ACT Government | Canberra Health Services

Canberra Health Services

Consultation Paper

Proposal to establish an Integrated Discharge Unit

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Contents

1. Introduction

Canberra Health Services (CHS) is focussed on the delivery of high quality, effective, person-centred care. It provides acute, sub-acute, primary and community-based health services to the Australian Capital Territory (ACT)—a catchment of approximately 400, 000 people. It also services the surrounding Southern New South Wales region which includes the Bega Valley, Bombala, Cooma-Monaro, Eurobodalla, Goulburn, Mulwaree, Palerang, Queanbeyan, Snowy River, Upper Lachlan Shire and the Yass Valley.

CHS administers a range of publicly funded health facilities, programs and services including but not limited to:

- **The Canberra Hospital (TCH):** a modern 600-bed tertiary hospital providing trauma services and most major medical and surgical sub-specialty services.
- **University of Canberra Hospital (UCH) Specialist Centre for Rehabilitation, Recovery and Research**: a dedicated and purpose-built rehabilitation facility, with 140 inpatient beds, 75-day places and additional outpatient services.
- **Mental Health, Justice Health, Alcohol and Drug Services (MHJHADS):** provide a range of health services from prevention and treatment through to recovery and maintenance at a number of locations and in varied environments for people suffering from mental health issues.
- **Dhulwa Secure Mental Health Unit (DMHU):** a purpose designed and built facility providing clinical programs and treatment options for people suffering from acute mental health issues.
- **Seven community health centres (CHCs):** providing a range of general and specialist health services to people of all ages.
- **Five Walk-in Centres (WiCs):** which provide free treatment for minor illness and injury.
- A range of **community-based** health services including early childhood services, youth and women's health, dental health, mental health and alcohol and drug services.

CHS is a partner in teaching with the Australian National University (ANU), the University of Canberra (UC) and the Australian Catholic University (ACU).

On 1 October 2018 ACT Health transitioned into two separate organisations being the ACT Health Directorate (ACTHD) and CHS.
To enable CHS to have a strong focus on operational effectiveness, efficiency and accountability in the health services we provide, CHS is proposing a realignment of functions.

The current organisational chart and the recent Annual Report and the ACT Government Budget Papers provide more detail about CHS.

2. Purpose

This paper proposes the establishment of an Integrated Discharge Unit (IDU) within CHS. Standardising our approach to care coordination will support patients to move safely from the acute, sub-acute, non-acute settings and into appropriate community services to receive the right support at the right time.

The IDU will assist in identifying the patient's ongoing needs and coordinate the timing of services to best meet the needs of the patient and to achieve the planned Estimated Date of Discharge (EDD).

Strategies already implemented to consolidate and streamline discharges include:

- **Care Optimisation and Transition Unit (COTU)** the primary goal is optimise patient flow and resource utilisation by collocating maintenance care type patients in one location. This approach aims to enhance acute bed turnover, reduce length of stay, and streamline care coordination, ensuring all patients receive care that is tailored to their individual needs, leading to improved health outcomes.
- **Multi Agency Discharge Events (MADEs)** involving senior multi-disciplinary staff.
    - to support improved patient flow across CHS;
    - recognise and unblock delays; and
    - challenge, improve and simply complex discharge processes.

The proposed structure change aims to:

- Enhance the MADE and COTU models.
- Streamline discharge planning systems and processes to enable a more consistent, efficient approach to discharge planning.
- Improve patient health outcomes, the patient experience, quality of care and efficiency of care delivery by CHS.
- Achieve alignment of roles that support the timely discharge of patients across CHS.
- Support a sustainable staff structure for growth and innovation in discharge planning activity.
- Connect key strategic deliverables for CHS, including timely care and patient flow.
- Support appropriate and timely discharge and transition of care to community-based services.

3. Current model

Under the current model, discharge activity at CHS is primarily undertaken by individual team members within each of the relevant clinical divisions. There is currently no coordinated or integrated approach to facilitate streamlined patient discharge planning across CHS. This leads to duplication resulting in confusion, repetitive processes, problematic information sharing, and delays in making a final discharge decision.

A number of roles across CHS have a dedicated focus on discharge planning activity. These roles include:

- **Discharge Liaison Nurses (DLNs) -** play an integral role within the health care team to coordinate safe, appropriate, and timely discharges to achieve targeted discharge dates.
  The current breakdown of DLNs across Canberra Hospital includes.
  - *Division of Medicine*
    - RN2 x 2.68 FTE
    - Emergency Department RN2 x 2.0 FTE
  - *Division of Surgery*
    - RN2 x 2.0 FTE
  - *Division of Rehabilitation, Aged and Community Services*
    - Acute Care of the Elderly RN2 x 1.0 FTE
  - *Division of Cancer and Ambulatory Support*
    - Across Wards 14A/14B RN2 x 1.0 FTE.

- **Social Workers (Discharge Liaison),** Currently Social Workers are embedded in teams across Canberra Health Services and contribute to the discharge planning process as a primary part of their role. The Acute Social Work Team provides a (Discharge Liaison) HP3 casual to support in a liaison capacity patient who are transferred to dispersed beds in residential aged care facility respite care. Acute Allied Health, Division of Allied Health and Rehabilitation, Aged and Community Services (RACS) Social Work both have NDIS Social workers who are specialised in supporting teams with complex discharge planning.

- **LINK Nursing Team, Community Care Program, Division of RACS**
  The LINK Nursing Team provides after-hours community nursing services to CHS clients including those who are receiving primary and specialised palliative care, support for home care chemotherapy, COVID Care@Home, and to ACTAS. The LINK Nursing Team comprises of 12 FTE of Registered Nurses and Enrolled Nurses, including a Complex Care Clinical Nurse Consultant (CNC) position.

- **Residential Aged Care Liaison Nurse (RACLN), Division of RACS**
  The RACLN RN2 x 1.0 FTE assists patients and care givers to understand the aged care system and the process of placement in a residential aged care facility. The RACLN also assists in identifying and shortlisting residential aged care facilities that

meet the specific needs and requirements of patients' and liaises with Residential Aged Care Facilities (RACFs) on behalf of patients, as well as advising when placements become available.

- **Veteran Liaison Nurses (VLN)**
  The VLN RN2 x 1.0 FTE and RN1 x 1.0 FTE to provide support to Veterans admitted to the Canberra Hospital and University of Canberra Hospital who hold Department of Veteran Affairs (DVA) cards. This includes liaising with DVA to ensure seamless transfers of care, including discharge planning support to appropriate services.

4. Proposed change

As overarching responsibility for the management of patient flow across CHS rests with the Chief Operating Officer (COO) it is proposed that the IDU will sit within the Flow and Coordination Hub (FaCH), Office of the COO.

To remove silos and create a single, integrated discharge process it is proposed that the IDU will:

- Optimise active participation in discharge planning.
- Improve discharge processes to reduce demand and improve capacity.
- Provide accountability and transparency in discharge planning processes.
- Enhance discharge from ED for appropriate patients.
- Take a multidisciplinary approach to transitions of care with all members of the healthcare team providing input into discharge planning.
- Effective transitions of care and discharge processes between primary, community and acute services.

The IDU will include the following Allied Health and Nursing profiles:

- **Acute Allied Health, Division of Allied Health**
  Acute Social Worker (Discharge Liaison) HP3 to support people who are utilising CHS paid respite beds.
  The Acute Social Work Manager will act as an escalation point for the IDU where support of the complex discharge is required.
  Social Workers are supported by Senior Social workers in each unit who provide support and management of complex cases.

- **LINK Nursing Team, Community Care Program (CCP), Division of RACS**
  Complex Care RN3 x 1.0.

- **Residential Aged Care Liaison Nurse (RACLN)**
  RACLN RN2 x 1.0 FTE

- **Veteran Liaison Nurses (VLN)**
  VLN RN2 x 1.0 FTE; and RN1 x 1.0 FTE
  Note: A consultation process has already commenced within the Division of RACS for the proposal to combine the duties and functions of the RACLN and VLO roles to support a team-based approach. The aim of this proposal is to optimise services and

support for both veterans and people accessing placement within a RACF. Centralising these roles within the IDU will provide a more efficient and effective liaison service.

- **Division of Medicine**
  - RN 2 x 2.68 FTE
  - Emergency Department RN2 x 2.0 FTE

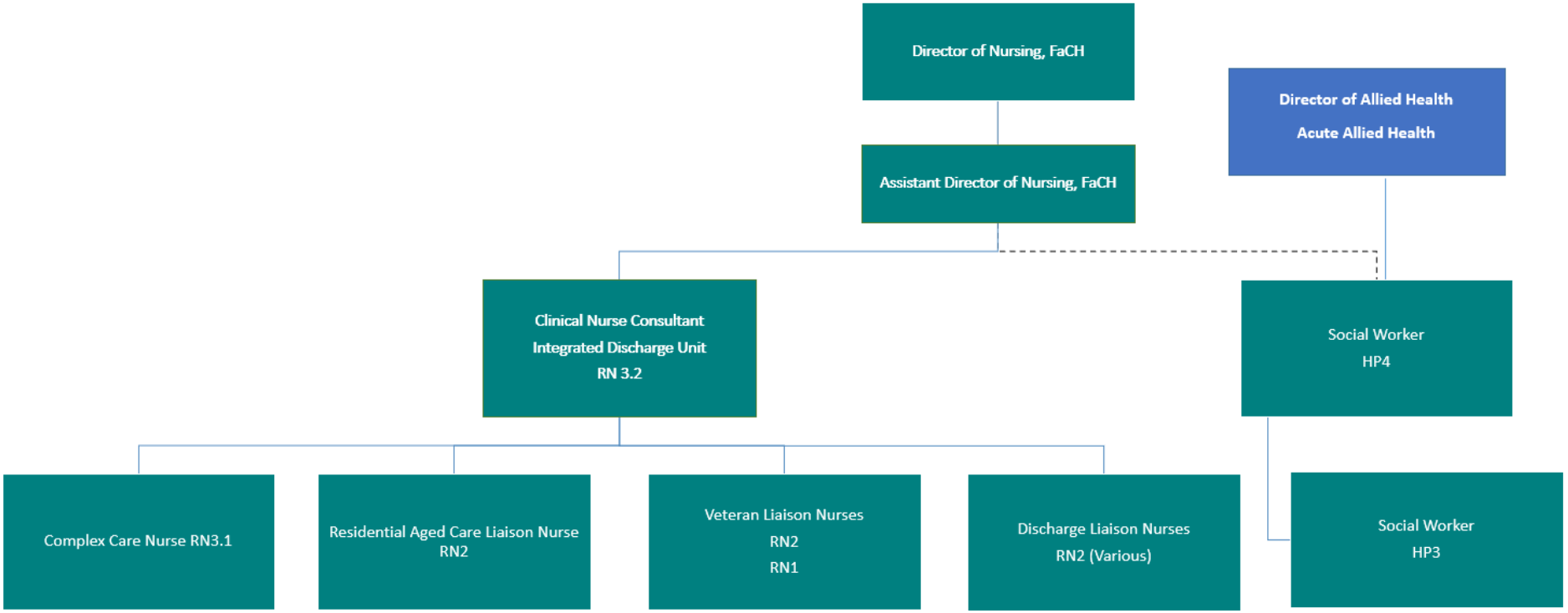
- **Division of Surgery**
  - RN2 x 2.0 FTE

- **Division of RACS**
  - Acute Care of the Elderly RN2 x 1.0 FTE.

- **Division of Cancer and Ambulatory Support**
  - Across Wards 14A/14B RN2 x 1.0 FTE.

Proposed structure

The proposed structure represented below:



5. Rationale for change

Despite the dedication and best efforts of individual team members, complex discharge planning too often requires the availability of resources from across teams to efficiently and effectively undertake all of the clinical and operational tasks required for a successful, timely discharge.

The benefits to be realised by bringing together discharge resources to form the Integrated Discharge Unit (IDU) include:

1. Improved patient outcomes and staff experience
2. Improved communications
    a. Better informed patients, families, carers and staff
    b. Transparency on the discharge plan for the entire health care team
    c. Clear point of contact for external stakeholders involved in discharge planning.
3. Improved efficiency
    a. Early decisions leading to a streamlined discharge.
    b. Reducing clients' length of acute hospital stay through proactive discharge planning and transition to home and community services.
    c. Increased timely discharges.
    d. Reduced readmission rates.

6. Future model

6.1. Scope of the future model

Under the future model, the IDU will work with team members and patients and their families across CHS to proactively plan for streamlined discharge transitions, thereby improving patient flow and patient outcomes.

The IDU will consist of pooling together a multi-disciplinary team (MDT) into one dedicated unit to make discharge planning more efficient, standardised and consistent. It is proposed that the identified positions will report through the FaCH to form a coordinated unit to proactively plan for patient discharge.

The benefits to be realised by having a dedicated team focused on discharge planning at CHS will help to alleviate bottlenecks in the discharge process. The team will work collaboratively to solve complex problems more quickly and efficiently, ultimately allowing beds to become available as soon as possible. The team will plan for discharge in partnership with the entire health care team, including patients and/or their carer. The team will also have a systematic mechanism and central point of contact to escalate actual or potential delays to patient discharge.

The IDU will:

- Improve processes for complex patient discharge management across CHS and target resources to the most appropriate patients.
- Drive improvements to address operational challenges and better manage complex patients for discharge, including improvements in identifying when patients are to be discharged and what steps need to be taken to facilitate a timely discharge.

- Provide a consistent approach to the prioritisation of tasks that need to be completed for a patient to be discharged by ensuring that all clinical and operational tasks for a timely discharge are completed.
- Prioritise the identification and classification of patients in order to allocate the necessary resources to better manage complex patients, including the early identification of need, proactive identification of a post-discharge destination, and active discharge planning management.
- Improve and provide consistent discharge communications to team members, patients, and their families and carers to facilitate timely discharge.
- Follow a clearly defined process of escalation to build a culture of accountability and empower team members to escalate barriers to discharge for resolution by hospital executive, where appropriate.

6.2. Physical design/structure

- Physical design will need to be considered as part of the Canberra Hospital overall campus master plan.
- It is envisaged that, over time, the roles within the Integrated Discharge Unit could be co-located to facilitate coordinated discharge activity.

6.3. Benefits of the future model

The scope of the future model aims to:

- Improve patient outcomes, the patient experience, quality of care and efficiency of care;
- Ensure connection and synergies between the key strategic deliverables of timely care and patient flow; and
- Consolidate resources to optimise the safe and timely discharge of patients with complex care needs with a particular focus on:
    - Complex patients
    - Barriers to identifying an appropriate discharge location (including issues of complex financing and housing)
    - Transport logistics
    - Equipment requirements
    - Optimising and communicating proactive discharge processes

6.4. Implementation of the future model

Implementation of the future model will only occur following review, feedback and consideration of all proposed changes.

Under the Union Encouragement Policy, employees will be given full access to union officials/delegates and facilities during working hours to discuss the restructure on the provision that work requirements are not unreasonably affected. It is envisaged that proposed structure will be implemented as soon as possible after the consultation period is closed as per Table 1.

Table 1

Steps	Action	Dates
1	Consultation document to be provided to Unions	31 August 2023
2	Consultation period begins with all affected staff and unions	14 September 2023
3	Consultation period ends	12 October 2023
4	Any provided suggestions from consultations will be reviewed and any changes incorporated into the final paper, to be distributed for information	From 13 October 2023
5	Activate change	TBC

7. Consultation methodology

This proposal provides more detail in relation to the establishment of a Integrated Discharge Unit. There are still details that need to be determined and your feedback, suggestions and questions will assist in further refining the proposed model.

Feedback can be provided via email to CHS.RACS@act.gov.au

Feedback is due by close of business **12 October 2023.**

In particular we are seeking responses to the following questions:

1. Do you support the proposal to establish an Integrated Discharge Unit?
2. Is the name Integrated Discharge Unit appropriate or can you suggest alternatives?
3. Is the proposed Integrated Discharge Unit best located within the Flow and Coordination Hub?
4. Do you have any concerns about the proposal so far, if so, what are they?
5. Do you have any other feedback you would like to be considered in relation to the proposed establishment of the Integrated Discharge Unit?

For any further information relating to the change and subsequent consultation process, please contact CHS.RACS@act.gov.au.

7. References

Document
Canberra Health Services Strategic Plan
Canberra Health Services Corporate Plan