Guideline

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NSW Transitional Aged Care Program Guidelines

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Functional Sub group Clinical/ Patient Services - Aged Care
Clinical/ Patient Services - Governance and Service Delivery

Summary The NSW Transitional Aged Care Program (TACP) is an initiative jointly funded by the Australian and NSW Governments and administered under the Aged Care Act 1997 to provide short-term restorative care to optimise the functioning and independence of older people after a hospital stay. The NSW TACP Guidelines provide practical guidance to NSW TACP Service providers in meeting the national legislative and policy requirements for service delivery. The Guidelines are designed to complement and make reference to the national Transition Care Program 2011 Guidelines wherever relevant, rather than duplicating the information they provide.

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Applies to Local Health Districts, Specialty Network Governed Statutory Health Corporations, Affiliated Health Organisations, Community Health Centres, NSW Ambulance Service, Private Hospitals and Day Procedure Centres, Public Health Units, Public Hospitals

Audience All NSW Health staff with responsibility for the health care of older people

Distributed to Public Health System, Divisions of General Practice, NSW Ambulance Service, Ministry of Health, Private Hospitals and Day Procedure Centres, Tertiary Education Institutes

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Director-General

GUIDELINE SUMMARY

NSW TRANSITIONAL AGED CARE PROGRAM GUIDELINES

PURPOSE

The NSW Transitional Aged Care Program Guidelines complement the Australian Government Department of Health and Ageing *Transition Care Program Guidelines 2011*, providing guidance in the implementation of national policy and the delivery of Transitional Aged Care Services in NSW to meet the conditions of the *Aged Care Act 1997*.

KEY PRINCIPLES

The NSW Ministry of Health, as the Approved Provider of the NSW Transitional Aged Care Program, must meet the conditions specified under the *Aged Care Act 1997*, the Commonwealth/State Transition Care Payment Agreement and the Transition Care Recipient Agreement for the operation of the Program.

The Guidelines set out the legislative and policy frameworks and the mandatory components for Program management and service delivery, including all policy statements and/or practice guidelines with a legislative or regulatory basis.

The Guidelines also support compliance with the national *Transition Care Guidelines 2011* and align to Transitional Aged Care Program service requirements under the national Quality Standards where relevant.

USE OF THE GUIDELINE

The Guidelines provide a management tool for clinical and corporate governance, a training and orientation tool for NSW Transitional Aged Care Service managers and staff, a quality improvement resource and a reference document with links to other legislation and policies to support the provision of safe, consistent, efficient and effective transitional aged care services in NSW.

The Guidelines are for the use of Transitional Aged Care Service managers and staff, with practice guidelines targeted to either ‘all TACP staff in NSW’ or ‘TACP Service Managers in NSW’.

The Guidelines have been developed following extensive consultation with key stakeholders.

REVISION HISTORY

Version	Approved by	Amendment notes
July 2013 GL2013_004	Deputy Director-General, Strategy and Resources	New guideline.

ATTACHMENTS

1. NSW Transitional Aged Care Program Guidelines.

NSW Transitional Aged Care Program Guidelines

NSW Health

GUIDELINE

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CONTENTS

1 CHAPTER 1 – INTRODUCTION AND BACKGROUND

1.1 Purpose and use of these Guidelines

The NSW Transitional Aged Care Program (TACP) Guidelines are designed to complement the national *Transition Care Program Guidelines 2011* and to provide policy guidance for TACP Services in NSW. They are also:

- a mechanism for promoting consistency of application of the model of care and services provided by TACP in NSW;
- a reference tool with links to other policy documents relevant to the provision of safe, consistent, efficient and effective TACP services;
- a management tool to promote good clinical and corporate governance of TACP in NSW;
- an orientation and training tool for new TACP managers and staff;
- a continuous quality improvement resource; and
- an information resource for other services working alongside TACP in NSW.

Local Health Districts (LHDs) in NSW are expected to align their local TACP protocols with the principles and protocols outlined in this guideline.

These practice guidelines comply with the national Transition Care Guidelines 2011. They also align with TACP Service requirements under the national Transition Care Program Quality Standards where relevant. The practice guidelines, as appropriate, are targeted to either 'all TACP staff in NSW' or 'TACP Service Managers in NSW'.

All cross referencing within the Guidelines (e.g. 'See **7.3**') refers to sections of the Guidelines and not to page numbers.

All staff and managers working in a TACP service for the first time should have access to and be required to read the entire document . It is also recommended that relevant staff in hospitals, community health, geriatric medicine, rehabilitation services and aged health services are made aware of the Guidelines.

The Guidelines are intended to be a dynamic document. Individual TACP services should keep contents up to date with advice received from either the Australian Government or NSW Ministry of Health (NSW MoH).

Individual team managers/leaders should ensure their local copies are kept current. When citing the Guidelines, TACP teams should make sure they are referencing the latest version.

A comprehensive review will be undertaken after 12 months experience with the document and thereafter on a two-yearly basis to ensure policies and recommended practices remain current.

1.2 The NSW TACP

The Transition Care Program (TCP) is a joint Australian Government and State funded program. Established in 2005, this national program was developed to assist older people in regaining physical and psychosocial functioning after a hospital stay. TCP services are delivered across Australia through State and Territory Departments or Ministries of Health as the Approved Providers under the Aged Care Act 1997. In NSW, the Transition Care Program is referred to as the Transitional Aged Care Program (TACP) to distinguish it from numerous other health programs that use the term 'transition care'.

The TACP provides short-term restorative care to optimise the functioning and independence of older people after a hospital stay. It is goal-oriented, time limited and therapy-focussed. It provides older people with a package of services that includes low intensity therapy such as physiotherapy and occupational therapy, as well as social work, nursing support and/or personal care. It seeks to give older people the opportunity to return home after a hospital stay rather than enter residential care prematurely.

The TACP facilitates continuity of care across the health and aged care sectors for older people who have completed their hospital episode (including all subacute care (rehabilitation, geriatric evaluation and management) and who need more time and support to make a decision about their long term aged care options. The 'transition' aspect of TACP is important in assisting older people in moving seamlessly from the acute/sub-acute hospital system to the aged care system, while receiving the support they need.

Legal Definition of Transition Care

The kind of care for which flexible care subsidy in the form of transition care (TACP in NSW) is payable is defined in the Aged Care Act, Flexible Care Subsidy Principles 1997.

15.28 Transition Care is a form of flexible care that is provided to a care recipient:

(a) at the conclusion of an inpatient hospital episode; and

(b) in the form of a package of services that includes, at least:

(i) low intensity therapy; and*

(ii) either:

(A) Nursing support; or

(B) Personal care; and

(c) as care that can be characterized as:

(i) goal oriented; and

(ii) time limited; and

(iii) therapy focused; and

(iv) targeted towards older people; and

(v) necessary to:

(A) complete the care recipient's restorative process; and

(B) optimize the care recipient's functional capacity; and

(C) assist the care recipient, and his or her family or carer, to make long-term arrangements for his or her care.

** Refer to **Chapter 11 - Glossary**.*

1.2.1 TACP Aims and Objectives

TACP is a goal oriented, time limited and therapy-focussed service to support older people at the conclusion of a hospital episode to complete their restorative process, optimize their functional capacity and finalise and access their longer term care arrangements.

For some clients, their episode of TACP will help them to remain at home longer with or without ongoing community care services, and avoid premature admission to residential aged care. Other clients who still require permanent residential care at the end of the TACP episode should achieve a higher level of functioning than they had if they had entered the facility directly from hospital. Many clients also benefit from the time TACP gives them to come to terms with new care needs and, along with family and carers, make difficult decisions about their longer term care.

The program is not to be used as a bed management tool and its key function is to support older people to regain their functional abilities in order to remain as independent as possible. An outcome of Transitional Aged Care is that inappropriate extended hospital lengths of stay and premature admission to residential aged care are minimised. However, Transitional Aged Care's primary function is therapeutic, rather than administrative.

1.2.2 TACP Target Group

To be eligible for the TACP an individual:

- is classified as an inpatient in hospital, either in a hospital facility or in a Hospital in the Home or equivalent program;
- must have completed his/her acute and sub-acute care, be medically stable and ready for discharge at assessment and discharged from hospital directly to TACP;

- must be assessed in hospital by the Aged Care Assessment Team (ACAT) as eligible to receive at least low level permanent residential aged care if he/she applied;
- is assessed by the ACAT as being able to benefit from a period of care in a non-hospital environment to:
    - access low intensity therapy;
    - assess their circumstances; and
    - explore their preferred aged care options; and
- must wish to access TACP.

A more detailed explanation of the ACAT assessment process and key considerations in assessing potential clients for eligibility for TACP can be found in the national *Transition Care Program Guidelines 2011*.[1]

1.2.3 Key participants in TACP Delivery

Australian Government

The Australian Government is the majority funder of the TACP. The Department of Health & Ageing (DoHA) undertakes roles and responsibilities on behalf of the Australian Government, including:

- developing and implementing national policies to meet the objectives of the TACP in partnership with State and Territory governments;
- allocating TACP places under the Aged Care Act;
- providing subsidy under the Act per occupied TACP place per day;
- collaborating with State and Territory governments to evaluate the program; and
- providing strategic direction.

'Approved Provider'

NSW MoH is the Approved Provider of all Transitional Aged Care services in NSW, and has specific responsibilities under the Aged Care Act 1997, including:

- liaising with the Australian Government about policy and operational matters related to the NSW TACP;
- ensuring quality care is provided in accordance with the Transition Care Quality Improvement Framework;
- collation and reporting of TACP data to the Australian Government;

[1] Section 3.4, p 18

- providing mechanisms to ensure that the national *Transition Care Program Guidelines 2011* and the Australian Government's conditions for managing the TACP are met in service delivery;
- providing proportionate funding towards the operation of the TACP. Funding for TACP is contributed by both NSW Health and the Australian Government DoHA based on a formula

Aged Care Unit, Integrated Care Branch, NSW MoH

Within the NSW MoH, the Aged Care Unit, Integrated Care Branch fulfils the responsibility of the Approved Provider. To assist in coordinating activities and information between TACP Services and the Aged Care Unit, an Aged Care Contact has been designated to represent each LHD.

TACP Service staff may raise issues or queries with their LHD Aged Care Contact in relation to NSW/Australian Government policy and protocols relating to the day-to-day operation of their Service, who will seek advice from or notify the Aged Care Unit.

'Transitional Aged Care Service'

TACP places are allocated to NSW MoH as the Approved Provider and operate through Transitional Aged Care Services. Each Transitional Aged Care Service is given a Service ID Number by Medicare Australia and can only operate the number of places allocated to it by the Australian Government. Transitional Aged Care Services are always part of Local Health Districts; there are no non-government Transitional Aged Care Services, although service provision is sometimes brokered to non-government providers. The activities performed by Transitional Aged Care Services can range from centralised coordination functions to direct service provision to clients. A list of TACP Services in NSW can be found on the NSW Health website.[2]

'Transitional Aged Care Service Provider'

The Service Provider is the organisation that provides TACP care and services directly or via sub-contracting to one or more non-government organisations for some or all of the types of care provided under the TACP. In many cases the LHD represents both TACP Service and TACP Service Provider, with LHD staff delivering the care and services.

1.2.4 Key definitions

A full glossary of terms is provided at Chapter 11.

1.3 Legal and legislative framework

These Guidelines contains mandatory components applicable to all TACP Services (including brokered services) in each LHD in NSW. Mandatory components include all

[2] www.health.nsw.gov.au

Practice Guidelines with a legislative or regulatory basis. Reference is made directly to relevant legislation or policy as applicable.

Other components of the Guidelines include references to Australian Government publications. These are intended to give direction to the NSW MoH, to LHDs, and to TACP managers and staff in order to meet their responsibilities under the Aged Care Act 1997.

1.3.1 Commonwealth Legislation & Policy

- Aged Care Act 1997 (subject to review in 2013)
- Aged Care Principles 1997
- Australian Government *Transition Care Program Guidelines, 2011*

1.3.2 NSW Legislation & Policy

NSW Work Health & Safety Act 2012

NSW Health Records and Information Privacy Act 2002

NSW MOH 2005 Aboriginal and Torres Strait Islander Origin – Recording of Information of Patients and Clients. PD2005_547

NSW MOH 2007 Aboriginal Health Impact Statement and Guidelines PD2007_082

NSW MOH 2007, NSW Carers Action Plan 2007-2012 PD2007_018 NSW MOH

NSW MoH 2011, Your Health Rights and Responsibilities (Policy Directive PD2011-022) NSW MoH

NSW Health Privacy Manual Version 2 (Policy Directive PD 2005_593)

NSW Health Complaints Management Policy (Policy Directive PD 2006_073)

NSW DOH 2005, Protecting People and Property. NSW Health Policy and Guidelines for Security Risk Management in Health Facilities PD2005_339

NSW Health Code of Conduct (Policy Directive PD2012_018)

NSW Health Interpreters - Standard Procedures for Working with Health Care Interpreters (Policy Directive PD2006_053)

Recruitment and Selection of Staff of the NSW Health Service (Policy Directive) PD2012_028

NSW Health Patient Matters Manual, Chapter 9 (the Manual is updated annually)

NSW Health Recommendation of Service Providers to Patients by Staff of Health Organisations (Policy Directive PD 2005_086)

NSW Ministry of Health 2009, Incident Information Management System (IIMS)

2 CHAPTER 2 – ADMISSION INTO TACP

2.1 Referral and intake:

TACP Services in NSW have local referral and intake protocols that comply with Australian Government, NSW Ministry of Health and Local Health District policies and guidelines.

LEGISLATIVE FRAMEWORK

Aged Care Act 1997 – Part 2.3, Division 20 – What is the significance of approval as a care recipient?

Subsidy cannot be paid under Chapter 3 of the Act to an Approved Provider for providing flexible care [Transition Care] unless the person is approved under this Part as a recipient of that kind of flexible care.

Approval of Care Recipients Principles 5.7A

A person is eligible to receive flexible care in the form of Transition Care only if the person:

is assessed under section 22-4 of the Act as satisfying the following requirements:

i. the person is in the concluding stage of an inpatient hospital episode;

ii. the person is medically stable*;

iii. the person has the potential to benefit from transition care; and

is in hospital at the time the assessment is undertaken; and

would be assessed, if the person applied for residential care, as eligible to receive residential care at least at a low level of residential care.

* *Refer to* ***Chapter 11 - Glossary***.

PRACTICE GUIDELINES:

All TACP staff in NSW (whether directly employed or contracted) understand that:

Pre-eligibility approval

- TACP Services have an ongoing role in providing information and education to hospital staff to ensure clients are appropriately identified for TACP. This may include in-service education and participation in multidisciplinary team meetings, in order to raise awareness of TACP and its aims (see **9.8**). It is essential for TACP Services to liaise closely with ACAT and hospital staff during the entire admission process.
- older people who are classified as inpatients, whether in a hospital setting or Hospital in the Home, are able to be considered for TACP, as long as they have completed their inpatient episode before commencing TACP;

- TACP Service staff can review prospective clients' notes or discuss a particular client's situation with ward staff or ACAT. Generally, TACP staff do not have direct contact with the client until TACP eligibility is established by the ACAT, to avoid confusing or disappointing the client. However, if direct contact is made prior to eligibility approval, TACP Service staff must not undertake eligibility screening as this is an ACAT role. TACP staff must make clear to the client that access to the program is dependent on:
    1. ACAT eligibility assessment and approval.
    2. Client wishing to access TACP.
    3. TACP service availability and capacity to provide the level of care required.

Eligibility approval and acceptance to TACP

- no eligibility criteria may be added to or removed from those defined under the Aged Care Act 1997, and spelt out in the Transition Care Program Guidelines 2011;[3]
- a current Aged Care Client Record (ACCR) must be completed by an ACAT assessor and approved by an ACAT Delegate prior to a client being formally admitted to the TACP. Once a client is approved for the TACP, admission as agreed by the TACP Service may occur on the same day as ACAT delegate approval. The entry period for admission to TACP is 29 days beginning the day the ACCR is delegated;[4]
- a delegated ACCR approving a client's eligibility for TACP is valid for admission to any TACP Service in Australia, and is not specifically related to the TACP Service local to the particular hospital where the prospective client is an inpatient;
- the final decision regarding the acceptance of an eligible client into the TACP is made by the TACP Service provider based on a case-by-case clinical judgement. This decision takes into account the capacity of the service to adequately meet the client's particular care needs and whether places are available.

Admission to TACP

- where there is a large distance between the referring hospital and the TACP Service and TACP staff cannot attend the referring hospital, the receiving TACP Service may use telephone/ telehealth facilities to meet with the client and their family while they are still in hospital;
- the referring hospital should provide any documentation required by the receiving TACP Service. TACP Services are encouraged to develop a referral checklist for use by hospital staff to ensure that required documentation accompanies the client on discharge from hospital. This is particularly useful when a client is being referred from an out-of-area hospital;

[3] Section 3.4, p 19
[4] DoHA 2011, Transition Care Program Guidelines, Section 3.4.4, p 20

- there must be no break between discharge from hospital and admission to TACP. Clients can only access the program directly from hospital or Hospital in the Home;
- using the Modified Barthel's Index to measure a client's level of functioning is mandatory on admission to and discharge from TACP;
- TACP Services should make contact with the client's GP, or a local GP where the client does not have a usual GP, as soon as possible after admission to the program, to facilitate care coordination and update any prescriptions post-hospital.
- A fee should not be charged to a client who has transferred from another service in which fees were not payable. (see **4.4)**

Catchment areas

- each TACP Service must prioritise the delivery of TACP within their Local Government Areas (LGAs), to ensure equity of access to TACP across NSW. However, should their local TACP Service be at full capacity, a client may be accepted by a neighbouring TACP Service provided it has the capacity to deliver TACP to a client out of their area (taking into consideration that there may be greater distances involved). Staff should note that:
    - accepting clients living in another LGA not normally covered by the TACP Service must be done in negotiation with the primary TACP Service in that location; and
    - a TACP Service has the discretion to consider their capacity to provide services to a client living outside their normal LGA coverage and may choose not to admit a client on this basis.
- TACP Services can accept referrals from any hospital in Australia for clients who live in or around their chief catchment area, provided their service has the capacity to deliver services to that client. Some TACP Services operate under the auspice of one particular hospital; however, equity of access considerations still apply in accepting referrals for local clients from any hospital.

TACP REFERRAL & INTAKE FLOWCHART

*No eligibility criteria can be added or removed from those defined by the Aged Care Act 1997, and spelt out in the **Transition Care Program Guidelines 2011 (p 19).***

A current Aged Care Client Record (ACCR) approving the client's eligibility for TACP must be delegated by the ACAT prior to client being formally admitted the TACP. The admission may be on the same day as the ACAT approval.

The TACP Service makes the final decision about whether an eligible client is admitted to the TACP.

If the client is being referred from out-of-area, and the receiving TACP Service is unable to meet them, telephone or telehealth facilities may be used.

TACP Services may develop a referral checklist to be used by hospital staff to ensure that all required documentation accompanies the client upon discharge from hospital.

TACP is identified as a post-discharge option for hospital inpatient

↓

With patient consent, referral to ACAT for eligibility assessment when patient is medically stable and ready for discharge

↓

Assessed by ACAT — **NOT ELIGIBLE** → **Other discharge options considered for patient**

↓ **ELIGIBLE**

ACCR completed by ACAT assessor and approved by Delegate

↓

TACP Service advised of ACAT eligibility approval, accepts or declines client and informs referrer

↓

TACP Service meets with client and their family/carer/representative to sign a Client Agreement and develop a preliminary care plan

↓

Approved and accepted TACP Client is discharged from hospital and begins TACP episode

IDENTIFYING APPROPRIATE CLIENTS

TACP Services:

- *Have an ongoing role in providing information and education to hospital staff about TACP;*
- *Must liaise closely with ACAT and hospital staff during the entire admission process;*
- *Usually do not have contact with the prospective client until approved for TACP by ACAT;*
- *To avoid confusing or disappointing the client, must make clear that access to the program is dependent on:*

1. *the outcome of the ACAT assessment which will determine eligibility*
2. *evidence that the client wishes to access the program*
3. *TACP service availability and capacity to meet care needs.*

KEY PLAYERS IN TACP REFERRAL & INTAKE

- *TACP Service staff*
- *Hospital Discharge Planners/Transfer of Care Coordinators*
- *Hospital allied health staff*
- *Acute to Aged Related Care Services (AARCS) staff*
- *Aged Care Assessment Teams (ACATs)*
- *Geriatricians – if available*

Close liaison and good communication is critical at all stages of the referral and intake process.

2.2 Transfer between TACP Services and care settings:

TACP Services in NSW have local protocols and procedures in place to allow smooth transfer of clients either across TACP care settings or between TACP Services across Australia during their episode of care.

Movement between care settings and services

To facilitate client-centred Transition Care delivery, it is possible for care recipients to move from one setting to another within the same Transition Care episode, ie. from residential to community setting or vice versa. Care recipients do not require an ACAT re-assessment to enable this move.

Care recipients are also able to transfer from one Transition Care Service provider to another (within their State or Territory or interstate), provided there is no break in care, ie. there is no day during which the care recipient does not receive Transition Care services from the first or second service provider.[5]

PRACTICE GUIDELINES:

Client transfers – general guidelines

All TACP staff in NSW (whether directly employed or contracted) understand that:

- TACP Services should be ready to facilitate clients moving between Services or between TACP care settings during their episode of care;
- there must not be a break in care provision during the transfer of the client from hospital to the TACP Service. A break in care is defined as a period of 24 hours or more in which a client is not under the care and supervision of the TACP. This means that the client must be under the care of the referring TACP Service on the day of discharge;
- the client transferring between TACP Services or care settings without a break in care is considered to have one continuous episode of TACP. Therefore the maximum period for provision of TACP across both Services or care settings is 12 weeks, unless an extension is approved;
- if the client is transferring from the residential setting to the community setting, it is desirable that an Occupational Therapist assesses the new living environment to confirm that the client is able to be safely managed in the community before the client arrives. This may involve arrangements by the receiving service for the installation of any required minor home modifications and/or equipment;
- both TACP teams must liaise closely to coordinate the TACP client's transport arrangements with the dates of transfer. Planning for a transfer should commence as early as possible, as the process may take several weeks;

[5] DoHA 2011, Transition Care Program Guidelines, Section 3.5.5, p 24

- TACP services must make sure the client is aware that different maximum care fees may be charged in the residential and the community care settings and may also be different across TACP Services, even in the same care setting:
    - the care fees charged by the receiving TACP Service apply after the transfer, and the Client Agreement must be updated to reflect this;
    - if care fees chargeable to a client who transfers from one service to another are different, this should be explained to the client prior to transfer and the Client Agreement updated accordingly;
- if a client wishes to move to another TACP Service in a different location or to one providing an alternative care setting, the referring TACP Service may obtain the contact details of TACP Services across NSW and in other States and Territories from their LHD Aged Care Contact or from the Aged Care Unit, Integrated Care Branch, NSW MoH, telephone 02 9391 9827.

Transfers between TACP Services

All TACP staff in NSW (whether directly employed or contracted) understand that:

- the referring TACP Service must provide all updated documentation related to the client, including the Client Agreement, to the receiving TACP Service. The fees charged by the receiving service apply to the client after transfer, and must be reflected as an amendment to the original Client Agreement;
- as many transfers between TACP Services are across long distances and the receiving team may not be able to meet beforehand with the client or referring team, TACP Services may develop an 'out-of-area information pack' containing all documentation required to accept a client transferring from another service (see Figure 1). This acts as a guide for the referring TACP Service about the appropriate information to send to the receiving TACP Service;
- if the client is moving interstate, a new Client Agreement must be signed with the receiving TACP Service, as the Approved Provider under the Aged Care Act will change with the transfer.[6] This is not necessary for transfers within NSW as all TACP Services are operated by NSW DoH as the Approved Provider. However, the receiving Service may choose to negotiate a new agreement with the client if they wish;
- the referring TACP Service should follow all normal discharge procedures for the client moving to the receiving TACP Service, including measuring Modified Barthel Index, reporting all discharge data to Medicare via the claim form, recovering loaned equipment and ensuring all discharge documentation is current (see **3.6**). The recorded date of exit from the first TACP Service (for which the first TACP

[6] DoHA 2011, Transition Care Program Guidelines, p 28

Service does not receive subsidy) becomes the recorded date of entry for the second TACP Service. This ensures there is no break in care; and

- for clients who transfer between care services, the 'MBI on exit' category in the Medicare claim form should be reported as '0' as the client is continuing their TACP episode elsewhere.

*****Please note that the requirement to record the MBI score of '0' for clients transferring to other TACP services is currently under national review. This section will be updated on resolution of this issue.*****

Figure 1: Out-of-Area Information Pack

Documentation that may be included in the Out-of-Area Information Pack to be sent to TACP Services referring clients who wish to transfer from other locations includes:

- Referral Form
- Home Visit Risk Assessment (if community-based TACP)
- Mini Mental State Examination (MMSE) results
- Modified Barthel's Index (MBI) on admission and at point of transfer
- Information from client/relatives/carers about the older person's situation
- Current care plan with nursing/therapist reports

This information pack may also be useful to send to out-of-area referring hospitals where the TACP Service cannot meet with the client or family/carers prior to admission to the TACP.

Transfers between care settings within the same TACP Service

All TACP staff in NSW (whether directly employed or contracted) understand that:

- The *Transition Care Program Guidelines 2011*[7] describe how TACP clients may move between care settings during their TACP episode, whether planned or in response to changing care needs ('step up' from community to residential setting, or 'step down' from residential to community setting);
- the 'step-down' transfer from a residential to community setting may be incorporated as part of the client's TACP goals during the initial care planning process, if appropriate to the client's individual condition. Considerations such as the appropriateness of the client's home environment (including the level of support they will have at home) should form a key part of the decision-making process;
- the client's carer and/or family should be involved in planning for the transfer. If moving to the community setting from the residential setting, the TACP Service must ensure that the client has support to be managed safely at home;

[7] Section 3.5.5, p 24

- the client should have a multi-disciplinary assessment and their care plan should be updated before transferring between settings;
- they should liaise with other geographically situated TACP Services to establish availability of places for the client in the alternative care setting if it does not provide TACP places in both settings;

Tables 1 and 2 below show examples of considerations that might lead to 'step up' or 'step down' being considered as an option for clients. This is a clinical decision based on the situation of individual clients, and the examples below are not intended to be prescriptive about when a transfer should take place.

TABLE 1

'Step up' transfers: community to residential care setting

Considerations	Examples of change in condition/situation that may indicate appropriateness of 'step up'
☐ Client dependency levels	• Borderline functioning – although attempting to remain at home, not quite coping in the home environment • The client is not coping well with reduced level of support available in the community after discharge from acute setting
☐ Carer support needs	• Change in carer arrangements has occurred, leaving the client's needs unmet, eg. carer acutely unwell • Carer stress/inability to cope with level of supervision required
☐ Additional monitoring required	• Ongoing observation/monitoring of behaviour needed • Client's mood/anxiety levels are diminishing their ability to cope with adjustment • Carer/family are unable to cope with required levels of supervision • Assessment of cognitive impairment needs revisiting
☐ Medication management needs	• The client's pain management needs change, or are not able to be met at home: need for greater observation • Client needs to trial new medication under supervision and observation

☐ Nutritional needs	• Client is becoming malnourished • Supervision of dietary intake required • Education of client required in a supervised environment

TABLE 2

'Step down' transfers: residential to community care setting

Considerations	Examples of change in condition/situation that may indicate appropriateness of 'step down'
☐ Carer/community support	• Client's level of family or carer support increases – eg. family moves closer to care for client, or arrangements made for client to be able to live with family • Carers able and willing to be trained to assist with care in the home
☐ Client has new goals to be achieved at home	• Client wishes to attempt to achieve new goals that cannot be realised in residential setting- eg. maintaining house and garden, re-integration with community activities, shopping etc. • Client has improved level of confidence in their ability to cope at home.
☐ Medication management	• Client is able to use Webster Pack with minimal prompting • High level of supervision is no longer required
☐ Improved mobility	• Client is able to bear weight post fracture • Client is able to step down from Forearm Support Frame (FASF) to walking stick • Client is able to manage stairs
☐ Improved functionality	• Improvement in client's ability to undertake activities of daily living/independent living skills

3 CHAPTER 3 – DELIVERY OF TACP SERVICES

3.1 Specified care and services for TACP:

All TACP Services in NSW have the capacity to provide the full range of care and services specified in Schedule 1 of the national *Transition Care Program Guidelines 2011*, as applicable to the care setting in which the places are operated.

Schedule 1: Specified Care & Services for TACP

Schedule 1 is divided into three parts – care and services to be provided to:

1. Transition Care clients who receive care in a residential setting
2. Transition Care clients who receive care in a community setting
3. All Transition Care clients

Schedule 1 indicates the basic level of care that Transition Care Service Provider must be able to provide, if required by a client. The therapeutic care required will vary from person to person.

In providing Transition Care specified care and services, the Transition Care Service Provider must have systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards, quality frameworks and guidelines relevant to Transition Care provision.[8]

PRACTICE GUIDELINES:

All TACP staff in NSW (whether directly employed or contracted):

- are familiar with the lists of care and services at Schedule 1(attached at 12.1 Appendix A) that represent the basic level of service for TACP;
- understand that these specified care and services must be provided if required by clients receiving TACP in the residential or community setting, in order to receive subsidy payments;
- understand that the provision of TACP care and services must comply with LHD policies and procedures as well as the National *Transition Care Program Guidelines 2011*.

The specified care and services may be provided by LHD staff or some or all may be sub-contracted to external providers. For guidelines about sub-contracting services, see **Section 9.3.**

[8] DoHA 2011, Transition Care Program Guidelines, Section 3.1.1, p 15

3.2 Models of service delivery:

TACP Services in NSW employ models of service delivery that are appropriate to the care setting and focused on achieving the best outcomes for clients.

3.2.1 Care settings

TACP Care Settings

There are three care settings in which TACP places are allocated to operate:

1. *Residential setting:* operated in a residential aged care facility or hospital/Multi-Purpose Service environment
2. *Community setting:* operated in the community, with services delivered in the home where the client is currently residing (not in residential aged care)
3. *Flexible or Combination setting:* able to be operated in either community or residential setting according to demand.

To change the care setting of TACP places, the NSW MoH must notify DoHA in writing. If the change in place classification is from the community setting to the residential or combination setting, then documentation about the facility that will accommodate the places when the setting has been changed must also be supplied.

The majority of TACP places in NSW are operated in the community setting. The NSW MoH and DoHA encourage the exploration of options to achieve a better balance between community and residential TACP in NSW.

PRACTICE GUIDELINES:

All TACP staff in NSW (whether directly employed or contracted) understand that:

- The range of care and services required to be provided by the TACP Service differs according to whether the places are operating in the community or in the residential care setting (see **3.1**);
- The maximum fee able to be charged to clients differs according to whether TACP is provided in the community or in the residential care setting (see **4.4**); and
- Clients may access TACP in both the residential and the community setting in one episode of care (see **2.2**).

TACP Service Managers in NSW understand that:

- The care settings in which TACP places are operated may be changed in consultation with the NSW MoH and DoHA. The care setting of operational places should only be altered in order to better meet the needs of the local community;
- There are also physical requirements governing the operation of places in the residential TACP setting. These include the 'more homelike, less institutional

environment' requirements found in the national *Transition Care Program Guidelines 2011*.[9] DoHA considers each facility individually and may relax these requirements for TACP Services operating in a rural/remote environment where there may be limited options available for residential TACP.

[9] Section 3.5.3, p 23

3.2.2 Service delivery models:

TACP Models of Service Delivery

The Specified Care & Services for TACP are set out in Schedule 1 of the national *Transition Care Program Guidelines 2011*. These services must be available for all clients receiving TACP should they require them (see **12.1)**. The services to be provided differ between residential and community settings. Some services are common to both (Part 3), some are specific to the residential care setting (Part 1) and some are specific to community based TACP (Part 2).

The way in which these services are delivered is at the discretion of the TACP Service, provided they are compliant with the National TCP Guidelines 2011, with LHD policies and procedures and with these Guidelines. Various models are employed by TACP Services in NSW to deliver the Specified Care & Services:

1. *Fully 'in house' model:* all TACP care and services including personal care, allied health and nursing are delivered by LHD staff, with no external, sub-contracted providers.
2. *Fully brokered model:* all TACP care and services are delivered by staff sub-contracted by the LHD. A TACP Service may choose to sub-contract to more than one provider or to just one provider to cover all the specified care and services relevant to the setting. In this case, the LHD still formally holds the allocation of places and continues to have responsibility to ensure that TACP services are delivered in accordance with the national *Transition Care Program Guidelines 2011* and the Transition Care Quality Standards.
3. *Partly brokered model:* some TACP care and services are delivered by LHD staff, with other services being sub-contracted to external providers. In this case, the LHD still formally holds the allocation of places and continues to have responsibility to ensure that TACP services are delivered in accordance with the national *Transition Care Program Guidelines 2011* and the Transition Care Quality Standards.

A sub-contracted provider may further sub-contract aspects of the TACP services they are providing, but the LHD must ensure compliance of these providers with TACP legislation and policy.

The model of service delivery is agreed at LHD level. All staff need to understand and work in compliance with locally agreed model of service delivery. The LHD remains accountable to the Ministry of Health as Approved Provider for meeting legal requirements and program guidelines.

PRACTICE GUIDELINES:

All TACP staff (whether directly employed or contracted):

- understand that the specified care and services for TACP (see **3.1**) can be delivered using a variety of different models;
- employ a model of service delivery that is focused on achieving the best outcomes for clients, fitting the local context and LHD requirements while also reflecting the intent of the TACP and its objectives to optimise independence and to support clients to achieve goals; and
- understand that all models of service delivery must comply with the national *Transition Care Program Guidelines 2011*, must be able to provide all the Specified Care & Services at Schedule 1 of the Guidelines[10] and must meet the Transition Care Quality Standards.

TACP Service Managers in NSW:

- when brokering services to non-government organisations, comply with Section **9.3**; and
- if operating places in a residential care setting, where TACP clients may be co-located with inpatients or permanent residents, ensure a distinct model of service delivery is used for TACP clients that reflects the unique short-term, goal-oriented and therapy-focussed nature of the TACP. Having TACP co-located with inpatients and/or permanent residents can be problematic if clients are asked to make a different contribution to the cost of their care than inpatients or residents while the care they receive may appear to be similar.

[10] p 68

3.3 Care plan development:

TACP Services in NSW develop a care plan for each client on admission to the TACP that is regularly monitored and reviewed throughout their episode of care to demonstrate compliance with the Transition Care Program Quality Standards relating to care planning (below).

Transition Care Program Quality Standards

Standard 1: Optimising independence and wellbeing

1.2 Care planning is focused on optimising independence and wellbeing and includes a goal-oriented care plan for the client that:

- responds to the identified needs of the client and targets those goals which optimise independence while taking into consideration the psycho-social needs of the client;
- provides the client with required therapies and treatments designed to teach the client to achieve their own goals;
- improves the client's functioning by promoting independence and monitors that improvement in consultation with the client, carers and families, clinicians and therapists;

Standard 2: Multi-disciplinary approach and therapy-focused care

2.2 Care planning processes demonstrate that:

- a goal-oriented therapy program is developed by the provider in consultation with the client, carer and family prior to the commencement of therapy or treatment, with input from the MDT of the transferring hospital and the ACAT;
- the therapy program duration is estimated and informs planning for the client's discharge;
- hospital discharge information is incorporated into the initial care planning process;
- care provision is responsive to the identified needs and goals of the client;
- therapy goals agreed with the client or their representative/carer are documented and prioritised;
- the client receives timely and appropriate access to therapy, care and equipment across the health, community and aged care sectors. This is demonstrated by:
    - ensuring aids, appliances, equipment and services required for a client's therapy are provided in a timely manner;
    - providing a broad range of services tailored to meet the client's therapeutic goals to improve or maintain function;
    - providing the client with low intensity therapy from appropriately qualified staff

to achieve their individual documented goals; and

- actively encouraging client, carer and family participation in all aspects of TACP service provision.

- the client's progress against therapy goals is regularly evaluated throughout their TACP episode and on exit, with changes in function measured and recorded to demonstrate achievement of the client's goals;
- the client's changing needs are reflected as they move between care settings; and
- client goals are delivered in accordance with the care plan, using an integrated case management approach.[11]

PRACTICE GUIDELINES:

All TACP staff in NSW (whether directly employed or contracted):

- undertake care planning in accordance with LHD clinical policies and procedures;
- inform the care plan through the use of assessment tools (see Figure 2) to determine client care needs and measure changes in client function while on the TACP, including:
  - Modified Barthel Index (mandatory in order to claim subsidy);
  - goal attainment or other measurement tools. There is no mandated tool for TACP, so TACP Services should choose a tool that is most appropriate for their team.
- comply with the Quality Standards relating to care planning by documenting the development and regular monitoring and review of each client's care plan**;**
- use client, carer and family, multidisciplinary team, ACAT, hospital discharge planning, Acute to Aged Related Care Services (AARCS) and geriatrician input where available to inform the care plan;
- understand that for older people with dementia, who may have difficulty expressing their care goals, the development of the care plan should involve the person's carer and family as appropriate; and
- ensure that each client's care plan is monitored and regularly reviewed and updated in response to progress in achieving their goals.

[11] DoHA 2011, Transition Care Program Guidelines, Attachment A, Appendix 1, p 48

FIGURE 2

ASSESSMENTS UNDERTAKEN TO INFORM TACP CARE PLANNING

In-hospital

- Mini Mental State Examination (MMSE)
- ACAT assessment
- Mobility assessment
- Occupational Therapist initial assessment

Physiotherapist

- Falls assessment
- Berg balance scale

OT

- Occupational Therapist home assessment
- Personal care assessment
- Functional task assessment

Social Worker

- Depression assessment eg. Kessler 10LM
- Carer stress assessment

Other

- Malnutrition screening tool
- Home risk assessment - to confirm safe working environment for staff

NOTE: These are examples only. Teams may employ a variety of assessment tools at different stages of the admission and care planning/review process. The only mandated assessment tool for TACP is the Modified Barthel Index.

3.4 Case management:

TACP Services in NSW provide all clients with case management services encompassing the coordination and monitoring of their care during the TACP episode and planning for post-discharge care and support needs.

GUIDELINES:

All TACP staff in NSW (whether directly employed or contracted):

- understand that appropriate case management is vital to achieve the best outcomes for clients and to ensure that the client experiences seamless care in their journey from hospital through TACP to their ongoing care arrangements;
- understand that key roles of the case manager, as defined in the Schedule of Care & Services[12] include:
    - ensuring that a comprehensive care plan is developed at the time of discharge from hospital;
    - ensuring that all aspects of the care plan are carried out, monitoring progress against the care plan goals and adjusting the plan where necessary;
    - identifying any changes to a recipient's care needs that occur during the TACP episode and arranging for appropriate adjustments to the services provided;
    - liaising with and organising all care requirements provided by external service providers (including GPs and specialists); and
    - arranging for appropriate care and support, if required, following the TACP episode or managing the return of the recipient to the community or their normal care arrangements.

TACP Service Managers in NSW:

- ensure that each client is assigned a case manager on admission to the TACP to coordinate and monitor their care; and
- develop local policies, procedures, tools and other local resources to assist staff with the case management role.

[12] DoHA 2011, Transition Care Program Guidelines, p 68

3.5 Multidisciplinary approach:

TACP Services in NSW employ a multidisciplinary team (MDT) of health professionals to inform the planning, delivery and review of care for clients, and can demonstrate achievement of Quality Standard 2, Outcome 2.3 (below).

Transition Care Program Quality Standards

Standard 2: Multidisciplinary approach and therapy-focussed care

2.3 The MDT approach to the planning and review of client care demonstrates that:

- documented procedures and protocols are available to support the multi-disciplinary team in the care and review of clients. This includes processes for communicating client information to relevant health professionals;
- care planning is carried out by members of the multi-disciplinary team with relevant clinical experience in goal-oriented, low intensity therapy;
- care plan reviews/case conferencing include those members of the MDT involved in the client's treatment and occur at pre-determined intervals;
- care is informed by discussions with and between the relevant geriatrician and the client's GP, where possible, and/or other appropriate medical input;
- MDTs have integrated client records;
- the MDT comprises an appropriate mix and level of staff, enabling the provision of effective client services; and
- a coordinator/case manager is in place to oversight and promote effective MDT and inter-agency working.[13]

PRACTICE GUIDELINES:

All TACP staff in NSW (whether directly employed or contracted):

- comply with the national Transition Care Quality Standards relating to the multi-disciplinary approach to TACP service provision;
- participate in and document regular multi-disciplinary case conferencing meetings to monitor and review client progress against care plans;
- maintain appropriate records demonstrating compliance with a multi-disciplinary approach to client care, including criteria set out in *Quality Standard 2, Outcome 2.3.*[14] and

[13] DoHA 2011, Transition Care Program Guidelines, Attachment A, Appendix 1, p 50
[14] DoHA 2011, Transition Care Program Guidelines, p 49

- maintain effective communication with other members of the multi-disciplinary team.

TACP Service Managers in NSW:

- ensure that following the client's admission to TACP, an assessment is undertaken to inform the client's care plan which builds on the hospital-based multi-disciplinary team assessment for discharge planning. This assessment includes ACAT, AARCS and geriatrician input, where available;
- ensure there is good multi-disciplinary communication at all times.

3.6 Discharging from TACP:

TACP Services in NSW demonstrate that they are achieving Transition Care Quality Standard 3 (below) governing the safe discharge of clients, including minimising the risk of readmission to hospital and facilitating continuity of care and support.

Transition Care Quality Standard 3 - SEAMLESS CARE

The Transition Care Service uses a collaborative service delivery model that delivers seamless care.

The Transition Care Service develops systems for the safe discharge of clients that help prevent readmission, including:

- providing Transition Care Service discharge care planning to any subsequent care organisation; and
- providing appropriate discharge documentation to the client, specifying:
  - length of stay in Transition Care;
  - destination post-Transition Care;
  - goals which client agrees have been achieved or not achieved (with reasons for non-achievement);
  - client functional levels on discharge, assessed using the same validated instrument used on admission;
  - client, carer and family education and support to improve functioning following discharge;
  - all services and equipment to be provided to the client on discharge from Transition Care, with key supplier contact details;
  - an up-to-date list of prescribed discharge medications; and
  - other follow-up arrangements/referrals such as information to the client's GP, which are the responsibility of the client and/or their representative.[15]

PRACTICE GUIDELINES:

All TACP staff in NSW (whether directly employed or contracted):

- identify an expected discharge date early in the client's TACP episode (recorded on the Client Agreement, the client's clinical record and care plan) and commence planning for discharge during the episode;

[15] DoHA 2011, Transition Care Program Guidelines, Attachment A, Appendix 1, p 51

- as part of the case management of clients, facilitate access to any required ongoing care and services post-TACP, and manage the return of the client to the community and their normal care arrangements;
- inform the client's GP that they are being discharged and provide appropriate discharge documentation to ensure that the GP is aware of the client's needs post-TACP. TACP Services may develop a template letter for GPs that can be adapted with GP and client information;
- provide appropriate discharge documentation to the client and/or carer and to any other organisation or professional involved in the client's care post-TACP;
- arrange for the return of any loaned equipment at the time of discharge from the program, and help the client purchase/access aids or equipment for long-term use if required;
- discuss with the client and their carer their change in functional independence and demonstrate the attainment of their goals over the course of their episode of care;
- facilitate access to a GP to update prescriptions for all discharge medications, and include information on medication management in discharge documentation;
- provide the client, their carer and family with the opportunity to give feedback about their TACP episode via a client survey or similar feedback form (see **5.3** for a recommended survey template);
- in the case of the unplanned discharge of a client, follow the guidance set in Quality Standard 3[16] in providing current documentation to the client, carer or representative, the hospital and/or other care providers, where appropriate.
    - A client may be discharged unexpectedly from the TACP due to an acute care episode requiring readmission to hospital or resulting in death, a carer issue requiring the client's admission to residential respite or a change in condition resulting in the TACP Service no longer being able to provide care to the client safely.
    - Occasionally, clients may also wish to end their TACP episode early to accept a CACP, EACH or EACH-D package, before they have achieved their TACP goals. In this case, TACP discharge planning should include strategies to help the client and their carer or family to work towards these goals after discharge from the TACP.[17]
    - The Modified Barthel Index for a client who is discharged due to death or readmission to hospital must be recorded as '0' on the Medicare Australia Claim Form.

[16] DoHA 2011, Transition Care Program Guidelines, p 51
[17] DoHA 2011, Transition Care Program Guidelines, Section 3.5.8, p 26

*****Please note that the recording of the MBI score of '0' for clients who have died, as well as for clients who have been admitted to hospital or transferring to another TACP service is currently a matter under national review. This section will be updated on resolution of this issue.*****

3.7 Readmission after a break in care:

TACP Services in NSW facilitate readmission to TACP after a break in care, in accordance with the national *Transition Care Program Guidelines 2011*.

PRACTICE GUIDELINES:

All TACP staff in NSW (whether directly employed or contracted):

- understand that a client must be discharged from TACP after a break in care in which TACP services are not provided to the client for more than 24 hours. A break in care is defined as a period of 24 hours or more in which a client is not under the care and supervision of the TACP;
- understand that where there has been a break in care lasting less than 24 hours such as an admission to hospital, the client may continue the TACP episode, providing there has been no deterioration in their condition.
- understand that a previous TACP client may only be readmitted to TACP directly from hospital as an inpatient with a current ACCR approval for TACP;
- understand that an ACAT eligibility approval for TACP is valid for a total of 29 days, comprising the date that the ACAT assessment is approved and signed by the ACAT delegate, plus a 28 day validity period beginning the day after the ACAT delegate's approval. If the older person wishing to be readmitted to TACP does not have a valid ACCR approval for TACP, a new ACAT assessment must be undertaken;[18]
- on readmission to the TACP, review the client's goals and care needs, which may have changed as a result of their re-hospitalisation, and develop a new care plan;
- understand that when a client begins a new episode upon readmission to TACP, a new 12 week period of TACP commences;
- follow all usual admission procedures for clients being readmitted to TACP as applicable to new clients; and
- understand that there are no limits to the number of times an older person may be readmitted to TACP. However, if a client is consistently being re-hospitalised, a systematic review of the multiple readmissions should be undertaken to determine whether TACP is the most appropriate care option for that person.

[18] DoHA 2011, Transition Care Program Guidelines, Section 3.4.4, p 20

3.8 Carers:

TACP Services in NSW involve carers, with client consent, in care planning and service delivery as and when appropriate during the client's TACP episode, and support carers to participate in the client's long-term care decisions.

Carers

Carers may include family members, 'person responsible', friends or neighbours who have been identified as providing regular and sustained care and assistance to the care recipient. Carers frequently live with the person for whom they are caring. A carer may also be the care recipient's advocate.[19]

PRACTICE GUIDELINES:

All TACP staff in NSW (whether directly employed or contracted):

- understand the important role of the carer in achieving the client's TACP goals and in maintaining the client's independence;
- ensure the client's consent to carer involvement in the planning and delivery of services is documented in the client's clinical record;
- ensure that the carer is involved, as appropriate, in negotiating administrative aspects of the TACP, including any fees and service delivery;
- ensure that the carer is involved, as appropriate, in the development of the client's care plan. This is particularly important when the client has difficulty expressing his or her care goals due to cognitive or communicative impairment;
- give carers the opportunity to be educated about providing therapeutic and personal care to the client, so that carers can support the client's TACP goal attainment and help maintain their independence post-TACP. Training and education of the carer may form part of the client's TACP goals;
- assist the carer, either with or on behalf of the client, make mutually acceptable decisions about the longer-term care options for the client following the TACP episode. This may include providing information about local services that the client may require post-TACP, and facilitating access to these services;
- provide appropriate support to the carer while the client is on the TACP. Part of achieving client goals during the TACP may involve helping the carer cope with the client's condition and be aware of services and support. This may include providing information about local carer support services and respite services. If necessary, TACP social work or counselling services may be provided to the carer during the client's TACP episode. This should be explicitly documented as part of the client's goals and care plan, and relate directly to the client's needs.

[19] DoHA 2006, Transition Care Training Handbook for Aged Care Assessment Teams

3.9 Advocacy:

All clients of TACP Services in NSW have access to advocacy services when required, and are able to choose their own advocate.

Advocate

A person who acts on behalf of another party. In the absence of a carer, an independent advocate may be a general practitioner, legal representative, person appointed by the guardianship board or another person who is able to represent the interests of the care recipient adequately.[20]

Advocacy Service

An advocacy service is an independent, confidential service provided free of charge in each state and territory. If a person is receiving Australian Government subsidised aged care service, advocacy services may help them exercise their rights by representing them, and providing information, advice and support to the person, their carer, family or friends.[21]

PRACTICE GUIDELINES:

All TACP staff in NSW (whether directly employed or contracted):

- understand that a client has the right to call on an advocate of their choice to represent them as required in the management of their care;
- provide information to clients on the role of advocates and help them to access an advocacy service if required[22]; and
- consult with a client's advocate, where nominated, in the signing and/or reviewing of the Client Agreement, negotiating fees and resolution of any complaints.

[20] DoHA 2006, Transition Care Training Handbook for Aged Care Assessment Teams
[21] Department of Health & Ageing, www.agedcareaustralia.gov.au, Accessed December 2011
[22] DoHA 2011, Transition Care Program Guidelines, Schedule 1, p 75

3.10 Substitute decision making:

TACP staff understand the different legal mechanisms for substitute decision making, and apply them where relevant in key decisions during the TACP client's episode of care.

Guardianship The NSW Guardianship Tribunal is an independent legal tribunal established under the Guardianship Act 1987. The Tribunal can appoint a guardian to make personal or lifestyle decisions on behalf of a person with decision–making disabilities. It may appoint a family member or friend as a private guardian or, if this is not possible or appropriate, it can appoint the Public Guardian. Enduring Guardianship One or more Enduring Guardians may be appointed by a person to make personal or lifestyle decisions on their behalf. The person nominating the Enduring Guardian identifies the functions to be performed on their behalf, which can include consenting to medical or dental procedures, but the Enduring Guardian cannot make a will, vote, consent to marriage or manage finances on behalf of the person.[23]
Power of Attorney A power of attorney is a legal document made by one person, who is called the 'principal', that allows another person to do things with the principal's bank accounts, shares, real estate and other assets. A power of attorney only authorises an attorney to act in relation to financial matters. It does not allow the attorney to make personal (including medical) decisions for the principal. Enduring Power of Attorney An enduring power of attorney is a legal document which can be used to appoint a person to make decisions about your property or financial affairs if you lose mental capacity. A general power of attorney ceases to have effect after the principal loses the mental capacity to make financial decisions. An enduring power of attorney will continue even after the principal loses mental capacity (eg. through developing dementia, having a stroke or sustaining a brain injury).[24]
Person Responsible If a person is unable to give consent for medical and dental procedures, the practitioner should seek consent from the 'person responsible' under the Guardianship Act 1987. A person responsible is not necessarily the person's next of kin. There is a hierarchy of appropriate persons to be nominated 'person

[23] Guardianship Tribunal, www.gt.nsw.gov.au, accessed December 2011
[24] Guardianship Tribunal, www.gt.nsw.gov.au, accessed December 2011

responsible': a useful tool for determining person responsible is included at 10.3.1 below.
Advance Care Directives Advance care planning refers to the process of preparing for likely scenarios near the end of life and usually includes assessment of, and dialogue about, a person's understanding of their medical history and condition, values, preferences, and personal and family resources. An advance care directive (ACD), sometimes called a 'living will', is a document that describes one's future preferences for medical treatment in anticipation of a time when one is unable to express those preferences because of illness or injury.[25]

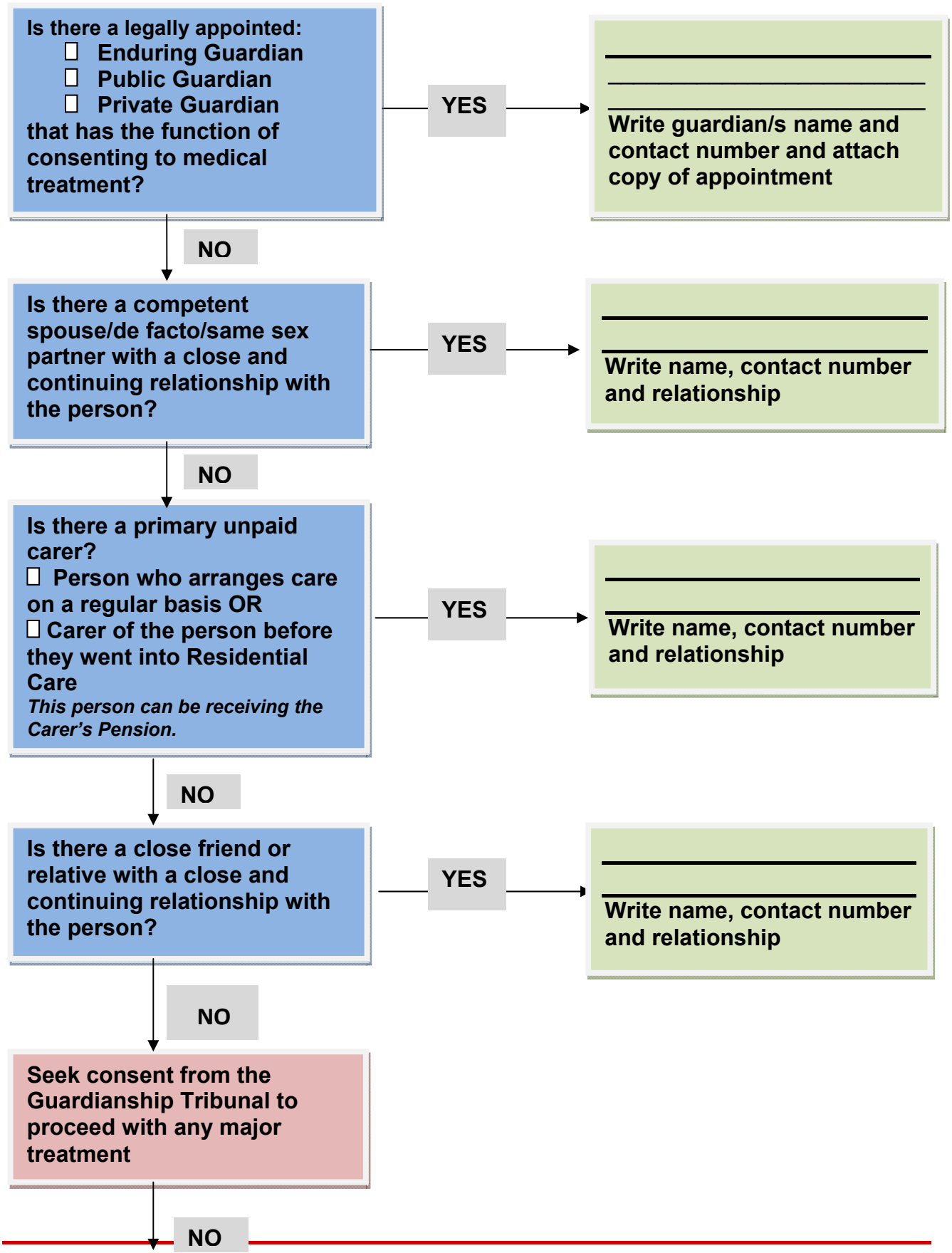
PRACTICE GUIDELINES:

All TACP staff in NSW (whether directly employed or contracted):

- understand how to apply the legal mechanisms for substitute decision making when TACP clients are unable or unwilling to make their own decisions about care, services and treatment;
- have access to all NSW Government guidelines, policy directives and information that give guidance about working with clients with:
    - advance care directives;
    - guardianship arrangements;
    - person responsible arrangements; and
    - power of attorney arrangements.
- involve legally appointed guardians, attorneys or persons responsible when appropriate in decisions about the client's care and service delivery, including negotiation of the Client Agreement and any fees.
- use the hierarchy flowchart (overleaf) to identify a legally authorised person responsible for a client. If a person identified as being a 'person responsible' declines in writing to exercise the function, or if a medical practitioner certifies in writing that the 'person responsible' is not capable of carrying out these functions, then the person next in the hierarchy is the 'person responsible'.

[25] NSW Health 2005, Using Advance Care Directives in NSW (GL2005_056)

3.10.1 Determining Person Responsible



3.11 Special needs groups:

People with special needs have equitable access to TACP Service in NSW and staff provide appropriate and tailored services to clients with special needs.

3.11.1 Aboriginal & Torres Strait Islander people

Aboriginal & Torres Strait Islander People

The expansion of the Transition Care Program from 2,000 to 4,000 places nationally by 2011/12 includes a commitment to improve access to the program by Aboriginal & Torres Strait Islander people. The Approved Provider must manage the delivery of Transition Care to ensure that Aboriginal & Torres Strait Islander people are equitably represented in the target population of the Transition Care Program. [26]

PRACTICE GUIDELINES:

All TACP staff in NSW (whether directly employed or contracted):

- understand the national objective of improving equity of access to the TACP for Aboriginal & Torres Strait Islander people;
- participate in cultural awareness training;
- are aware of the key challenges for Aboriginal & Torres Strait Islander people in accessing the TACP, and implement strategies to address them; and
- provide culturally appropriate services to Aboriginal clients, working with local Aboriginal health services where appropriate.

TACP Service Managers in NSW:

- ensure that all staff have appropriate, up-to-date cultural awareness training;
- develop a strategy for engaging with local Aboriginal health providers and Aboriginal Liaison Officers in the acute and community settings as a source of information and to raise awareness about the TACP; and
- develop culturally appropriate information material about the TACP for Aboriginal clients and their families.

[26] DoHA 2011, Transition Care Program Guidelines, Section 3.2.1, p 16

3.11.2 Culturally & Linguistically Diverse people:

Cultural and Linguistic Diversity

The Australian Bureau of Statistics defines Cultural and Linguistic Diversity (CALD) by three variables:

1. Country of Birth
2. Language Other Than English spoken at home
3. English language proficiency

Because CALD is a combination of factors, it is acknowledged that there is no one definition of CALD. The following is the most commonly cited description of CALD:

'In the Australian context, individuals from a CALD background are those who identify as having a specific cultural or linguistic affiliation by virtue of their place of birth, ancestry, ethnic origin, religion, preferred language, language(s) spoken at home, or because of their parents' identification on a similar basis.' [27]

PRACTICE GUIDELINES:

All TACP staff in NSW (whether directly employed or contracted):

- provide appropriate services for people from diverse backgrounds, taking into account their lifestyle, cultural, linguistic and religious preferences;
- ensure information regarding English proficiency and language spoken at home is obtained and documented and initiate contact with interpreter services as soon as possible;
- respect cultural differences in their communication with people from diverse backgrounds;
- adapt written and oral communication styles to suit the needs of clients from linguistically diverse backgrounds; and
- are able to access interpreters for clients when required, particularly during the development of the care plan and negotiations about services to be provided and any fees.

TACP Service Managers in NSW:

- develop information material about the TACP accessible to linguistically diverse communities, as appropriate to the local context.

[27] Victorian Multicultural Strategy Unit 2002

3.11.3 People living with dementia:

NSW Dementia Services Framework 2010-2015

The NSW Dementia Services Framework 2010-2015 was developed by NSW Health in partnership with Family & Community Services NSW, Ageing, Disability & Home Care, aiming to improve the care experience and outcomes for people living with dementia and their carers.

The Framework reviews service needs and makes recommendations along a service pathway of dementia care from awareness through diagnosis, assessment, community, hospital and residential care. Recommendations are practical and aim to improve access, diagnosis and continuing care. It provides a checklist for reviewing the way services are currently provided and encourages reflection on how services could be delivered differently to improve outcomes for people with dementia, carers and families.[28]

PRACTICE GUIDELINES:

All TACP staff in NSW (whether directly employed or contracted):

- understand that people living with dementia and/or cognitive impairment may benefit from accessing TACP services, provided they meet the ACAT eligibility requirements;
- accept referrals for clients living with dementia and/or cognitive impairment, if they can be managed safely in the TACP Service; educate hospital staff about the services available through the TACP for people with dementia;
- have access to and utilise resources to aid appropriate care planning and service provision for clients living with dementia, particularly the NSW Dementia Services Framework 2010-2015;
- develop links between the TACP Service and local dementia-specific services, such as the Dementia Behaviour Management Advisory Service (DBMAS) or Behavioural Assessment and Intervention Services (BASIS);
- where appropriate, consult services such as DBMAS and BASIS in developing care plans for clients with dementia, recognising that individual goals may be different for this group and may include:
    - re-establishing routines after a hospital event
    - recovering from a delirium
    - acceptance of services
    - reducing carer stress and improving carer education

[28] NSW Health 2011, NSW Dementia Services Framework 2010-2015 (GL2011_004)

  - reducing challenging behaviours
  - ensuring safety and compliance with medication
- involve carers and/or family as appropriate in developing care plans and goal identification, addressing the needs of carers in these plans where appropriate.

4 CHAPTER 4 – CLIENT INFORMATION

4.1 Client rights and responsibilities:

All TACP clients (and their families and carers) are aware of their rights and responsibilities while on the TACP.

PRACTICE GUIDELINES:

All TACP staff in NSW (whether directly employed or contracted):

- ensure that clients have access to the full list of rights and responsibilities at the beginning of their TACP episode and that they are fully understood by the client and their carer/family as appropriate;
- are trained in managing any issues arising in relation to client rights and responsibilities, and;
- document clients' understanding of their rights and responsibilities as part of the admission process.

The full list of client rights and responsibilities can be found in the *Transition Care Program Guidelines 2011* (p 27-28) and within this document at 12.2 Appendix B.

4.2 Privacy and confidentiality:

TACP Services in NSW have protocols and procedures in place governing protection of the privacy and confidentiality of clients' personal information.

PRACTICE GUIDELINES:

All TACP staff in NSW (whether directly employed or contracted):

- understand their obligations under the *Privacy Act 1988* in meeting the National Privacy Principles;
- adhere to privacy protocols as detailed in *NSW Health Privacy Manual Version 2*;
- understand that information concerning a client may only be used for a purpose connected with the provision of care to the client (*Transition Care Program Guidelines 2011*, p 29);
- obtain written client consent to release of information as necessary to health and aged care providers during the TACP episode;
- respect the privacy of clients' financial information in negotiating any client contributions to the program;
- as part of the Client Agreement, inform the client that all possible steps are taken to guarantee the privacy and confidentiality of personal information (see Error! Reference source not found.).

A proforma that may be used to obtain client consent to release information to health practitioners involved in the care of the client during the TACP episode is attached at 12.3 Appendix C.

4.3 Client Agreement:

TACP Service Providers in NSW enter into a formal agreement with individual clients or their representatives in compliance with NSW Health and Australian Government requirements.

MANDATORY REQUIREMENTS:

TACP Services in NSW must offer a Client Agreement to all clients on acceptance into the TACP that includes all the requirements set out in the *Transition Care Program Guidelines 2011 (p 27-28).* See checklist below for detailed list of requirements.

If a client does not wish to enter into a formal, written agreement, the TACP Service is still required to ensure that the client understands the services, the conditions under which they are to be delivered, and any fees payable by the client.

If the client chooses not to enter into a formal agreement, this situation and the reasons for not signing a Client Agreement must be documented in writing.

The agreement must be reviewed and updated in consultation with the client as required throughout the TACP episode.

If a client transfers to a different TACP Service in the same episode of care, a new agreement is not necessary, provided the new TACP Service is located within NSW. If the client transfers interstate, a new agreement must be offered as the Approved Provider will change.

The Model NSW TACP Client Agreement, complying with all requirements is attached at 12.4 Appendix D. This template should be adapted to include local information.

Client Agreement Checklist:

The following items must be included in a formal Client Agreement:

- ☐ statement of the range and limits of services that the client has been assessed as requiring according to his or her care plan and the method and frequency of their provision under the TACP;
- ☐ clear statement of any charges payable by the client, how often the fees will be paid and how they have been calculated (see **4.4**);
- ☐ planned start date of the TACP episode and an explanation of the maximum duration of care (12 weeks or 18 weeks with an ACAT-approved extension);
- ☐ conditions under which the Agreement may be terminated or varied by either party;
- ☐ statement that any readmission to hospital for longer than an overnight stay; i.e. less than 24 hours, will result in discharge from the TACP;

- ☐ statement that there are no provisions for clients to take leave from the TACP;
- ☐ guarantee that all reasonable steps will be taken to protect privacy and confidentiality of the client;
- ☐ statement of the client's rights and responsibilities while on the TACP; and
- ☐ a description of the internal and external complaints mechanisms relating to the service, including contact details for the Health Care Complaints Commission and the Aged Care Complaints Resolution Scheme.

PRACTICE GUIDELINES:

All TACP staff in NSW (whether directly employed or contracted):

- understand the content of Client Agreements;
- be able to clearly explain the Client Agreement to the client (and/or family and carer as appropriate);
- understand that the Client Agreement should be signed and dated by both a representative of the TACP Service and the client or their representative;
- understand that a signed copy of the initial agreement and a copy reflecting any amendments throughout the TACP episode should be given to the client or their representative; and
- ensure that the original signed copy of the Agreement and any subsequent amendments are securely stored with the client's records.

4.4 Fees payable by clients:

TACP Services in NSW understand that a Transitional Aged Care Service may charge a daily care fee as a client contribution to the cost of care and that, if fees are to be charged, appropriate protocols and procedures are followed to determine a level of contribution that does not create financial hardship for the client.

Maximum Fees

(*Transition Care Program Guidelines 2011, p 30-31)*

The Transition Care Payment Agreement between the Australian Government and the NSW Government sets the **maximum** amount that can be charged for client fees:

- 84% of the basic daily rate of the single pension for care delivered in the residential setting
- 17.5% of the basic daily rate of the single pension for care delivered in the community setting

The rules on maximum fees apply to both single and married clients. The NSW MoH will notify all TACP Service Providers of any changes to the maximum fee rate each March and September, when pension rates are announced by the Australian Government.

PRACTICE GUIDELINES:

All TACP staff in NSW (whether directly employed or contracted):

- understand that clients may be asked to contribute a fee to the maximum rate set out above, and advise all prospective clients before commencing the service that a contribution to the cost of care may be charged;
- ensure that no client is denied access to the TACP because of inability to contribute care fees. Clients should be made aware of this in any promotional material about the program (e.g. information brochures);

TACP Service Managers (or their designate) in NSW:

- develop appropriate procedures for sensitively negotiating care fees that respect the client's right to privacy and confidentiality, and make the process as simple and unobtrusive as possible;
- conduct any financial assessment of the client's capacity to contribute to the cost of care, on behalf of the Service Provider;
- when negotiating a contribution, take into account any major, unavoidable expenses incurred by the client , such as pharmaceutical or equipment needs, accommodation, utility, carer or social support costs, or the need to pay fees for other ongoing services while receiving Transitional Aged Care;

- offer clients the option to have fees reduced or waived if they are unable to pay, or if their financial circumstances change during the TACP episode;
- comply with LHD policies and requirements for determining client contributions up to the maximum prescribed by the Australian Government and assessing clients' financial disadvantage. It is not expected that TACP service staff are involved in the LHD billing process.
- understand that all money received via client fees must be used for the purpose of providing TACP services to clients. This is reported on in the Annual Accountability Reports to the Australian Government.
- If care fees chargeable to a client who transfers from one service to another are different, this should be explained to the client prior to transfer and the Client Agreement updated accordingly.
- A fee should not be charged to a client who has transferred from another service in which fees were not payable.

Where possible, the client should have a representative present during the process of financial assessment.

A model procedure for the assessment of client capacity to contribute to the cost of Transitional Aged Care is set out at 12.5 Appendix E. TACP Services are encouraged to base local practice on this procedure.

Refer to *Transition Care Program Guidelines 2011* (pp. 30-31) for more information about charging fees.

4.5 Leave from TACP:

TACP formally discharges all clients requiring a break in care for longer than 24 hours as required by the national Transition Care Guidelines 2011.

PRACTICE GUIDELINES:

All TACP staff in NSW (whether directly employed or contracted):

- understand that, as a short term program, there is no legislative provision for clients to take leave in excess of 24 hours from the TACP;
- understand that a client must be discharged from TACP after a break in care in which TACP services are not provided to the client for more than 24 hours. A break in care is defined as a period of 24 hours or more in which a client is not under the care and supervision of the TACP;
- understand an overnight stay in hospital or another location is acceptable provided TACP Services are delivered on consecutive days and there is no break in care provision to the client;
- ensure the client, when signing the Client Agreement, is aware that there is no provision for leave from the program for a period longer than overnight (see);
- arrange for the client to be discharged from the TACP, following all normal discharge protocols and procedures, if the client is admitted to hospital or residential respite for longer than an overnight stay (ie, if there is a 24 hour break in care provision);
- understand that residential TACP clients, as part of their care plan, may undertake a 'trial' stay in their home (eg. for a weekend) to see how they go living in the community. This requires significant coordination and supervision from the TACP Service, and is not considered to be a break in care, provided it is demonstrably part of the client's goal achievement in their therapeutic care plan;
- understand that towards the end of the client's TACP episode of care, where services are stepped down to promote functional independence, the client may not receive services every day, but remains under the care and supervision of the TACP service; and
- take a flexible approach in facilitating the attendance of clients at family and social events, consistent with the national *Transition Care Program Guidelines 2011*, recognising that this is often beneficial to the client's psycho-social functioning goals.

Clients living in rural and remote areas may need to travel to metropolitan centres for specialist medical appointments, and it is not always possible to make this trip overnight. If a client needs medical treatment in a distant regional or metropolitan location and the

TACP Service is concerned about a break in care occurring, staff should seek advice from the Approved Provider (the Aged Care Unit, Integrated Care Branch, NSW MoH) about each individual case.

***** Please note that leave arrangements are currently under national review. This section will be updated on resolution of this issue.*****

5 CHAPTER 5 – CONTINUOUS QUALITY IMPROVEMENT

5.1 National Quality Improvement Framework:

TACP Services in NSW demonstrate continuous improvement in their service delivery across the six dimensions of quality.

Transition Care Program Quality Improvement Framework - Requirements[29]

The six commonly recognised *dimensions of quality* form the basis for monitoring, managing and reporting on the quality of Transition Care services. All dimensions should be included in a system that promotes continuous quality improvement. The six dimensions of quality as they pertain specifically to Transition Care are:

1. *Safety* – risk management, police checks, building certification, professional registration of staff including contractors
2. *Effectiveness* – monitoring of functional improvements
3. *Appropriateness* – monitoring of program outcomes
4. *Stakeholder satisfaction* – monitoring client/family feedback
5. *Access to services* – monitoring utilisation of services by target special needs groups
6. *Efficiency* – monitoring of service performance.

Under the Quality Improvement Framework operating environment, to demonstrate continuous improvement against the six dimensions of quality, TACP Services are expected to:

1. comply with Australian Government, State and LHD legislative and regulatory requirements
2. participate in external accreditation (using Transition Care Quality Standards)
3. implement internal self-assessment and reporting systems
4. develop and continuously review a local quality improvement plan

Transition Care Quality Standards

The Transition Care Quality Standards have been developed covering the unique aspects of the TACP, to complement the generic quality standards used by external accreditation agencies to assess health and aged care services. The most common external accreditation standards in use by NSW TACP Services are:

- Australian Council on Healthcare Standards (ACHS) EQuIP – used for most LHD-operated TACP Services

[29] DoHA 2011, Transition Care Program Guidelines, Attachment A, Appendix 1, p 40

- Aged Care Standards and Accreditation Agency (ACSAA) – used for most TACP Services operating within residential aged care facilities
- Community Care Common Standards
- ISO 9001

The three Transition Care Quality Standards apply to both community and residential TACP Services. The Standards are referenced individually throughout these Guidelines where they are relevant to practice guidance.

Standard 1 – Optimising independence and wellbeing

The Transition Care service optimises the independence and wellbeing of its clients.

Standard 2 – Multidisciplinary approach and therapy focussed care

The Transition Care service provides its clients with high quality, evidence-based therapeutic services focussed on maintaining or improving function in line with established goals.

Standard 3 – Seamless care

The Transition Care service uses a collaborative service delivery model that delivers seamless care.

PRACTICE GUIDELINES:

All TACP staff in NSW (whether directly employed or contracted):

- are familiar with the six dimensions of quality set out in the Transition Care Program Quality Improvement Framework (QIF), and how they contribute to a system of continuous quality improvement;
- understand the QIF operating environment in which they work and their respective roles and responsibilities;
- participate in training and education activities relating to quality improvement, as appropriate; and
- contribute to and participate in internal self-assessment, external accreditation and local quality improvement planning and implementation processes.

TACP Service Managers in NSW:

- ensure staff understand their roles and responsibilities within the operating environment for quality improvement;
- provide staff with the opportunity to improve their knowledge and skills through training and education activities relating to quality improvement, as part of the orientation/induction package, and as appropriate;
- develop and manage systems to monitor and review the performance of the TACP Service against the six dimensions of quality, including:
    - staff have current national police checks (see **6.2**);
    - staff have professional registration as appropriate (see **7.1**);
    - client outcomes are monitored, including functional improvement, discharge destination and goal attainment;
    - client/carer feedback is sought, reviewed and incorporated into quality improvement activities (see **5.3**);
    - strategies to improve the utilisation of the program by key special needs groups including Aboriginal and Torres Strait Islander people and people with dementia are implemented (see **3.11**);
- develop and manage systems to ensure compliance with Commonwealth, State and LHD legislative and regulatory requirements;
- manage the participation of the TACP Service in external accreditation processes, including:
    - developing links with the LHD/organisational quality improvement staff in preparation for the incorporation of the TACP Service into existing arrangements for external accreditation of the LHD or organisation;
    - ensuring that the TACP Service is encompassed in the organisation-wide accreditation survey, incorporating the Transition Care Quality Standards in addition to the generic standards used by the external accreditation agency;
    - ensuring documented evidence is available to demonstrate achievement of the Transition Care Quality Standards;
- use the quality self-assessment template[30] to conduct regular self-assessments to demonstrate achievement of the Transition Care Quality Standards:
    - for all new TACP Services, a copy of the first self-assessment report must be provided to the NSW MoH within 6-9 months of commencement of operation. The Aged Care Unit will contact the relevant LHD Aged Care Contact to request the report during this period;

1. [30] DoHA 2011, Transition Care Program Guidelines, Attachment A, Appendix 2, p 53

- ongoing self-assessments against the Transition Care Quality Standards must be conducted regularly to monitor achievement of the three Transition Care Quality Standards. This is an important part of preparing for external accreditation assessment and copies of regular self-assessments should be made available to external accreditation agencies to demonstrate continuous quality improvement;

- provide a copy of the report on the results of any external accreditation process as evidence that the TACP Service meets the Transition Care Quality Standards when requested by the NSW Ministry of Health (in accordance with LHD reporting protocols).
- develop, implement and regularly review a local quality improvement plan that has links to the LHD/organisational quality improvement committee (or equivalent). This should be provided to external accreditation agencies as evidence of achieving the Transition Care Quality Standards.

***** Please note that the TCP quality framework is under national review. This section will be updated on resolution of this issue.*****

5.2 Local policy and procedure systems:

Local policies and procedures used in TACP Services are consistent with legislative frameworks and aligned with DoHA and NSW Health policy and guidelines as appropriate.

PRACTICE GUIDELINES:

All TACP staff in NSW (whether directly employed or contracted):

- are aware of all changes and updates to local, LHD or equivalent organisational (for brokered Service Providers) policies and procedures, and change their practice accordingly; and
- participate in in-service education and training to implement changes to policy and procedure, when appropriate.

TACP Service Managers in NSW:

- establish a formal, regular mechanism to review and update any local, LHD or organisational TACP policies and procedures;
- ensure all changes are incorporated in both hard copy and electronic versions of the policies and procedures;
- maintain an archival system as a record or changes to policy and procedure over time; and
- ensure TACP staff and associated workers are kept informed of changes to local policies and procedures. When appropriate, changes to policy and procedure should be accompanied by in-service education and training.

5.3 Feedback:

TACP Services in NSW offer each client and their carer/family the opportunity to give feedback about their experience of the TACP, and evaluate this feedback to support continuous quality improvement.

PRACTICE GUIDELINES:

All TACP staff in NSW (whether directly employed or contracted):

- understand that client feedback is an important aspect of quality improvement;
- offer clients and their carer/family formal and informal opportunities to give feedback during and after the episode of care. Feedback mechanisms may include opinion surveys, exit interviews/surveys, comments/suggestions boxes or focus groups. A Model Client Satisfaction Survey is included at 12.6 Appendix F;
- understand that complaints are also an important part of feedback, and follow the guidelines for complaints management at **Section 6.1**; and
- take action to address identified areas for improvement.

TACP Service Managers in NSW:

- evaluate feedback to monitor the satisfaction levels of clients and their carer/family, and to identify positive aspects of the program as well as areas for improvement; and
- use positive client feedback and the outcomes of action taken in response to feedback to demonstrate continuous quality improvement.

6 CHAPTER 6 – RISK MANAGEMENT

6.1 Complaints management:

TACP Services in NSW inform clients of internal and external complaints mechanisms, and have processes in place to record, resolve and monitor complaints.

Mandatory Requirements[31]

TACP Services must inform clients at the beginning of their episode of care (in the Client Agreement) about the mechanisms available for making a complaint. This includes both internal and external mechanisms.

Internal Mechanisms

Each TACP Service must have an internal mechanism for addressing complaints that are made directly through the Service or through the organisation operating the Service:

- for LHD-operated TACP Services, this may be part of the internal LHD complaints mechanism;
- for TACP Services operated by contracted non-government providers, this may be part of the broader complaints mechanism for the organisation. LHDs that contract non-government providers to operate TACP Services should ensure that the service agreement includes provision for the contracted provider to report complaints and the action taken to resolve them to the LHD.

External Mechanisms

Clients are encouraged to approach the TACP Service with any complaints in the first instance. However, TACP Services should also provide the contact details for the *NSW Health Care Complaints Commission* in the Client Agreement.

PRACTICE GUIDELINES:

All TACP staff in NSW (whether directly employed or contracted):

- recognise that complaints are an important aspect of client feedback and should be used positively to monitor and improve the quality of service delivery;
- provide details about internal and external complaints mechanisms to clients in the Client Agreement and on request of the client;
- comply with local processes for receiving, recording and resolving complaints made internally through the TACP Service; and

[31] DoHA 2011, Transition Care Program Guidelines, Section 6.1.5, p 36

- co-operate with the NSW Health Care Complaints Commission or the NSW MoH to investigate and resolve any complaints made through external complaints mechanisms.

TACP Service Managers in NSW:

- know and implement the local organisational (LHD or other) complaints management mechanism within the TACP Service, and monitor compliance against it through the resolution of complaints; and
- ensure staff understand and comply with the local complaints mechanism, as well as external mechanisms which may be used by clients.

Note:

The Australian Government *Aged Care Complaints Scheme* manages complaints relating to residential and community aged care, but in the current system does not manage complaints relating to the Transition Care Program. If a complaint relating to a NSW TACP Service is raised with the Scheme, the complaint will be referred to the NSW MoH, as the Approved Provider of TACP in NSW, for resolution. The role of the Aged Care Complaints Scheme is being reviewed by the Australian Government and may change in the future. These Guidelines will be updated to reflect any changes.

6.2 Police checks:

TACP Services in NSW comply with their legislative obligations in relation to maintaining current police checks for all staff.

Aged Care Act 1997: Accountability Principles 1998, Part 4

Operators of aged care services subsidised by the Australian Government must hold national police certificates that are not more than three years old for:

- all staff members, directly employed or contracted, who are reasonably likely to have access to clients, whether supervised or unsupervised; and
- volunteers who have unsupervised access to clients*.

Further information about the definition of volunteers under the Act can be found at Section **9.4.*

PRACTICE GUIDELINES:

TACP Service Managers in NSW:

- understand that all staff are required to have a current national police certificate, including staff sub-contracted through another agency to provide aspects of TACP. The contract between the agency and the TACP Service should state that any staff providing TACP services must have a current police certificate that does not preclude them from working in aged care.
- understand that police check requirements are not automatically extended to people engaged on an ad hoc basis, e.g. tradespeople. The policy intention is to allow for reasonable judgements to be made.[32]
- Approved Providers are bound by the Act not to allow a person to become, or continue as, a staff member or volunteer if their police certificate records a precluding offence (murder or assault). If in doubt, legal advice should be sought about the refusal or termination of employment on the basis of a criminal record.

Administration of Police Certificates

TACP Service Managers, as the agents of the Approved Provider, must keep records demonstrating that:

- there is a police certificate, which is not more than three years old, for each staff member and volunteer;
- an application has been made for a police certificate, where a new staff member or volunteer does not have a police certificate;

[32] DoHA 2011, Police Certificate Guidelines

- a statutory declaration has been provided by any staff member or volunteer who has not yet obtained a police certificate;
- their compliance with these record-keeping requirements in accordance with the Privacy Act 1998; and
- systems and procedures are in place to ensure suitable management and monitoring of the police certificate requirements for all staff members and volunteers, including:
    - three year police check renewal procedures; and
    - appropriate storage, security and access requirements for information recorded on a police certificate.

6.3 Safe practice:

TACP Services in NSW have up-to-date policies and procedures to manage, report and reduce risks, including falls, incidents of abuse of older people and Work Health & Safety incidents.

Key legislative and policy requirements

- Work Health & Safety (WH&S) Act 2012
- Protecting People & Property - NSW Health Policy and Guidelines for Security Risk Management in Health Facilities (PD2005_39) (Chapter 16 – Security of staff working in the community)
- national *Transition Care Program Guidelines 2011*: Chapter 6 - Quality Assurance
- Policy & Best Practice Guidelines for the prevention of manual handling incidents in NSW public health services, NSW Ministry of Health 2001 (PD2005_224)
- Interagency Protocol for Responding to Abuse of Older People 2007, available at www.adhc.nsw.gov.au

PRACTICE GUIDELINES:

All TACP staff in NSW (whether directly employed or contracted):

- comply with LHD procedures for incident management and reporting and investigation of serious incidents. Contracted service providers are required to use incident management systems compatible with the local LHD system;
- act in accordance with local, state and national protocols for identifying and reporting clients at risk from serious incidents, including abuse of a client or clients at risk from natural disasters or weather events, in order to notify the NSW Ministry of Health. As Approved Provider, the NSW MoH has an obligation to notify the Department of Health & Ageing of this information without delay;[33]
- are familiar with local internal (organisational) and external (community) emergency management procedures and protocols;
- participate in Work Health & Safety (WH&S) training, and demonstrate compliance with numerical profile and WH&S accreditation requirements. This includes the maintenance of attendance records;
- comply with the LHD risk management policy for manual handling of clients and equipment, including undertaking a 'patient handling assessment' to minimise the risk to clients by having the appropriate level of staff assistance and devices to

[33] DoHA 2011, Transition Care Program Guidelines, Section 5.1.2, p 32

assist manual handling. The mobility assistance needs of prospective clients should be considered when determining whether the TACP Service has the capacity to safely provide care;

- comply with safety requirements when transporting clients, including standards relating to manual handling of clients and any equipment. Access issues at the health service, in the client's home and in public places should be considered as part of a risk assessment;
- are aware of, and implement, NSW Health policy on security risk management of community/home visiting by conducting a risk assessment to determine any potential risks for NSW Health and community service workers. This includes communicating risk management requests to clients and carers (eg. no smoking during visit) and/or arranging alternate safe consultation locations; and
- understand that TACP Services operating in residential aged care facilities must meet building certification standards, and that TACP Services operating in hospital buildings must meet standards for hospital or health service buildings in NSW.

TACP Service Managers in NSW:

- ensure all staff have access to the relevant NSW Health policies and procedures governing safe practice;
- ensure the TACP Service is included in the appropriate internal and external emergency management plans;
- ensure all staff have training in evacuations and other appropriate emergency management procedures; and
- ensure all staff have up-to-date Work Health & Safety training.

6.4 Key Personnel:

TACP Services in NSW maintain an updated list of Key Personnel as authorised representatives of their service.

Key Personnel: Definition

Key Personnel are defined in the Aged Care Act 1997 as:

a. A member of a group of persons who is responsible for the executive decisions of the entity at that time;

b. Any other person who has authority or responsibility for (or significant influence over) planning, directing, or controlling the activities of the entity at that time;

c. If, at that time, the entity conducts an aged care service;

   i. Any person who is responsible for the nursing services provided by the service, and

   ii. Any person who is responsible for the day-to-day operations of the service (whether or not the person is directly employed by the entity).[34]

PRACTICE GUIDELINES:

TACP Service Managers in NSW understand that:

- Key Personnel are legally nominated as representatives of the TACP Service, and are responsible for providing appropriately authorised information on behalf of the Service. Therefore, nominated Key Personnel must have a level of responsibility that enables them to make these declarations;
- Key Personnel are different from 'Authorised Signatories'. Prior to 2009, Authorised Signatories were registered with Medicare Australia and were the only staff able to certify Medicare subsidy claim forms. This has now changed, and Medicare no longer keeps a register of Authorised Signatories. Key Personnel are now responsible for ensuring that the Medicare claim forms are certified by an appropriately authorised person;
- the duties of the Key Personnel include:
  - signing the Aged Care Approved Provider Statement on behalf of the TACP Service;
  - ensuring that the Medicare monthly claim forms are certified by an appropriate person (the form does not need to be signed by the Key Personnel; they may nominate another authorised signatory);

[34] Aged Care Act 1997, Chapter 2, Part 2.1, Division 8-3

- ensuring that any information provided as part of activity, financial and quality reporting is authorised by an appropriate person.

The DoHA keeps a list of current Key Personnel for each TACP Service ID. The DoHA must be notified of the change within 28 days of any staff or organisational changes resulting in a change to Key Personnel.

Forms can be found on the DoHA website for adding, ceasing or changing a Key Personnel (www.health.gov.au). To remove a person from the Key Personnel list, the 'cease' form must be completed. To change a person's details (eg. job title) while they are still the Key Personnel, the 'change' form must be completed.

The NSW MoH, as Approved Provider, must sign these forms before they are sent to DoHA. All add, cease or change Key Personnel forms must be completed and forwarded to the Aged Care Unit, Integrated Care Branch, NSW MoH within 21 days of the change in Key Personnel for forwarding to DoHA for processing.

7 CHAPTER 7 – HUMAN RESOURCE MANAGEMENT

7.1 Clinical staffing profile:

TACP Services in NSW directly employ or access via contracted third parties the full range of staff required to provide clients with all services as described in the relevant set of Schedule 1: Specified Care and Services.[35]

PRACTICE GUIDELINES:

NSW TACP Service Managers:

- depending on local availability, recruit and maintain a core team comprising:
  - management and administrative staff as appropriate to the efficient and effective delivery of services;
  - appropriate mix/representation of clinical disciplines in line with the Schedule of Specified Care & Services (as described in Figure 3); and
  - temporary, flexible arrangements such as utilising community health capacity or contracting local private providers may be used to help ensure that required TACP care and services are available to clients at times when difficulties in recruitment are experienced to maintain continuity of care and service (see **9.7**).
- ensure that all staff and contracted workers understand the relevant set of 'Specified Care and Services' applicable to their service setting (either community or residential).[36] Further detail on the Specified Care and Services is found in Section **3.1**. See also **Section 9.3** for information on sub-contracting/ brokerage of services;
- ensure that all staff (whether directly employed or contracted) are appropriately qualified and experienced to provide 'Specified Care and Services' to clients, as determined through initial and ongoing assessment of care needs;
- consider the specific characteristics of a region in the selection of TACP staff; eg. high representation of Culturally And Linguistically Diverse or Aboriginal & Torres Strait Islander communities or other special needs groups, or rural/ remote factors (see **3.11**);
- ensure that all professional staff have appropriate qualifications and current professional registration as applicable and current police checks, as required under legislation (see **6.2**); and
- ensure that all staff have job descriptions detailing their roles and responsibilities in the delivery of TACP services.

[35] DoHA 2011, Transition Care Program Guidelines, Schedule 1, p 68
[36] DoHA 2011, Transition Care Program Guidelines, Schedule 1, p 68

Figure 3: Transitional Aged Care Service Clinical Staffing Profile

In addition to management, case management and administration staff, the following clinical disciplines are involved in the day-to-day delivery of TACP services set out in the Schedule of Specified Care & Services. It is not compulsory for TACP teams to include all of these disciplines; however, depending on client need, the TACP team must be able to facilitate access to any low intensity therapy, personal care and GP or specialist medical services required by clients while on the TACP. Teams may choose to sub-contract some of these services to third party providers.

NURSING	ALLIED HEALTH
• Assistant in Nursing • Endorsed Enrolled Nurse • Registered Nurse	• Dietitian • Occupational Therapist • Physiotherapist • Podiatrist • Social Worker • Speech Pathologist • Therapy Aide/Assistant

7.2 Orientation:

TACP Services in NSW have an orientation program for all new members of the TACP Service (both directly employed and sub-contracted staff) that includes outlining the legal, policy and administrative obligations of their role.

PRACTICE GUIDELINES:

TACP Service Managers in NSW:

- provide an orientation or induction program for all new team members encompassing:
    - instruction and support to acquire the proficiency needs to provide a quality service for clients;
    - administrative requirements. This includes, but is not limited to, maintenance of medical records and documentation, report writing, and data collection and reporting requirements;
    - policies and procedures. This includes these Guidelines, the *Transition Care Program Guidelines 2011*, legislative requirements, quality improvement processes, clients' rights, and all related issues;
    - local organisational charts, including orientation to the local work environment and introductions to all relevant staff and associated service providers as soon as practicable, meeting LHD orientation requirements; and
    - attendance at local meetings as relevant to the position and/or required by management.
- maintain appropriate personnel records documenting outcomes of the orientation program for inducted staff; and
- ensure new team members receive:
    - practical peer support and discipline-specific clinical supervision; and
    - the opportunity for joint home visits and care planning with experienced staff as required.

7.3 Performance appraisal:

TACP Services in NSW use annual staff appraisals/performance management plans to review individual performance and encourage professional development.

PRACTICE GUIDELINES:

TACP Service Managers in NSW:

- implement a staff appraisal/performance review system consistent with LHD policy and practice and in accordance with service agreements with sub-contracted service providers;
- tailor the process, as appropriate, to the roles and responsibilities of TACP workers under the Aged Care Act 1997 and in accordance with the *Transition Care Program Guidelines 2011*; and
- identify opportunities for improved performance and continuing professional development for their staff.

7.4 Continuing education and professional development:

All staff (whether directly employed or contracted) in TACP Services in NSW have regular access to ongoing education and professional development pertinent to their roles and responsibilities in the efficient and effective provision of TACP services.

PRACTICE GUIDELINES:

TACP Service Managers in NSW:

- identify and commit resources and funding for continuing education activities;
- encourage team members to be self-motivated in contributing to and maintaining professional competency and understanding of aged care issues and changing practices, including practical knowledge of functional and goal measurement tools as well as notions of wellbeing, reablement and consumer directed care;
- facilitate access to ongoing clinical supervision which empowers individual practitioners to develop their knowledge and competence, maintain responsibility for their own practice, develop skills in multi-disciplinary team work and enhance consumer protection and the safety of care in complex clinical situations;
- facilitate staff attendance at relevant professional and industry conferences and other educational forums;
- provide opportunities for staff to progressively expand their knowledge of the management of health conditions in older people so that they are able to provide sound clinical services to clients and their carers;
- maintain appropriate records of staff education and professional development in accordance with local health district policy; and
- provide clinicians with access to and education regarding navigating CIAP, the Clinical Information and Access Program for NSW Health staff, where available.

Useful resources

The ACAP Assessment Toolkit 2011[37] was developed by the National Ageing Research Institute in consultation with the ACAP Expert Clinical Reference Group and contains a comprehensive set of validated assessment tools to assess an older person's cognitive and physical function. This may be a useful resource for TACP staff in using measurement tools when assessing and reviewing clients.

The Superguide: a handbook for supervising allied health professionals (2ed, 2012)[38] was developed by the Allied Health Directorate of the Health Education and Training Institute (HETI), in collaboration with the NSW Allied Health Directors Network, to

[37] National Ageing Research Institute 2011, ACAP Assessment Toolkit
[38] HETI 2012, available at www.heti.nsw.gov.au

support allied health professionals within NSW Health providing supervision to allied health staff.

It contains information about:

- supervising allied health professionals in ways that contribute to the safety and better care of patients
- effective methods of contributing to the education, welfare and professionals development of allied health professionals.

8 CHAPTER 8 – INFORMATION MANAGEMENT

8.1 TACP data collection and reporting

8.1.1 Quarterly Reports

PRACTICE GUIDELINES

TACP Managers in NSW:

- Prepare Transition Care Quarterly Reports using the TCP Quarterly Reporting template for submission through LHD Aged Care Contacts to the NSW Ministry of Health.

  Transition Care Quarterly Reports provide useful data on service activity and, together with the Transition Care Annual Accountability Report, assist the Approved Provider in observing and understanding service levels, trends, costs and budgetary requirements.

8.1.2 Annual Accountability Reports

TACP Services and Service Providers cooperate with LHD Finance staff to complete Annual Accountability Reports in a timely and accurate manner by maintaining accurate records of income and expenditure.

PRACTICE GUIDELINES:

TACP Service Managers in NSW understand that:

- under the Transition Care Payment Agreement, the full amount of TACP subsidy (both NSW and Australian Government funds) must be directed to meeting the needs of TACP clients. Any unspent surplus may be recalled by the Australian Government. All TACP income and expenditure must be reported each financial year to DoHA through the Annual Accountability Report;
- the TACP Annual Accountability Report is required to be submitted to the Australian Government by 30 September each year. As DoHA is the majority funder of the NSW TACP, these reports are an integral part of NSW MoH's responsibility as Approved Provider under the payment agreement. It records income and expenditure in a reporting template developed by DoHA;
- in July/August each year, the NSW MoH forwards a formal request to Chief Executives for the submission of the Annual Accountability Reports. With this request is enclosed the latest subsidy payment figures for each Service ID in the LHD, as well as the template and the names of the TACP Services that must submit a report for the previous financial year;
- all TACP Services that were operational at any time during the reporting period must complete a report showing how they expended any subsidy paid; and
- the Annual Accountability Reports are to be submitted to ACU, NSW MoH in electronic form by the date indicated on the request to LHD Chief Executives, and are to be signed by an appropriately authorised operational or finance manager.

8.2 Clinical recordkeeping and documentation:

NSW TACP Services maintain and retain documentation and supporting evidence to a standard which meets clinical, legal and quality requirements.

Key NSW Health Policies

- NSW Patient Matters Manual, Chapter 9 Health Records & Information, 2008
- NSW Health Privacy Manual Version 2 (PD2005_593)

PRACTICE GUIDELINES:

All TACP staff in NSW (whether directly employed or contracted):

- maintain systems and entries in the client health care (medical) record that meet statutory documentation and record keeping requirements;
- store health care records in a secure place at all times that can only be accessed by authorised personnel;
- ensure that all written and oral communication of clinical information meets the NSW Health policy on privacy/confidentiality of health records and information (NSW Patient Matters Manual 2008):
    - Using email to transmit health information within the LHD should be restricted to wherever it is essential for immediate, ongoing care, and must only include information required for the purpose.
    - When using email to send health information outside NSW Health, limit the number of recipients, exclude patient-identifying information if feasible, and protect documents with a password that is given separately over the phone.
    - No personal health information should be given over the phone unless it has been established that the caller has legitimate grounds to access the information and can give proof of identity. It is advised that, prior to disclosing personal health information, TACP staff should return the call of the person requesting information to confirm the request is legitimate.
    - A file note should be made by TACP staff recording all information disclosed, to whom, for what purpose and on what date;
- manage client records to optimise confidentiality and security while facilitating continuity of care when planning for continuing service provision after discharge from the TACP;
- maintain a chronological file of all contact investigations, meetings and decisions regarding a client, and document a summary of assessment details and recommendations for use by other service providers as appropriate;

- maintain records of discussions and negotiations with the client or their representative about the Client Agreement and care plan, including services to be delivered and any fees, updating the records as these arrangements are reviewed; and
- maintain documentation of activity that demonstrates the achievement of the Transition Care Quality Standards:
    1. Optimising independence and well-being
    2. Multidisciplinary approach and therapy-focussed care
    3. Seamless care.

9 CHAPTER 9 – LEADERSHIP AND MANAGEMENT

9.1 Corporate and clinical governance:

TACP Services in NSW establish appropriate clinical and corporate governance mechanisms.

Key NSW Health Policies

- NSW Health Code of Conduct, 2005 (PD2005_626)
- NSW Health Corporate Governance & Accountability Compendium, 2005

PRACTICE GUIDELINES:

All TACP staff in NSW (whether directly employed or contracted):

- comply with internal structures, systems and processes to ensure recognisably high standards of care, transparent accountability and a constant dynamic of improvement;
- sign the *NSW Health Code of Conduct* (NSW Health staff) or equivalent organisation-specific code of conduct and understand the ethical terms of their employment;
- understand the roles and responsibilities of the key participants in the delivery and administration of the TACP, including LHD Aged Care Contacts, the NSW MoH and DoHA;
- have regard to their individual safety and follow all guidelines in delivering TACP care and services;
- have a readily identifiable manager/team leader with clear and formal reporting lines in the LHD or organisation.

TACP Service Managers in NSW:

- integrate clinical and corporate governance of the TACP Service, as appropriate;
- incorporate principles of clinical governance into a systematic approach to maintaining and improving the quality of client care and outcomes, including:
    - clear lines of responsibility and accountability for the overall quality of clinical care;
    - a comprehensive quality improvement framework (see **Chapter 4**);
    - education and training plans giving staff access to continuous professional development (see **7.4**);
    - *clear protocols and procedures aimed at managing risk (see **Chapter 6**);*

  - clear protocols and procedures for recordkeeping and documentation of client care (see **8.2**);
  - integrated procedures for all professional groups to review performance (see **7.3**)
- incorporate principles of corporate governance into a systematic approach to accountability of decision-making in the TACP Service, including:
  - clearly defined roles and responsibilities for TACP staff;
  - mechanisms for informed, transparent decision-making and risk management; and
  - clear reporting lines for activity, quality and financial reporting linked to LHD/organisational and NSW MoH/DoHA requirements.

9.2 TACP service planning:

TACP Services monitor and evaluate the demand for TACP in their local area.

PRACTICE GUIDELINES:

TACP Service Managers contribute data to LHD strategic services planning through:

- demographic analysis to ascertain demand for TACP, particularly noting the proportion of non-indigenous people and Aboriginal and Torres Strait Islander people in the service catchment area. The Australian Government allocation of TACP places to States and Territories is based on this population.
- analysis of available acute and sub-acute health services to ascertain the potential key referrers to TACP in the local area;
- analysis of availability of community and aged care programs such as Compacks, Community and Post Acute Care services, Home Care services and residential aged care services, including dementia-specific services and aged care services specialising in care for Aboriginal and Torres Strait Islander people and people from Culturally and Linguistically Diverse communities, as discharge options for TACP clients;
- analysis of hospital data to identify older patients being discharged from local hospitals who might benefit from the TACP if available.

Each TACP Service should also undertake business planning, considering aspects of program management such as: recruitment; potential brokered partnerships; capital works; equipment; staff training and education; compliance with quality improvement requirements.

If monitoring and evaluation supports a change in configuration of places within the LHD to better meet demand, LHDs may apply to transfer some places to a new or existing TACP Service (see **9.6**).

9.3 Sub-contracting/brokerage of services:

TACP Services in NSW ensure arrangements for subcontracting or brokering of TACP services to a third party comply with NSW Health and NSW Government procurement policies.

Procurement and Disposal of Goods and Services (PD2009_021)

Effective 1 April 2009, the NSW Health requirements for tendering for goods and services, which apply to all NSW Health entities, including Local Health Districts (LHDs), are as follows:

a) Goods and Services up to $3,000 in value incl. GST – not required to obtain quotations subject to conditions set out in the policy directive;

b) Goods and Services over $3,001 and up to $30,000 in value incl. GST – required to obtain one written quotation subject to conditions set out in the policy directive;

c) Goods and Services over $30,001 and up to $250,000 in value incl. GST – required to obtain three written quotations subject to conditions set out in the policy directive;

d) Goods and Services over $250,001 in value incl. GST – required to go to open tender.

PRACTICE GUIDELINES:

TACP Service Managers in NSW are able to demonstrate compliance with:

1. NSW Health Procurement Policy

NSW Health Procurement Policy has different tendering requirements depending of the value of the goods and services. A useful resource for these generic requirements is the NSW Health Procurement Portal, which can be accessed through a link on the Homepage of the NSW Health Intranet site.

Through the Procurement Portal, TACP Service Managers can access:

- templates, checklists and forms, including for writing and evaluating tenders;
- links to policies and procedures for NSW Health;
- contact details for the Procurement Advisory Service;
- links to NSW Government protocols and resources for tendering.

2. NSW Government Procurement Policy

Information about the NSW Government Procurement Policy is available at www.nswprocurement.com.au which is a useful resource that provides tendering

guidelines, information about the prequalification scheme and information about NSW Government e-tendering.

LHD support and resources may also be available through contacting LHD Procurement and Contracts Management staff.

3. TACP Requirements for Sub-contracting

TACP Service Managers in NSW:

- Recognise the NSW MoH as the Approved Provider for the delivery of TACP services in NSW;
- Understand that, as part of its responsibilities as Approved Provider, NSW MoH must ensure that any non-government provider of TACP services has a formal service agreement in place guaranteeing compliance with the legislative requirements for the TACP are met;
- must cooperate with all NSW MoH requests for information and any direction given regarding sub-contracting and brokering of TACP service delivery in NSW. This includes:
    - provision of information to NSW MoH regarding the name of sub-contracted service providers and the nature of brokered services, and prompt advice if sub-contracted service providers change;
    - provision of information regarding current accreditation status of sub-contracted service providers;
    - supplying signed copies of current service agreements to NSW MoH as part of Applications for Determination to operationalise new places, as well as when agreements are amended, reviewed or updated.
- must keep copies of all relevant service agreements, including agreements covering the further sub-contracting of an aspect of TACP service provision by a brokered service provider.
- ensure tender documents and final service agreements for the provision of TACP services include the requirement for brokered services to comply with the *Transition Care Program Guidelines 2011*, and specifically in relation to:
    - Schedule of Required Care and Services for Transition Care, as relevant to the services being sub-contracted through the tender (p 68-75);
    - Providing equitable access for Aboriginal & Torres Strait Islander people, people with dementia and other groups with special needs (p 16);
    - any requirements for the sub-contracted service provider under the Quality Improvement Framework (p 40-47);
    - complaints handing processes (p 36-37);

- ensure tender documents and final service agreements include a list of NSW Health policies that the tenderer must comply with, including:
    - LHD Incident Management Systems
    - NSW Health Privacy Manual
    - Safety in the Community Policy
    - Infection Control
    - Abuse of Older People Policy
    - Manual Handling

9.4 Volunteers:

TACP Services in NSW meet all legislative obligations when engaging volunteers to provide services to TACP clients.

Volunteers – Aged Care Act 1997, Accountability Principles

Under Section 1.18 of the Accountability Principles (Aged Care Act 1997), a volunteer is defined as a person who:

- is not a staff member; and
- offers his or her services to the Approved Provider (or agent); and
- provides care or other services on the invitation of the Approved Provider and not solely on the express or implied invitation of a care recipient; and
- has, or is reasonably likely to have, unsupervised access to care recipients; and
- has turned 16 years of age, or if the person is a full-time student, has turned 18 years of age.

PRACTICE GUIDELINES:

All TACP staff in NSW (whether directly-employed or contracted):

- recognise that volunteers provide valuable support to older people, and that some clients may have pre-existing arrangements with volunteers in place before they enter the TACP;
- understand that a person only fits the definition of a volunteer under the legislation if they have been invited by the TACP Service to provide care or services to a client and meet all the criteria listed in the definition above;
- understand that a current police check must be held by the TACP Service whenever volunteers invited by the TACP Service to provide services on their behalf have unsupervised access to clients;
- understand that whenever pre-existing arrangements with volunteers are in place, the TACP Service should endeavour to maintain these arrangements to preserve continuity of care for the client during and post-TACP; and
- understand that arrangements may continue when a client has a pre-existing arrangement with a volunteer for the delivery of a service that would usually be provided under the TACP. No police check or formal service agreement is required with the volunteer in this case for the period the client is on the TACP.

9.5 Funding and claiming:

TACP Services in NSW claim their subsidy payments in a timely and accurate manner.

9.5.1 Funding

Transition Care Program Payment Agreement (NSW & Australian Governments)

Clause 2.1

A TACP Service is eligible for subsidy payment if, during that day the TACP Service:

a) holds an allocation of places;

b) is providing regular care according to a care plan;

c) provides Transition Care as defined in the Aged Care Act 1997 to an eligible care recipient.

Clause 3.1

The full amount of the flexible care subsidy must be directed to meet the needs of care recipients.

PRACTICE GUIDELINES:

NSW TACP Service Managers understand that:

- the NSW TACP is a joint Australian Government-State program that is funded through subsidy payments per occupied day for each operational place;
- the Australian Government is informed of each TACP Service's activity each month by a claiming process through Medicare Australia (see **9.5.2**);
- upon receipt of information about TACP clients in the claim form, Medicare Australia makes the Australian Government component of the subsidy payment to NSW Ministry of Health, which then pays the full amount to the LHD on a monthly basis;
- the NSW Government also pays a component of the subsidy on a weekly basis to LHDs. The daily rates of both the Australian Government and State contributions to TACP subsidy are determined each financial year;
- subsidy is paid in advance, based on an estimate of occupancy for each month. Once a month's subsidy claim has been processed, the following payment is adjusted for any over- or under-payment in the previous month; and
- it is the responsibility of the LHD to ensure that the full amount of TACP subsidy is directed to meeting the needs of TACP clients. This should be reflected in the Annual Accountability Reports which are completed for each TACP Service and submitted to the Australian Government by 30 September each year (see **8.1.2**).

9.5.2 Claiming:

TACP Claiming Process

Approved Providers are required to submit a claim for each month containing details of each care recipient for whom they are claiming subsidy in that month. The amount paid for the month is the sum of the amounts due each day of the month for each eligible care recipient.

Where an Approved Provider has transition care places in more than one approved transition care service, separate claims must be made for each service. The payment system will generate a claim form for each uniquely identified transition care service linked to an approved provider.[39]

PRACTICE GUIDELINES:

TACP Service Managers understand that:

- to receive subsidy payment for TACP services delivered to clients, TACP Services must submit a claim form to Medicare Australia for each claim period (each month), providing details of clients;
- a separate claim form must be submitted to Medicare for each TACP Service ID, even if there are several Service Providers operating places under that ID;
- the claim for subsidy is a certification by the authorised agent of the Approved Provider that the subsidies claimed are legally due from the Australian Government under the Aged Care Act 1997. TACP Services should note the statement on the first page of the claim form indicating that providing false information is a serious offence;

Completing & submitting claims

- once the previous month's claim is processed, Medicare will send out a new form for the following payment period in hard copy, along with a Payment Statement detailing the previous month's payment;
- the explanatory notes on page 2 of the claim form are a good guide to ensuring that the claim is correctly completed prior to forwarding to Medicare;
- for clients still in the TACP Service as at the end of the previous claim period, Medicare pre-populates the first eight columns. If any of these clients were discharged from TACP, the rest of the information must be completed, including the number of days the client has been on the program in both the community and residential settings;

[39] DoHA 2006, The Claim & Advance Payment Cycle

- to add new clients to the claim, columns 2-8 must be completed. Medicare will allocate the Care Recipient ID in column 1;
- claim forms must be signed by a signatory who is designated by the Key Personnel for each TACP Service to be appropriately authorised to sign (see **6.4**). Medicare does not keep a list of authorised signatories; it is the responsibility of Key Personnel to ensure that the signatory is appropriately authorised. The claim must not be signed or dated before the first day of the following period (ie. it must be completed after the end of the payment period);
- monthly claims should be submitted by the 15th calendar day of the following month (ie. the February claim should be submitted by 15 March). Prior to sending to Medicare, ensure a copy is kept on file;

Understanding Medicare's payment system

- where a claim for TACP subsidy is rejected, Medicare will notify the TACP Service in writing, setting out the reasons. On the Payment Statement sent to TACP Services with the next month's claim form, notes in the 'advice' column detail the reasons for non-payment. TACP Services must take the action requested in the advice column as soon as possible in order for payment to be processed.

Main reasons for non-payment of subsidy[40]
Claiming for more care recipients on any one day than there are places allocated to the TACP Service (exceeding the allocation).
A care recipient has exceeded their maximum number of days approved for TACP. The maximum number of days is 84, unless granted an extension to a total maximum of 126 days.
A care recipient does not have a valid ACAT approval for TACP. This may occur because the 29 day entry period has elapsed, or the ACAT approval date is after the date of admission to TACP, or the Transition Care Extension form has not been received.
A care recipient's ACCR has not been received by Medicare. This may occur particularly for ACATs that do not have e-ACCR capabilities. The TACP Medicare claim may reach Medicare before the ACAT has submitted the ACCR. Medicare is then unable to verify that the care recipient has been approved as eligible for TACP. In this case, no subsidy will be claimed for this care recipient, and the TACP Service must follow up with the ACAT to ensure the ACCR is forwarded to Medicare. When the ACCR is received, Medicare will pay subsidy back to the date of admission for this

[40] Medicare Australia, 2009

care recipient when the next claim form is processed.
No claim for previous month has been lodged. If Medicare has not received and processed a claim form for the previous month, they are unable to pay subsidy. For example, the June claim cannot be paid until the May claim has been processed.
Missing information required about the care recipient on the claim form.

9.6 Transfer of places:

LHDs maintain and manage their TACP Service configuration in order to best meet local needs.

PRACTICE GUIDELINES:

To ensure TACP is most effectively meeting local demand, LHDs should continually monitor and evaluate demand for TACP, including by analysing long term occupancy trends in existing TACP Services:

- if a change in demand drivers is identified, and it is considered that TACP packages may be better utilised elsewhere, the LHD may apply to transfer some TACP places from one Service to another to create a configuration that best meets demand;
- in order to transfer TACP places from one Service to another within an LHD:
    - contact the Aged Care Unit, Integrated Care Branch, NSW MoH to discuss proposed changes;
    - provide evidence to support the proposed transfer of places and nominate a date for the transfer to take effect. If the places are being transferred to a new TACP Service, additional information about the staffing and operation of the new Service must also be provided;
    - the NSW MoH, as Approved Provider, will seek approval from DoHA to formally transfer the places, via an Application for Variation of Conditions of Allocation form.[41] This may take up to 60 days to process;
    - while approval is being formalised, the LHD should develop a strategy to implement the transfer with the least disruption possible to existing and future clients. Such a strategy should involve planning for a gradual 'wind down' of services to the places ahead of their transfer date, as well as ensuring the receiving Service is resourced to operate the additional places from the transfer date;
    - once DoHA approval has been received, from the nominated date of transfer the affected places will be operated by the receiving TACP Service, and subsidy for the places will be claimed under that Service's ID number.

[41] Available at www.health.gov.au

9.7 Accessing additional services:

TACP Service staff understand the payment arrangements for accessing TACP services through additional providers during a client's episode of care, and coordinate and monitor care for the maximum benefit to the client.

PRACTICE GUIDELINES:

TACP Service Managers in NSW understand that:

- each TACP Service must be able to provide clients with access to all elements listed in the Schedule of Specified Care & Services[42] according to individual client need. In the case where a TACP Service is not able to obtain suitable workers or a permanent brokerage arrangement to provide part of the required services for TACP, they may 'hire' these services on a client needs basis;
- this 'hiring' of services should be on a fee-for-service basis, governed by a written agreement, with the TACP case manager arranging for aspects of the client's care plan to be provided by a private or government provider and paid for using TACP funds (at no cost to the client);
- the 'hiring' arrangement may also be appropriate when a client has a pre-existing arrangement with a HACC or private care provider (eg. nursing or personal care) for an aspect of TACP care and wishes to keep using this provider during their TACP episode. In this case, the TACP Service would arrange to meet the costs for that service according to the client's needs in their care plan for the duration of their episode of care;
- in order to come to this arrangement, TACP Services must:
    - agree to a fee with the 'hired' provider to be paid by the TACP Service for the relevant aspect of TACP care; and
    - ensure that the 'hired' provider's care is regularly monitored and reviewed as part of the client's care plan by the TACP case manager.
- where the TACP Service arranges for a HACC or other government-funded provider to provide an aspect of TACP care for a client during their TACP episode, the costs are met from the TACP and not the HACC program, even if the client is otherwise eligible for HACC services;
- the exceptions, where the client accesses services through the HACC program, rather than being funded by the TACP, are when they access Meals on Wheels and minor Home Modifications:
    - If a client requires Meals on Wheels while on the TACP, staff should facilitate access to this service but the client must meet the costs of the meals and delivery. If the client is HACC eligible, they may receive the

[42] DoHA 2011, Transition Care Program Guidelines, Schedule 1, p 68

HACC subsidy to cover the delivery costs of Meals on Wheels. The payment arrangements for Meals on Wheels should be clearly set out in the Client Agreement.

- If a client requires minor home modifications while on the TACP, staff should ascertain whether the client is HACC eligible or eligible under the Veteran's Home Care program, and if so, seek the home modifications under these programs. If the client is not eligible for HACC services, the TACP Service may seek a contribution from the client to pay for the costs of these services. If the client requires major home modifications, the TACP Service may seek a contribution from the client for the costs of these services.[43]

- if a client is accessing another clinician/specialist outside the care plan of the TACP at their own cost, TACP staff should be aware of the arrangement and ensure that the client's TACP outcomes are not adversely affected.

[43] DoHA 2011, Transition Care Program Guidelines, Schedule 1, p 71

9.8 Communication and promotion of TACP services:

The TACP is widely promoted to maximise the referral of appropriate clients to the program and to increase awareness and understanding of the services offered.

PRACTICE GUIDELINES:

TACP Service Managers in NSW:

- understand that promotion of the TACP Service and its benefits to key hospital referrers is vital in maximising the referral of appropriate clients;
- develop an ongoing communication strategy to promote the TACP Service, targeting both referrers and clients.
- utilise a range of communication strategies to promote their service as appropriate – see following table.

TABLE 3

Communication Strategies	Considerations
Client information brochure	Aimed at prospective clients and their families, explaining what the TACP is in easily-accessible language. Culturally appropriate resources may be developed for local Aboriginal & Torres Strait Islander communities and Culturally and Linguistically Diverse communities. Key information to be included in all brochures: • eligibility criteria as listed in the national *Transition Care Program Guidelines 2011* and the ACAP assessment process; • maximum duration of the program (12 weeks plus extension); • services provided by the program; • arrangements for client contributions to the cost of the program (if applicable) , accompanied by a statement that no client will be excluded from the program based on inability to pay; • where the program will be provided (at the client's home or in a residential location); • contact details for the TACP Service. Ensure these brochures are widely available at the main referring hospitals.

Referrer information pack/education sessions	Aimed at hospital staff who may identify appropriate patients for referral to the TACP. An information pack containing key information as identified above, with additional information about referral processes and any documentation required at the client's admission to the TACP. A laminated 'TACP referral pathway' page available in hospital wards may also help referrers. An education session for key referrers may help in increasing understanding of the benefits of the TACP, the availability of the local TACP Service and improving identification and referral of appropriate clients. This is particularly important when starting a new TACP Service where hospital staff may not be aware of the program. Discussing patient case studies demonstrating patients who are and are not appropriate for referral to the TACP may also be helpful. Promotion of the availability of culturally appropriate care and services for Aboriginal & Torres Strait Islander people and Culturally and Linguistically Diverse people should also be a key aspect of this strategy.
Regular, ongoing communication to referrers about availability of local TACP places	Aimed at ensuring that referrers always consider TACP as a discharge option for appropriate patients through regular communication with hospital discharge planners, for example by: • developing an email list of chief referrers to provide regular updates of TACP place availability; • participating in regular hospital discharge planning meetings to help identify appropriate clients and provide information about vacancies.
Good news story opportunities	Aimed at taking opportunities to publicise the TACP Service in the local media (in compliance with LHD media policies). Promotional material may encapsulate the TACP, the services provided, and perhaps some examples of how the TACP has helped local clients.

General information about the NSW TACP for the general public can be found at www.health.nsw.gov.au.

10 CHAPTER 10 – WORKING WITH OTHER SERVICES

10.1 Aged health and aged care services in NSW:

TACP Services in NSW establish and maintain effective links with aged health and aged care services in their local area, consistent with Transition Care Quality Standard 3 (below).

Transition Care Quality Standard 3 - SEAMLESS CARE

The Transition Care Service uses a collaborative service delivery model that delivers seamless care.

3.2 The Transition Care Service works within an integrated system of care with other organisations by:

- Establishing relationships and communication strategies that govern collaboration between acute/subacute, aged and primary health services, promoting a clear understanding of each other's roles, responsibilities and admission criteria;
- Establishing systems for the secure, timely and effective transfer of Transition Care client information between service providers;
- Facilitating effective interagency case conferences;
- Facilitating the client's entry to and exit from Transition Care so that the client experiences a seamless move;
- Effectively coordinating the client's needs and goals between services;
- Keeping the client and their representative well informed prior to moving to a new service;
- Facilitating education, training, networking and support across sectors and service boundaries in the broader health and aged care community where appropriate;
- Facilitating access to ongoing care and service provision post-discharge from the Program, as required.[44]

[44] DoHA 2011, Transition Care Program Guidelines, Attachment A, Appendix 1, p 51

PRACTICE GUIDELINES:

All TACP staff in NSW (whether directly employed or contracted):

- foster close links with key local aged health services, including:
    - Aged Care Assessment Teams (ACATs)
    - Acute to Aged-Related Services (AARCS)
    - Aged Care Services Emergency Teams (ASETs)
    - Hospital discharge planners/Transfer of Care Coordinators
    - Geriatricians
    - Community health services
    - General Practitioners
    - Psychogeriatric services
    - Dementia-specific services
    - Chronic and complex care services
    - Aboriginal and Torres Strait Islander health and liaison services
- foster close links with key local aged care services, including:
    - HACC service providers
    - Residential aged care facilities
    - EACH & EACH-D providers
    - CACP providers
    - Commonwealth Respite and Carelink Centres
    - Aboriginal and Torres Strait Islander aged and community care providers
    - Department of Veterans Affairs Service Providers
    - Private nursing services
- Use communication strategies to promote understanding of the TACP among other local aged health and aged care providers (see **9.8**).

10.2 TACP Services across NSW:

TACP Services actively network with other TACP Services, both within their own Local Health District and across NSW.

PRACTICE GUIDELINES:

All TACP staff in NSW (whether directly employed or contracted):

- are able to access the contact details of all local and neighbouring TACP Services. NSW TACP Service contact details are available on the NSW Health Intranet, or through the Aged Care Unit, Integrated Care Branch, NSW MoH and are regularly updated;
- are aware of the Aged Care Contact and communication mechanisms between their LHD and the Aged Care Unit, Integrated Care Branch, NSW MoH;
- participate in mentoring activities across TACP teams;
- network across and within LHDs to promote consistency of practice and decision-making across NSW, and to facilitate the transfer of clients between TACP Services when necessary;
- are encouraged to participate in regional, NSW and national forums; and
- share policy, protocols and knowledge in a network of professional support.

11 GLOSSARY

Acute to Aged-Related Services (AARCS)	AARCS services target early and appropriate identification of the discharge support needs of older people admitted to hospital who have multiple health and care needs that put them primarily at risk of, or in need of residential aged care directly from hospital. They identify, plan and facilitate an older person's care after hospital along with monitoring the person's presenting problem and acute care intervention using a case management model across the continuum of care. AARCS discharge planning/case management services for the older person help to eliminate unnecessary delays in the transfer of care of older patients, thus reducing the number of patients having prolonged and potentially unsafe hospital stays.
Advocate	A person who acts on behalf of another party. In the absence of a carer, an independent advocate could be a general practitioner, legal representative, person appointed by the Guardianship Tribunal or another person who can adequately represent the interests of the client.
Aged Care Assessment Teams (ACATs)	Aged Care Assessment Teams are multi-disciplinary teams of health professionals who assist frail older people to gain access to the types of services most appropriate to meet their care needs. This includes responsibility for determining eligibility for entry to Australian Government subsidised residential aged care, community care and flexible care (including Transition Care) as and when appropriate. ACATs conduct a comprehensive assessment of the restorative, physical, medical, psychological, cultural and social dimensions of care, and provide a choice of appropriate services to meet the person's needs. ACATs refer clients to services that are appropriate and available to meet their needs and preferences.

Aged Care Client Record (ACCR)	The Aged Care Client Record is the approved form used by ACATs to record a summary of the assessment and approval information and by people applying for Australian Government funded aged care services under the Aged Care Act 1997. This care includes residential respite care, permanent residential aged care, community care and some flexible care services.
Aged Care Complaints Scheme	The Aged Care Complaints Scheme is an Australian Government service for people to raise concerns about the quality of care or services being delivered to people receiving residential or community aged care service subsidised by the Australian Government. Currently, the TACP is not covered under the Scheme. It can refer complaints that fall outside its scope to other organisations. The scope of the Scheme is currently under review by the Australian Government.
Aged Care Contact	Each Local Health District (LHD) has a senior aged care manager nominated as the 'Aged Care Contact' for liaison with the Aged Care Unit, Integrated Care Branch, NSW MoH. The Aged Care Contacts meet with the ACU monthly to discuss issues related to the Aged Care Assessment Program, the TACP and Long Stay Older Patients (LSOP) activities and aged care policy matters generally. They play an important role in ensuring important information is passed from the NSW MoH to LHD program staff and vice versa. They also coordinate mandatory reporting for submission to the NSW MoH as required.
Aged Care Unit (ACU)	The Aged Care Unit is located in the Integrated Care Branch in the NSW Ministry of Health. The Unit has strategic policy responsibility for a range of aged health care services in NSW, including Aged Care Assessment Teams, Acute to Aged Related Care Services, Aged Services in Emergency Teams, State-Government Residential Aged Care Facilities and the TACP. The Unit carries out the responsibilities of the NSW MoH as Approved Provider of TACP services in NSW and as program manager for the Aged Care Assessment Program (ACAP) to 30 June 2014.

Aged Care Services in Emergency Teams (ASETs)	Aged Care Service in Emergency Teams (ASETs) undertake the screening and comprehensive assessment of older people who present to the emergency department. The assessment may require the ASET worker to facilitate and advocate access to available care services appropriate to the frail older person's care needs and deliver clinical interventions as required. ASET service delivery includes the development of a plan of care that can be utilised by inpatient services and in the community.
Approved Provider	The Approved Provider means a person or body in respect of which an approval under Part 2.1 of the Aged Care Act 1997 is in force, and includes any state or territory, authority of a state or territory or local government authority. For the purposes of the Transition Care Program, state and territory governments, represented by the Department or Ministry of Health, are the Approved Provider under the Act.
'Break in care'	A 'break in care from the TACP occurs whenever the client is not under the care or supervision of the TACP service for a period of 24 hours or more.
Care Plan	A plan developed by the TACP Service in consultation with the client. The care plan describes the TACP goals agreed with the client, the type of services to be provided, the frequency and hours of actual service provision, the location at which the service will be provided and the respective responsibilities of the service agency, its staff and the client. The TACP care plan should be informed by hospital discharge planners and ACAT assessments as well as the TACP multi-disciplinary assessment.
Client Agreement	A signed agreement between the TACP client and a TACP Service which details services to be delivered by the service provider, any charges payable by the client to the service provider, external complaint mechanisms and how to access these and other arrangements.

Carer	Carers may include family members, next of kin, friends or neighbours who have been identified as providing regular and sustained care and assistance to the client. Carers frequently live with the person for whom they are caring. A carer may also be the client's advocate.
ComPacks	A ComPacks is a NSW Health initiative that provides a **non-clinical** coordinated package of community care to people being discharged from a participating NSW public hospital, for a maximum of six weeks following discharge from hospital. It is available to public hospital inpatients assessed as requiring support from case management and immediate access to at least two community services to safely return home from hospital.
Community Aged Care Packages (CACPs)	Care consisting of a package of personal care services and other personal assistance provided to a person living in the community setting. (Note: to be updated following changes to the Aged Care Act in 2013).
Dementia Behaviour Management Advisory Service (DBMAS)	The NSW DBMAS is an advisory service that helps workers and carers manage the care of people living in residential care or in the community with severe and persistent behavioural and psychological symptoms of dementia. Clinical staff at the service provide information to better understand the underlying influences of behaviours and suggest possible strategies to reduce the impact of such behaviours.
Department of Health & Ageing (DoHA)	The Australian Government is the majority funder of the national Transition Care Program and the Department of Health & Ageing is responsible for the day-to-day administration of the program. The DoHA chairs the Transition Care Working Group comprising representatives from each state and territory, which meets to develop national policy and provide strategic direction for the TCP.

Extended Aged Care at Home (EACH)	Extended Aged Care at Home is a form of flexible care that is provided in the client's home. This package of care includes including nursing care, personal assistance (or both) for a client with care requirements equivalent to high level residential care. EACH-D is a form of flexible care that targets people with dementia and is provided in the client's home. Nursing care or personal assistance (or both), are provided in an individually and managed package of care and provided to clients assessed as having behavioural dysfunction associated with dementia and complex care needs because of behavioural dysfunction associated with dementia. This package of care is provided to a client with care requirements equivalent to high level residential care. (Note: to be updated following changes to the Aged Care Act in 2013).
Flexible Care	Flexible care means care provided in a residential or community setting through an aged care service that addresses the needs of clients in alternative ways to the care provided through residential care services and community care services.
Health Care Complaints Commission	The NSW Health Care Complaints Commission is an independent body established under the Health Care Complaints Act 1993. The scope of the Commission's work is to: • receive and assess complaints relating to health service providers in NSW; • resolve or assist in the resolution of complaints; • investigate serious complaints that raise questions of public health and safety; • prosecute serious complaints. www.hccc.nsw.gov.au
Home And Community Care (HACC)	Home and Community Care provided a comprehensive, coordinated and integrated range of basic maintenance and support services to help people maintain their

	independence at home and in the community. It is a joint Australian and state/territory government program for which applicants do not require ACAT assessment.
Local Health Districts (LHDs)	In 2010, the NSW Government announced the boundaries for the Local Health Districts, which are a key requirement of the National Health Reform Agreement finalised in April 2010. NSW has 15 LHDs, eight of which cover the Sydney metropolitan region and seven cover regional and rural NSW. In addition, two specialist Networks focus on Children's & Paediatric Services, and Forensic Mental Health. A third network operates across the public health services provided by three Sydney facilities operated by St Vincent's Health Network (St Vincent's Hospital, Sacred Heart Hospice, St Joseph's at Auburn). LHDs are administered by a Chief Executive and local Governing Board headed by Chairs that include clinicians, healthcare management experts and community representatives.
Low intensity therapy	The therapeutic care delivered through the Transitional Aged Care Program includes low intensity therapy such as physiotherapy, occupational therapy, podiatry, dietetics, speech pathology, counselling and social work to maintain and improve physical and cognitive functioning and to facilitate improved capacity in activities of daily living.
'Medically stable'	The recipients of Transitional Aged Care must have medical care needs that must not exceed those that can be managed by General Practitioners. The medical management should be consistent with that provided to comparable older people living at home or in a residential aged care facility.
Modified Barthel Index (MBI)	The Modified Barthel Index is a validated assessment tool used to measure performance in Activities of Daily Living and mobility. In the TACP, the use of the MBI by the TACP Service to measure the functioning of each client at entry to and exit from the program is mandatory for Australian Government subsidy payments and must

	be recorded on the Medicare Australia subsidy claim form.
Multi Purpose Services (MPSs)	Multi Purpose Services (MPS) are integrated health and aged care services that provide flexible and sustainable service options for small rural and remote communities. The Australian Government provides aged care funding which is combined with State and Territory government funding for health services and infrastructure to bring a flexible mix and range of aged care and health services together under one management structure. This provides small communities that are having difficulty supporting a range of independently-run services with the opportunity to develop a more coordinated and cost-effective approach to service delivery.
NSW Ministry of Health (NSW MoH)	The NSW Ministry of Health is a central NSW public service organisation that supports the executive and statutory roles of the NSW Minister for Health & Medical Research and monitors the performance of the NSW public health system. The NSW MoH is the Approved Provider of TACP services, and these responsibilities are fulfilled by the Aged Care Unit, Integrated Care Branch.
Transitional Aged Care Program (TACP)	The national Transition Care Program is known as the Transitional Aged Care Program (TACP) in NSW to distinguish it from numerous other 'transition' programs. Please see Chapters 1 – 2 for the legal definition of Transition Care under the Aged Care Act 1997.

12 APPENDICES

12.1 Appendix A – Schedule of Specified Care & Services

NATIONAL TRANSITION CARE PROGRAM GUIDELINES 2011

Schedule 1: Specified care and services for transition care services

Note Section 5.1 of the Payment Agreement provides that the care and services listed in Schedule 1 are to be provided in a way that meets the standards set out in Schedule 2 of the Agreement.

The following lists of care and services are not intended to be exhaustive or to limit the range of care and services provided. They indicate the basic level of care that transition care service providers must be able to provide, if required by a recipient of transition care, for receipt of flexible care subsidy for that recipient. The use of telehealth and telecare devices should be considered where medically indicated and appropriate to the client's goals. The availability and adoption of this equipment may be subject to adequate infrastructure to support the transmission of data and images.

Part 1 Care and services that must be provided, when required, to transition care recipients in a residential setting

Col. 1	Column 2 Service	Column 3 Content
1.1	Maintenance of all buildings and grounds	Adequately maintained buildings and grounds.
1.2	Accommodation	Utilities such as electricity and water.
1.3	Furnishings	Bed-side lockers, chairs with arms, containers for personal laundry, dining, lounge and recreational furnishings, draw screens (for shared rooms), resident wardrobe space, towel rails, over-bed tables.
1.4	Bedding materials	Beds and mattresses, bed rails, bed linen, blankets and absorbent or waterproof sheeting, incontinence sheets, restrainers, ripple mattresses, sheepskins, tri-pillows, and water and air mattresses appropriate to each resident's condition.
1.5	Cleaning services, goods and facilities	Cleanliness and tidiness of the entire service. Excludes: a resident's personal area if the resident

Col. 1	Column 2 Service	Column 3 Content
		chooses and is able to maintain it himself or herself.
1.6	General laundry	Heavy laundry facilities and services, and personal laundry services, including laundering of clothing that can be machine washed. Excludes: cleaning of clothing requiring dry cleaning or another special cleaning process, and personal laundry if a resident chooses and is able to do this himself or herself.
1.7	Toiletry goods	Bath towels, face washers, soap and toilet paper, sanitary pads, tissues, toothpaste, denture cleaning preparations, shampoo and conditioner, and talcum powder.
1.8	Meals and refreshments	Preparing nutritious meals that are culturally appropriate and of adequate variety, quality and quantity for each resident, served each day at times generally acceptable to both residents and management, and generally consisting of 3 meals per day plus morning tea, afternoon tea and supper. Special dietary requirements, having regard to either medical need or religious or cultural observance. Food should include fruit of adequate variety, quality and quantity, and non-alcoholic beverages, including fruit juice. Assisting care recipients in eating meals. For care recipients requiring enteral feeding in residential based transition care, the transition care service provider is responsible for providing the enteral feeding formula at no extra cost to the care recipient. See also 3.3 of this Schedule regarding the provision, care and maintenance of tubes for enteral feeding.
1.9	Emergency assistance	At least one responsible person is continuously on call in the facility in which transition care is delivered to provide emergency assistance. In a medical emergency, which requires immediate action, appropriate medical assistance must be sought, e.g. by dialling 000.
1.10	Treatments and procedures with respect to ongoing	Treatments and procedures that are carried out according to the instructions of a health professional, such as a GP or a person responsible for assessing a

Col. 1	Column 2	Column 3
	Service	**Content**
	medical management	resident's personal care needs, or undertaken according to the resident's wishes, including supervision and physical assistance with taking medications, and ordering and reordering medications, subject to requirements of state and territory law. It is expected that the provision of primary medical care to a transition care recipient would be undertaken by a GP. If the care recipient is a permanent resident of a residential aged care facility, then the care recipient may be eligible for the Chronic Disease Management (CDM) items and associated individual allied health items in the Medicare Benefits Schedule (MBS). If the care recipient is not a permanent resident of a residential aged care facility, then the care recipient may be eligible for the community setting CDM items. Where GPs are asked to provide different medical services or a higher volume of services than specified in the MBS requirements, then funding of these additional services should occur through the Transition Care Program. For the purpose of monitoring the care recipient's health status, telehealth and telecare devices may be used where medically indicated and appropriate to the care recipient's goals.
1.11	Assistance in obtaining health practitioner services	Arrangements for aural, community health, dental and oral health, medical, psychiatric, optometry and other health professionals to visit residents whether the arrangements are made by residents, relatives or other persons representing the interests of resident's, or are made direct with the practitioner.
1.12	Goods to assist residents to move themselves	Crutches, quadruped walkers, walking frames, walking sticks, wheelchairs and off-the-shelf aids to assist with upper limb function, should be available as required for the duration of a care recipient's stay. Excludes: motorised wheelchairs and custom-made aids.

Col. 1	Column 2	Column 3
	Service	**Content**
1.13	Goods to assist staff to move residents	Medical devices for lifting residents, stretchers, trolleys should be provided as required for the duration of a care recipient's stay.
1.14	Goods to assist with toileting and incontinence management	Includes the provision as required of absorbent aids, commode chairs, disposable bed pans and urinal covers, disposable pads, over toilet chairs, shower chairs, urodomes, catheter and urinary drainage appliances, and disposable enemas.
1.15	Basic medical and pharmaceutical supplies and equipment	Includes analgesia, anti-nausea agents, bandages, creams, dressings, laxatives and aperients, mouthwashes, ointments, saline, skin emollients, swabs, urinary alkalising agents, and anti-diarrheals. Excludes any goods prescribed by a health practitioner for a particular resident and used only by the resident. In this case, the medication would be covered, as is normal, under the Pharmaceutical Benefits Scheme (PBS).
1.16	Medications	Medications subject to requirements of state or territory law.

Part 2 Care and services that must be provided, when required, to transition care recipients in a community setting

Col. 1	Column 2	Column 3
	Service	**Content**
2.1	Bedding materials	Provision of absorbent or waterproof sheeting, incontinence sheets.
2.2	General laundry	Assistance with laundry.
2.3	Meals and refreshments	Arrange, where required, transport to help a person shop. Assistance with nutrition, hydration and preparing and eating meals. The definition of preparing and eating meals assumes that the care recipient is responsible for providing and paying for the food, including enteral feeding formula, if required. See also 3.3 of this

Col. 1	Column 2 Service	Column 3 Content
		Schedule regarding the provision, care and maintenance of tubes for enteral feeding. However, where Meals on Wheels are required, it is important that the payment arrangements for Meals on Wheels services are clearly described in the care recipient agreement between the service provider and the care recipient. While the transition care service provider would facilitate access to Meals on Wheels, the cost of the Meals on Wheels would be borne by the care recipient. Assistance with special dietary requirements, having regard to either medical need or religious or cultural observance.
2.4	Emergency assistance	Having at least one responsible person or agency, approved by the organisation providing the community care, in close proximity and continuously on call to give emergency assistance when needed. For example, this could be through a personal alert system or a phone number to a mobile or land line which is staffed 24 hours per day. In a medical emergency, which requires immediate action, appropriate medical assistance must be sought, e.g. by dialling 000. Each transition care service provider must develop a protocol for emergency situations and this protocol must be reflected in the service provider's policies and procedures.
2.5	After hours assistance	As part of each care recipient's care plan, the service provider must manage the risk of the care recipient requiring after hours assistance. The possible risk factors for each care recipient should be identified and management strategies implemented for these risk factors. Where the need for after hours assistance has been identified, there should be 24 hour on call access to at least one responsible person or agency in reasonable proximity who is familiar with the care plan and who has given consent to be included in the care plan as

Col. 1	Column 2 Service	Column 3 Content
		contact. The responsible person may be a relative, friend or neighbour who is located close to the care recipient and who will organise after hours assistance or emergency assistance when required. The service provider may also have their own staff on call (i.e. from a nearby aged care service) to go to the care recipient's home after hours. Should the care recipient not nominate a person as a contact, the transition care service provider must provide the after hours assistance. If the care recipient requires 24 hour on call assistance and access to an emergency call system, this must be provided. If a care recipient requires access to an emergency call system on a long-term basis, the care recipient should be given the option of having an emergency call system of their choice installed at their own cost.
2.6	Home help	Assistance with home help including domestic assistance. This includes assistance with cleaning or the provision of cleaning services, goods and facilities, if required.
2.7	Home maintenance and functional safety	Home maintenance reasonably required to maintain the home and garden in a condition of functional safety and provide an adequate level of security. Efforts to ensure functional safety must also include identifying and addressing any Occupational Health and Safety issues that might have an adverse affect on care staff working in the home. If a care recipient requires home modifications, such as the installation of grab rails, hand rails and ramps to enable the care recipient to continue living at home, service providers, in their role as case manager, should confirm eligibility of the care recipient for home modification services provided under the Home and Community Care (HACC) or Veterans' Home Care Programs and availability of the required home modifications through these Programs. For care recipients who are not eligible for services under these Programs, the service provider may ask the care recipient to make a contribution to the home

Col. 1	Column 2 Service	Column 3 Content
		modification. As a follow-up, the prescribing therapist should liaise with the care recipient after the transition care episode to ensure that the care recipient's functional needs have been met once the home modifications are complete or the necessary equipment has been supplied. The follow-up by the relevant therapist could be a home visit or a phone assessment, depending on what type of home modification has been undertaken and the needs of the care recipient.
2.8	Treatments and procedures with respect to ongoing medical management	Control and administration of medication prescribed by a medical practitioner, subject to legal restrictions on providing the medication. Administration of treatment such as eye drops, pressure care, dressings and urine tests, subject to legal restrictions on providing treatment. Telehealth and telecare devices may be used where medically indicated and available for monitoring the care recipient's health status, especially for those who live in rural, remote and outer metropolitan areas.
2.9	Assistance in obtaining health practitioner services	Transport to help a care recipient visit a medical practitioner or assistance in arranging a home visit by a medical practitioner.
2.10	Goods to assist residents to move themselves	Service providers may need equipment to assist in the provision of transition care services and meet care recipients' needs (e.g. a wheelchair for assistance with mobility or a personal alert system to provide on-call emergency assistance). Transition care service providers using Australian Government subsidies may purchase such equipment and, where appropriate, this equipment may be loaned temporarily to individual care recipients. When purchasing equipment for the service, ownership of the equipment vests with the service provider. Any equipment loaned to individual care recipients should be returned to the provider at the conclusion of the transition care episode, for use by other care recipients. It is important to note that the provider is

Col. 1	Column 2 Service	Column 3 Content
		purchasing the equipment for use in service provision. If a care recipient requires aids and equipment on an ongoing basis, service providers should, in their role as case manager, seek equipment from such places as state/territory government equipment schemes or equipment loan services. For care recipients who are not eligible for services under these programs and the required services are not available, the service provider may ask the care recipient to make a contribution to the purchase of the required equipment.
2.11	Goods to assist with toileting and incontinence management	The provision of continence aids as required without additional charge to the care recipient.
2.12	Other	Other services required to maintain the person at home as agreed with the care recipient.

Part 3 Common care and services that must be provided, when required, to all transition care recipients

Col. 1	Column 2 Service	Column 3 Content
3.1	Administration and care planning	General operation of the transition care service, including care recipient documentation and care planning and management. When an older person is in a transition care service, initial and ongoing assessment, planning and management of care will be undertaken by appropriately qualified and trained staff members or others (including external practitioners) with expertise in geriatric and/or therapeutic management, with the involvement of the care recipient (or his or her representative), and his or her carer, where appropriate.
3.2	Case management	The transition care service provider should ensure that appropriate case management is available to recipients of transition care, to coordinate and monitor all aspects of their care and their movement from hospital, through

Col. 1	Column 2 Service	Column 3 Content
		transition care and back into the community or to their normal care arrangements, and act as a central point of contact for everyone involved in the care of the recipient. This will include: ▪ ensuring that a comprehensive care plan is available at the time of discharge from hospital; ▪ ensuring that all aspects of the care plan are carried out, monitoring progress against the care plan goals and adjusting the plan where necessary; ▪ identifying any changes to a recipient's care needs that occur during transition care and arranging for appropriate adjustments to the services provided; ▪ liaising with and organising all care requirements provided by external service providers (including GPs and specialists); and ▪ arranging for appropriate care, if required, following transition care or managing the return of the recipient to the community or their normal care arrangements. Throughout the time spent in transition care and with respect to any subsequent arrangements, the case management role includes ensuring that the individual lifestyle choices of the recipient are taken into account and that everything possible is done to enable social contact between the care recipient and their family and friends.
3.3	Specialised clinical services	Clinical care provided as part of the Transition Care Program, where required, is to be carried out by a registered nurse, or under the direct or indirect supervision of a registered nurse or other professional appropriate to the service delivery and in accordance with professional standards and guidelines. These services may include, but are not limited to, the following: ▪ Assessment for pain and a plan implemented to keep the care recipient as free from pain as possible;

Col. 1	Column 2	Column 3
	Service	**Content**
		▪ Provision and care and maintenance of tubes, including enteral feeding, naso-gastric and tracheostomy tubes etc; ▪ Establishment, review and maintenance of urinary catheter care and/or stoma care program; ▪ Complex wound management; ▪ Enema administration or insertion of suppositories; ▪ Suctioning of airways and tracheostomy care; ▪ Oxygen therapy requiring ongoing supervision because of a care recipient's variable need, including the provision of oxygen and oxygen equipment at no additional cost to the recipient; ▪ Appropriate medication management; ▪ Appropriate nursing services; ▪ Taking appropriate action to prevent falls among care recipients; ▪ On-call access to specialist nursing services, if required; and ▪ Specialised swallowing management.
3.4	Therapy services	The therapeutic care to be delivered through the Transition Care Program includes low intensity therapy such as physiotherapy, occupational therapy, podiatry, dietetics[45], speech pathology, counselling and social work to maintain and improve physical and cognitive functioning and to facilitate improved capacity in activities of daily living. This care is to be provided by appropriately qualified and trained staff or consultants and in accordance with any levels of care specified under the recipient's care plan, developed as specified in section 3.1. Recreational activities and diversional therapy are provided that are suited to the care recipient, including lifestyle and general exercise programs. Participation in the activities is encouraged and access to recreational equipment facilitated.

[45] Day to day diabetes education and management forms part of 'dietetics' and is to be undertaken by a qualified diabetes educator who oversees and manages diabetes therapy where clinically appropriate, according to the transition care recipient's care needs and care plan .

Col. 1	Column 2	Column 3
	Service	**Content**
		Psychological or counselling services may also be required to provide emotional support and to assist recipients deal with their psychological and emotional states as they experience changes to their circumstances and confront alterations to their dependency levels, their normal accommodation etc. For example, this may be the case where, following a period in hospital followed by transition care, a recipient requires a higher level of ongoing care than previously. A key component of the Transition Care Program is the therapeutic services that care recipients can receive. These services are not a substitute for the sub-acute care delivered through the hospital sector. Hence eligibility for transition care includes an ACAT assessment that concludes that, where appropriate, a care recipient has already received hospital-based subacute rehabilitation care and/or geriatric evaluation and management where necessary (or will have received it prior to discharge). The therapy services do not include acupuncture and as such, the cost of the provision of acupuncture is not covered by the Transition Care Program .
3.5	Daily living activities assistance	Personal assistance, including individual attention, individual supervision and physical assistance with: ▪ bathing, showering, personal hygiene and grooming; ▪ maintaining continence or managing incontinence, and using aids and appliances designed to assist continence management; ▪ eating and eating aids, and using eating utensils and eating aids (including actual feeding if necessary); ▪ dressing, undressing and using dressing aids; ▪ moving, walking, wheelchair use and using devices and appliances designed to aid mobility, including the fitting of artificial limbs and other personal mobility aids; ▪ communication, including to address difficulties

Col. 1	Column 2 Service	Column 3 Content
		arising from impaired hearing, sight or speech, or lack of common language (including the fitting of sensory communication aids).
3.6	Social activities	Arranging social programs and activities or providing / coordinating transport to socialisation activities/functions at a reasonable frequency. Encouraging transition care recipients to take part in social activities. Providing other services that help to prevent social isolation and promote and protect the dignity and well-being of recipients.
3.7	Religious and cultural activities	Provide support to the care recipient in accessing religious and cultural activities.
3.8	Advocacy	Advocacy services to help protect the care recipient's interests.
3.9	Support	Support services to maintain personal affairs.
3.10	Waste disposal	Safe disposal of organic and inorganic waste material.

12.2 Appendix B – Client Rights & Responsibilities

NATIONAL TRANSITION CARE PROGRAM GUIDELINES, 2011

4.1 Care Recipient Rights

The rights of care recipients are reflected in the Transition Care Payment Agreement.

All recipients of care from the Transition Care Program have specified rights, including the right to have a Transition Care Recipient Agreement with the service provider.

In addition to a Transition Care Recipient Agreement (see clause 4.2 below) care recipients have the following rights:

- to full and effective use of his/her personal, civil, legal and consumer rights;
- for transition care delivered in a residential setting to be in a safe, secure and as home-like an environment as possible;
- to have written information about his/her rights, care, accommodation and any other information that relates to the care recipient personally;
- to be involved in deciding, and choosing, the care most appropriate to meet their needs;
- to be given sufficient information, and a translator or interpreter services where required, to make an informed choice about their care;
- to receive care that takes account of their lifestyle, cultural, linguistic and religious preferences;
- to be given a written plan of the services they will receive;
- to take part in social activities and community life as fully as practicable;
- to be treated with dignity, with their privacy respected;
- to complain about the care they are receiving, including the manner in which it is being provided, without fear of losing the care or being disadvantaged in any other way (see also clause *6.1.5 Complaints* and subclauses); and
- to choose a representative to speak on their behalf for any purpose.

4.3 Care Recipient Responsibilities

The Transition Care Payment Agreement between the Australian Government and each state and territory government provides for the care recipient's responsibilities as a recipient of transition care to be included in the Transition Care Recipient Agreement between the transition care service provider and the care recipient.

As well as having rights that must be respected, transition care recipients have responsibilities to the transition care service provider, care staff, other care recipients and

themselves. While the *Aged Care Act 1997* and the Aged Care Principles do not define the responsibilities of care recipients, the Department of Health and Ageing expects that responsibilities will be agreed between both parties and would not be inconsistent with any requirements of the Act and the Aged Care Principles. These responsibilities should be clearly articulated in the Transition Care Recipient Agreement.

In the spirit of the transition care recipient and the transition care service provider having reciprocal responsibilities, the care recipient's responsibilities include the following:

- 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; and
- providing constructive feedback to the provider about the service's performance.

12.3 Appendix C – Client Consent Proforma

TACP SERVICE TITLE/LOGO

I, _____, authorise the (***SERVICE NAME***) Transitional Aged Care Service to exchange information, either verbally or in written form, regarding my continuing support at home, during my involvement with the Transitional Aged Care Program.

Please circle (YES) if you agree or (NO) if you do not agree.

My Doctor:	YES	NO
Specialist:	YES	NO
Hospital	YES	NO
Homecare service	YES	NO
Other community support services	YES	NO
Other agencies involved with my care and support	YES	NO
I have been provided information regarding the NSW Health Records & Privacy Act	YES	NO
I have been given information about my Rights and Responsibilities as a client of NSW Health.	YES	NO

I understand that I may change or cancel this authority at any time by providing a written and dated request.

Care Recipient (or person responsible/advocate)

Signed: ✖_____

Print name: _____

Date: _____

Witness

Signed: ✖_____

Print name: _____

Date: _____

12.4 Appendix D – Model Client Agreement

TRANSITIONAL AGED CARE SERVICE TITLE / LOGO

NSW GOVERNMENT Health

Agreement for the provision of Transitional Aged Care Services

This agreement is made on the _____ day of _____ 20__

Between: _____
(The Client)

And [***SERVICE NAME***] Transitional Aged Care Service (the Service Provider).

1. The Transitional Aged Care Program

Transitional Aged Care provides short-term care that aims to optimise the functioning and independence of older people after a hospital stay. Transitional Aged Care is provided for a maximum of 12 weeks*, either in the client's own home or a dedicated residential facility. Transitional Aged Care is a package of services that includes low-intensity therapy such as physiotherapy and occupational therapy, social work, nursing support or personal care. These services are delivered over a period of time that allows the client to make decisions about his or her future care requirements.

Further information about Transitional Aged Care is set out in the [***SERVICE NAME***] Transitional Aged Care Service information brochure, which has been provided to the client.

The client requires, and agrees to receive Transitional Aged Care as defined by the Service Provider and consistent with guidelines and directions of the Australian Government Department of Health & Ageing and the NSW Ministry of Health, who jointly auspice the Transitional Aged Care Program.

The Approved Provider of NSW Transitional Aged Care Services (as defined in the *Aged Care Act 1997*), is the NSW Ministry of Health.

The [***LOCAL HEALTH DISTRICT / CONTRACTED NON GOVERNMENT AGENCY***] acts on behalf of the Approved Provider for the purposes of this program.

The client is the person receiving the care under this program.

The client agrees to inform the Service Provider in writing of any person who may act on his or her behalf during the period of care under this Agreement and the legal status, if any, of this person. This person is named as the client's representative for the purpose of this Agreement.

*In exceptional circumstances, a Client may require an extension to a Transitional Aged Care episode exceeding 12-weeks. An ACAT-approved extension may be arranged for up to 18 weeks.

2. Responsibility

The Transitional Aged Care Service Manager or designate is responsible for the completion of this agreement on behalf of the Service Provider, together with the client.

3. Fees and charges

3.1 A Transitional Aged Care Service **may** charge a client a daily care fee as a contribution to the cost of their care.

3.2 The client contribution, payable by pensioners and non-pensioners, is calculated on a daily basis. The **maximum** care fee is:

- 84% of the basic daily rate of the single pension for care delivered in a residential setting;
- 17.5% of the basic daily rate of the single pension for care delivered in a community setting.

This charge is indexed to the Commonwealth Pension, variations of which occur each March and September

3.3 A reduction or waiver in relation to fees may be negotiated where a case of reduced capacity or inability to pay can be established, on the assessment of the client's financial circumstances by the Transitional Aged Care Service Manager or designate.

3.4 No older person is denied access to Transitional Aged Care because of incapacity to pay. Fees can be negotiated and waived where necessary. The Transitional Aged Care Service Manager or designate uses the [***LHD/TACP Service financial assessment method***] to determine a client's capacity to pay fees. In doing so, the Transitional Aged Care Service Manager or designate takes into account any unavoidable expenses incurred, or exceptional expenses such as high pharmaceutical costs, any other care fees that the client may be paying elsewhere and/or any other financial commitments that he or she may have.

Current Charge

Period _____

Fee per day $ _____ Per Fortnight $ _____

Payment method can be arranged with the Transitional Aged Care Service Manager.

3.5 If the client has a current agreement with Meals on Wheels or Community Transport, it remains valid for the duration of the client's Transitional Aged Care episode. The costs of these services are the responsibility of the client.

3.6 If the client requires Meals on Wheels or Community Transport during the Transitional Aged Care episode and does not have a current agreement with these services, the [***SERVICE NAME***] Transitional Aged Care Service may arrange these services. The costs of these services are the responsibility of the client.

4. Program Start and End Dates

The start date for the program is the Client's date of discharge from hospital, on the:

_____ day of _____ 20___

4.1 The end date for participation in this program is dependent on the care requirements of the client and the assessment by the Service Provider.

4.2 The duration of the program is up to 12 weeks. In exceptional circumstances, a client may require an extension to a Transitional Aged Care episode exceeding the 12-week maximum. The maximum duration for an extension is 6 weeks, and only one extension may be granted per Transitional Aged Care episode.

4.3 The client acknowledges that this program is strictly time-limited, and planning for discharge begins early in the episode of care, following admission.

4.4 The Service Provider notifies the client and any nominated representative of the client's expected date of discharge and the range of post-discharge support services that may be required by the client.

4.5 The Service Provider assists the client with referral to these post-discharge services.

4.6 The Service Provider and the client agree on the client's discharge strategy, which is set out in writing.

5. Conditions under which either party may terminate the service

5.1 The client or his or her representative may terminate this Agreement at any time and request discharge from the Transitional Aged Care Program. The client or his or her representative is responsible for arranging alternative care and support, as required. The Service Provider agrees to assist with this process.

5.2 The Service Provider may terminate this Agreement and assist the client to access more suitable care if:

5.2.1 The service is closing.

5.2.2 The program no longer provides care suitable for the client, in regard to the client's needs for medical care in a hospital setting.

5.2.3 An assessment by the Service Provider demonstrates that the client's needs cannot be adequately met by the Transitional Care Program.

5.2.4 The client has achieved the agreed Care Plan goals and/or functional independence to levels that support the client's discharge.

5.4 If the client is readmitted to hospital for longer than an overnight stay, the client is discharged from Transitional Aged Care Program in accordance with the Australian Government's Transition Care Guidelines 2011.

5.5 There are no provisions for clients to take leave from the Transitional Aged Care Program. If a client takes leave from the program for any reason, he or she is considered to have concluded the episode of care and therefore, to have been discharged from the Program.

6. Variations to this agreement

6.1 Both parties are able to vary this agreement by mutual consent.

6.2 The Service Provider will ensure that:

- there is sufficient consultation with the Client or his or her representative with regard to any changes to the agreement;
- any changes to the agreement will occur to reflect changes to the Client's Care Plan resulting from an assessment of the Client.

6.3 Both parties may request a formal review of this Agreement.

7. Rights and Responsibilities

The client agrees to comply with the Rights and Responsibilities as follows.

7.1 Each client has the right to:

- full and effective use of his or her personal, civil, legal and consumer rights;

- Transitional Aged Care delivered in a residential setting that is safe and secure and that provides as home-like an environment as possible;
- have written information about his or her rights, care, accommodation and any other information that relates to the client personally;
- be involved in deciding and choosing the care most appropriate to meet his or her needs;
- be given sufficient information, and a translator or interpreter services where required, to make an informed choice about his or her care;
- receive care that takes account of his or her lifestyle, cultural, linguistic and religious preferences;
- be given a written plan of the services her or she will receive;
- take part in social activities and community life as fully as practicable;
- be treated with dignity, and with respect for his or her privacy;
- complain about the care he or she is receiving, including the manner in which it is being provided, without fear of losing the care or being disadvantaged in any other way; and
- choose a representative to speak on his or her behalf for any purpose.
- know the identity, professional status and qualifications of the health professionals providing his or her care.
- maintain his or her personal independence;
- accept personal responsibility for his or her own actions and choices, even though some actions may involve an element of risk;
- refuse examination or treatment by, or in the presence of, health care students or other personnel not directly involved in providing care;
- withdraw from the health care service regardless of physical or financial status and regardless of whether it is against medical advice.

7.2 Client's Responsibilities:

In accepting the concept of rights, each client also has the responsibility to:

- respect the rights of staff and the service provider to work in a safe and healthy environment free from harassment;
- (in a residential Transitional Aged Care setting) respect the rights and needs of other clients;
- care for his or her own health and well-being as far as he or she is capable;
- work to achieve the goals articulated in his or her agreed individual care plan;
- inform the service provider about any required changes to the care plan or agreement;

- provide information to the service provider about his or her needs or wants;
- notify the service provider of any special requirements;
- provide feedback to the service provider about the service's performance;
- contribute to the cost of care, where appropriate; and
- inform the staff of his or her intention not to comply with suggested treatment and accept responsibility for his or her informed decision.

7.3 Staff Responsibilities:

It is important that staff are aware of the rights of clients and of their own responsibility in safeguarding these rights.

- Staff must be committed to the concept of client's rights.
- Staff have a responsibility to maintain a high standard of care and to keep professional knowledge updated.
- Staff have a responsibility to recognise their own professional limitations and refer to other professionals as required.
- Staff must recognise that they are accountable for the health care they deliver and must be fully aware of their legal responsibilities.
- Staff must respect the client's right to privacy and to be treated with dignity at all times. Staff must also treat with due respect, all confidential aspects of the client's care.

8. Care plan

8.1 The client and the Service Provider agree to the Care Plan as discussed at the time of the client's initial assessment for Transitional Aged Care.

8.2 Both parties acknowledge that the Care Plan may vary over time as the client's needs and circumstances change and may be revised as and when required.

9. Limits to service provision

9.1 The Client acknowledges that there may be limits to service provision.

9.2 The Service Provider agrees to keep the client, and/or his or her representative informed regarding any limits or changes to service provision.

10. Use of information

10.1 All reasonable steps will be taken to protect the privacy and confidentiality of information provided by the client in accordance with the *Health Records and Information Privacy Act 2002*.

10.2 The client agrees to the use and supply of non-identifying information to the NSW Ministry of Health for program management and program evaluation purposes.

10.3 The client may nominate a representative to act on his or her behalf during his or her episode of care under this program. This nomination must be in writing and provided to the Service Provider. The client also acknowledges that his or her representative will have reasonable access to all relevant information regarding the care provided and recommendations for the future care of the client.

10.4 The Service Provider may disclose personal information regarding the client in accordance with the written consent of the client or his or her representative in accordance with the *Health Privacy Principles.*

11. Complaints and disputes resolution mechanisms

11.1 The client retains the right to access a range of complaints and disputes resolution mechanisms, both via the [***SERVICE NAME***] Transitional Aged Care Service and via other, external complaints resolution processes.

11.2 The Transitional Care Program addresses complaints made by the client or his or her representative in the manner set out below.

Complaints

The Aged Care Act 1997 requires The Transitional Care Service:

- To establish and use a complaints process to deal with any complaints by or on behalf of clients and:
- To advise clients and/or their representatives regarding other mechanisms that are available to them and provide such assistance as may be required.
- While receiving Transitional Aged Care, clients and/or their representatives can direct questions, concerns or complaints to [***NAME AND CONTACT DETAILS OF SERVICE MANAGEMENT***]
- Clients and/or their representatives dissatisfied with the outcome of their complaint within fourteen (14) days, may choose to forward a written complaint to [***NAME AND CONTACT DETAILS OF LOCAL HEALTH DISTRICT COMPLAINTS MANAGEMENT***]

Alternatively, complaints can be directed to the following external agencies:

The NSW Health Care Complaints Commission
Locked Mail Bag 18
STRAWBERRY HILLS NSW 2012
Ph: 1800 043 159
www.hccc.nsw.gov.au

Aged Care Complaints Scheme

GPO Box 9848
SYDNEY 2000
Ph: 1800 550 552
www.health.gov.au/internet/main/publishing.nsf/content/ageing-complaints

12. Acknowledgement

12.1 The client or his/her nominated representative acknowledges that he or she has been informed of, and assisted to understand the terms of this Agreement, and in particular:

- the rights and obligations of the client;
- The care and services to be provided by the Service Provider.

12.2 In signing this document, the client and the Service Provider agree to the conditions outlined above.

13. Signatories to this agreement

Client (or representative)

Signed _____

Print name:

Date:

Witness

Signed _____

Print name:

Date:

Service Provider

Signed _____

Print name:

Date:

NB: If a client does not want to formally acknowledge a Transition Client Agreement, the Service Provider is still required to observe its responsibilities to negotiate and deliver the level and type of care each client needs. The Service Provider must document the reasons for not having a signed Agreement with the client and the basis on which agreed care is delivered.

12.5 Appendix E Model Procedure for Client Contributions to Transitional Aged Care

TRANSITIONAL AGED CARE SERVICE TITLE / LOGO

NSW GOVERNMENT Health

NSW TRANSITIONAL AGED CARE PROGRAM

1. Policy

A Transitional Aged Care Service **may** charge a client a daily care fee as a contribution to the cost of their care.

The charging of fees for Transitional Aged Care should be explained to the potential client prior to the commencement of the Transitional Aged Care episode, ideally on assessment by the Aged Care Assessment Team. More detailed information should be provided to the potential client by the Transitional Aged Care Manager or designate in the process of completing the Client Agreement prior to the commencement of care. The Client Agreement must reflect any arrangements put in place for client contributions.

The process of negotiating care fees should be conducted in a sensitive, non-judgemental manner with respect for the client's right to privacy and confidentiality. The Service Provider may only request information that is reasonable to request under the circumstances and is reasonably necessary for establishing the ability of the older person to contribute to the cost of their care.

All monies received via client fees must be used for the purpose of providing Transitional Aged Care Services. This is reported in the Service's Annual Accountability Report to the Australian Government.

A client transferring from another Transitional Aged Care Service in which he or she has not been charged a fee should not be charged a fee by the receiving service.

A client's access to the TACP should not be affected by his or her ability to financially contribute to the cost of care, but assessed on the basis of need for care, and the capacity of the TACP to meet that need.

The client should have his or her representative, carer, family member or advocate present in the process of the financial assessment and in determining the level of care fees to be charged, capacity to pay, fee reduction or waiver.

2. Responsibility

The Transitional Aged Care Service Manager or designate is responsible for the conduct of any financial assessment of the client's capacity to contribute to the cost of care, on behalf of the Service Provider.

3. Procedure

- The charging of fees should be included in any information about Transitional Aged Care provided to the prospective client on assessment for eligibility for Transitional Aged Care, by the Aged Care Assessment Team.
- The rationale and method for the charging of fees should be fully explained to the client and his or her representative by the TAC Service Manager or designate as part of the process of completing the client Agreement prior to the commencement of the episode of care. The TAC Service Manager or designate is responsible for conducting any assessment of the client's capacity to pay in determining the level of fee to be charged.
- The fee amount and preferred method of payment is recorded on the client's Transitional Aged Care Client Agreement.
- If the fee is waived, this is recorded on the client's Transitional Aged Care Client Agreement.

3.1 Maximum fees chargeable

The **maximum** care fee chargeable for transition care is calculated on a daily basis and aligns with the fee structure for residential aged care placement or a Community Aged Care Package (CACP):

- 84% of the basic daily rate of a single pension for care delivered in a residential setting
- 17.5% of the basic daily rate of single pension for care delivered in a community setting

This applies to both single and married clients.

Aged pension rates rise in March and September each year.

All clients will have been discharged from hospital and can access the Pharmaceutical Benefits Scheme and the Medicare Benefits Schedule.

3.2 Factors for consideration in determining the level of care fees to be charged

The LHD or TACP Service's financial assessment method should take into account both the client's income and his or her financial commitments, including any excessive and unavoidable expenses for which the client is responsible, such as:

- pharmaceutical medication
- aids and equipment;
- specialist care;
- special foods;
- costs associated with being a carer, such as respite care, transport, etc.;
- high utility costs (for usage in supporting people with disabilities or medical needs);

- health or medical insurance costs;
- private rental accommodation (public housing rent may be waived during the episode of care);
- personal debts;
- other social support services delivered in the home setting, such as Home and Community Care Services and Meals on Wheels.

In addition, it should be noted that:

- A client who is also an existing recipient of residential aged care may continue to be charged fees whilst on leave and receiving Transitional Aged Care. There may be an opportunity for the Transitional Aged Care Service Manager or designate to negotiate a reduced or waived fee with the residential aged care provider while the client receives Transitional Aged Care;
- A Client receiving a CACP, Extended Aged Care at Home (EACH) or EACH Dementia (EACH D) package will not be charged a client fee by their service provider while they are in receipt of Transitional Aged Care;
- The costs of rental accommodation, or care for another person may also be a contributing factor in the client's inability or reduced capacity to contribute to the cost of Transitional Aged Care.

Two examples of methods for financial assessment are set out at **Attachment 1**.

3.3 Determining the level of care fees to be charged

The level of the fee to be charged should be determined according to the client's financial capacity to meet the chargeable fee using the LHD or TACP Service's financial assessment method.

The client should have his or her representative present at the time of the financial assessment and when determining the level of care fees to be charged, capacity to pay, fee reduction or waiver.

The financial assessment must be undertaken by the Transitional Aged Care Service Manager or designate.

3.4 Fee Reduction or waiver

In determining whether a fee reduction or waiver applies, the Transitional Aged Care Service Manager or designate should check that the client is receiving all the financial assistance available to him or her, including Rental Assistance, Health Care Card, concession on utilities, Carer's Allowance. Fees may still be reduced or waived where a consumer who receives all relevant assistance experiences difficulty in paying fees.

4. Payment arrangements

The most appropriate payment method may be agreed between the Transitional Aged Care Service Manager or designate and the client.

Fees may be requested up to one week in advance. If a client leaves the Transitional Aged Care Program, any payment in advance beyond the date of cessation must be refunded to the client as soon as possible.

If a client moves from one setting to another within the TACP (i.e. from community to facility-based care, or vice versa), the client contribution will need to be re-negotiated by the Transitional Aged Care Service Manager or designate and the client and his or her representative, and new payment arrangements put in place.

5. Review of the Client contribution

The client may request a review of the fee in consultation with the Transitional Aged Care Service Manager or designate if his or her financial circumstances change during the care episode.

Attachment 1

Determining fees for Transitional Aged Care

Method 1

Transitional aged care fees may be determined as a percentage of the daily maximum fee chargeable, after the client's income and expenditure have been taken into account.

Facility-based Transitional Aged Care	**84% of single aged pension. Maximum $ per week**	**70%**	**50%**	**25%**	**10%**	**Fee waived**
	$308.1 or 44.02 per day	256.79 or 36.68 per day	183.425 or 26.20 per day	91.71 or 13.10 per day	36.68 or 5.24 per day	nil

Community-based Transitional Aged Care	**17.5% of single aged pension. Maximum $ per week**	**15%**	**10%**	**5%**	**Fee waived**
	$64.19 or 9.17 per day	55.02 or 7.86 per day	36.68 or 5.24 per day	18.34 or 2.62 per day	nil

Note the figures above are based on single aged pension rate at March 2013.

Method 2

1. Weekly income and expenses are assessed to determine available funds.
2. Where a client's outgoing expenses are between 50-59% of their monthly income, the weekly fee is reduced by 75%.
3. Where a client's outgoing expenses are between 60-79% of their monthly income, they can be asked to pay the amount of $5.00 per week.
4. For a client whose outgoing expenses are 80% or more of their monthly income, the weekly fee can be waived.
5. Should a client be experiencing extreme financial difficulty, the above calculation can be negotiated with the Transitional Aged Care Service Manager or designate.

Income / expenditure assessment table.

HOUSE HOLD INCOME (include income of all adults who reside in the family home)		**OUTGOING EXPENSES (per month)** (include all expenses of adults who reside in the family home)	
Centrelink Benefit Type:		Mortgage Repayments	$
Amount per week/month:	$	Rent	$
Overseas Pension Type:		Car/Transport Expenses	$
Amount per week/month:	$	Groceries/Food	$
Other Income (i.e. self funded retiree/investments)	$	Electricity	$
Amount per week/month:	$	Gas	$
		Water	$
		Telephone	$
		Chemist/Medical	$
		Equipment Hire	$
		Other services	$
		Other goods	
		TOTAL	$

.

12.6 Appendix F – Model Client Satisfaction Survey

Client Satisfaction Survey: Quality of Care

The [***SERVICE NAME***] Transitional Aged Care Service aims to provide a high standard of care to clients, their family and carers. As part of our commitment to the continuous improvement of our service, we ask you to take some time to complete this survey. In doing so, you do not have to give your name, and the information you provide will be treated as confidential. This survey may also be completed by a carer, friend or family member.

***If applicable*:**
Please use the enclosed reply paid envelope to return your completed survey form to the [***SERVICE NAME***] Transitional Aged Care Service. Your comments and suggestions are of value to us and assist in further developing our service to better meet client needs.

Please refer to the scale below to provide your response to the following questions:

Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree	Not Applicable
1	2	3	4	5	6

1. Before I commenced Transitional Aged Care, I was given a clear understanding of the program.	☐
2. I was given a clear explanation about my Transitional Aged Care plan.	☐
3. I was involved in the preparation of my Transitional Aged Care plan and in decisions about my care.	☐
4. My care was well-co-ordinated and I was able to contact staff as required.	☐
5. I was given therapy and care appropriate to my needs.	☐
6. My rights and wishes were respected by staff.	☐
7. The program met my expectations.	☐
8. I am satisfied with the outcomes of the program.	☐

9. What did you particularly like about the Transitional Aged Care you received?

_____

_____

_____

10. How do you think the service could be improved?

_____

_____

_____

11. Any further comments you may wish to make would be appreciated. Please feel free to do so using the space provided below.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Thank you for taking the time to complete this survey

If applicable:

Please return this survey form in the enclosed reply paid envelope.

12.7 Appendix G – Acknowledgements

The NSW TACP Guidelines have been developed by a State Working Group.

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