Improving resident transfers between hospitals and residential aged care facilities

Laura Meese and Jennifer Poole

December 2008

Brotherhood
of St Laurence
Working for an Australia free of poverty

This research was undertaken by Laura Meese and Jennifer Poole as a placement requirement for fourth year Bachelor of Social Work at La Trobe University, Melbourne.

Contents

Acknowledgments

Summary

Literature Overview

With increased life expectancy coupled with an ageing population we have witnessed aged care shift from a dominant medical model to a cooperative model of care based around shared service support measures. One of the key relationships between the medical model and a shared care model is the interface between the hospital system and the aged care residential sector. Analysis reveals that the relationship between these two systems is problematic: the current trend is to aim for a collaborative partnership approach within a complex systems operation. In particular, the two sectors share a responsibility around discharge planning procedures and the transfer of elderly patients from hospital back to a registered aged care facility (RACF). While the search for effective discharge planning strategies is ongoing, the two service systems continue to juggle major shortfalls in information and communication procedures within a framework that lacks standardised policy procedures. These issues do not arise in a vacuum: rather improving patient transition processes from hospital to an RACF can be identified at both a local and global level.

Methodology

The *Improving Resident Transfers* research project was undertaken by Laura Meese and Jennifer Poole as a placement requirement for fourth year Bachelor of Social Work at La Trobe University. As part of the consultative process we approached St Vincent's Hospital Aged Care In-reach program, Melbourne General Practice Network and Aged Care at the Brotherhood of St Laurence. Each of these organisations identified that residents of aged care facilities are among the frailest Australians and often have complex health care needs requiring multidisciplinary approaches (Department of Health and Ageing, 2008). The Brotherhood of St Laurence has a commitment to continued improvements surrounding discharge planning processes, and this project builds on work it has already undertaken.

Seven residential aged care facilities (RACFs) participated in the research. The participants were selected based on geographical location, their involvement in the *Yellow Envelope strategy*, and their use of St Vincent's Public Hospital as the primary medical provider. The interviews were held with the manager and often the Division 1 nurse of the residential aged care facility. Five of the residential aged care facilities were low-care facilities and two were high-care facilities.

The interviews with the RACFs were transcribed and the content of the discussions was analysed thematically. Common issues were grouped together and given weight by the number of times raised, time spent talking about specific issues and the emphasis placed on a particular problem. Upon the completion of the RACF interviews, independent discussions were once again held with St Vincent's Hospital and the Melbourne General Practice Network as part of our consultation process.

Results

Residential Aged Care Facilities

The participants who were interviewed were employed by RACFs that operated as government or not-for-profit organisations. The low-care RACFs ranged in bed capacity from 30 to 43. The high-care RACFs had bed capacities from 30 to 49. All services used personal care assistants (PCAs), with one exception, the high care government facility, which paid employees under the Nursing Award and required all staff to have a minimum qualification of Division 2 Nursing. With the exception of one culturally specific RACF, none of the RACFs articulated race, gender or sexuality as issues of diversity that they readily address. Six out of the seven RACFs had won awards, including Excellence in Care, Resident of the Year, Carer of the Year and Employer of the Year Awards.

Standardisation

Only two of the RACFs had documented standardised procedures for hospital admission. All of the RACFs stated that they had standardised processes but they were not documented so that they were available to all staff. The standardised processes were in line with the concept of 'practice wisdom' and the RACFs' Division 1 Nurses' experience. Six out of seven RACFs reported that the 'Yellow Envelope strategy' was common admission practice, as well as calling the admitting officer, the resident's family and resident's regular GP (if available). Upon resident discharge from hospital, four RACFs identified an attempt to reinforce that they can only accept residents back during business hours.

Information

The study found in the St Vincent's discharge processes a number of weaknesses that impact on the quality of care received by residents of aged care facilities. The doctor's discharge summary was often not received at all, or not in a timely manner. It was reported that RACFs were generally waiting up to two weeks for the doctor's discharge summary. While the RACFs recognised there were significant time constraints on medical, nursing and allied health professionals, it was imperative for effective care planning that the information was received in a timely manner. In particular, for those residents who have complex needs, a lack of information impacts on individual health care. The nursing discharge summary was often reported as missing vital information (such as time of last medication given and last bowel movement).

Communication

Five of the RACFs were actively engaging with St Vincent's Hospital and tried to remain an advocate for their residents while in the hospital system. Although responsibility for communication and coordination processes with the hospital had not been articulated as part of staff members' job description, either the manager or Division 1 Nurse saw it as their role. The RACFs that did not actively engage the hospital seemed to have difficulty communicating their expectations of acute care and were unprepared for the residents' return to their facility. It was not that no one had

attempted to communicate with the hospital, but that communication was ad hoc and executed by many different people.

Cooperative Care

All the RACFs agreed that the hospital system now had a better understanding of their role and the type of care they were able to provide. It was reported that there had been a dramatic decrease in the transfer of residents still needing care beyond the scope of the aged care facility. Again it was noted that good support from GPs made the transition much easier. The RACFs utilised the Winter Demand strategy (hospitals providing in-reach services to lower the number of residents from aged care facilities presenting to emergency departments) to varying degrees and felt that it was a useful service.

Discussion

This study found that the transition between acute health care and residential aged care settings was impacted by four key factors: there were shortfalls in information and communication processes, cooperative care, and discharge planning procedures. The Department of Human Services needs to develop indicators to define effective discharge processes, measurement scales and practice in order to form a baseline for measuring improvements (Department of Human Services, 2008). Analysis of previous research identified that responsibility surrounding discharge processes was one-sided. The research literature has focused on the responsibility of the hospital in discharge process. While the RACFs' duty of care has been maintained, their responsibility in collaborative discharge processes has not been the subject of intense research to date. Consolidating communication processes between internal and external health care providers would serve to streamline hospital discharge processes through a single point of communication.

In an attempt to improve communication processes from RACF to acute health care settings, the North East Valley Division of General Practice developed a tool commonly known as the 'Yellow Envelope'. The aim of the Yellow Envelope concept is to embed relevant patient information into routine transfer practices (North East Valley Division of General Practice, 2007). The present study argues for a redesign of the Yellow Envelope (Appendix 4), because the tool only includes the transfer of information to the hospital. It recommends restructuring the design to include information for transfer both to and from the hospital setting. This is an attempt to strengthen communication and timely information sharing between the two care sectors. Our proposal has been reaffirmed by the RACFs interviewed, St Vincent's Hospital (Aged Care In-reach program) and the Melbourne General Practice Network.

It was found that some RACFs were more proactive in engaging with St Vincent's Hospital and aware of the resources available to them. It would have been useful to sample more high care RACFs as well, in order to ascertain whether resident transfers were experienced differently by facilities with different staff qualification levels. A common theme identified throughout this research was the inadequacy of the Certificate III in Aged Care training. This is a concern that requires further investigation.

Due to the limited time available to complete this research, it was decided to build on existing strategies for developing and improving information and communication processes. The Yellow Envelope concept and Winter Demand (or Bed) strategy were identified as effective tools in improving information, communication, cooperative care and discharge procedures. Therefore, the research was steered towards improving these strategies and working in an applied practical policy framework. This would not only enhance and strengthen the existing strategies, but also provide benefits to both the hospital and aged care sectors. The ultimate aim of the research was to improve the practices around admission and discharge processes for resident transfers and the quality of care provision for the aged. Embarking on a new research topic would have required more time, promotion and resources for a beneficial outcome – luxuries which the researchers did not have while on placement.

Recommendations

These recommendations emerge from a study of seven RACFs within inner urban Melbourne. All RACFs used St Vincent's Public Hospital as their primary medical provider and had participated in the Yellow Envelope strategy. These recommendations (6.3 and 6.4) could be applicable to all RACFs within Victoria, if the funding for the DHS Winter Demand strategy and Division of General Practice Yellow Envelope strategy is broadened and continued. The researchers recommend:

6.1 That the resident's experience of transfer between hospital and RACF would benefit from DHS standardised procedures and uniform documentation between RACF and hospital sectors.

6.2 That all RACFs be required to implement and document standardised coordinated procedures for communicating with the hospital sector. A standardised approach, such as a single entry point for communication, will improve communication and information sharing procedures.

6.3 That the proposed re-design of the Yellow Envelope (Appendix 4) be utilised as the basis for re-publication by the Division of General Practice.

6.4 That the DHS funding for the Winter Demand strategy continue on an ongoing basis as it is an effective tool for communication, cooperative care and information sharing. The researchers recommend an extension of this winter initiative to include funding for bi-annual educational workshops on effective communication between the two sectors. This education program would include using the right tools, such as the Yellow Envelope and uniform documents.

6.5 That the Improving Resident Transfers Report be referred to the regional office of DHS and the sector of DHS responsible for the Winter Demand strategy to faciliatate consideration of our proposals.

6.6 That the Department of Health and Ageing develop specific aged care guidelines for discharge planning procedures which are separate from the current discharge planning policy.

6.6.1 That the DHS in conjunction with one or two metropolitan hospitals develop a working party to identify indicators of effective discharge processes. This pilot project would be responsible for developing measurement scales and a baseline for measurable outcomes of post discharge care issues such as medication, reasons for readmission and a definition of optimal discharge.

6.6.2 That Aged and Community Care Victoria undertake further research of the key areas identified and develop a more coordinated approach to resident transfers.

6.7 That the approach recommended in this report be trialled in other areas. Increased attention in the St Vincent's catchment area has suggested benefits for both hospital and aged care sectors.

Conclusion

The project and report demonstrate that there is a wealth of research and practice both locally and internationally to support the continuing efforts to improve resident transfers between hospital and RACFs. This research reinforced previous literature that identified standard processes, effective communication, information and cooperative continuing care as key needs in resident transfers. The project also offers some practical recommendations towards continuous improvement of the hospital–RACF relationship. The findings from this small study cannot directly be generalised to all resident transfers between RACF and hospital. However, the study does offer some practical suggestions that could improve the hospital–RACF relationship. There is scope here for another study that trials and extends the recommendations made in this research.

1 Literature Overview

1.1 Population Trends

Between 1988 and 2008 the proportion of Australia's population aged 65 years and over increased from 10.8% to 13.3%, and the proportion aged 85 years and over more than doubled from 0.8% to 1.7% (ABS 2008). This increase is related to a health transition that has been incremental since the period of industrialisation. The increased life expectancy of older people, especially women, aligns with a shift from high to low mortality rates, coupled with better health and nutrition (Kinsella and Phillips, 2005). With a persistent decline in fertility rates and a shift in migration patterns (ABS, 2008) and increased longevity, it follows that there will be an increase of elderly people within the population.

There has been an acceleration in the proportion of the elderly in the global population. The global population aged 65 years and over was estimated at 461 million in 2004, an increase of 10.3 million since 2003. Population projections estimate the annual net gain will exceed 10 million over the next decade – which equates to 850,000 per month (Kinsella and Phillips, 2005).

1.2 Structural Operations

The critical changes that come with an ageing population have an impact on structural operations and the provision of supports. This strain is evident in the juxtaposition of public health policy and the ongoing challenge to meet the demand for resources in the aged care sector. This means there is pressure on operational policy in the hospital sector to provide cost effective service delivery in conjunction with meeting case-mix formulae (Department of Human Services, 2008).

Operational pressures exist between state and federal governments. In particular, there is an emphasis to negotiate supply and demand issues, for example, the number of hospital beds available, or the number of people on waiting lists. The Victorian government has argued for the improvement of the interface between the hospital (acute care) and aged care sectors; however, reform proposals for such were excluded from the 2003–08 Australian Health Care Agreements (AHCAs). Further, the federal government has delayed the negotiations for the 2008–13 AHCA, and thus, the opportunity to use the agreement as an operative tool for improving the health system and health care outcomes for the aged (Australian Labor Party, 2007). Figures reveal the average length of hospital stay has declined under case-mix and is currently set at 3.98 days. Whilst there is insufficient evidence to argue that budgetary factors are driving the reduction in the length of hospital stays, there is a general consensus that shorter hospital stays require thorough 'Discharge Planning' and 'Post Discharge' follow-up measures, particularly for aged people who have complex care needs (Department of Human Services, 2008).

1.3 Discharge Planning Processes

Improving cost effective 'Discharge Planning' strategies is a key goal of hospital operations. There is a plethora of information available (locally and globally) surrounding 'Discharge Planning' models aimed at facilitating and streamlining hospital discharge processes. The Rapid Assessment Medical Unit (RAMU) operational at Western Hospital, Footscray, is an example of a working model. The model, which originated in the United Kingdom and the United States, was established to facilitate a comprehensive multidisciplinary team approach to patient assessment and Discharge Planning procedures. It offers streamlining of care coupled with effective and efficient care delivery in conjunction with the adoption of strategies aimed at reducing potential hospital readmission (Sinclair, Boyd and Sinnot, 2003). Part of the success of the model lies in the appointment of a clinical coordinator (advanced nurse practitioner) whose role is to oversee coordination and documentation in the lead-up to an appropriate management plan for discharge and post acute care (Sinclair, Boyd and Sinnot, 2003).

While theory is nicely meshed with theoretical considerations (for both reasons of costs and health care) there are aspects of 'Discharge Planning' that are not clearly thought through in terms of after-care mode. Two common complaints are information and communication processes (McDonald, 2007). Thus, the lack of information and communication is evidence enough to argue that there is a failure of the overall discharge strategy. Hospitals should continue to see themselves as responsible for working towards building bridges between themselves and RACFs (as responsibility doesn't entirely cease upon discharge).

1.4 Communication and Information

There is evidence at a local level that hospitals and the broader aged care sector are working more collaboratively towards improving communication and information procedures; however, it is a work in progress. The issue surrounding communication processes and the provision of clinical information cuts both ways. The best evidence of an attempt to resolve clinical handover has been identified by aged care homes, the Division of General Practice and selected Melbourne hospitals. The Division of General Practice has worked collaboratively to initiate, develop, and trial, a receptacle for a resident's medical-related documentation – commonly known as the Yellow Envelope. The Envelope is a checklist for aged care home staff and it accompanies the resident to the hospital Emergency Department. The aim is to embed the transfer of relevant patient information via the Envelope into routine policy practice between RACF and hospitals (North East Valley Division of General Practice, 2007). The concept links in with the Department of Human Services Effective Discharge policy and its philosophy that hospitals continue to work towards ensuring a smoother patient discharge transition based on a 'shared care' model – given that 'Discharge Planning' is not a single event (Department of Human Services, 2008).

1.5   Cooperative Care

It is argued that effective continuing care planning should be part of normal practice procedures. This is a concept that the Department of Human Services adheres to in its Effective Discharge strategy framework. One place where this process is being dealt with is the 'East Gippsland Care Planning Development Project' model (Department of Human Services, 2003). The main objectives of this model are to consolidate communication between the hospital sector, clients, health care providers and community-based service providers, with a focus on streamlining hospital discharge processes through a centralised single point of communication (for both internal and external referrals). This program focuses on a system where clinical nurses are empowered to activate discharge processes. Their role is supported by a Manager Home Based Services and a Discharge Planning Project Nurse – to undertake evaluation against outcomes specified in the funding submission (Department of Human Services, 2003).

1.6   Standardised Procedures Policy

Research indicates that the standard protocols of 'Discharge Planning' fall down due to the lack of a Standardised Procedure policy. While the Department of Human Services 'Effective Discharge strategy' framework outlines follow-up procedures for post discharge (Department of Human Services, 2008), the Victorian Government is yet to develop indicators that measure effective discharge processes and practice to form a baseline with which to measure improvements (Department of Human Services, 2008). Although the structure of Australian health care delivery differs from that of the United States, it may be useful to refer to the adoption of their post-acute care reform principles and the Deficit Reduction Act (DRA) 2005, as a recently developed model and comparison for standardised policy procedures (Centres for Medicare and Medicaid Services, 2006).

Until government mandates ways of determining and measuring what happens to patients/residents after discharge, some incidents will continue to occur and possibly go unremarked.

This issue surrounding Aged Care and Standardised Procedure policy is of interest to the federal government which is currently working towards improving the Australian health care system. It has initiated extensive reform aimed at improving the provision and delivery of primary health care and the overall service system (Australian Government, 2008). An external group has been established to support the government in developing a draft strategy due for the Minister's consideration by mid 2009 (Department of Health and Ageing, 2008).

2 Methodology

The *Improving Resident Transfers* project was undertaken by Laura Meese and Jennifer Poole as a placement requirement for fourth year Bachelor of Social Work at La Trobe University. As part of the consultative process we approached St Vincent's Hospital Aged Care In-reach program, Melbourne General Practice Network and Aged Care at the Brotherhood of St Laurence. Each of these organisations identified that residents of aged care facilities are among our frailest citizens and often have

complex health care needs requiring multidisciplinary approaches (Department of Health and Ageing, 2007). The Brotherhood of St Laurence has a commitment to continued improvements surrounding discharge planning processes. This project builds on work that has already been conducted by the Brotherhood of St Laurence.

During November 2008 Meese and Poole, in consultation with Alan Gruner (Senior Manager Residential Aged Care and Major Projects), jointly undertook semi-structured interviews with seven residential aged care facilities. These interviews were approximately one hour in length; and were held with the manager and often the Division 1 nurse of the residential aged care facility. Five residential aged care facilities were low-care facilities and two were high-care facilities. One agency had a high-care nursing home and low-care hostel on the same site: for the purposes of this study they were considered as two separate facilities. The participants were selected on geographical location, their involvement in the Yellow Envelope strategy, and their use of St Vincent's Public Hospital as the primary medical provider.

All of the RACFs were contacted by mail. Participants were given the *Resident Transfers – Hospital to Residential Aged Care Project Brief* (Appendix 2), *For Their Sake – Can we improve the quality and safety of resident transfers from acute hospitals to residential aged care?* document and an accompanying cover letter (Appendix 1) (McDonald, 2007). Initially eight residential aged care providers were contacted but when they were followed up, one chose not to participate. This spokesperson stated that their facility accesses the Austin Hospital more regularly than St Vincent's, and consequently felt they could not contribute.

The RACF participants were interviewed on-site. The purpose of the research was informally outlined for the participants. Participants were asked to confirm that they had previously received the *Resident Transfers – Hospital to Residential Aged Care* (Appendix 2) and *For Their Sake* (McDonald, 2007) documentation; extra copies were available if required. Participants consented to the interview being recorded for the purpose of researcher review and contributing anecdotal evidence to the study. It was explained that all evidence would be anonymised.

The semi-structured interviews started with an overview of the context of the RACF. This included information on bed capacity, whether high or low care facility, staffing arrangements, mission statement and fee structures. The questionnaire (Appendix 3) was structured to gain insight into some of the key issues identified in the *For Their Sake* document. The key issues addressed in the questionnaire were: 'timing of transfer', 'pre transfer preparations', 'patient medical records and other documentation do not exist', 'low standard of hospital documentation' and 'medication issues'. The issues that were excluded from this study were patients with a mental illness (who constitute a special category of transfer), nutritional deficiencies, compromised skin integrity and relationships between families and hospital staff (McDonald, 2007). These key issues were excluded due to the time constraints placed on the researchers and advice from the Melbourne General Practice Network and St Vincent's Hospital; and also because St Vincent's Hospital identified the recent establishment of dedicated teams to improve skin integrity, nutritional deficits and mental illness.

The questionnaire was intentionally structured to flow from 'incident' causing admission, to RACF admission processes; to acute hospital care, to discharge

planning, to discharge and, finally, post-discharge care (Appendix 3). Answers were investigated with supplementary questions on a case-by-case basis. An attempt was made to use open non-leading questions wherever possible. At the end of the interviews, participants were asked if they would like a copy of this report – all requested a copy.

The interviews with the RACFs were transcribed and the content of the discussions was analysed thematically. Each issue was prioritised by the number of times the issue was raised and time spent talking about the problem. Upon the completion of the RACF interviews independent discussions were once again held with St Vincent's Hospital and the Melbourne General Practice Network as part of our consultative process.

3 Results

3.1   The Residential Aged Care Facilities

The seven residential aged care facilities that participated in this study were from the inner-northern suburbs of Melbourne. They had all participated in the Yellow Envelope strategy completed by Division of General Practice. The participants included two high-care facilities, and five low-care facilities, four with 'ageing in place' programs. All participants were employed by RACFs operated by government or not-for-profit organisations. The low-care residential aged care facilities ranged in bed capacity from 30 to 43. The high-care RACFs had bed capacities of 30 and 49. The staffing arrangements varied between the agencies and care requirements. Primarily all services used personal care assistants (PCAs), with one exception; the high care government facility that paid employees under the Nursing Award and required all staff to have a minimum qualification of Division 2 Nursing.

In general, the RACFs that we interviewed could articulate the 'culture' of the aged care facility. Participants described their aged care facility as 'positive', 'respectful', 'individuality' and 'flexibility'. We interviewed personnel at one RACF that was nationality/language specific and they believed this significantly impacted on the type of care received and the culture of the RACF. They indicated that they catered to the needs of their residents better by using their mother tongue, performing games and activities from their country of birth and providing food & drink in line with the residents' culture. The RACF staff believed it made their residents feel more comfortable and 'at home' in this environment. Others spoke about the staff morale as well and quality of care. This question did seem to confuse some participants, who didn't quite understand what was being asked of them and struggled to articulate much beyond their mission statement (staff from some RACFs were better at this than others). The question was intended to gain insight into the day-to-day philosophy and whether mission statements affected everyday living experiences for the residents.

All of the RACF staff that were interviewed experienced residents from diverse economic backgrounds. The RACFs had concessional beds at varying percentages.

> We cater for the disadvantaged persons. There is a large culture around our staff, that we are a team. The not for profit culture is not about making money but that we are here to provide the best quality of care. We market ourselves

as the best quality of care available, and I think that is what people are looking for. That includes the best possible care while a resident is in hospital; families are quite anxious when someone goes into hospital and it's just about keeping that communication line on. (Interview 3)

With the exception of the culturally specific RACF, none of the RACFs named race, gender or sexuality as issues of diversity that they readily address. Six out of the seven RACF had won awards including Excellence in Care, Resident of the Year and Carer of the Year Awards.

3.2 Key Themes

3.2.1 Standardisation

Only two of the RACFs had documented standardised procedures for hospital admission. All of the RACF staff stated that they had standardised processes, but they were not documented so as to be readily available to all staff. The standardised processes were more 'practice wisdom' perspectives from the RACF's Division 1 Nurse's experience. 'If there is a chance that they [a resident] are going to go to hospital, we try to do that during the day so I [the Division 1 Nurse] can coordinate that' (Interview 4).

Six out of seven RACFs articulated that the Yellow Envelope strategy was common admission practice, as well as calling the admitting officer, the resident's family and resident's regular GP (if available). No RACF offered information on what the admissions procedure was before the introduction of the Yellow Envelope strategy.

> We don't have a standardised process but we always ring ahead, and I have trained the personal care workers to do that as well. And they feel confident enough now to ask for the admitting officer themselves. We always call ahead so they know we are coming and that just smoothes the transition as well. When the ambulance officers get here, they know that the resident is already known at St Vincent's. (Interview 2)

Upon a resident's discharge from hospital, four RACFs identified an attempt to insist that they can only accept residents back during business hours because of the constraints around medication charts, pharmacy needs and time to organise possible extra aids, for example, oxygen. However, on the whole, processes around the readmission of a resident after discharge from hospital were underdeveloped in comparison to transfer to hospital.

3.2.2 Information

The hospital's responsibilities for discharge were lacking too. The doctor's discharge summary was often not received at all, or not in a timely manner. It was reported that RACFs sometimes waited up to two weeks for the doctor's discharge summary. While the RACFs recognised there were significant constraints on a professional's time, it is imperative to receive information in a timely manner, particularly when a resident/patient has complex needs and this information will impact on their health care.

It's just very difficult, because residents have a lot of tests and procedures in hospital, and if you don't get the discharge summary and something goes wrong and a locum doctor comes out, you have no documentation to say what happened while the resident was in hospital. (Interview 2)

The nursing discharge summary was also often reported as incomplete, missing vital information such as last medications given or when the patient last opened their bowels. There was also a call for information to be documented rather than a verbal hand-over from the Nurse Unit Manager.

Even for an inpatient visit, we send residents in with all the information. And that encourages the practitioner to put in the same amount of effort. I would say that 98% of the time we get that response. It's good to communicate any concerns to GP. We always send a medication chart with the residents, because I don't expect staff to remember what medication everyone is on and the residents may not remember, so it's just good practice. It is about being proactive; it just comes down to duty of care for the residents at the end of the day. (Interview 3)

3.2.3 Communication

The greatest diversity in answers related to communication processes. Five of the RACFs were actively engaging with the hospital and trying to advocate for their residents while in the hospital system. While coordinating with the hospital had not been articulated as part of this particular person's job description, either the manager or Division 1 Nurse had seen it as part of their role.

If I have not had the capacity to catch up with the hospital, I ask the weekend manager to touch base. We usually make sure that within the first two days we contact the hospital to check how the resident is going. And usually if the residents are well enough we say 'Ring us'. A lot of our longer term admissions get lonely, so they ring us for a chat. If a resident's health care needs have changed, I've told St Vincent's that I am more than happy to come and visit them in hospital to help assess what support is needed when they return to the residential aged care facility. (Interview 3)

While this process was reported as time consuming, particularly when professionals are not reading a patient's history before calling, or multiple professionals are calling asking the same questions (rather than conversing and getting an update from hospital colleagues or the patient), it did lead to better outcomes. The RACFs who supported their staff to adjust to new care requirements experienced the least difficulty with discharge processes.

When residents are admitted it is really painful when you have to take five or six calls from the physiotherapist, the OT, the social worker, the doctor and they all want to know the whole story. I'm thinking, don't they communicate? And then you ask, 'Have you seen this person?' And they say, 'No, I thought I'd speak to you first'. I say, 'Why don't you go and see them and then call me back'. (Interview 2)

Some RACF staff even visited their residents in hospital, although this was a luxury due to the closeness of the hospital to the RACF. While no RACF described a

completely smooth transition of care between the two settings, engaging with the hospital seemed to prepare the RACF better to receive the resident back.

The RACF staff that did not actively engage the hospital seemed to have difficulty communicating their expectations of acute care and were unprepared for the residents' return to their facility. It was not that no one had attempted to communicate with the hospital, but that communication had been ad hoc and executed by many different people. This practice increased the likelihood of miscommunication across the two settings.

3.2.4 Cooperative Care

All the RACF staff agreed that the hospital system had a better understanding of their role and the type of care they were able to provide. It was reported that there had been a dramatic decrease in the transfer of residents that still needed care beyond the scope of the aged care facility. Again it was articulated that good support from GPs made the transition much easier.

> Sometimes we have agreements with the hospitals, if it is a planned admission. For example, a gentleman that had blood transfusions, it was in his best interests to get him back here as soon as possible. He is happy in this environment. Now I would say that for the residents, there's no one who enjoys going into hospital. They understand when they have to go, but they are fearful. (Interview 3)

> The hospital is getting better at respecting that and they are better with medication management. Because we are low care and we rely on community pharmacy, the hospital respect that and action medication quicker. (Interview 2)

The RACFs utilised the Aged Care In-reach program to varying degrees, but staff felt that it was a useful service that helped prevent readmissions and provide quality care in the resident's home environment.

> Last week we had a lady here, her catheter came out. We rang St Vincent's and one of their employees was in the area and she said 'That's OK, I'll pop in!' Ideally it would be great to have a doctor or a GP that could come out in any situation but we realise they have constraints as well. For a trial it does work.

> Lets not put it all on St Vincent's, it's all too easy to call St Vincent's, and get them to put the catheter in, but you've got a Division 1 (nurse) at the RACF; whether in or not, they should be your first point of call. That's why we need to educate our own staff, to use the RACF resources first. The demands on St Vincent's staff are great. (Interview 1)

> I've been really positive about the project [winter demand strategy (see p.7)] because it's given us a line of communication. We sat down with [the coordinators] and said that we don't really have a lot of hospital admissions and the data supported that. When we send residents to hospital there is generally a really good reason. (Interview 3)

The RACF staff also observed that when a resident has an outpatient's appointment it is often difficult to coordinate the transport to and from this service. If the resident has

no family, and the hospital can't organise an ambulance, then the responsibility falls to the RACF and this is not meant to be part of their service and is quite resource-intensive.

4 Discussion

4.1 Standardisation

While the Victorian Government has attempted to standardise a discharge procedure policy with the 'Effective Discharge strategy' framework, the document only outlines follow-up procedures for post discharge (Department of Human Services, 2008). The government needs to develop indicators that identify what defines effective discharge processes, measurement scales and practice in order to form a baseline to measure improvements (Department of Human Services, 2008).

Previous research identifies that responsibility surrounding discharge processes has been one-sided. The research literature has primarily focused on the responsibility of the hospital in discharge processes. While RACFs' duty of care has been maintained, their responsibility in discharge processes has not been the subject of intense research, to date. A defined means to document and standardise processes of RACF hospital transfer procedures would enable a smoother transition for the resident and potentially contribute to a higher standard of care. Further, standardisation of transfer procedures would benefit RACF staff – by decreasing staff stress and anxiety levels when there is a need for an unplanned admission, or when the usual staff member is not available to coordinate transfers.

Standard 2 of the Aged Care Accreditation Standards states that 'Residents' physical and mental health will be promoted and achieved at the optimum level in partnership between each resident (or his or her representative) and the health care team' (Aged Care Standards and Accreditation Agency, 2008). Working more collaboratively with the hospital and sharing the duty of care for the resident/patient will work towards achieving this standard and will improve outcomes and facilitate cooperative community care relations.

4.2 Communication

The 'East Gippsland Care Planning Development Project' model has identified the objective of consolidating communication as key to the success of the model (Department of Human Services, 2003). This includes communication between the hospital sector, clients, health care providers and aged care and community-based service providers. Consolidating communication attempts to streamline hospital discharge processes through a central single point of communication (for both internal and external referrals).

Encouraging RACFs to appoint a person in each shift as 'hospital coordinator' will increase RACF staff expertise in hospital processes. This includes their knowledge of hospital discharge processes, medical procedures and governance requirements. The benefits of a ontact person for every RACF would be to reduce poor communication processes and increase the potential to develop a working relationship with the hospital discharging staff. Such an arrangement would also alert RACFs to the

ongoing role of advocacy and continuing care while a resident is in hospital. A contact person for each RACF would improve the quality of care received by residents during the transfer between the two care settings.

4.3   Information

The Division of General Practice has worked collaboratively to initiate, develop, and trial the Yellow Envelope. The envelope is a checklist for aged care residential staff and it accompanies the resident to the hospital Emergency Department. The aim of this concept is to embed the transfer of relevant patient information via the Envelope into routine practice between RACF and hospitals (North East Valley Division of General Practice, 2007). The concept links in with the Department of Human Services Effective Discharge policy and its philosophy and belief that hospitals should continue working towards ensuring a smoother patient discharge transition based on a 'shared care' model, given that 'Discharge Planning' is not a single event (Department of Human Services, 2008).

The redesign of the Yellow Envelope (Appendix 4) is an attempt to strengthen communication and timely sharing of information upon discharge. All RACFs, St Vincent's Hospital and the Division of General Practice have given feedback on the redesign. The changes include re-arranging the residential aged care information onto the front of the envelope to allow room for 'transfer FROM hospital checklist; the inclusion of a 'transfer FROM hospital checklist'; the inclusion of standard punch holes on the left hand margin (so that the 'Yellow Envelope' can be placed inside a standard hospital chart); the name of RACF contact person (in line with recommendation 6.2). The re-design of the Yellow Envelope includes a directive to hospital staff: 'PLEASE FILE IN FRONT OF HISTORY – TO BE RETURNED WITH PATIENT TO FACILITY'. These two measures were introduced in consultation with St Vincent's Hospital staff. The redesign of the Yellow Envelope is another attempt to strengthen the relationship between RACFs and the hospital system.

4.4   Limitations

The sampling of eight inner-city RACFs had both advantages and disadvantages. Some RACFs were more proactive in engaging with St Vincent's Hospital and more aware of the resources available to them. It would have been useful to sample more high care RACFs as well, in order to ascertain whether resident transfers were experienced differently by facilities with different staff qualification levels. A common theme identified throughout this research was the inadequacies of the Certificate III in Aged Care training. This is an area that requires further investigation.

This was a qualitative research project, a deliberate choice, as there been much quantitative research into discharge planning and continuing care and little information around the individual resident and/or the RACF experience of transitions between the two service settings. This research attempted to identify the differences in experience of resident transfers and the contributing factors to its success or failure. Due to restrictions in resources, such as time constraints, we were only able to speak to RACF managers and their on-staff Division 1 Nurse. We would have liked to speak

with the after hours staff and Personal Care Assistants to get their perspective of resident transfers also.

Due to the limited time available, a decision was made to build on existing strategies for developing and improving information and communication processes. It was identified that the Yellow Envelope concept and the Aged Care In-reach program were effective tools in improving information, communication, cooperative care and discharge procedures. Therefore, the research was steered towards improving these strategies and working in an applied policy framework. This would not only enhance and strengthen the position of the existing strategies, but also provide benefits to both the hospital and aged care sectors. The ultimate aim of the research was to improve the practices around admission and discharge processes for resident transfers and the quality of care provision for the aged. The introduction of a new research topic would have required more time, promotion and resources – luxuries which the researchers did not have while on placement.

5 Recommendations

These recommendations emerge from a study of seven RACFs within inner urban Melbourne. All RACFs used St Vincent's Public Hospital as their primary medical provider and had participated in the Yellow Envelope strategy. These recommendations (6.3 and 6.4) could be applicable to all RACFs within Victoria, if the funding for the DHS Winter Demand strategy and Division of General Practice Yellow Envelope strategy is broadened. Recommendations 6.1 and 6.2 are applicable to all RACFs across Australia.

6.1   That the residents' experience of transfer between hospital and RACF would benefit from DHS standardised procedures and uniform documentation between RACF and hospital sectors.

6.2   That all RACFs be required to implement and document standardised coordinated procedures for communicating with the hospital sector. A coordinated standardised approach, such as a single entry point for communication, will improve communication and information sharing procedures.

6.3   That the proposed re-design of the Yellow Envelope (Appendix 4) be utilised as the basis for re-publication by the Division of General Practice.

6.4   That the DHS funding for the Winter Demand strategy continue on an ongoing basis as it is an effective tool for communication, cooperative care and information sharing. The researchers recommend an extension of this winter initiative to include funding for bi-annual educational workshops on effective communication between the two sectors. This education program would include using the right tools, such as the Yellow Envelope and uniform documents.

6.5   That the Improving Resident Transfers Report be referred to the regional office of DHS and the sector of DHS responsible for the Winter Demand strategy to facilitate consideration of our proposals.

6.6   That the Department of Health and Ageing develop specific aged care guidelines for discharge planning procedures, to be separate from the current discharge planning policy.

6.6.1   That the DHS in conjunction with one or two metropolitan hospitals develop a working party to identify indicators of effective discharge processes. This pilot project would be responsible for developing measurement scales and a baseline for measurable outcomes of post discharge care issues such as medication, reasons for readmission and a definition of optimal discharge.

6.6.2   That Aged and Community Care Victoria undertake further research into the key areas identified and develop a more coordinated approach to resident transfers.

6.7   That the approach recommended in this report be trialled in other areas. Increased attention in the St Vincent's catchment area has suggested benefits for both hospital and aged care sectors.

6 Conclusion

The project and report demonstrate that there is a wealth of research and practice both locally and internationally to support the continuing efforts to improve resident transfers between hospitals and RACFs. This research project reinforced previous literature that identified standard processes, effective communication, information and cooperative continuing care as key needs in resident transfers. The project also offers some practical recommendations towards continuous improvement of the hospital–RACF relationship. The findings from this small study cannot directly be generalised to all resident transfers between RACF and hospital. However, it does offer some practical suggestions that could improve the hospital–RACF relationship. There is scope here for another study to trial and extend the recommendations made in this research.

Appendix 1 Cover letter for engaging participants

67 Brunswick Street,
FITZROY 3065

6 November 2008

Dear Sir/Madam,

**Project: Improving Resident Transfers – Hospital to Residential Aged Care
Facility**

In October last year a report entitled **"For Their Sake – Can we improve the quality
and safety of resident transfers from acute hospitals to residential aged care?"**
was released. This report was undertaken by Professor Tracey McDonald of ACU
National, and commissioned by the Aged Care Association of Australia. The report
demonstrated a number of serious deficits in the current system of transferring
residents from hospitals back to their residential aged care facilities. It also contained
a number of recommendations to address the identified problem areas.

The Brotherhood of St Laurence has developed a project aimed at responding to the
recommendations of this report. A copy of the brief for this project is attached
together with an executive summary of the abovementioned report.

Preliminary discussions have been held with the Melbourne Network of General
Practitioners and St Vincent's Hospital. These organisations have agreed, in principle,
to be involved in this project.

Sumner House and Sambell Lodge, our two inner city aged care facilities, are
involved in this project. Our goal is to include a further three, or four, facilities in this
research project. We would like to set up interviews with key staff from each of the
facilities in order to identify issues involved in resident transfers and develop a brief
of common experiences. We then intend to discuss these issues with St Vincent's

Hospital staff with the overall aim of developing a 'good practice' model for resident transfers from hospital back to residential aged care facilities.

The abovementioned research is being conducted by Jennifer Poole and Laura Meese, who are both final year social work students. Jennifer and Laura will be under the directive of Associate Professor Gerry Naughtin, Senior Manager Research and Policy, and myself.

As a facility that has a working relationship with St Vincent's Hospital, we would like to meet with you and any of your staff to discuss your experiences with resident discharge from hospital.

We believe the project could result in the development of a new systems model, which could be used across the industry to greatly improve the transfer of aged residents from acute care back to residential care. The model would also benefit residents/patient, and enhance the relationship between residential aged care facilities and treating hospitals.

I will contact you in a week or so to gauge your interest in participating in this project. In the meantime, if you have any questions about this proposal please do not hesitate to contact me on [phone number].

Yours sincerely,

Alan Gruner
Residential Aged Care and Major Projects

Appendix 2 'Improving Resident Transfers' Project Brief

Brotherhood of St Laurence
Working for an Australia free of poverty

Improving Resident Transfers – Hospital to Residential Aged Care Facility

Project Brief

(Compiled by Jennifer Poole and Laura Meese)

1. Aims

    1.1   To develop a 'good practice' model for the transferring of residents from hospital back to residential aged care facilities.

    1.2   To identify all required information and documentation required accompanying residents when transferring from hospital back to residential aged care facilities, and to develop a system to ensure relevant information and documentation is provided.

    1.3   To develop a communication system whereby the process of transferring residents from hospital back to residential aged care facilities are fully coordinated.

2. Background

In September 2007 a report commissioned by the Aged Care Association of Australia entitled *For their sake: Can we improve the quality and safety of resident transfers from acute hospitals to residential aged care?* was released. This report was undertaken as a consequence of numerous concerns raised by the residential aged care industry regarding the transfer of residents from hospitals back to residential aged care facilities. This has been an ongoing problem for residential aged care facilities for many years, and it can no longer be ignored.

The report, based on the results of survey responses from 371 respondents from residential aged care facilities around Australia, presents detailed evidence to support a number of disturbing deficiencies in hospital practices when transferring residents back to residential aged care.

These deficiencies relate to a number of areas and include the following:

- Lack of co-ordination of transfers resulting in inappropriate timing of transfers. Residents are often discharged from hospital on Friday afternoon when aged care staff cannot organise medication.

- Lack of information and documentation, in particular, medical records, prescriptions and clinical care issues.

- Poor communication so that aged care staff are unaware of assessments and treatments conducted by hospital.

- Residents returning from hospital with medical conditions requiring treatment, especially compromised skin integrity, with aged care facilities bearing the costs of these treatments.

The report also makes a number of comments about the lack of understanding by some key hospital staff about residential aged care. This can be seen in the inappropriate discharge of residents with medical conditions, such as, drug-resistant infections, life threatening illnesses, and serious skin problems, to aged care facilities.

This practice places enormous pressure on aged care staff that then spend a great deal of their time trying to contact hospital staff to find out about suitable treatment.

It is clear that there is a real problem in the communication between hospitals and aged care facilities. In addition, there is a lack of trust, which is evident in the large number of aged care staff who have ethical concerns about hospital practices.

The report has put forward a number of recommendations to address all of the abovementioned issues, and these form the template for the present project.

4. Proposed Methodology

This needs to be developed with the consultant undertaking the project and we would be interested in receiving feedback from the consultant as to how he/she intends to conduct this project. Minimum requirements in regards to the methodology should include the following:

- Literature search.
- Identification of and commitment from, suitable Residential Aged Care Facilities (RACF) and hospital/hospitals to be involved in the research.
- Identification of and commitment from, other stakeholders and possible partners to be involved in project.
- Engage the Residential Aged Care Facilities in a 'discussion group' forum to draw out common issues experienced by RACF.
- Summarise accounts made during the 'discussion groups' and develop these into a brief of common experiences of Resident transfers from the ACF point of view.
- Use the forementioned brief to develop and produce of a preferred 'good practice' model document in accordance with 'discussion group' initiatives.
- Consultation and workshop the preferred 'good practice document' with the relevant BSL staff, facilities staff, St Vincent's Hospital staff, ACF and key stakeholders about the validity of its recommendations.
- Outline proposed stages, including tasks and timelines.

5. Benefits

5.1 **Higher standard of care for residents**: Having all necessary information and documentation for a resident from hospital back to residential aged care means that the proper treatment and care can be provided to the resident immediately. At present the lack of necessary information and documentation means there is often a delay before staff are able to provide all necessary treatment and care required by the resident.

5.2 **Less stress and staff anxiety**: Staff often become stressed as they strive to provide suitable care for residents who are sent back from hospital without adequate notice, or at inappropriate times. There is also constant concern among staff about ensuring appropriate treatment for residents' conditions when they are sent back from hospital without required information, or records.

5.3 **Savings in time and overall costs**: Knowing when a resident is going to be returned from hospital, and having all the necessary documentation and information at the correct time would result in more efficient use of staff time

and other resources, thereby saving costs. At present residential care staff are required to continually contact hospitals to try and obtain relevant information and documentation when residents are received back from hospital – often without suitable advance notice.

6. Required Resources

6.1 Funding for a research person to undertake the project and to produce the required report as outlined above.

6.2 A manager, or senior manager, would be required to provide directions to the researcher, and to oversee the whole project.

7. Program Monitoring and Measurement

The monitoring of the program will need to be undertaken by a steering committee, such as the ACF, and a manager, or senior manager who would oversee the whole project.

8. Risks and Opportunities

Some of the risks are:
- Unable to recruit suitable researcher
- Researcher unable to produce required report
- Not able to secure support from an acute hospital for the project
- Cost over-run in producing report.

While some opportunities are:
- Improved quality of care
- Improved staff morale
- Making budget savings.

Appendix 3 'Improving Resident Transfers' Questionnaire

'Improving Resident Transfers' Research Project.
Discussion Questions for ACF.

1. How would you describe your RACF?

●**High/Low care?**

●**Bed no.?**

●**Staffing Arrangements- ratios, skill level of staff members**

●**Professional development opportunities and staff education/training**

●**Culture of ACF**

●**Diversity issues**

●**Mission Statement/Vision**

●**Client Mix – health/economic status**

●**Fee Structure – Business/NFP**

2. Which hospitals do your residents regularly access?

3. How frequently do residents go to hospital?
●**i.e. Approximately how many per week?**

4. What are your typical reasons for sending residents to hospital?
●**e.g. Falls, epilepsy, UTI**

5. Do you find that there is a time (hour or day) that is more common for residents to require medical attention? If so, when?

6. What kind of medical care are you providing to residents within the premises of the RACF?

7. What level of treatment is provided by your staff and what percentage is outsourced?

8. What percentage of residents are transferred to A & E because the treatment required is beyond the skill level of staff, or beyond the policy mandates attached to your agency?

9. Do you have standardised procedures upon admission of a resident from hospital?

10. Is it common practice for your RACF to use the 'Yellow Envelope' to accompany resident to hospital

11. Who takes responsibility for following up the resident's progress once they have been transported to hospital?

12. On average, what would be the length of hospital stay for each resident?

13. Do you have standardised procedures upon discharge of a resident from hospital? If no, then how is information communicated between your facility and the hospital?

14. Upon resident discharge, what kind of care /treatments is the hospital expecting the RACF to take responsibility for?

15. Are you appropriately supported to provide this level of care?

16. Do you find that there is a difference in the level of care and discharge support between hospitals?

17. Do you find the hospital returns residents with the appropriate level of support services?
If yes, what types of services?

If no, what would you identify as the support services most urgently required?

18. What post-discharge support services are you aware of?

19. Are there any things that you believe are relevant that have not been included in this survey?

20. Explain the proposed 'good practice' Model of care and receive feedback?

21. If we were to extend the 'Yellow Envelope' strategy, so that it was utilised in discharge, what information do you need upon residents returning from hospital?

22. If you were to appoint a discharge coordinator as part of a position description, whose role do you see it as? e.g. Manager, Head of Nursing, administration?

Appendix 4 Proposed Yellow Envelope Redesign

❈❈Aged Care Home Transfer-to-Hospital & Transfer-from-Hospital Envelope ❈❈

This envelope contains medical information which should remain with patient record

Patient's / Resident's Name

Name of Residential Aged Care Facility (RACF):

RACF Contact Person (In hours): ------------------------------

Contact Person's Phone Number: --------------- -

Out of hours Phone Number: ---------------------------

This RACF is: High Care ☐   Other (Specify) --------------------------- --- ☐
              Low Care ☐   Low Care with 'Ageing in Place'   ☐
                             (Has <u>high care</u> and low care residents)

This RACF is staffed by: <u>In hours</u>   <u>Out of hours</u>

                             Div 1 RN   ☐   Div 1 RN   ☐
                             Div 2 RN/EN   ☐   Div 2 RN/EN   ☐
                             PCA   ☐   PCA   ☐

Guide to RACF Level of Care:

High Care = Nursing Home. Division 1 Registered Nurse usually present at all times.

Low Care   = Hostel, but may have 'Ageing in Place' – residents may have complex medical
              and/or personal care needs (i.e. <u>high care</u>). Usually staffed by Division 2
              Registered Nurse/Enrolled Nurse, and/or Personal Care Attendants. <u>Generally,
              medications must be administered from a Dose Administration Aid.</u>

Other   = There is a range of accommodation with varying levels of supervision or
              assistance for residents e.g. Supported Residential Service (SRS). Usually no
              Registered Nurses (Division 1 or Division 2/Enrolled Nurse). PCA's assist
              residents with medication administration from a Dose Administration Aid.

Adapted from Dandenong District Division of General Practice template – coordinated by NEVDGP Aged Care GP
Panels Initiative June 2007.
Template available at <www.nevdgp.org.au>. Tel. (03) 9496 4333

PLEASE FILE IN FRONT OF HISTORY
TO BE RETURNED WITH PATIENT TO FACILITY

Preparing transfer <u>TO</u> hospital checklist (<u>completed by RACF staff</u>)

☐ Hospital notified by telephone (Emergency Department or Admitting Officer)

Information included in envelope

☐ Reason for transfer / letter from GP or locum if available
☐ Copy of drug chart / list of current medications
☐ Relevant medical history (most recent CMA/Comprehensive Medical Assessment if available)
☐ Usual condition and functioning: alertness, mobility, continence
☐ Advance care directives
☐ Next-of-Kin and/or Medical Enduring Power of Attorney contact details
☐ Telephone contact details @ ACF including after-hours telephone number
☐ Clear indication of level of care and support available to and needed by resident including level of training of staff @ ACF
☐ Name of usual GP and contact details
☐ Hospital UR number if available
☐ Copy of documents faxed to hospital <u>OR</u>   ☐   No documents have been faxed to hospital
☐ Health Insurance Status: (i.e. specify if Medicare only / DVA / Privately insured, and include details)

Preparing transfer <u>FROM</u> hospital checklist (<u>completed by hospital staff</u>)

☐ ACF contact person notified by telephone. Time:_____Date:_____

Information included in envelope

☐ Doctor's Discharge Letter (comprehensive)
☐ Nursing Transfer Summary (comprehensive)
☐ Medication Chart
☐ ACF Pharmacy notified. Time: _____ Date: _____
☐ Scripts faxed to ACF Pharmacy
☐ Post discharge Care Management Plan (tests performed / test results, allied health reports, wound care requirements, follow-up outpatient appointments)
☐ Belongings sent with patient (dentures, glasses, walking and hearing aids etc.)
☐ Details of hospital contact person/unit for post-discharge support/information.

Contact person/unit:_____

Contact telephone number:_____

References

Aged Care Standards and Accreditation Agency (1997). *Accreditation Standards*. Retrieved 27 November 2008 from www.accreditation.org.au

Australian Bureau of Statistics (2006). *Australian Social Trends 2006.* Retrieved 17 November 2008 from www.abs.gov.au

Australian Bureau of Statistics (2008). *Population by Age and Sex, Australian States and Territories June 2008.* Retrieved 1 May 2009 from www.abs.gov.au

Australian Government (2008). *Primary Health Care Standards: Towards a National Strategy*. Retrieved 17 November 2008 from www.health.gov.au

Centres for Medicare and Medicaide Services (2006). *National Evaluation of the Transition Care Program: Post Acute Care Plan Reform*. Retrieved 25 September 2008 from www.health.gov.au/aged

Department of Health and Ageing (2007). *Guidelines for the Aged Care GP Panels Initiative August 2007*. Retrieved 20 November 2008 from http://www.health.gov.au/internet/main/publishing.nsf/Content/aged-care-gp-toc~aged-care-gp-initiative-ch1

Department of Health and Ageing (2008). *Primary Health Strategy*. Retrieved 20 November 2008 from www.health.gov.au

Department of Human Services (1998). *Background paper: A Framework for Effective Discharge.* Retrieved 18 September 2008 from www.health.vic.gov.au/archive/achive

Department of Human Services (1999). *Victoria's Post Acute Care Program Final Report: East Gippsland Care Planning Development Project – Bairnsdale Regional Health Service*. Retrieved 9 October 2008 from www.dhs.vic.gov.au/health/archive/archive

Kinsella, K. and Phillips, D. (2005). *Global Ageing: The Challenge of Success.* Population Bulletin, 60 (1): 1–42. Retrieved 27 November 2008 from www.prb.org/pdf05/06

McDonald, T. (2007) *For Their Sake: Can We Improve the Quality and Safety of Resident Transfers from Acute Hospitals to Residential Aged Care?*. Canberra: ACU National.

North East Valley Division of General Practice Ltd (2006). *National Clinical Handover Initiative: Aged Care Transfer to Hospital Envelope.* Aged Care GP Panels Initiative (4). Retrieved 11 November 2008 from www.nevdgp.org.au

Rudd, K., Roxon, N. and Lucas, J. (2007).*New Directions for Older Australians: Improving Transition between Hospital and Aged Care.* Australian Labor Party. Retrieved 27 November 2008 from www.alp.org.au

Sinclair, C., Boyd, K. and Sinnott, H. (2003). Advanced Practice Nurses in Melbourne's Hospitals: Clinical Co-ordinators in A Rapid Assessment Medical Unit. *Australian Journal of Advanced Nursing 21* (2), 42–5.