligible for a permanent Residential Care type and Flexible / Transition Care;
- Is deemed psychiatrically stable and medically ready for discharge by the treating team
- Is occupying a psychogeriatric or mental health hospital bed.
- Can enter ***Transition Care*** directly upon discharge from hospital;
- Is suitable for GP management; and
- Agrees (or advocate agrees) to transfer to ***Transition Care***.

Role and Responsibilities

Transferring Health Service Provider

It is the responsibility of the transferring Health Service Provider to ensure that:

- A planning process for discharge to the relevant Commonwealth aged care service has occurred and action has commenced prior to the patients transfer to the OAMH TCP service. This should be coordinated via the Social Worker at the relevant inpatient facility.
- Due the complexity of the OAMH patients, each patient should have at the minimum **one suitable and confirmed waitlist** place at a Residential Aged Care Facility (RACF) prior to being waitlisted for TCP.
- A comprehensive hand-over will be prepared by the treating inpatient multidisciplinary team. This handover will have addressed the specialist needs of the patient, any family issues of concern and any outstanding outpatient and medical appointments.
- Technical nursing skills, experience and competencies that may be needed to care for the person will be included in the hand-over.
- Any behavioural symptoms will have been accurately defined in this assessment and strategies to managing these behaviours including maintaining the safety of others will have been communicated to the OAMH TCP Provider.
- The patient and their family and carer are clearly informed of the time limited or transitional nature of the OAMH TCP service, of fees and charges and of their rights to compliment and complain about the service.
- The most appropriate means of transfer of the patient from the acute unit to the OAMH TCP service will be determined by the assessed needs of the individual patient. Where required, the patient may be accompanied to the OAMH TCP service to ensure a smooth transition from the acute setting.
- Reporting is accurate and maintained weekly.

- Patients on the pathway to Transition Care (and all Commonwealth Aged Care Services) are entered in the Transition and Aged Care Services (TACS) database and referral system and referred to the OAMH TCP Coordinator when the patient is ready for discharge.

Admitting TCP Facility

It is the responsibility of the admitting OAMH TCP Provider to ensure that:

- The patient receives a detailed assessment of needs and a plan of care is documented and actioned, in conjunction with the comprehensive handover from the transferring Health Service Provider.
- The discharge planning process is progressed in a timely and sensitive manner
- The patient and their family and carer are clearly informed of the time limited or transitional nature of the OAMH TCP service, of fees and charges, the level of allied health input, and of their rights to compliment and complain about the service
- If the patient requires acute medical care, they will be transferred to an acute care facility in a timely manner,
- If the patient requires acute care relating to their psychiatric diagnosis and they are assessed by the transferring team as requiring admission, they will be transferred to the original referring inpatient unit.
- The OAMH TCP service GP will liaise with the patient's referring psychiatrist, as necessary, to ensure that optimal patient care is maintained.
- Upon discharge of the patient from the OAMH TCP service, written feedback will be provided to the patient's GP and the referring service and where required, provide any necessary mental health related referral information to ensure appropriate follow up.
- Maintain adequate records of patients and ensure that evaluation criteria are recorded and reported weekly.
- OAMH TCP Coordinators are informed of patients re-admitted to hospital, and the patients' remaining leave entitlements.

Coordinating Referrals

Central coordinator/s for the OAMH TCP are appointed from the relevant Metropolitan Area Mental Health Service Providers. The OAMH TCP Coordinators will:

- liaise with the inpatient units regarding potential referrals
- coordinate, prioritise and allocate appropriate referrals from the inpatient mental health units to the OAMH TCP service using TACS;
- liaise directly with the OAMH TCP service regarding referrals and transfers and provide referral documentation including patient details and other relevant information
- advise the metropolitan inpatient mental health teams of vacancies in the OAMH TCP service; and
- advise the Central TCP Coordinators (for mainstream TCP) of vacancies in the OAMH TCP service.

The OAMH TCP Provider will appoint a coordinator to liaise directly with the hospital (health service) OAMH TCP coordinator regarding referrals, admission, management and reporting requirements.

Follow-up care

The referring inpatient team will provide clinical follow–up care to the OAMH patient as and when required.

Emergency Care

In the case that emergency mental health care is required the OAMH TCP service can contact:

- Weekdays 8.30-4.30 the contact person or the community visiting team to be identified on admission to the unit. The emergency will receive a triage response within 2 hours.
- After hours and weekends/public holidays the Mental Health Emergency Response Line (Formerly Psychiatric Emergency Team) on 1300 555 788.

Ongoing Education

To optimise patient care and minimise the need to use emergency options, ongoing training opportunities should be provided to all OAMH TCP staff including the OAMH TCP GP.

Mental Health Area Services may provide these training options or the TCP Provider may purchase services as required.

Appendix D: Readmission to acute care Transition Care Program

Government of **Western Australia**
Department of **Health**

Transition Care Program (TCP)

Readmission to Acute Care

To be completed by TCP nursing staff prior to hospital readmission and sent with client. Scanned Copy to be forwarded to TCP Facility Manager & TCPCentralCoordinators@health.wa.gov.au prior to client leaving the facility

First Name _____ Surname_____

D.O.B __/__/_____

Is currently receiving care at _____

TCP Pathway – Residential ☐ Restorative ☐

Date admitted to TCP _____/_____/_____

Date TCP approval expires (28 days from date of approval) _____/_____/_____

Days of TCP leave left (0-7) _____

ADMITTING HOSPTIAL

Please liaise with TCP Site Coordinator regarding return to TCP

TCP provides interim restorative or maintenance care in a residential setting. The aim of the program may enable patient to return home or provide interim transition care awaiting permanent residential care

To return to TCP the patient must meet the following criteria

- Medically stable.
- Eligible for GP Management.
- Have ability to improve or maintain current function.

TCP exclusion criteria – Patients requiring sub-acute care such as

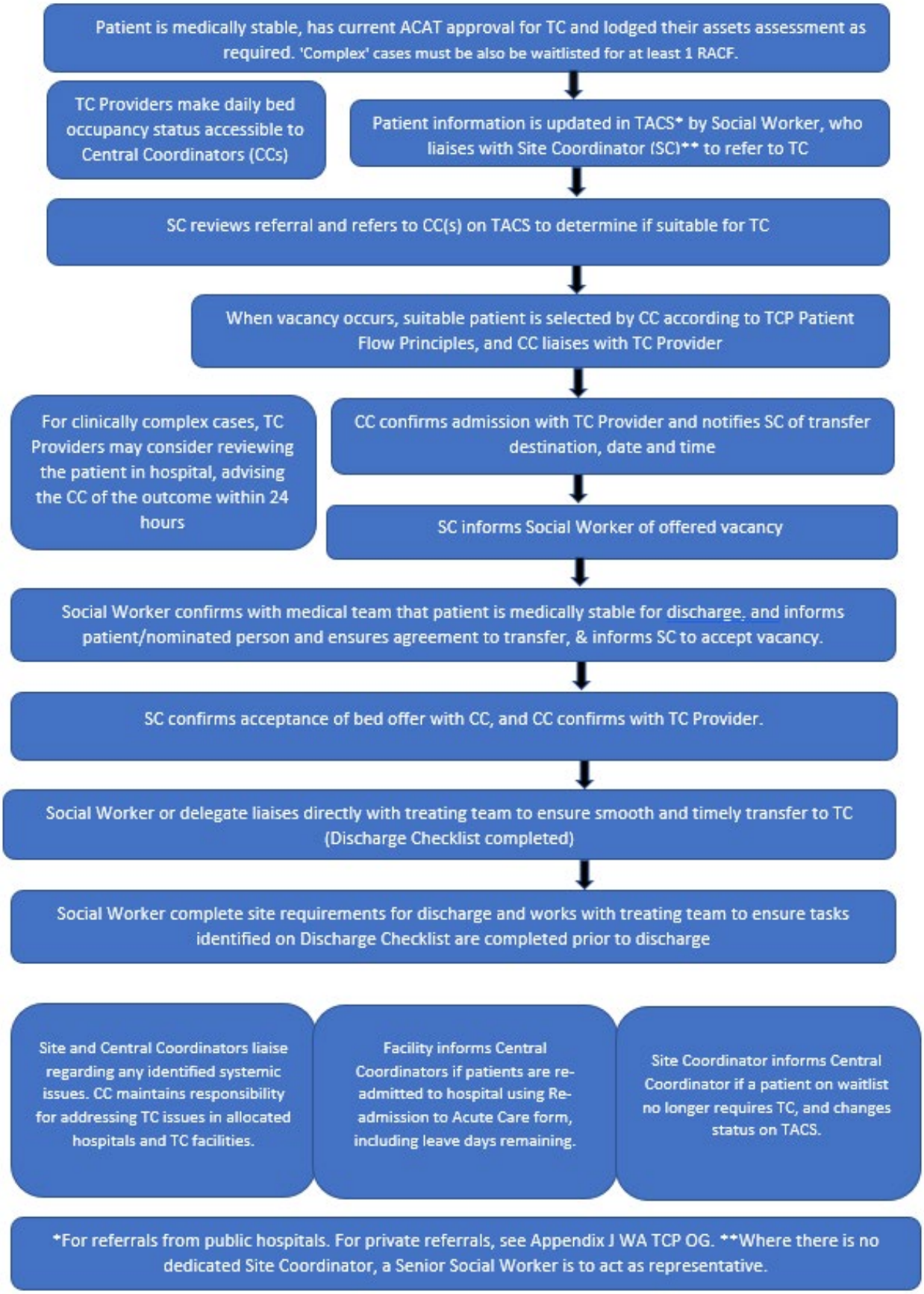
- Requiring IVAB's
- IV or SC Infusions
- Palliative pathway

Patients readmitted to hospital will be given priority waitlisting to return to the TCP facility once they are medically stable & meet TCP admission Criteria. Please contact & liaise with your TCP Site Coordinator for further information.

TRANSITION CARE CENTRAL COORDINATORS January 2022

Appendix E: Transition Care Coordination Process Flowchart

Transition Care Coordination Process Flowchart



Appendix F: Covid-19 & Influenza TCP Screening form

COVID-19 and TCP : Screening and Guidelines

To limit the spread of **COVID-19** in TCP Residential setting

ALL REFERRALS TO TCP MUST BE SCREENED FOR COVID-19& INFLUENZA

- As aged persons with multiple comorbidities, the TCP patient cohort are the most vulnerablecohort for **COVID-19**
- Unprecedented measures have been implemented to reduce the spread of **COVID-19**
- Please refer regularly to **https://ww2.health.wa.gov.au/Articles/A_E/Coronavirus** for latest updates

Patients referred to TCP must be screened for the following

- **Does patient have a temperature of 37.5 degrees or above or symptoms of acute respiratoryinfection?**
- **Has the patient returned from Overseas/ Interstate in the last 14 days?**
- **Has the patient been informed that they are a close contact of a person with confirmed COVID-19?**

If the response is **NO** to all the questions, they may be referred to TCPIf the answer is **YES** to any of the questions.

- **Has the patient been tested for COVID-19 - YES or NO?**

If **NO,** why not? Other medical reason i.e. Chronic cough & does not meet the other criteria – They may bereferred to TCP

If **YES** what was the result? ***Documented proof of test results must be provided***

If **negative (-ve)** to **COVID-19** may be referred to TCP

If **Positive (+ve**) to **COVID-19** must be medically cleared of the disease according to the current WA HealthGuidelines before being considered for TCP.

Family/ visitors must have documented evidence they have had:

1. ***2021 Influenza vaccination or have documented medical contraindication to the influenzavaccine***
2. ***From 31/1/22, a double dose of COVID -19 Pfizer , Astra Zeneca or Moderna vaccinations or havedocumented medical contraindication to the COVID-19 vaccine***

Influenza and TCP: Guidelines

An outbreak of influenza at a residential TCP facility is to be avoided because:

- The TCP patient cohort is vulnerable, and influenza creates a higher risk for other serious illnesses
- Access to TCP facilities ceases and patient flow is impacted when TCP is unable to admit ordischarge their residents because of confirmed Influenza.
- It only takes two (2) cases of positive confirmed Influenza for the WA Department of Health toimplement facility lockdown*

Definition of Influenza-Like-Illness (ILI) for residential care facilities*

- Sudden onset of symptoms
- **AND at least ONE** of the following three respiratory symptoms:
    - Cough (new or worsening)
    - Sore throat
    - Shortness of breath
- **AND at least one** of the following four systemic symptoms
    - Fever or feverishness
    - Malaise
    - Headache
    - Myalgia

Patients displaying the above symptoms should have a laboratory test to confirm or reject Influenza diagnosis. As it is possible, though very unfortunate, for patients to contract a different strain of Influenza from one they have previously had and been treated for, the use of respiratory panels in laboratory testingis useful in identifying the Influenza.

In most cases patient should be clear for transfer to TCP

- 5 days post flu onset **or**
- 3 days if given Tamiflu
- Medically stable

To ensure the TCP residential facilities are protected from spread of Influenza, Transition Care Site Coordinators should liaise with the medical teams to ensure the patient has not been exposed to Influenza.

Government of Western Australia
Department of Health

Transition Care Program (TCP)

COVID -19 & INFLUENZA SCREENING TOOL

PATIENTS NAME	URN
HEALTH SITE	DATE COMPLETED

COVID SCREEN **Does patient have a temperature of 37.5 degrees or above or symptoms of acute respiratory infection?**	**YES □** **NO □**
Has the patient arrived from Overseas/Interstate in the last 14 days?	**YES □ Location? _____** **NO □**
Has the patient been informed that they are a close contact of a person with confirmed COVID-19	**YES □** **NO □**
COVID -19 Vaccinations **Has the patient received a COVID-19 Vaccination?** **YES □**	**PFIZER □** **ASTRA ZENECA □** **1st dose □ Date __/__/___** **2nd dose □ Date __/__/____** **Booster □ Date __/__/____** **If the patient has documentation confirming they have been vaccinated, please provide copy** **Copy attached □ n/a □**
NO □ **DECLINED □**	**If NO . Please advise medical team to discuss COVID Vaccination with patient / Legal Guardian to provide prior to discharge to TCP** **Was the COVID Vaccination declined due to a medical exemption? YES □ NO □**
INFLUENZA Vaccination **Has the patient received the current 2021 Flu vaccine?**	**YES □** **NO □** **DECLINED □**
Visitors MUST have current Influenza Vaccination and, from 31/1/22, Double COVID-19 Vaccinations to be able to enterTCP facility. **Please ensure they are aware.**	**Influenza YES □** **NO □** **Double COVID -19Vax YES □** **NO □**

Appendix G: TCP Fact Sheet

Government of Western Australia
Department of Health

Transition Care Program (TCP)

Your hospital treating team has recommended Transition Care for you upon discharge from hospital. This may be residential or a community TCP program. TCP helps older people at the end of their hospital stay. It gives them more time and care in a non-hospital environment to improve or maintain their level of independence, whilst assisting them and their family to make longer term care arrangements. This may include planning for residential aged care.

Services at the facility include:

- Support from a Social Worker to help plan your discharge, with identification of community or residential care options depending on the goals of Transition Care
- Regular visits from a general practitioner
- Low intensity therapy (such as Physiotherapy or Occupational Therapy) which supports you to maintain or improve your physical, cognitive and psychosocial functioning. Therapy staff will engage you in activities of daily living to work towards your goals.
- Nursing staff and care assistants will provide personal care and domestic support.

What is the cost?

Most of the cost of Transition Care is covered by Government subsidies. Clients of the program are also expected to contribute to the costs of their care. The maximum daily care fee for residential Transition Care is 85% of the basic daily rate of the prevailing single age pension for care delivered in a residential setting.

For community based Transition Care, the maximum daily care fee is 17.5% of the basic daily rate of the prevailing single pension.

Waitlisting & Admission process

An approval by an Aged Care Assessment Team (ACAT) is required before you enter the program, and will be arranged by your hospital team. Your hospital Social Worker will discuss the process and the system with you and organise a referral to the Transition Care central waitlist.

Patients are allocated to suitable vacancies by the TCP Central Coordinators, governed by the following WA Department of Health policy:

- "Patients are to be waitlisted for all facilities suitable to meet their care needs and be counselled that they will be expected to accept the first allocated vacancy, (with) preference given to a facility within their metropolitan region
- Consideration for allocation of a facility outside the patient's normal metropolitan region will be in consultation with all stakeholders"

How long can you stay?

TCP is interim care, with the average duration of Transition Care expected to be 7 weeks, and up to a maximum of 12 weeks.

Transition Care Facilities

TCP facilities are located across the metropolitan area. Residential Transition Care is currently available at:

- Aegis in Bayswater and Calista
- Amana Living in Mosman Park and Bull Creek*
- Brightwater in Kingsley and Innaloo
- Carinya in Bicton
- Juniper in Bentley

Once a vacant bed has been allocated to you, the social worker will provide details of the facility. Due to the privacy needs of residents, and the focus on interim care, Transition Care facilities are unable to accommodate visits by patients or carers prior to admission.

For current visitor restrictions related to COVID-19, please speak with your Social Worker.

** The Bullcreek facility is only for patients requiring a secure environment and for patients from an Older Adult Mental Health service.*

Complaints

If you are unhappy with your experience of Transition Care and wish to lodge a complaint, we encourage you to contact the following:

- The Transition Care service provider/Facility Manager concerned.
- The hospital's own complaints process where there are concerns about the care received as an inpatient or regarding transfer to Transition Care.
- If the matter is not resolved by the above steps, please contact the Health and Disability Services Complaints Office (HaDSCO) to discuss options or request a complaint form on (08) 6551 7600 or 1800 813 583

TCP appreciates any feedback which helps to improve the service.

Assistance

If you have further queries regarding Transition Care during your hospital stay, please contact your team Social Worker.

Your Social Worker is:

Contact details:

This publication is available in alternative formats on request for a person with a disability upon request. *April2021Version*

Appendix H: Private Hospital Referral Process and Form

TRANSITION CARE PROGRAM (TCP)

PRIVATE HOSPITAL REFERRAL PROCESS FOR RESIDENTIAL TCP

Thank you for your interest in referring a patient to TCP. Please note the below guidelines & documentation required to enable the referral to be processed.

Private hospital patients will be considered for TCP if there are no suitable public hospital patients on the waitlist.

What is TCP?

TCP provides time-limited (12 weeks), goal-oriented and therapy-focused services to older people after a hospital stay.

Services include low intensity therapy such as physiotherapy, occupational therapy and social work. Nursing support is also provided. Transition Care is designed to improve older peoples' independence and confidence after a hospital stay. It allows them time to transition to either permanent residential aged care or return home.

TCP is Commonwealth and State funded program.

TCP may be provided in a residential setting referred to as TCP or for those patients whose realistic goal is to return home in a community setting - referred to as TCS.

TCP facilities are staffed with at least 1 RN per shift, EN's and carers. The facility has dedicated allied health staff including a Social Worker, Physiotherapist, Occupational Therapist and Therapy Assistants. Access to a Dietician, Speech Pathologist and Podiatrist is also available. Medical governance is provided by a GP with a Consultant Geriatrician providing specific aged care guidance in a consultative advisory role.

As with all Commonwealth Aged Care Services there is a daily fee for service.

As TCP is a time limited interim care program, patients cannot be transferred from one TC site to another within the 12 week time frame unless there is a clinical need (ie. if the patient starts wandering and is at risk).

ELIGIBLE PATIENTS

- Patients 65 years and over and assessed as eligible for Commonwealth funded aged care services under the Aged Care Act 1997 i.e. Flexible Care (Transition Care) by an Aged Care Assessment Team (ACAT). ACAT approval is valid for 28 days from date of the ACAT delegation.
- Patient must be medically stable and suitable for GP medical care.

- Discharging Hospital has a responsibility to ensure all barriers for discharge to TCP and eventual discharge destination, have been identified and addressed prior to hospital discharge. This may include Guardianship & Administration issues.
- There much be a realistic exit destination from TCP.
- Patients under 65 years of age will only be considered for TCP if assessed as eligible in exceptional circumstances by an ACAT. For more information on younger people entering residential aged care please refer to the Australian Department of Health Website: https: https://www.dss.gov.au/disability-and-carers-programs-services-for-people-with-disability-younger-people-with-disability-in-residential-aged-care-initiative/younger-people-in-residential-aged-care-action-plan

EXCLUSIONS

- Patients with Tracheostomies;
- Patients with NGT – if enteral feed is required patient must have PEG inserted prior to discharge to TCP;
- Patients requiring hospital substitution care - such as intravenous antibiotics (IVAB), intravenous cannulation (IV) or subcutaneous (SC) infusions and complex wound care which would require frequent dressings;
- Patients with vacuum-assisted closure (VAC) dressings may be considered on an individual basis;
- Patients with life limiting illness or requiring subacute palliative care who do not have the ability to improve or maintain current function within TCP timeframe (12 weeks).

REFERRAL PROCESS **Patient must be medically stable**

- The **TCP Fact sheet** should be provided to the patient & family when discussing TCP with them. It provides an over view of what TCP is, length of stay & applicable fees
- Patients requiring SAT must have their SAT application lodged prior to referral to TCP and date of lodgement documented on the TCP referral. Due to long wait times for SAT hearings the patient will be considered for TCP 3 weeks after date of lodgement
- **TCP referral form** – to be completed electronically by the referring Social Worker and emailed back to TCPCentralCoordinator@health.wa.gov.au (attachments on one email please)
- All fields need to be addressed
- NSAF approval date is the date when approval was delegated – this will be on the Support Plan completed by ACAT.
- *Patient and family should be counselled to waitlist for a number of TC facilities. The WA TCP Guidelines do not support the concept of choice or preference for TC placement as it is an interim programme with average length of stay approximately 7 weeks. The majority of TC facilities are within reasonable driving distance from most Perth suburbs.*
- **TCP Medical Discharge summary** completed by the medical team
- **TCP Allied Health Report** completed by allied health members who have been involved with the patients care

- **My Aged Care Support Plan** with valid Transition Care approval to be provided with referral
- Note for transition care delivered in a residential care setting, the person is required to enter care immediately (within 24 hours) on discharge from hospital. Where transition care is to be delivered in a home setting (Community TCP), the person needs to enter transition care service within 48 hours from their date of discharge from hospital. In this situation, it remains the discharging hospital's responsibility to ensure safe discharge practices are followed and as such, to be confident that the discharging patient will be adequately supported for the period prior to entry into home-based (Community) TCP.

DISCHARGE PROCESS

- When a residential TCP bed is available, the Central Coordinator will contact you with the facility location, date/ time of transfer, and a discharge checklist for team to complete.
- While awaiting TCP the family should continue to actively waitlist for permanent residential aged care placement
- Please notify Central Coordination as soon as possible if circumstances change i.e. Patient becomes unwell or finds permanent placement.

REFERRAL DOCUMENTS

- TCP Private Hospital Referral Form

TCP Private Hospital Referral Form May 2(

- TCP Medical Discharge Summary

TCP Medical Discharge Summary M

- TCP Allied Health Report

TCP Allied Health Report 2018.docx

- TCP Facilities Overview (see Appendix Q)

TCP Facilities Overview July 2021.p

Appendix I: TCP Patient Flow Principles

Principle One: Patient flow to TCP should be governed by the chronological order of referrals to minimise the time patients spend inappropriately in hospital, where this is possible taking into account the type of TCP vacancy available, the care requirements of the patient and the below criteria.

Principle Two: The care needs of patients discharging to TCP should be prioritised to the greatest extent possible consistent with good patient flow, including minimising the risk of harm associated with extended hospital LOS.

Principle Three: Patient flow to TCP is supported to maximise:

- Availability of inpatient beds and resources;
- Value for money in the allocation and use of public health resources;
- Flexibility in managing inpatient demand across Health Services Providers (HSP).

Principle Four: Health Service Central TCP Coordinators are recognised as the primary managers of residential TCP vacancy allocation within the metropolitan health system.

Principle Five: Hospital treating teams will ensure that their patients who are approved for TCP:

Are waitlisted for the highest possible number of TCP facilities; and

Accept the first available TCP vacancy offered to them. Rarely, there can be extenuating circumstances that mean a patient is unable to waitlist for more than one TCP facility and limit a patient's ability to accept an offered vacancy.

Appendix J: Fee Reduction Assessment Tool for Transition Care

The Fee Reduction Assessment (FRA) Tool

TC Fees Reduction Assessment Tool 201

The Fee Reduction Assessment (FRA)Tool was developed in response to:

- reports of patients and/or carer concerns regarding their abilities to pay TC fees;
- a need to provide consistency in fee reduction assessment.

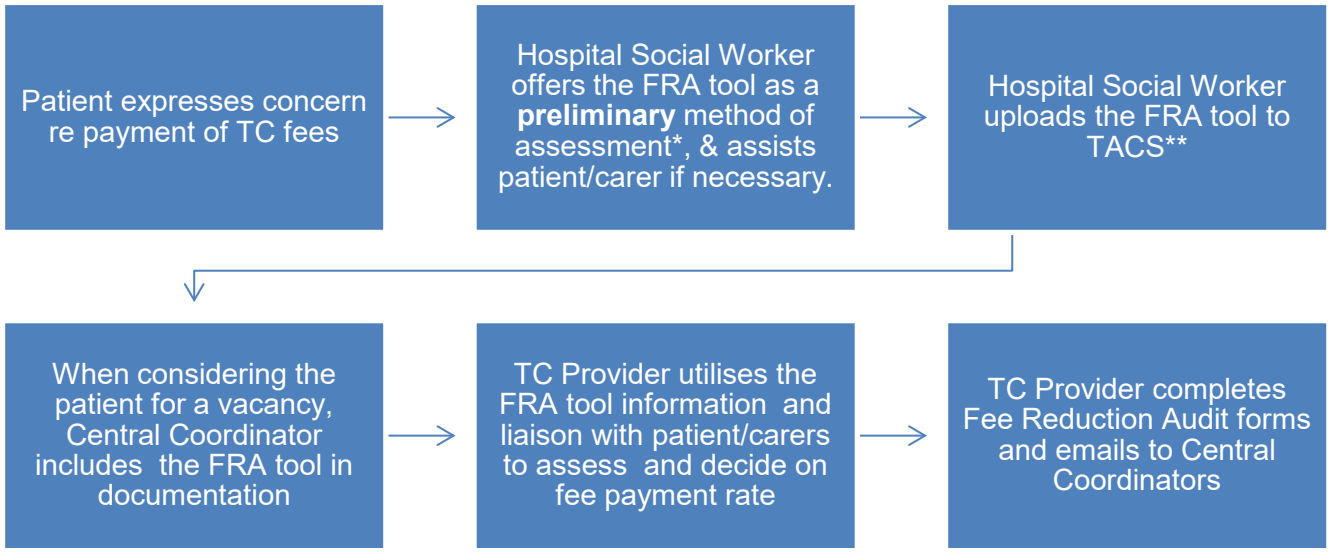
An additional benefit would be that the process will also reinforce clear, early and identifiable discussion regarding fees at TC.

The FRA Tool will be trialled for 6 months across the metropolitan area. The spreadsheet includes a formula for calculating the balance of income and expenditure, which can be accessed if data entry is via Excel.

Process

The FRA tool is not to be included in standardised information packs provided to patients and families regarding TC.

Instead, please follow the following process:



Please refer to your Site Coordinator for the Fee Reduction Assessment tool.

Appendix K: WA TCP Fee Policy

The WA TCP Fees Policy has been introduced to foster consistency and fairness for clients paying fees in TCP facilities.

Under the WA TCP Fees Policy:

- All TCP clients are asked to contribute to the daily cost of the service they receive.
- Clients who are able to contribute do so in accordance with their provider's fee statement.

The WA TCP Fees Policy was established in line with the Commonwealth Department of Health *TCP Guidelines*, and aims to promote equity between clients in receipt of similar services.

To provide a consistent framework for the collection of fees, all TCP Service Providers are required to have a:

1. Written Fees policy
2. Consistently applied Statement of Fees
3. Process to manage:
    a. Clients who are unable to pay
    b. Clients who refuse to pay

The following will expand on each of these policy principles and provide a broad guideline for their application. All TCP Service Providers are required to adhere to this Policy.

WA TCP FEE PRINCIPLES

These principles underpin the WA TCP Fees Policy and are consistent with those applied to other government fee charging services.

Principle:

1. All clients assessed as having a capacity to pay are to be charged fees. The fee charged should be determined in accordance with the client's capacity to pay.
2. The period during which fees can be charged should not exceed the period during which the client is admitted to the program.
3. Fees charged should not exceed the actual cost of service provision.
4. The fee charged for a service should be all-inclusive and cover all material used in the delivery of the service.
5. Fee collection should be administered efficiently and the cost of administration should be less than the income received from fees.
6. Revenue from fees should be used to enhance and/or expand TCP services.
7. For the purposes of this Policy, solicited donations for services are equivalent to fees and are subject to all provisions of this Policy.
8. Inability to pay cannot be used as a basis for refusing a service to a person assessed as requiring a service.
9. Procedures for the determination of fees should be clearly documented and publicly available.

10. Procedures for the determination and collection of fees should take into account the situation of individuals from special needs groups; for example, Aboriginal and Torres Strait Islander people, clients from culturally and linguistically diverse populations, people with conditions requiring specialised support (eg Dementia).
11. Assessment of a person's capacity to pay fees should be as simple and unobtrusive as possible, with any information obtained treated confidentially.
12. Clients and their advocates have the right of appeal against a given fee determination.
13. If a TCP client's place is put on hold pending that client's return, the client fee should continue to be charged during that period.

TCP SERVICE PROVIDER – WRITTEN FEES POLICY

TCP Service Providers should have a written fees policy including the fee to be charged for the services provided under the relevant program and the payment procedures. Each TCP Service Provider needs to make available and explain its written fee policy to all new and existing clients.

TCP clients should be informed of the fees applicable to them prior to or at the time of admission to the service. It may also be necessary, particularly in relation to their financial situation, to review fees charged a client due to a change in circumstances.

An Example - Service Provider Fee Policy is included at Appendix C.1 of this document. Service Providers can adopt the model policy as their own or adapt it to suit their individual circumstances. However, the Service Providers policy should include the following elements:

- Service Provider Fee Statement
- How fee income is used
- How fees will be collected
- Options for clients experiencing difficulty in paying
- Protocols if a client refuses to pay
- Appeals process for clients

STATEMENT OF FEES

All TCP Service Providers are required to develop a Statement of Fees. This Fee Statement should be provided to the client and should be kept as simple as possible to allow clients to easily understand the Statement.

The maximum fee charged a TCP client is set by the Commonwealth Department of Health and is intended to provide some consistency for people moving from acute hospital to TCP and then to another form of Commonwealth funded aged care service.

4.1 Administering Fees

TCP Service Providers should administer fees in a manner that best suits their service delivery. TCP Service Providers may choose to invoice clients on a weekly/fortnightly/monthly basis.

4.2 Method of Fee Collection

TCP Service Providers should take in to account the special needs of key groups in devising collection mechanisms. Service Providers should identify protocols accordingly, for example, for those people with cognitive impairments or for those without family members or carers to assist with financial management.

HARDSHIP PROVISIONS

The aim of the Hardship Provisions is to ensure that clients are not disadvantaged because of additional costs associated with their ongoing care or with any sudden changes in their circumstances. People should not be declined a TCP service if unable to pay the client fee.

As part of the intake process, TCP Service Providers need to assess if the client requires consideration for a fee reduction. The Service Provider will need to consider the following factors when making a decision regarding reducing fees:

- Does the client incur any significant additional costs that affect the client's capacity to pay the set fee for the service they receive?
- What fee, if any, is the client able to pay?
- Can payment of the client fee be deferred until such time as the client has capacity to pay?

There are a number of factors that could impact on the client's ability to pay. The transition period into permanent residential aged care commonly involves significant assessment and reconfiguration of an older person's financial situation, which may not be complete at the time of entry to TCP. A TCP client returning to the community may also continue to be responsible for ongoing accommodation payments (e.g. rent).

APPEALS

Clients are entitled to appeal the level of fees they are paying if they believe they face financial hardship. Clients may appeal themselves, or request an advocate to represent them.

The TCP Service Providers written Fees Policy must describe the appeals process that applies to fee arrangements. The policy should be:

- freely available;
- clearly explained to consumers of the service at the time of initial assessment and also during follow-up reviews or re-assessments;
- include information about consumers' right to complain; and,
- provide information explaining the services offered by Advocare and the assistance they can provide to a consumer when they wish to make a complaint.

At the outset of the complaint management process, the TCP Service Provider should explain that Advocare is able to support the consumer to advocate to resolve the complaint with the agency and that the TCP Service Provider can refer and assist the consumer to access these services.

Advocare

4/61 Kitchener Avenue
Victoria Park WA 6100
Telephone: (08) 9479 7566
Freecall: 1800 655 566
Email: rights@advocare.org.au
Website: www.advocare.org.au

APPENDIX K.1 - EXAMPLE SERVICE PROVIDER FEE POLICY

[Insert Agency Name] Fees Policy

Services delivered by Agencies funded through TCP must adhere to the WA TCP Fees Policy.

This policy seeks a contribution from clients toward the cost of the TCP service they receive, at a level that is fair and affordable, but sufficiently flexible to adapt to individual circumstances.

In all cases:

- No client will be refused a service because of an inability to pay a fee.
- Mechanisms limit the total fee a client can pay, and allow an assessed fee to be reduced in individual circumstances.

Payment of Fees

All clients are informed of the fee associated with any service at the time of income assessment, and a copy of the [*Insert Agency*] Fee Statement is provided to them. Clients will be given reasonable notice of any changes to the Agency Fee Statement.

In charging fees, [*Insert Agency*] applies the following principles, consistent with the WA TCP Fees Policy:

- Payment of a fee that contributes to the cost of a TCP service is only sought from clients who have a capacity to pay.
- A client who does not have a capacity to pay will have their fee reduced in accordance with the WA TCP Fees Policy.
- The fee for a service is all-inclusive and covers all materials used in the delivery of the service, unless otherwise stated.

Fee Statement

The [*Insert Name of the Agency's Governing Body]* has determined the fees for services it provides. Please see attached for the current Fee Statement. The Fee Statement is consistent with the requirements of the WA TCP Fees Policy.

Collection of Fees

The client is advised of their fee in writing. The written notification includes:

- The total fee payable, including any fee reduction or the application of a fee limit.

Refusal to Pay

If a client is identified as being in arrears, without prior arrangement, the Coordinator will contact and/or visit the client to explore the reasons for non-payment. The client will be advised of their right to have an advocate present during the visit.

Depending on the circumstances a number of fee payment options may be considered including the client paying the outstanding amount in instalments or reducing the outstanding amount. The ongoing fee should also be reviewed to consider whether there is a case for fee reduction in accordance with the WA TCP Fees Policy. The client will be informed of the outcome of this process in writing.

Further visits may be considered and all reasonable attempts to negotiate with the client should be made to arrive at a mutually agreed fee. The client should be made aware of their right to appeal and use the services of an advocate. If the client still fails to pay the agreed outstanding amount, a written reminder will be issued, requesting payment within 14 days.

Once all avenues have been explored, the [*Insert Name of the Agency's Governing Body*] will decide how to manage the debt. The client will be informed in writing of the Agency's decision and will have their right of appeal explained to them.

Appeals

Clients or their advocates have the right of appeal if they are unhappy with any aspect of income assessment or fee setting. All clients shall be advised of this right and the process of appeal at the time of assessment and subsequent reviews.

The process for appeal endorsed by the *[Insert Name of the Agency's Governing Body]* is:

- ☐ The client contacts the Coordinator about their concerns.
- ☐ The Coordinator acknowledges the approach in writing within 7 working days and arranges to meet with the client to discuss the situation.
- ☐ The Coordinator verifies that
  - ♦ The client is appropriately supported or represented by a carer, guardian or advocate.
  - ♦ The correct fee has been set for the client's current circumstances.
  - ♦ Fee reduction avenues have been explored.
  - ♦ The client correctly understands the fee outcome.

A client who appeals the level of fees charged will receive a written statement of the outcome of their appeal within 7 working days of a decision being made and advised about any further steps they may take.

Contact details of independent advocacy services (Appendix B), which may be available to negotiate the payment of fees on the client's behalf, will also be provided.

If this process does not resolve the issue the [*Insert name of the Agency's Governing Body*] and/or the client may refer the matter to an Independent Appeals Tribunal for resolution.

No client will be disadvantaged or penalised as a result of lodging an appeal. If appropriate, the Coordinator will negotiate with the client to reduce the disputed fee while the appeal is being considered.

APPENDIX K.2 - USEFUL CONTACTS:

Advocare

4/61 Kitchener Avenue
Victoria Park WA 6100

Telephone: (08) 9479 7566

Freecall: 1800 655 566

Email: rights@advocare.org.au

Website: www.advocare.org.au

The Health and Disability Services Complaints Office (HaDSCO)
GPO Box B61
PERTH WA 6838

Telephone: (08) 6551 7600

Country Free Call: 1800 813 583
TTY: (08) 6551 7640

Email: mail@hadsco.wa.gov.au

Website: https://www.hadsco.wa.gov.au

Health Consumers Council WA (Inc)

Unit 6 Wellington Fair
40 Lord Street

EAST PERTH WA 6004

GPO Box C134
PERTH WA 6839

Telephone: (08) 9221 3422
Country Freecall: 1800 620 780
Email: info@hconc.org.au

Website: http://www.hconc.org.au

Aged Care Quality and Safety Commissioner

GPO Box 9818

Perth WA 6848

Freecall: 1800 951 822

Email: info@agedcarequality.gov.au

Website:

https://www.agedcarequality.gov.au/making-complaint

Ombudsman Western Australia

Level 2, Albert Facey House
469 Wellington Street
PERTH WA 6000

PO Box Z5386

Perth WA 6831

Telephone: (08) 9220 7555

Freecall: 1800 117 000

Email: mail@ombudsman.wa.gov.au

Website:
http://www.ombudsman.wa.gov.au

Appendix L: Generic TCP Recipient Agreement

[Insert company logo]

[Insert company name]

RECIPIENT AGREEMENT

FOR

TRANSITION CARE PROGRAM

[Insert company name, corporate office address and telephone number, and ABN]

TRANSITION CARE PROGRAM AGREEMENT

INDEX TO AGREEMENT

[Insert company name]

TRANSITION CARE PROGRAM AGREEMENT

THIS AGREEMENT is made on this: Insert day of Month Year

BETWEEN

The person named in the Schedule as the Recipient ("the Recipient")

AND

[Insert company name, corporate office address and telephone number, and ABN]

The company named in the Schedule as The Provider of Care Services to the Recipient ("the Provider")

1. DEFINITIONS

"Act"	means the Aged Care Act 1997, and where the context permits, also means the Aged Care Act 1997 Principles.
"Aged Care Assessment Team" or "ACAT"	means a multi-disciplinary team of health professionals responsible for determining eligibility for entry to an Approved Facility.
"Approved Care Recipient"	means a person assessed by an Aged Care Assessment Team as in need of temporary Transition Care Program in an Approved Facility.
"Approved Provider"	means a provider who has been approved to provide Care Services under the Act.
"Approved Facility"	means a Facility approved under the Act with an approved Aged Care licence.
“Care Plan”	means a document detailing those services to be provided in order to meet the Care Recipient’s daily care needs and maintain or improve her or his physical, cognitive and psycho-social

functioning. The Care Plan also documents the Care Recipient's longer-term goals of care.

"Care Recipient" means a person participating in the Transition Care Program.

"Care Services" means the range of personal and nursing care services provided to all Care Recipients in an Approved Facility.

"Recipient" means the Care Recipient who is named in Item 2 of the Schedule as the Recipient.

"Recipient Contribution" means the fee charged the Care Recipient for services provided. The maximum fee that can be charged is 85% of the basic daily rate of a single aged pension for residential transition care or 17.5% of the basic daily rate of single aged pension for community transition care.

"Recipient Representative" means the Recipient Representative (if any) named in Item 5 of the Schedule.

"Daily Fee" means the Recipient Contribution payable by the Recipient to the Provider pursuant to Clause 8 of the Agreement.

"Facility" means the Facility described in the Schedule.

"Parties" means the Recipient or Recipient Representative and the Provider.

"Place" means a bed in a residential transition care facility or a community transition care package of services for Care Recipients in their own homes.

"Principles" means those Principles described in the Aged Care Act 1997 Principles, being the Principles to which the Provider must adhere when providing the Care Services to the Recipient, and the Principles that are set out in the document headed "User Rights Principles 1997" contained within the Disclosure Information Pack.

"Provider" means the Provider of Care Services under this Agreement named in Item 1 of the Schedule as the Provider.

"Schedule" means the Schedule to this agreement.

“Setting” means the environment in which TCP is delivered. TCP can be delivered in either a residential aged care facility or in the client’s own home (community setting).

2. AGREEMENT

2.1 The Provider agrees to provide transition care to the Recipient and to provide to the Recipient a right to occupy a Place on the terms and conditions contained in this Agreement.

2.2 The Recipient agrees to enter the program as a Care Recipient in either a residential setting in a single or shared room or in a community setting and pay the Provider the relevant Daily Fee in exchange for Care Services on the terms and conditions contained in this Agreement.

2.3 The Recipient agrees to have the Provider nominate a treating general practitioner if the Recipient’s general practitioner is unable to provide ongoing care.

3. WARRANTIES

3.1 The Provider warrants that it is an Approved Provider under the Act in respect of Residential Care Services to provide approved Recipients with temporary transition care services.

3.2 The Provider warrants that the Facility in respect of which the Recipient is to become a Care Recipient meets the building requirements for certification and meets the requirements for accreditation by the Aged Care Standards Accreditation Agency or an equivalent agency for purposes of the Act, and is thus an Approved Facility.

3.3 The Provider warrants that it shall at all times comply with the Act and the terms of the Transition Care Program Agreement entered into with the Western Australian Department of Health.

4. CARE SERVICES OFFERED BY PROVIDER TO RECIPIENT

4.1 The Recipient acknowledges that he or she may only enter the Facility after being approved by an Aged Care Assessment Team for transition care on a temporary basis.

4.2 The Provider will provide a Care Plan outlining the transition care that the Care Recipient has been assessed as requiring and how the care will be provided.

4.3 The Provider agrees that it shall promote the rights of the Recipient as promulgated by the Principles. In particular, the Provider agrees to adhere to the Charter of Residents Rights and Responsibilities which is annexed to this Agreement as Annexure C.

5. DISCLOSURE OF INFORMATION

5.1 The Recipient by his or her signing of this Agreement acknowledges that he or she has received information on the Transition Care Program supplied by the Provider prior to entry into this Agreement. The Recipient also acknowledges that he or she has made the decision to enter the Facility on the basis of the information provided by the Provider and the referring agency.

5.2 The Recipient or Recipient Representative acknowledges that at the time of signing this Agreement he or she has understood its contents and that his or her decision to enter into the Agreement was based upon that understanding.

6. RECIPIENT REPRESENTATIVE

6.1 Where this Agreement is entered into by a Recipient Representative, he or she warrants that he or she is legally appointed as the Recipient's guardian or guardian and administrator and has the power to make decisions in relation to the Recipient's residential care.

6.2 Where a Recipient Representative is nominated, he or she agrees to share information provided directly to him or her about the Recipient's care in the Transition Care Program with the Recipient where appropriate.

7. ENTRY, EXIT AND ROOM CHANGE POLICY

7.1 The Residential TCP Recipient (including the Recipient's Representative/s when required) agrees that he or she may be moved to another residential place or room/suite in the Facility if;

- The move is requested by the Recipient and a vacant room is available; or
- The move is necessary on genuine medical grounds; or

- The move is necessary to carry out repairs or improvements; or
- The move is necessary to enable the effective operation of the Transition Care Program.

7.2 In the event that a Recipient is to be moved to another residential place or room, the Provider agrees to notify the Recipient of the proposed move within 24 hours of when it is scheduled to occur.

7.3 The Recipient and the Provider agree that the Recipient's right to occupy a TCP place (either residential or community) will commence on the date shown in Item 4 of the Schedule.

7.4 The Provider will work with the Recipient or the Recipient Representative to develop a planned exit strategy for the Recipient prior to the completion of the Transition Care Program.

The planned exit strategy is to include an expected date of discharge to align with achievement of the Recipient's goals of care.

7.5 The TCP Recipient's goals of care include:

7.5.1 For those on a pathway to permanent residential aged care, the acceptance of the first available vacancy that arises from the Recipient's list of preferred facilities;

7.5.2 For those on a restorative pathway, the completion of those objectives agreed on entry between the Recipient and the Provider that aim to improve the Recipient's functioning in order to return home. In some cases, the Recipient's functioning may not, in the opinion of the TCP clinical team, improve enough to safely return home. In these cases, alternative pathways, including permanent residential aged care, must be explored.

7.6 In cases when the Recipient's goals of care are not met the Provider reserves the right to discharge the Recipient to the first available alternative service that can safely meet the Recipient's care needs.

7.7 In case when the Recipient has to be readmitted to the hospital for more than 24 hours, the Recipient will be automatically discharged from TCP. A new ACAT

assessment and approval for Transition Care will be required before the Recipient can be re-referred to the TCP.

8. CHANGES TO THIS AGREEMENT

8.1 The Parties agree that this Agreement sets out the terms and conditions agreed between the Parties covering:

(a) the requirement of the Recipient to pay the Recipient Contribution to the Provider;

(b) the rights and responsibilities of the Recipient and the Provider one to the other.

8.2 The Parties agree that the terms and conditions of this Agreement may be changed in writing with the mutual consent of both parties.

9. PAYMENT OF FEES

9.1 The Recipient shall pay to the Provider the Daily Fee set down in the Fee Schedule marked as Annexure A on a weekly in advance basis, except for the initial payment.

10. TERMINATION OF THIS AGREEMENT

10.1 This Agreement will be terminated upon the Recipient's discharge from the Facility.

10.2 The Provider agrees to consult the Recipient or Recipient Representative, however the Provider reserves the right to terminate the Agreement regardless of the Recipient or Recipient Representative's wishes.

10.3 Examples of circumstances which may lead to termination of the Agreement are as follows:

(a) Where care can no longer be provided because the Provider no longer has a contract with the WA Department of Health to provide a Transition Care Program service;

(b) Where the available care no longer meets the needs of the Care Recipient;

(c) Where the Provider believes the Recipient has committed a criminal offence, including, but not limited to, damaging property and assaulting Facility staff or Recipients.

11. RE-ENTRY INTO TRANSITION CARE PROGRAM

11.1 Where the Recipient has left the Transition Care Program to be admitted to a hospital and then is discharged from the hospital within twenty eight (28) days of their approval date to enter the Transition Care Program, where appropriate the Recipient is able to re-enter the Transition Care Program.

11.2 Where the Recipient is admitted to hospital from the Facility and is not discharged from the hospital within twenty eight (28) days of his or her approval date to enter the Transition Care Program, the Recipient will require a new ACAT assessment and approval before re-entering the Transition Care Program.

12. OBLIGATION TO REPAY UPON TERMINATION

12.1 The Provider agrees to repay any portion of moneys owing to the Recipient under this Agreement upon the termination of the Agreement.

13. DISPUTE RESOLUTION

13.1 Where the Recipient or Provider informs the other party, either verbally or in writing, of a complaint, the parties shall meet within 48 hours of receipt of the complaint with a view to resolving the complaint. Before resorting to external dispute resolution mechanisms, the parties shall, in good faith, exercise their best efforts to settle by negotiation any dispute in relation to this agreement.

13.2 In the event that the Parties are unable to resolve a dispute, the Parties agree that the complaint shall be referred to the Health and Disability Services Complaints Office (HADSCO) and/or the Aged Care Complaints Commissioner for resolution by arbitration.

14. PERSONAL INFORMATION

14.1 The Provider agrees to keep confidential all personal information relating to the Recipient and in particular shall comply with the provisions of the Aged Care Act,

section 62.1, and the provisions of the Privacy Amendment (Private Sector) Act 2000.

14.2 Information pertaining to the Recipient that is acquired by the Provider in the course of the provision of transition care may be disclosed to ACAT staff, appropriate medical and nursing staff, appropriate service providers, relevant Australian Government and State Government agencies and entities for data analysis and service monitoring.

15. INCONSISTENCY AND SEVERANCE

15.1 Inconsistency

In the event that any clause in this Agreement is inconsistent with the Act then the provisions of the Act shall prevail.

15.2 Severance

To the extent that any one or more of the provisions in this Agreement is prohibited by any applicable law, those provisions are deemed to be ineffective without invalidating or modifying the remaining provisions of this Agreement which continue in full force and effect as if the provision or provisions so prohibited had not been included in this Agreement as from the date of execution of this Agreement.

16. ENTIRE AGREEMENT

The terms and conditions contained in this Agreement comprise the entire agreement between the parties and no other representation is to apply to the agreement between the parties.

17. NO MERGER UPON EXECUTION

Any term of this Agreement that has been performed or satisfied in full as at execution of this Agreement will continue to be a term of this Agreement and will not merge on execution.

18. WAIVERS

Any waiver given, or to be given, under this Agreement must be in writing signed by the party giving the waiver.

19. GOVERNING LAW AND JURISDICTION

This Agreement is to be governed by, and construed in accordance with, the laws of Western Australia and of the applicable laws of the Commonwealth of Australia in force from time to time. The parties submit irrevocably to the non-exclusive jurisdiction of the courts of Western Australia and all courts entitled to hear appeals from them.

[Insert company name]

TRANSITION CARE PROGRAM AGREEMENT

SCHEDULE TO AGREEMENT

1. **The Provider**

   [Insert company name, corporate office address and telephone number, and ABN]

2. **The Recipient**

   Name of Recipient

   (Name of Recipient)

   Address of Recipient

   (Address of Recipient)

3. **Facility to be entered by the Recipient**

   Name and address of the TCP facility

4. **Date of Right to Occupy a Transition Care Program residential place**

   (Clauses 7.3-7.6 in the *Recipient Agreement for Transition Care Program*)

   The dates during which the Recipient may have the right to occupy a residential Transition Care Program place.

   From: Insert day of Month Year

   Proposed Exit Date: Insert day of Month Year

   (To align with achievement of Recipient's goals of care)

1. **Recipient Representative**

The Recipient Representative shall be:

NAME (Name)

ADDRESS (Address)

OCCUPATION (Occupation)

Enduring Power of Attorney Details (if any)

Insert if applicable

Insert if applicable

(Copy to be kept on file)

ANNEXURE A

Fee Schedule

The care fee for Transition Care Program is calculated on a daily basis, but this does not imply that this is limited only to specific days on which services are provided to the care recipient. Care fees are set at 85% and at 17.5% of the basic daily rate of the single pension for care delivered in residential and community settings, respectively. This applies to both single and married transition care recipients. Fees are payable a week in advance and if the care recipient leaves the Transition Program, any payment in advance beyond the date of cessation will be refunded.

Residential Service

Pay the current daily fee of $ XX.XX ***per day*** for a ***residential care place*** plus any costs that do not form part of the service's agreed care program and would not normally form part of the residential TCP services. Recipients in residence will be responsible for any increase in the Daily Care fee as set down by the Commonwealth Government.

Community Service

Pay the current daily fee of $ XX.XX ***per day*** for a ***community care place*** plus any costs that do not form part of the service's agreed care program and would not normally form part of the community TCP services. Recipients will be responsible for any increase in the Daily Care fee as set down by the Commonwealth Government.

Provision of Equipment

The Transition Care Program is responsible for the provision of basic equipment to meet a care recipient's needs. Any basic equipment that has been provided and subsequently loaned to an individual care recipient should be returned to the TCP/Service Provider when the equipment is no longer required. The Service will have a process in place to recover items of equipment that are no longer required.

ANNEXURE B

This Agreement was signed by:

NAME/S (print) .....

.....

SIGNATURE/S .....

DATE .....

This form should be signed by the TCP Recipient. Only in exceptional circumstances should someone else sign. If this is the case, please COMPLETE the following:

Why was the TCP Recipient unable to sign?

……..

Relationship of Signatory to the TCP Recipient (e.g. Next of Kin, Guardian, Power of Attorney)

……..

Where the TCP Recipient has both a legal Guardian AND a Power of Attorney, both parties should sign the Agreement.

Please attach copies of the relevant Guardianship and/or Administration Orders to this Agreement.

Signature(s) witnessed by:

Witness (signature) .....

Name (print) .....

Address .....

Date.....

Signed by a Director for and on behalf of **[Insert company name]**

Signature.....

Name (print) .....

Date.....

Signature witnessed by:

Witness (signature) .....

Name.....

Address .....

Date.....

ANNEXURE C

CHARTER OF RESIDENTS RIGHTS AND RESPONSIBILITIES

A. Care recipients have the following rights:

1. Safe and high quality care and services;
2. be treated with dignity and respect;
3. have my identity, culture and diversity valued and supported;
4. live without abuse and neglect;
5. be informed about my care and services in a way I understand;
6. access all information about myself, including information about my rights, care and services;
7. have control over and make choices about my care, and personal and social life, including where the choices involve personal risk;
8. have control over, and make decisions about, the personal aspects of my daily life, financial affairs and possessions;
9. my independence;
10. be listened to and understood;
11. have a person of my choice, including an aged care advocate, support me or speak on my behalf;
12. complain free from reprisal, and to have my complaints dealt with fairly and promptly;
13. personal privacy and to have my personal information protected;
14. exercise my rights without it adversely affecting the way I am treated.

We recognise that for cultural, religious or personal reasons you might ask to be seen by a carer of the same gender as you in certain situations. Please let us know as soon as possible if this is the case.

We will try to meet your needs. It will not always be possible to do so, however, and we cannot guarantee a carer of your gender for every occasion. For example, if it is in an emergency and you need urgent attention, you will be cared for by the available staff who could be female or male. If we cannot provide you with a carer of the same gender, you can ask us for another staff member of the same gender to be in the room.

We will prioritise requests for same-gender care where possible for people with specific religious or cultural needs and for people who have experienced trauma.

B. In the spirit of the Transition Care recipient and the Transition Care Service Provider having reciprocal responsibilities, the care recipients have the following responsibilities:

- Respecting the rights of staff and the provider to work in a safe and healthy
- environment free from harassment;
- Respecting the rights and needs of other care recipients (for Transition Care delivered
- in a residential setting);
- Caring for their own health and well-being, as far as he or she is capable;
- Working to achieve the goals articulated in their agreed individual care plan;
- Informing the provider about any required changes to the care plan or agreement;
- Providing information to the provider about their wants and needs;
- Notifying the provider of any special requirements;
- Providing constructive feedback to the provider about the service's performance; and
- Contributing to the cost of care where appropriate

Appendix M: TCP Discharge Planning Process

TCP Entry:

- Client agreement signed[#] and time-limited nature of TCP discussed with Client, Representative and /or Next of Kin (NOK).
- Note that if Client has a publically appointed Guardian and/or Administrator, both of these persons should sign the agreement.
- If Client does not have publically appointed Guardian and/or Administrator, but is still unable to sign, then the NOK should sign the Agreement.

Discharge Planning:

- Expected discharge date (when TCP goals met: on average 49 days (7 weeks) post-entry) discussed and discharge planning commenced.
- If TCP goals and preferred discharge plan unable to be met within 84 days (12 weeks), option that an ACAT extension of up to 42 days (6 weeks) may be granted discussed with Client/Representative/NOK.
- In the rare case that TCP goals are not met within 126 days (18 weeks), then option to discharge Client to first available safe alternative discussed with Client/Representative/NOK.
- Emphasise that the Client's family are the key drivers in identifying longer-term discharge options for Client in a timely way, and TCP staff are available to support this process.

Initial Family Meeting:

- Initial family meeting held within 2 weeks of entry.
- TCP goals agreed with Client/Representative/NOK.
- Prospective discharge date reviewed and agreed with Client/Representative/NOK.
- Assessment of Client complexity* undertaken.
- Assessment of risk that Client may not be discharged within 126 day time limit commenced.
- Note that if Client has a Guardian and/or Administrator appointed after entry to TCP, then the TCP Client Agreement should be discussed and signed with the appointee/s as soon as possible.

Ongoing Care Planning:

- Ongoing family meetings held as clinically indicated.
- TCP goals reviewed and agreed with Client/Representative/NOK if updated.
- Prospective discharge date reviewed and agreed with Client/Representative/NOK if updated.
- Assessment of Client complexity* reviewed.
- Assessment of risk that Client may not be discharged within 126 day time limit reviewed.
- Note that if Client identified as at risk of not being discharged within 126 days, then WA DoH Senior Project staff should be notified by 42 days (6 weeks) post entry.

Risk Management Strategies:

- Increased family meetings and an application to involve WA DoH staff in family meetings/communications should be considered as risk management strategies.
- Decision whether WA DoH staff will become involved will be made by WA DoH staff on a case by case basis. This may include a review of all information relating the Client's entry to and progress in TCP.
- Note that if all risk management strategies are unsuccessful, transfer of Client to the first available permanent vacancy may need to be considered, even against the wishes of the Client/Representative/NOK. Invoking this clause of the TCP Client Agreement must involve prior discussion with WA DoH Staff.

It should be noted that if the TCP Client/Representatives declines to sign a TCP Client Agreement, the TCP Provider should ensure that an explanation of the time-limited nature of TCP and of the option to discharge the Client to the first available safe alternative service when client goals of care are met is clearly documented, along with the reason/s that the Client declined to sign the Agreement.

***Complex TCP clients include those who:**

- Are ACAT approved for secure permanent residential and require a concessional place; and/or
- Have significant behavioural or clinical needs that limit the number of permanent facilities that may accept their application; and/or
- Are relatively functionally independent and may not be financially attractive to a permanent facility, thereby limiting the number of permanent facilities that may accept their application; and/or
- Are younger, thereby limiting the number of permanent facilities that may accept their application; and/or
- Have limited family support, complex family dynamics or family members who are resistant to permanent placement; and/or
- Have significant unresolved financial/legal issues that may delay permanent facilities accepting their application.

Community care options that may be able to assist a complex TCP client should be considered as part of the TCP discharge planning process.

Appendix N: Transition Care and Leave

From 1st July 2021, there are new rules regarding Transition Care and leave entitlements

1. **7 day rule**: TCP clients can take up to 7 days leave within a TCP episode for social or medical reasons, including a hospital stay.
2. **48 hour rule**: Clients entering community TCP can take up to 48 hours to commence their TCP episode after discharging from hospital

A total of seven (7) days leave is allowed in total during a Transition Care episode

- For hospital admissions, leave will be counted by the number of nights that the TC client is a hospital inpatient as at midnight
- Both social leave and hospital admissions are included in the 7 nights leave entitlement.
- The 7 nights can be taken in blocks or as individual days
- If the client has an approved extension, they are not eligible for any additional leave nights
- TCP Providers are paid by WADOH for leave days
- TCP Providers can charge clients a contribution fee for leave days subject to the standard arrangements
- TCP Providers must provide Transition Care up to the point of admission and then again from the point of discharge on the same day or the next day. This will ensure that there is no break in the TC Provider's eligibility for flexible care subsidy under the Act.
- ACAT approval for community TCP needs to be completed during the hospital stay

The process:

- TC Providers maintain responsibility for tracking the number of leave days taken by each client
- Days of leave taken are entered on the WA TCP Data Portal by TC Providers
- If a client requires re-admission to hospital and has exhausted their 7 day leave entitlement, the Transition Care episode will cease and the client must be discharged from the program.
- If the client is sent to hospital, the TC Provider must complete the "Readmission to Acute Care" form and send this with the client, as well as emailing a copy to the TC Central Coordinators at TCPCentralCoordinators@health.wa.gov.au
- During business hours, Monday to Friday, the TC Central Coordinators will access information from the WA TCP Data Portal regarding the client's remaining leave entitlements.
- It remains very important that notification of patients being sent to hospital from TC facilities is timely
- Where the hospital wishes to discharge the client back to TC after hours, hospital staff will communicate directly with the TC Provider regarding leave entitlements

- If 7 days leave have been used and the client no longer has a valid ACAT approval for Transition Care, a new ACAT assessment and a new referral to TC must be completed. For public hospital clients, the recent episode may be cloned from the Transition Care Program and Aged Care Services (TACS) database, and updated with current information
- Clients admitted to hospital and wanting to return to a TC facility will be given priority access for admission to TC by the Central Coordinators once they are ready to return and the new referral has been accepted.
- Any concerns regarding whether the patient is medically ready for discharge should be directed to the Central Coordinator.

Transition Care Central Coordinators 28 June 2021

Appendix O: WA Transition Care Program (TCP) Complaints Process

If you are unhappy with your experience of the Transition Care Program (TCP) service and wish to lodge a complaint, we encourage you to contact the following:

The TCP Service Provider/Facility Manager where there are concerns about the care being received. The contact details for each of the TCP Facilities are:

- Aegis Ascot. Telephone: (08) 6279 1500
- Aegis Banksia Park. Telephone: (08) 9419 1244
- Amana Living Bull Creek. Telephone: 1300 794 519
- Amana Living Cottesloe. Telephone: 1300 794 519
- Amana Living Mosman Park. Telephone: 1300 794 519
- Brightwater Birralee. Telephone: (08) 9309 0308
- Brightwater Kingsley. Telephone: (08) 9309 0308
- Carinya. Telephone: (08) 9438 5333

The discharging hospital's own complaints process where there are concerns about the care received as an inpatient or regarding transfer to Transition Care. Public hospital Patient Liaison or complaints services can be contacted via the main switchboards on:

- Armadale Health Service. Telephone: (08) 9391 2000
- Bentley Hospital. Telephone: (08) 9416 3666
- Fiona Stanley Hospital. Telephone: (08) 6152 2222
- Fremantle Hospital. Telephone: (08) 9431 3333
- Joondalup Health Campus. Telephone: (08) 9400 9400
- Osborne Park Hospital. Telephone: (08) 9346 8000
- Rockingham General Hospital. Telephone: (08) 9599 4000
- Royal Perth Hospital. Telephone: (08) 9224 2244
- St John of God Midland Public Hospital. Telephone: (08) 9462 4000
- Sir Charles Gairdner Hospital. Telephone: (08) 6457 3333

If the matter is not resolved by the above steps, please contact:

- The WA Government's Health and Disability Services Complaints Office (HaDSCO) to discuss options or request a complaint form on **(08) 6551 7600** or **1800 813 583**; **OR**
- The Aged Care Quality and Safety Commission on 1800 951 822 or at: https://www.agedcarequality.gov.au/

Appendix P: SIRS Notice of Reportable Incident

SERIOUS INCIDENT RESPONSE SCHEME (SIRS) - NOTICE OF REPORTABLE INCIDENT

Reference

TCP Service Provider facility name:	
Date of Incident Report:	
Surname of Victim:	
Date SIRS report submitted *(DOHWA to complete)*	

Notice of Collection

I acknowledge that I have read and understood the Notice of Collection https://www.agedcarequality.gov.au/resources/notice-collection — Choose an item.

I acknowledge that I have made all reasonable steps to ensure that the individuals identified in this form have been provided with the Notice of Collection or they are aware the contents of Notice of Collection — Choose an item.

Your Details

Question	**Response**
First name	
Last name	
Position/Role at Residential Aged Care Facility	
Email	
Work Phone	
Mobile	

Incident Details

Question	**Response**
Who initially raised concern/made the allegation?	☐ Resident (Victim) ☐ Care Recipient (3rd Party) ☐ Staff Member ☐ Family/Friend ☐ Other (*please enter*)
Date and time Incident Reported	
Date and time the Alleged Incident Occurred	
Has a death occurred as the result of this incident?	Choose an item.
Select the most relevant incident Type	☐ Unreasonable use of force ☐ Unlawful or inappropriate sexual contact ☐ Unexplained absence from care ☐ Unexpected death ☐ Stealing or financial coercion by a staff member ☐ Psychological or emotional abuse ☐ Neglect ☐ Inappropriate physical or chemical restraint
Please provide a detailed description of the alleged incident	

Victim Details

Question	Response
Victim's Unique Client ID	SPARC number: ACMPS number:
First name	
Last name	
Gender	
DOB	
Please select appropriate level of cognition of the Victim	☐ No impairment ☐ Mild impairment ☐ Moderate impairment ☐ Severe impairment ☐ Unknown
Has the Victim been named or described in any incident previously?	Choose an item.
Did the Victim suffer **psychological** impacts	Choose an item.
If *Yes*, select the appropriate level of **psychological** impact to the victim	☐ No impact ☐ Minor psychological injury or discomfort which were resolved without formal psychological interventions ☐ Psychological injury or illness requiring psychological treatment ☐ Psychological injury or illness requiring hospital admission (but not permanent) ☐ Permanent psychological impairment ☐ Fatality or severe permanent psychological impairment
Victims **psychological** impact details (*Please describe psychological impact*)	
Did the Victim suffer **physical** impacts	Choose an item.
Select the appropriate level of **physical** impact to the Victim	☐ No impact ☐ Minor physical injury or discomfort which were resolved without formal medical interventions ☐ Physical injury or illness requiring medical or psychological treatment ☐ Physical injury or illness requiring hospital admission (but not permanent) ☐ Permanent physical impairment ☐ Fatality or severe permanent physical impairment
Victims **physica**l impact details (*Please describe physical impact*)	

Alleged offender details

Question	Response
Is Alleged Offender an Aged Care Recipient?	Choose an item.
Alleged Offender's Unique Client ID	SPARC number: ACMPS number:
First name	
Last name	
Gender	
DOB	

Please select appropriate level of cognition of the Alleged Offender (*Mark one with "x")*	☐ No impairment ☐ Mild impairment ☐ Moderate impairment ☐ Severe impairment ☐ Unknown
Has the Alleged Offender's been named or described in any incident previously?	Choose an item.
Did the Alleged Offender's suffer **psychological** impacts	Choose an item.
Select the appropriate level of **psychological** impact to the Alleged Offender	☐ No impact ☐ Minor psychological injury or discomfort which were resolved without formal psychological interventions ☐ Psychological injury or illness requiring psychological treatment ☐ Psychological injury or illness requiring hospital admission (but not permanent) ☐ Permanent psychological impairment ☐ Fatality or severe permanent psychological impairment
Alleged Offender's **psychological** impact details (*Please describe psychological impact*)	
Did the Alleged Offender suffer physical impacts?	Choose an item.
Select the appropriate level of **physical** impact to the Alleged Offender	☐ No impact ☐ Minor physical injury or discomfort which were resolved without formal medical interventions ☐ Physical injury or illness requiring medical or psychological treatment ☐ Physical injury or illness requiring hospital admission (but not permanent) ☐ Permanent physical impairment ☐ Fatality or severe permanent physical impairment
Alleged Offender **physica**l impact details (*Please describe physical impact*)	

Action taken

Question	**Response**
Has the incident been reported to the police	Choose an item.
Reason	
Has the Victim's NOK or EPOA been contacted about the incident?	Choose an item.
Has the Victim's NOK or EPOA expressed any concerns regarding the incident?	Choose an item.
Has the Alleged Offender (Care Recipient)'s NOK or EPOA been contacted about the incident?	Choose an item.
Has the Alleged Offender (Care Recipient)'s NOK or EPOA expressed	Choose an item.

any ongoing concerns regarding the incident?	
What specific actions have been taken to ensure the health, safety and wellbeing of the care recipient(s) involved?	
What specific actions have been taken to manage or minimise the risk of reoccurrence of this or similar incident in future?	
Is there any other information or details you wish to include in relation to this notification?	

- Use this form as the Initial Notice of the Incident for both Priority 1 and Priority 2 incidents.
- If you are providing an initial notice in respect of a Priority 1 reportable incident, then you are only required to provide the information that is known to you at that time.

Guidelines, Resources, Forms

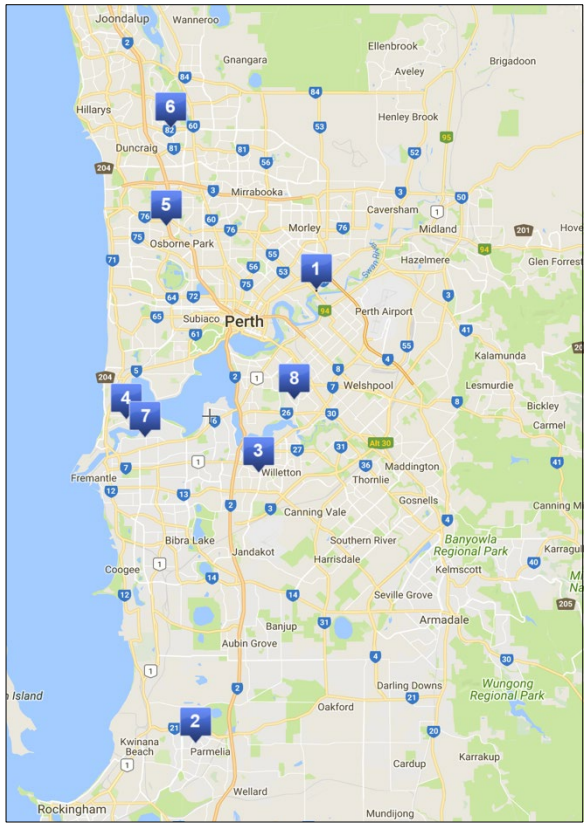
- Serious Incident Response Scheme Guidelines
- Full range of SIRS resources
- Notice of Additional Information (Priority 1) Form
- Notice of Significant New Information Form
- Final Report on Reportable Incident Form

Office Use Only

Appendix Q: TCP Facilities Overview

TCP Facilities Overview *For use by referring staff, not for distribution to patients/families

TCP Facility	Total Beds	Non Secure	Secure	Room Type Single rooms are allocated according to clinical need. Patients are to be waitlisted for all suitable facilities.	Central Coordinator
Aegis Ascot 29 Neville Street, Bayswater Ph: 6279 1500 Fax: 6279 1599	30	30	-	All shared (2, 3, 4 bed rooms), no ensuites	**NMHS** Amanda Humphreys Robyn Lieblich Shannon Brussen
Aegis Banksia Park 20 Bright Road, Calista Ph: 9419 1244 Fax: 9439 5282	25	15	10	*Non secure wing - 2 bed rooms with shared ensuite *Secure wing – single rooms with ensuite	**SMHS** Chris Perriam Frith Hart
Amana Living Bull Creek 22 Lefroy Rd, Bull Creek Ph: 1300 918 295 Fax: 9310 5569	18	-	7	Single rooms with shared ensuite	**EMHS** Susan Sweet
			11 OAMH	Single rooms with shared ensuite	**OAMH TCP Coordinators**
Amana Living Mosman Park 99 McCabe St, Mosman Park Ph: 1300 496 481 Fax: 9385 1871	47	47	-	Double rooms with ensuite	**SMHS** Chris Perriam Frith Hart
Brightwater Birralee 155 Odin Rd, Innaloo Ph: 9445 6612 Fax: 9445 6661	30	15	15	Single rooms with ensuite	**NMHS** Amanda Humphreys Robyn Lieblich Shannon Brussen
Brightwater Kingsley 44 Renegade Way, Kingsley Ph: 9309 0308 Fax: 9309 0354	71	49	22	Mainly single rooms with ensuite, some 2 bed rooms	**NMHS** Amanda Humphreys Robyn Lieblich Shannon Brussen
Carinya 220 Preston Point Rd, Bicton Ph: 9339 3760 Fax: 93393595	45	39	6	Mixture single and double rooms with ensuite	**EMHS** Susan Sweet
Juniper Charles Jenkins 4-10 Hayman Rd, Bentley Ph: 6363 6710 Email: jcjtcp@juniper.org.au	60	60	-	Mixture single, double and 4 bed rooms, no ensuites	**EMHS** Susan Sweet



(1) Aegis Ascot
(2) Aegis Banksia Park
(3) Amana Living Bull Creek
(4) Amana Living Mosman Park
(5) Brightwater Birralee
(6) Brightwater Kingsley
(7) Carinya
(8) Juniper Charles Jenkins

TCP Central Coordinators:
Email: TCPCentralCoordinators@health.wa.gov.au

OAMH TCP Coordinators:
Email: OAMHS.TCP@health.wa.gov.au

This document can be made available in alternative formats on request for a person with disability.