Response to the

Tasmanian Health Service

Statewide Hospitals Discharge Framework

November 2022

About Carers Tasmania

Carers Tasmania is the Peak Body representing the more than 80,000 informal carers (hereafter carers) in the state.

Carers Tasmania's vision is for an Australia that values and supports carers.

Our mission is to work to improve the health, wellbeing, resilience and financial security of carers and to ensure that caring is a shared responsibility of family, community, and government.

Our values drive everything we think, say, and do.

- **Carers first** – we listen to what carers need, commit to their desired action plan, and deliver results that matter most to carers
- **Care in all we do** – we care for our work, about each other, about Tasmania's family and friend carers, and the bigger world we all share
- **Integrity always** – we are transparent, act ethically, own when things don't go to plan and do what we say we will
- **Quality every time** – we don't accept 'good enough' because carers deserve our very best every time
- **Speed that matters** – we are agile and don't put off what can be done today

These values represent how we engage with and serve carers, how we work with each other, and our commitment to the broader community. Carers Tasmania encourages partnership with government and the health and community sectors to enhance service provision and improve conditions for family or friend carers through policy development, research and advocacy.

Carers Tasmania has offices in Moonah, Launceston and Burnie.

Please direct any enquiries about this report to:

David Brennan
Chief Executive Officer
Phone: (03) 6144 3700
Email: ceo@carerstasmania.org

Contents

1. Background

Carers Tasmania acknowledge the Aboriginal and Torres Strait Islander peoples as the traditional custodians of the land of lutruwita/Tasmania and we pay our respects to Elders past and present. We acknowledge and support people of all genders, sexualities, cultural beliefs, and abilities and understand that carers in Tasmania, whilst sharing the common theme of caring for a family member or friend, are diverse individuals with varying beliefs, experiences, and identities.

Carers Tasmania is the Peak Body representing the more than 80,000 informal carers in the state.

A carer is a person who provides unpaid care and support to a family member, or friend, with disability, mental ill health, a chronic or life-limiting condition, alcohol or other drug dependence, or who are frail or aged. A carer may also be a kinship carer of a child under the age of 18. Carers are predominantly family members, but may also be friends, neighbours, or colleagues. Informal carers are not to be confused with paid support workers who are often called ‘carers’, with the difference being that support workers are fully employed and remunerated with all the benefits of employment. On the contrary, informal carers perform their caring duties without remuneration, other than minimal carer payments and allowances from the Australian Government.

In addition to representing carers through the Peak Body activities, Carers Tasmania provides support to carers living in Tasmania through its service delivery arm, Care2Serve. The Commonwealth Carer Gateway program is delivered through Care2Serve, as are other supports and services, such as the Tasmanian Government’s Home and Community Care program.

The Carer Gateway program provides a range of services and supports for carers which are designed to build resilience, increase wellbeing, improve quality of life, and sustain carers to effectively continue their caring roles. The available supports include the provision of information, advice and referrals, holistic identification of carer strengths and needs through a carer support planning process, professional counselling, peer support, and coaching which aims to support carers in achieving specific goals.

Care2Serve, through the Carer Gateway, has capacity to fund certain instances of planned, practical support services such as in-home respite, personal care, domestic assistance, and meal preparation. Care2Serve may also fund items such as laptops to assist carers who are studying or trying to enter the workforce. Care2Serve also coordinates the provision of emergency support during instances where a carer may be unable to provide the care that they usually do, resulting from unexpected illness or injury of the carer.

2. Introduction

Thank you for the opportunity to provide feedback on the *Tasmanian Health Service Statewide Hospitals Discharge Framework 2022*[1] (hereafter described as 'the Framework'). We acknowledge the commitment and progress made so far by the reforms aimed at advancing health services for all Tasmanians.

The Australian Bureau of Statistics 2018 *Survey of Disability, Ageing and Carers* (SDAC)[2] revealed that there were 80,100 carers in Tasmania, representing 15.5% of the Tasmanian population. Of these carers, females accounted for 41,400 (51.7%) and males accounted for 38,000 (47.4%). The report also found that there were 6,200 (11.6%) young carers aged under 25 years in Tasmania.

We know that Tasmania when compared with the rest of Australia ranks quite poorly in health outcomes. Despite providing care to their family members or friends, many carers living in Tasmania experience poor health or disability themselves. In Tasmania, there are greater rates of disease burden (arthritis, asthma, diabetes, cancer, heart disease) and high rates of mental ill health[3] when compared with other parts of Australia, as well as an ageing population.

Carers also have poor economic security despite the significant savings they provide state and federal governments. In 2020, Deloitte Access Economics[4] modelled the national replacement value of informal care at $77.9B resulting from more than 2.2 billion hours of unpaid care. In Tasmania, this would cost approximately $2.2B if the care provided by informal carers were to be replaced through the state health system or service providers.

In 2021, the Carers Australia network, which includes Carers Tasmania, commissioned the *Caring Costs Us*[5] report to identify the impact on lifetime earnings and retirement savings. On average, every year in Australia, a carer will lose $17,700 in superannuation and $39,600 in lifetime earnings. By age 67, that is $392,500 and $175,000 respectively. The most affected carers will lose $940,000 in income and $444,500 in retirement savings.

It is our understanding that a major aim of the Tasmanian health system reforms is to ensure that people who live in Tasmania can access the *'right care, in the right time, at the right place'.*[6] Ensuring discharge practices are completed, using best-practice and person-centred Frameworks is a crucial step towards ensuring this aim is achieved.

As the Peak Body for carers within the state, we emphasise the valuable and significant role that carers play in supporting the health and wellbeing of their family and friends. Despite the positive aspects of caring for a family member or friend, we also hear about many of the challenges that carers are often faced with, particularly in health settings.

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[1] Department of Health Tasmania. Tasmanian Health Service Statewide Hospitals Discharge Framework. November 2022

[2] Australian Bureau of Statistics (2021) 44300DO006_2018 Disability, Ageing and Carers, Australia: Tasmania, 2018. Released at 11:30am Wednesday 5 February 2020

[3] https://www.abs.gov.au/articles/snapshot-tas-2021#:~:text=In%20the%202021%20Census%2C%20the,city%20area%20of%20Greater%20Hobart.

[4] https://www2.deloitte.com/au/en/pages/economics/articles/value-of-informal-care-2020.html

[5] https://www.carersaustralia.com.au/wp-content/uploads/2022/04/Final-Economic-impact-income-and-retirement-Evaluate-Report-March-2022.pdf

[6] https://www.health.tas.gov.au/sites/default/files/2022-06/Advancing%20Tasmania%27s%20Health%20Strategy%20-%20Exposure%20Draft%20-%20Our%20Healthcare%20Future.pdf

Carers often report feeling invisible within the health system and that the important information they have to share about the person being cared for is not listened to by health providers. Carers report that they don't feel valued or respected as a crucial part of the care planning team, despite the knowledge and experience that they gain from caring for their family member or friend.

In a recent round table event facilitated by the Minister for Community Services and Development, Nic Street, carers who identify or care for someone who identifies as LGBTIQ+ shared their personal experiences about processes that lacked inclusive practice within healthcare settings. They described a general lack of awareness and understanding of being a carer who identifies as LGBTIQ+ or caring for someone who does.

On numerous other occasions, carers have voiced their frustration and confusion reporting that the person they care for was sent home from hospital:

- Before they were ready
- Before additional supports were organised
- At unsuitable times
- And sometimes in a taxi without the carer being notified

For these reasons and others, we have written previously to the Minister for Health, the Honourable Jeremy Rockliff, sharing the challenges and concerns experienced by carers. We have also had the opportunity to provide input into recent statewide health reform consultation opportunities such as:

- Establishment of a Statewide Clinical Senate *(our Healthcare Future)*[7]
- Advancing Tasmania's Health Exposure Draft *(Our Healthcare Future*[8]*)*
- Terms of Reference for the Tasmanian Health Senate *(Our Healthcare Future)*[9]

Throughout these submissions, we have amplified the voice and experiences of carers, and highlighted the challenges being experienced around inappropriate hospital discharge across the state.

Whilst the discharge Framework aims to improve discharge planning and does make mention of carers to some extent, there are still various aspects of the document which could be amended to better support carers. Our response firstly provides a small handful of scenarios experienced by carers and the people they care for. This is followed by taking a solutions-focused approach and outlining our specific recommendations on how the Framework can be updated to be more inclusive and supportive of carers, and by doing so provide better outcomes for the people receiving care.

[7] https://www.health.tas.gov.au/publications/our-healthcare-future-establishing-statewide-clinical-senate
[8] https://www.health.tas.gov.au/sites/default/files/2022-06/Advancing%20Tasmania%27s%20Health%20Strategy%20-%20Exposure%20Draft%20-%20Our%20Healthcare%20Future.pdf
[9] https://www.health.tas.gov.au/sites/default/files/2022-09/tasmanian-health-senate-terms-of-reference.pdf

3. A snapshot of experiences

As the Peak Body for carers in Tasmania, engagement with carers is crucial to gain an understanding of the positive and challenging aspects of being a carer in Tasmania. From listening to and collecting experiences from carers, we are able to then appropriately share these stories to support advocacy for positive change. The following are several case studies that represent some of the reported challenges faced by carers supporting a friend or family member within the Tasmanian hospital system.

Case study:

Mrs. A phoned Care2Serve on Friday 19 November 2022 because her mother (Mrs. B) had been discharged from a Tasmanian hospital. Mrs. B is aged 68, has a history of falls, low mobility, and had been in hospital for about 6 weeks for cirrhosis and anaemia.

Upon calling Care2Serve, Mrs. A was not clear on what services had been organised for her mother's discharge and was panicking because someone did stay overnight but could not stay past the upcoming Sunday. Mrs. A said that the social worker had organised an assessment that she thought might be an Aged Care Assessment (ACAT) or a Regional Assessment (RAS) but wasn't sure and didn't know what the next steps were. Mrs. A and Mrs. B had not had contact with My Aged Care (MAC) and was not set up as a representative for MAC but was going to do that with her mother on the weekend.

The Care2Serve staff member informed Mrs. A about the Commonwealth Home Support Program (CHSP) and that she would most likely be waiting a while for a home care package, but the CHSP could be an option to begin receiving services within a few weeks.

Mrs. A also cares for her child with disability. She was registered with Care2Serve so she participated in a carer support planning discussion with a staff member. As a result, a carer-directed package for personal care was put in place whilst waiting for ongoing support to commence.

Case study:

Ms. C called Care2Serve on 3 October 2022, looking for urgent residential respite for her father who was in the Royal Hobart Hospital (RHH). Ms. C stated that she felt her father was not medically stable, but the hospital staff had mentioned that they may be looking to discharge him from the hospital sometime within the week.

Ms. C said that her father had just had a peg feeding tube inserted and that they were exploring him feeding himself. He was also permanently on oxygen. Ms. C's father had a form of cancer that was causing difficulty swallowing. He weighed under 50 kilos.

Ms. C asked to try and book residential respite at a place where a family member worked to try and ensure that it was a comfortable setting. She was also happy to look elsewhere if needed as there were long wait lists for most residential aged care facilities in Tasmania.

Care2Serve staff contacted a number of residential aged care facilities but were then informed that Ms. C's Father passed away on 5 October 2022.

Case study:

Mr. E. phoned Care2Serve on 26 August to organise emergency respite for his mother, Mrs. F. Mrs. F recently had a fall and cracked her hip. She had been in hospital recently and refused forms of care as a patient, including pain medication. Mr. E expressed his concerns

about the situation as his mother was released from the hospital without him being notified despite him being her carer.

Mr. E explained that Mrs. F went home the day prior, and he found her today in her armchair. She had slept in the chair all night as she couldn't get up. Mr. D stated that his mother had not eaten since the day before or taken any medication for over 24 hours. Mr. E wanted to organise emergency respite for his mum, but the Southern ACAT team stated that Mrs. F needed to be reviewed by her GP or a doctor before respite could be considered an option.

Upon further discussion, Mr. E planned to take Mrs. F back to the royal Hobart hospital to be assessed and to ensure that there wasn't an underlying issue that hadn't been managed. This was also an opportunity for Mr. E to mention that after speaking with ACAT, that the hospital could flag whether Mrs. F needed to be re-assessed and possibly to a higher level of care. Mr. E said he would contact the discharge planner and request readmission into the hospital to get her the support and care required until a RACF was available.

On 30 August, Mr. E called Care2Serve to provide an update that his mother was taken to the hospital on the Friday afternoon. Mr. E stated that they waited for 8 hours in the emergency ward before his mother, after 7.5 hours blacked out and had a seizure in the emergency waiting room.

Mrs. F was then seen and taken to a ward. She was still currently in the hospital at the time of this call, with staff looking to complete more testing as Mrs. F had also experienced some cognitive decline. Mr. E mentioned that he could have lost his mother if he wasn't so persistent with her receiving the right care at the RHH.

An example of well-coordinated supports:

The following email was sent to Care2Serve from a hospital social worker:

> *"Good afternoon, I've been working with Mr. D as he is a current inpatient. My understanding is that his wife who he is a carer for has been receiving emergency in home respite care from your service for the past 4 days from 12-5pm since Mr. D has been in hospital. Tomorrow is the last emergency shift planned. I had a conversation with Mr. D today and I'm wondering if there is any scope at all with regards to funding if some additional care hours could be accessed during this week? Mr. D plans to discharge home tomorrow as his daughter must return to work. If worst comes to worst and the Dr's don't discharge Mr. D tomorrow, then his daughter could cancel work and stay with her mother for an additional day. Mr. D's wishes are to return home tomorrow. Some additional hours of in-home respite may be beneficial as Mr. D settles back home following his major head surgery.*
>
> *I don't work Monday but am back to work Tuesday. Please contact Mr. D and his wife directly if you can put any additional hours in."*

This connection provided the opportunity to ensure that Mr. D's wife was cared for whilst he was in hospital and that there was adequate support upon his return home.

4. What are the key challenges?

Discussions with Carers Tasmania Peak Body, Care2Serve's Carer Support Officers and Respite Booking Officers, ACAT assessors, and representatives from COTA have informed the identification of several issues that if addressed could reduce the significant physical, mental and emotional strain on informal carers who are critical in supporting some of Tasmania's most vulnerable people. The key areas of challenge are listed below.

The health of Tasmanians:

- There are significantly high rates of chronic illness in Tasmania, as well as an ageing population with greater survival rates for people with complex needs. This means that for a lot of patients, their carers may also be elderly or have chronic conditions themselves which may limit their ability to provide the full level of care required. This can be mitigated if carers are identified as early as possible and they are routinely referred for carer support to ensure the whole family unit is supported as holistically as possible.

The actual discharge process:

- Barriers to effective discharge planning for patients continue to occur. Sometimes discharge planning is not conducted to the knowledge and understanding of the patient and carer
- It can sometimes be difficult to understand the presentation of patients (particularly with dementia) in hospital compared to at home due to being in an unfamiliar environment
- Transitional care planning is not routinely or consistently applied to eligible patients
- There are variances in access to services depending upon the funding status of the person and the region they reside in
- Staff shortages result in patients being discharged without appropriate discharge planning and the necessary in home or residential respite supports
- Patients and their carers are not equal partners in decision-making. It is crucial for carers to be identified and included as partners in care
- There is often little or no collaboration with NDIS plan managers or home care package case managers
- Carers are not routinely identified and referred to Carer Gateway

Limited access to residential respite (RACF) and or rehabilitation:

- There are significant waitlists for RACF in Tasmania, with some facilities not having availability until at least February 2023 (as of November 2022)
- Pressure on the number of available hospital beds as a consequence of significant gaps in community-based service provision (respite beds)
- Rehabilitation services appear to not be fully developed across the continuum of care in each region

- Demand for inpatient rehabilitation and respite services is increasingly having major implications for sub-acute care needs

5. Feedback on the Framework

Firstly, it is positive to observe that the word 'carer' has been used on numerous occasions throughout the Framework document. For example, the purpose section describes that the Framework[10] aims to:

1. *"Describe how we partner and communicate with patients, carers, family and other providers to ensure a safe and appropriate discharge*
2. *Assist in achieving standardised and comprehensive discharge*
3. *Define the way discharge occurs*
4. *Describe a coordinated and seamless patient journey between service systems and care settings*
5. *Outline best practice discharge*
6. *Describe interventions, activities and tasks required for effective discharge*
7. *Describe accountabilities and responsibilities for discharge*
8. *Describe a multidisciplinary approach to discharge"*

Although carers are noted, more work is required throughout this document and the processes that follow to ensure it is truly inclusive and supportive of carers, which in turn will have a positive impact on the quality of life of the patient.

The document also cites the following paragraph:

> *"Discharge planning is an interdisciplinary approach to continuity of care; it is a process that includes identification, assessment, goal setting, planning, implementation, coordination, and evaluation and is the quality link between hospitals, community-based services, non-government organisations and carers."*[11]

This Framework and associated processes must specify ways to practically involve carers, not just note that they must be involved. It must be made clear to staff how they can recognise, involve, and include carers.

With the Tasmanian Carer Recognition Legislation progressing in Tasmanian Parliament,[12] we advocate for elevated levels of carer recognition and referral to support as this will increase the capacity of carers to best support the people they care for. If carers are not considered in discharge planning or it is assumed that they will have the ability to provide all care required for their family member or friend upon discharge, the likelihood of carer burnout or readmission of the patient to hospital is high.

Carers must know what supports are being organised by the hospital and what supports they need to organise. They will need to be informed of what medications and dosage are

[10] Department of Health Tasmania. Tasmanian Health Service Statewide Hospitals Discharge Framework. November 2022
[11] Discharge Planning. Lin, C., Cheng, S., Shi, S, Chu, C. Tjung, J.: International Journal of Gerontology (2012), Vol. 6.
[12] https://www.parliament.tas.gov.au/Bills/Bills2022/reprint/33_of_2022.pdf

needed, any physiotherapy needs, personal care support required, any specific dietary requirements, and any other recovery tasks that their family member or friend may need. They must also be provided with information on what to expect and any mobility equipment and information on how to safely use the equipment.

The Framework[13] describes three levels of discharge planning, which include "*simple discharge, moderately complex discharge, and highly complex discharge"*. We seek for carers to be considered and identified at each stage and for staff to have an understanding of how they can involve carers most effectively in each stage.

For example, a patient considered as needing a simple discharge plan, their carer (if they have one) must be identified and referred to Carer Gateway as a preventative measure should they need additional support. The carer will need all the relevant information (eg medication, physio, follow-up appointments), but may not need additional practical or post-hospital discharge support.

For someone considered to have moderate discharge needs, their carer (if they have one) must be identified and referred to Carer Gateway as a preventative measure should they need additional support. The carer will need all the relevant information on what the patient needs (eg medication, physio, follow-up appointments), but they may not need additional practical supports on top of the post-hospital supports which should be organised prior to discharge.

For someone considered to have highly complex discharge needs, their carer (if they have one) must be identified and referred to Carer Gateway as they will most likely need additional emotional and practical support as well as information and referrals to other organisations. In these situations, it is usually best for the staff member to gain consent and make the referral as opposed to just telling the carer to call and register. The carer will need all the relevant information on what the patient needs (eg medication, physio, follow-up appointments). Post-hospital supports should be organised prior to discharge as well as a referral for ongoing support (as there are often long waitlists). The level of information provided to the carer should be significant enough to assist the carer to understand any complex needs and care requirements.

The Framework[14] identifies the following as fundamental principles of effective hospital discharge:

- Communication
- Consideration
- Comprehensiveness
- Coordination
- Collaboration

If carers are identified and communicated with under each principle, the chances of an effective, safe, and informed discharge will be increased.

[13] Department of Health Tasmania. Tasmanian Health Service Statewide Hospitals Discharge Framework. November 2022

[14] Department of Health Tasmania. Tasmanian Health Service Statewide Hospitals Discharge Framework. November 2022

We recommend the following amendments to the description of each of these principles within the Framework.[15] These recommendations aim to ensure the recognition of carers and a better experience for the patient as a result, noting that our specific recommendations are presented in **bold**.

Communication:

> *"Good communication should involve having a common language and mutual understanding of the plan among the multidisciplinary team, treating team, patient, family and carer. This includes the use of a professional interpreter for non-English speaking backgrounds and deaf or hard of hearing patients. Discharge is not a one-time event but a process that takes place throughout the hospital stay as part of the care journey. This requires effective information sharing between the treating team, multidisciplinary team, patient, family, carer and community service providers e.g., GPs, community nursing,"* **transitional care support, home care package case managers, or NDIS plan manager/support coordinator** "to *ensure the smooth transfer of care."*

Consideration:

> *"A person-centred approach needs to be embraced as part of effective discharge planning. This needs to be a process that provides patient-centred care to ensure that each patient's journey from the hospital back to the community is seamless. It is essential for the planning process to consider the needs and expectations of the individual in their particular circumstance. Patient-centred care is the practice of caring for patients,"* **carers**, *"(and their families) in ways that are meaningful and valuable to the individual patient. It includes listening to, informing and involving patients* **and carers** *in their care in a respectful and responsive way that ensures patient values guide all clinical decisions."*
>
> "*Patients with complex discharge needs require more resources than those with simple discharge needs to ensure efficient and effective discharge. The right resources need to be considered for the right patients at the right time. This includes health professionals with knowledge and expertise in discharge planning processes"* **and consideration of what the carer of the patient needs to effectively support the patient at and after discharge.**

Collaboration:

> *"Discharge planning is interdisciplinary in its approach to ensure the continuity of care. The planning and communication need to effectively collaborate between all disciplines involved in the development of the discharge plan. The multidisciplinary team, treating team, and consultants need to work together to achieve common goals. This requires trust, respect, joint ownership, and early planning to assist the patient"* **and their carer** *"with goal setting and planning for discharge. It is important to break down professional barriers and develop a culture of collaboration and joint work toward the patient journey home."*

Coordination:

> *"The patient's experience and their journey home are partly determined by the quality of the coordination of their care. Discharge planning"* **must** *"be facilitated by an*

[15] Ibid.

identified coordinator. This may be a ward nurse for a simple discharge or a complex care/discharge coordinator for a more complex discharge. This journey should coordinate and facilitate the involvement of individual clinicians, services", **and informal carers,** "*to ensure continuum of care, a seamless service, and result in quality outcomes for the patient."*

"Discharge processes should ensure integration and collaboration of care between hospitals, community-based organisations, non-government organisations, and carers. Communication through care planning, documentation, handover, multidisciplinary meetings, and case conferences are an important aspect to coordination and integration" **and carers must be fully informed of arrangements.**

Comprehensiveness:

"Part of the comprehensive care planning process is planning for discharge from the THS hospital pre-admission or inpatient setting. This should consider all aspects of patient needs. This includes:

- *Engaging the person, and their family and carers in discharge planning from the beginning of the episode of care*
- *Identifying any services, equipment and follow-up that may be needed to safely discharge the patient*
- *Ensuring follow-up arrangements are made before the patient leaves the hospital*
- *Any required referrals are sent and dealt with promptly*
- *Inclusive of all relevant health professionals as part of the care when leaving hospitals"*
- **Ensuring that carers are made aware of information that will assist them to support the person they care for. The *'I Care'* booklet[16] would be an incredibly important resource to be provided to carers as soon as they are identified as well as a referral to Carer Gateway.**

[16] https://www.carerstas.org/resource/i-care-book-2019/i-care-book-2019-web/

The Framework[17] depicts a flow chart called The BETTER Journey Home which highlights the key tasks that the discharge planning Framework involves.

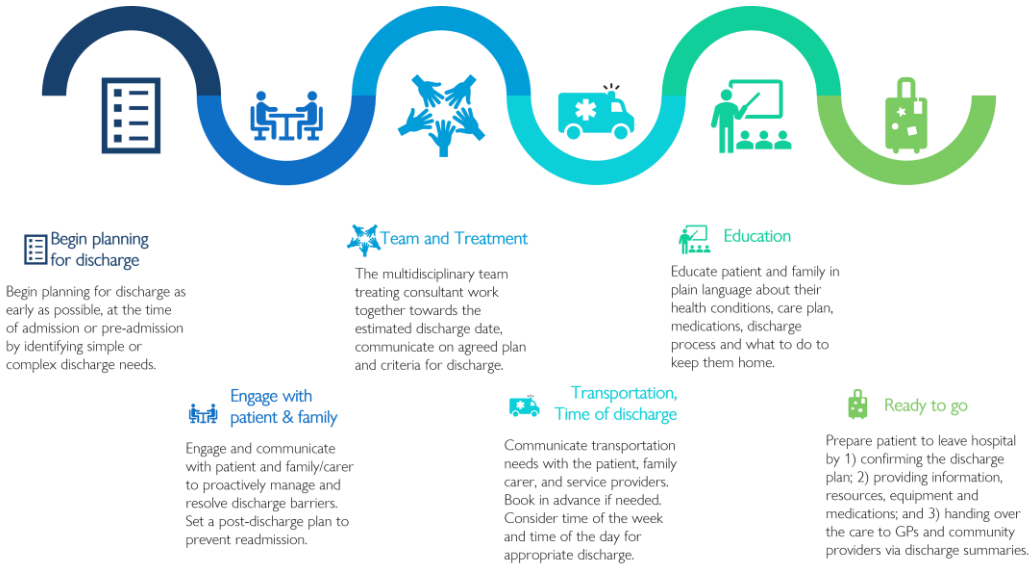

Figure 1: BETTER Journey Home

We recommend the following amendments to the key elements of the BETTER Journey Home process within the Framework[18] noting that our specific recommendations are presented in **bold.**

Begin planning for discharge:

- *"Begin planning for discharge as early as possible at the time of admission (for unplanned/emergency patient) or pre-admission (for planned/elective patient).*
- *Complete a patient needs assessment to identify simple or complex discharge needs including physical, social, psychological and safety support.*
- *Identify key contact people (family, carer, community supports, GPs, community service providers – RACFs, Disabilities Services/Agents)"*
- **Where there is a carer identified, they must be provided with the *'I Care'* booklet[19] and a referral to Carer Gateway**
- *"Obtain an accurate pre-admission medication list including allergies and adverse reactions*
- *Establish patient, family, and carer preferences for discharge destination and transport requirements. The transportation requirements need to be documented for a later communication with non-emergency patient transport or community transport services."*

[17] Department of Health Tasmania. Tasmanian Health Service Statewide Hospitals Discharge Framework. November 2022
[18] Ibid.
[19] https://www.carerstas.org/resource/i-care-book-2019/i-care-book-2019-web/

The distribution of the "*I Care' booklet*[20] is action 2.7 as outlined in the Tasmanian Carer Action Plan.[21] This action describes responsibility of the DoH to support the distribution of the *'I Care' booklet* throughout THS hospitals. The *'I Care' booklet* is a resource for family and friends who are caring for someone in hospital. If this book is provided early on, ideally upon admission, this may be used as an additional tool for the carer to record any important information about the person they care for and also provides contact details on how to access carer support. This fits under the banner of "*Begin planning for discharge"* and should be listed under this heading.

Engage with patient and family:

We recommend that the title of this process item to be renamed to **engage with patient, family, and carers.**

Engagement and collaboration with patients and carers must occur, but aside from the discharge Framework, we are interested to understand what else is being put implemented to guide this. We refer to action 2.8 *of the Tasmanian Carer Action Plan 2021-2024*[22]*,* which refers to an action for the Department of Health (DoH) to develop clinical guidelines for working with carers. We would be more than happy to collaborate with the Department of Health and with carers in the development of this resource.

Team and treatment:

- **"***The treating team determine the Estimated Discharge Date (EDD) following evidence-based information and the patient's conditions"* **and notify the carer**
- "*Identify health professionals which required to be part of the multidisciplinary team to contribute to patient's treatment plans and discharge planning*
- *Reconcile pre-admission medications with admission medications*
- *The multidisciplinary team to develop and agree on a care plan and discharge plan in collaboration with the treating team, patient, family, carer, and community services*
- *The treating team and multidisciplinary team work together towards EDD*
- *Daily review of the EDD, care plan and discharge plan and document progress and actions to address discharge barriers*
- *Develop clinical criteria for discharge, document and communicate the agreed criteria with patient, family, treating team, nursing staff and multidisciplinary team to inform decision-making that enables discharge seven days a week*
- *Share information and discharge plans between all clinicians in the treating team, multidisciplinary team, the hospital Integrated Operations Centre/Patient Flow Unit and communicate with external stakeholders including GPs, community supports,*

[20] https://www.carerstas.org/resource/i-care-book-2019/i-care-book-2019-web/
[21] Department of Premier and Cabinet Tasmania. Supporting Tasmanian Carers. Tasmanian Carer Action Plan 2021-2024. https://www.dpac.tas.gov.au/__data/assets/pdf_file/0026/246248/Supporting-our-Carers-Action-Plan-2021-24_-JULY-2021.pdf
[22] Department of Premier and Cabinet Tasmania. Supporting Tasmanian Carers. Tasmanian Carer Action Plan 2021-2024. https://www.dpac.tas.gov.au/__data/assets/pdf_file/0026/246248/Supporting-our-Carers-Action-Plan-2021-24_-JULY-2021.pdf

community service providers – community nursing, RACFs", **disability or aged care supports, transitional support services and Carer Gateway**

Transportation and time of discharge:

- *"Communicate the patient's transportation requirements with the patient, family and carer as well as non-emergency patient transport or community transport services if the patient does not have a private transportation arrangement*
- *Communicate the Estimated Discharge Date that the patient may be leaving the hospital to the patient, family and carer or non-emergency patient transport or community transport services to ensure they are ready to pick up the patient*
- *Consider the time of the week to discharge the patient as this could impact the availability of GPs, community supports, community service providers – community nursing, RACFs, and Disabilities Services/Agents to provide continuity of care to the patient after leaving the hospital*
- *Consider the time of the day to discharge, the morning is preferable. This allows enough time during the day for the patient to get the transportation and settle back into the community environment"*
- **Consider whether the time proposed is suitable for the carer and if the carer has all the supports they need in place**
- *"Confirm the discharge date, time of the day and transportation requirements with the patient, family and carer as well as non-emergency patient transport or community transport services 24-48 hours prior to the agreed discharge date and time"*

Education:

- *"Information specific to health conditions, including symptom management, medications, and health management in-hospital and post-discharge, are communicated to the patient, family and carer with consideration given to health literacy and cultural barriers*
- *Provide information to the patient"* **and carer** *"in small chunks and repeat key pieces of information throughout the hospital journey*
- *Ask the patient, family and carer to repeat what you said back to you in their own words to be sure that the patient"* **and carer understands**
- *"Educate the patient, family and carer in plain language about their health conditions, care plan, medications, process and what they need to do to keep them safe at home"*

Ready to go:

- *"Confirm ongoing care arrangements with external providers, GPs and RACFs, and Disabilities Services/Agents. Communication should include changes in functional capacity, health conditions, medications, level and type of care required, post-surgical instructions and follow-up arrangements*

- *The day before leaving the hospital, medical staff prescribe and prepare discharge medications ensuring adequate supply until the next GP visit. Conduct medication education, reconciliation and provide written medication profile*
- *The day before leaving the hospital, equipment delivery/provision is confirmed by allied health professionals*
- *Confirm"* **the patient and carer** *"understand the discharge plan and is aware of outpatient clinic follow-up appointments that have been organised*
- *Separation summaries (discharge summaries) are prepared by a medical practitioner and sent to the patient's GPs, and other relevant agencies including RACFs, and Disabilities Services/Agents as well as supplies a printed copy to the patient from HealthCare Suite (HCS)*
- *Providing discharge information that is appropriate to the patient, family and carer circumstances, cognitive, cultural, language and level of health literacy*
- *In the event that the discharge outcome for the patient is death, the GPs, RACFs, Disabilities Services/Agents and community-based service providers must be informed on the day, preferably by phone and in writing"*

It is important to highlight that there are currently waitlists for most residential aged care facilities in Tasmania, with some that have availability for bookings from the end of November 2022, whilst other facilities have beds booked already up until April 2023. For patients who would ordinarily be discharged into a residential aged care facility but are sent home due to the high need for hospital beds and the limited access to RACFs, it is crucial that they are only discharged if the right level of in home support is put in place. This might include a combination of aged care, palliative care and or Carer Gateway supports.

Recommendations on the next comprehensive care plan:

To support the translation the Framework into meaningful actions, the comprehensive care plan must be completed and explored fully with the patient, carer, and any other relevant people. We have provided some specific recommendations on the yet-to-be-implemented Comprehensive Care Plan document. We strongly encourage our recommendations to be implemented to achieve effective collaboration with carers and other relevant services to ensure that the patient and carer are supported as best as possible for a safe return home. The addition of these simple questions and checkboxes will have significant positive flow-on effects and ensure that patients and their carers are enabled the opportunity to access support that is available when required. Our recommendations on simple amendments to the comprehensive care plan are presented as comments in red:

Also ask if the patient HAS a carer

TRIAL

(Tick ☑ as appropriate, format time as 00:00 (24 hour) and date as DD/MM/YYYY)

DISCHARGE PLAN	▲	◆	■	Ⓟ
Living situation on admission:	☐ Home (with family or carer)	☐ Home (alone)	☐ Aged Care Facility	
☐ Supported accommodation	☐ Homeless	☐ Other *(specify)*:		
Patient has dependants:	☐ No	☐ Yes (number and age):		
Patient is a carer:	☐ No	☐ Yes (for):		
NDIS participant:	☐ No	☐ Yes → NDIS provider involved in discharge plan		
Location of discharge:	☐ Home (with family or carer)	☐ Home (alone)	☐ Aged Care Facility	
☐ Hospital (internal transfer)	☐ Supported accommodation	☐ Respite	☐ Other *(specify)*:	
Estimated date of discharge: DD / MM / YYYY				
Contact person for discharge *(print name)*:				
Phone number:			☐ Notified	
Transport arranged:	☐ Public	☐ Private	☐ Not applicable	

Also ask if there is a home care package. If so, consult with the case manager.

Add

Transitional support plan

and

Carer Gateway

If patient had suspected dementia or episode of delirium or self-harm, or suicidal ideation during admission:			
☐ Referral/s to appropriate services completed	☐ Follow up information communicated to General Practitioner		
Referrals sent:	☐ Community Nursing	☐ Allied Health	☐ Other *(specify)*:
Invasive devices in situ:	☐ No	☐ Yes *(specify)*:	
Review date: DD / MM / YYYY	Invasive Device Alert registered:	☐ No	☐ Yes
Discharge script/medications:	☐ Medication reconciliation (pharmacist)	☐ Given to patient/carer	
☐ Discussed with patient/carer (Pharmacist)	☐ Medication chart	☐ Medication dose administration aid	
☐ Collecting from private pharmacy	☐ Collected from pharmacy		
Items returned to patient:	☐ Own medications	☐ Valuables	☐ Property
Provided to patient or carer:	☐ Appointment(s)	☐ Medical Certificate	☐ Equipment
☐ Education	☐ Consumer brochure(s)	☐ Continence aids	☐ Health promotion info
☐ Other *(specify)*:			

Add

'I Care' Booklet or referral to Carer Gateway

Clinical Governance:

We recommend better inclusion of carers throughout the clinical governance section of the Framework to ensure that carers are considered at all levels. A simple way to be more inclusive of carers would be to include the words **and carers** wherever the word consumer is used. For example, under the THS Clinical Governance Framework, which is aligned with the National Model Clinical Governance Framework ACSQHC (2017)[23] component number five – partnering with consumers could be updated to so that it reads:

> *"Partnering with Consumers"* **and Carers***.*
>
> *"The THS Health care system is designed to support consumers and"* **carers** *"to be partners in healthcare planning, design, measurement and evaluation."*

It cannot be assumed that the word consumers also encompasses carers, or that people understand that it does. Carers and consumers have significant differences in needs and experiences. Therefore, we strongly advocate for the word carers to be clearly articulated alongside consumers. This will align with the push for better carer recognition within the state. The upcoming Carer Recognition Bill 2022[24] states:

> *"Carers should be consulted in relation to the development and evaluation of policies and programs, and the provision of resources, in so far as those policies, programs and resources affect their role as carers."*

It is important to note that the National Model Clinical Governance Framework clearly identifies carers within the explanation:

> *"systems are designed and used to support patients, carers, families and consumers to be partners in healthcare planning, design, measurement and evaluation; elements of this component.."*

In terms of planning, design, and evaluation activities, we recommend that a wide range of consumers, carers, and relevant stakeholders are invited directly to participate in engagement and consultation. We draw on our recent experience of finding out about this current Framework draft. Our experience was that despite being the Peak Body for carers in Tasmania, we were not contacted directly and invited to participate in this consultation, rather we found out about the consultation second-hand. This could have resulted in the voice of Tasmanian carers not being heard as part of this important consultation.

[23] National Model Clinical Governance Framework ACSQHC (2017). https://www.safetyandquality.gov.au/publications-and-resources/resource-library/national-model-clinical-governance-Framework

[24] https://www.parliament.tas.gov.au/Bills/Bills2022/reprint/33_of_2022.pdf

6. Putting the Framework into practice

Whilst we are supportive of the progress towards the statewide discharge Framework and the proposed updates to the comprehensive care plan, we would like to understand further how it can be certain that discharge planning will occur consistently. For example, the document notes *"Discharge planning should be facilitated by an identified coordinator. This may be a ward nurse for a simple discharge or a complex care/discharge coordinator for a more complex discharge."* This statement leaves room for flexibility by using the word *'should'*. We hope that hand-in-hand with the Framework is the delivery of more education to all Tasmanian hospital staff on best-practice discharge planning processes and how to appropriately include carers for effective discharge and recovery.

It is time to recognise the valuable unpaid support that carers provide in the health context and ensure that carers are identified, included, and connected with appropriate support.