Australian Government
Department of Veterans' Affairs

Discharge Planning

Resource Kit

Planning entitled persons' discharge from hospitals and day procedure centres

First edition 1996

Revised October 2002 and 2003 (P606)

The DVA Discharge Planning Resource Kit (2005): published by Department of Veterans' Affairs, Australia, ISBN1920720162. There is no printed version and it is only available in electronic format at this site.

The DVA Discharge Planning Resource Kit (2003): published by Department of Veterans' Affairs, Australia, ISBN1920720162 was based on an October 2002 revision of the Department of Veterans' Affairs Discharge Planning Resource Kit (first edition 1996), and was undertaken by a team from the Centre for Allied Health Research [Karen Grimmer and Saravana Kumar (University of South Australia), Julie Falco (seconded from Lyell McEwin Hospital, DHS, SA) and John Moss (Adelaide University)] in conjunction with Department of Veterans' Affairs staff.

This June 2005 revision of the Department of Veterans' Affairs Discharge Planning Resource Kit was undertaken by the Department in consultation with providers and entitled persons and carers.

It has retained the general structure of the 2003 version, but has three new resources linked to it on the website. They are:

(a) 6 one-page charts entitled DVA Funded Health Services in (State). These are for: Victoria, Queensland, South Australia/Northern Territory, NSW & ACT, Tasmania, and Western Australia. It is suggested you print out the one relevant to you and put it on the wall near the phone at the nurses station or in your surgery. They can also be found in the "provider" area of this website;

(b) Six 4–5 page "Eligibility at a Glance in (State)". They can be found at the "provider" area of this website; and

(c) A factsheet entitled "Tips to assist with hospital admission and discharge – A checklist for veterans, carers and other entitled persons" can be found at the "factsheet" area of this website for you to print out and give to them. It replaces the brochure "Planning your discharge from hospital".

The Discharge planning checklist has been moved from the Appendix to near the front of the Kit to give it more prominence. Also, some detail in appendices has been excluded, and web-links are provided to State government discharge planning materials, Department of Health and Ageing information, and other information on the DVA website, including factsheets on further information about topics in this kit.

It is suggested that you print out this kit to replace the old one in your Discharge Planning Kit folder.

ABOUT THE PHILOSOPHIES UNDERLYING EFFECTIVE DISCHARGE PLANNING

- Effective discharge planning should be a routine part of health care, and should be a part of an **overall health care plan** for the person involved, that spans not only a hospital admission, but their overall care that occurs primarily in the community. This overall approach to health highlights the importance of primary health care and sends a positive and powerful message regarding longitudinal rather than episodic care.
- Effective discharge planning should be consistent/standard for all "patients" receiving care in the health care system, and should not be different for the veteran community.
- Hospitalisation should be seen as an opportunity to review health status, and make recommendations/take action about ongoing care that needs to be actively managed with the Local Medical Officer/General Practitioner (LMO/GP) and other community players, including the veteran and his/her family.
- Effective discharge should result in seamless integration into local community services – it therefore relies on good local knowledge of community services (not only for treatment but also for psycho-social health) and partnerships with these organisations.
- Effective discharge relies on timely processes and good communication.

ABOUT THE DVA DISCHARGE PLANNING RESOURCE KIT

The Department of Veterans' Affairs (DVA) fosters these philosophies and through this kit attempts to turn them into applications for providers which will enable them to implement best practice for entitled persons (in most cases an Entitled Person is the holder of a Gold Card or a White Card for a specific condition) being discharged from hospitals and day procedure centres. The DVA Discharge Planning Resource Kit provides discharge planners and other health professionals in hospitals and day procedure centres with up-to-date information regarding current DVA procedures and services (updated regularly on the web), and best practice principles in discharge planning.

The objective of the Discharge Planning Resource Kit is to facilitate the provision of best practice discharge planning for all entitled persons during admissions to hospitals or day procedure centres. It is designed as a resource for discharge planners and others in multi-disciplinary teams with key roles in discharge planning. It is intended to supplement the general discharge planning process which is undertaken in each hospital/centre, not to replace it.

Most States now use well-designed discharge planning processes and materials, so the information in this kit can be used as a reference source, to which you can refer when necessary to ensure all the special needs of entitled persons are addressed in the process implemented in the hospital/centre.

Services available for the general public are available for entitled persons too, and the discharge planner, or other health professional making referrals, needs to refer the entitled person to the most appropriate service, which may be a state government, community, private, Department of Health and Ageing (DoHA) or DVA service.

The use of this Kit

This kit should assist in the seamless transfer of the entitled person to the community following such admissions, thus optimising the independence and health of the patient and their carer.

The contents of the DVA Discharge Planning Resource Kit are outlined on page iv–v. A Discharge Planning checklist, which summaries the process, is on pages vi–xi. On pages xii–xv, you will find a series of prompts to guide you through the Kit. Follow these prompts for quick reference to key issues in planning an entitled person's discharge from hospital.

At many points in the kit there are web-links to up-to-date contact details for locally contracted service providers.

At other points there are web-links to forms and checklists used by State Health Services in their discharge planning processes, as it is important that services for entitled persons are seamlessly linked with general discharge planning systems and procedures.

Veterans, war widows or widowers and their dependants who are provided with treatment at DVA expense are referred to in this Kit as entitled persons. Family, friends or paid carers who are providing assistance to the entitled person after discharge from hospital are referred to as the entitled person's carer.

ABOUT THE FACTSHEET LINKED WITH THIS KIT

A factsheet entitled 'Tips on how to manage hospital admission and discharge effectively – Checklist for veterans, their carers, and other entitled persons' is available in the "factsheets" area of the website. Copies of these should be printed out and given to all entitled persons and their carers before admission, or as soon as possible after admission.

Its purpose is to:

- answer many frequently asked questions by entitled persons and their carers about discharge from hospital and day procedure centres;
- encourage entitled persons and their carers to become more involved in the discharge planning process; and
- inform entitled persons and their carers about discharge planning processes in hospital and day procedure centres.

This factsheet prompts entitled persons and their carers to identify issues that concern them about being discharged from hospital or day procedure centre, and to communicate these issues to hospital staff, so that appropriate actions can be taken before they leave hospital.

TABLE OF CONTENTS

Use the prompts and flow chart on the following pages as a quick way to navigate through the DVA Discharge Planning Resource Kit

DISCHARGE PLANNING CHECKLIST

This checklist is for an entitled person who anticipate returning to their own home or independent community dwelling

Entitled Person Name

Carer Name

Relationship of carer to entitled person

Date of admission

Reason for admission

Date of commencement of formal discharge planning

Specified date and time of discharge

On Admission

1. Phone LMO/GP and inform them patient is in hospital (if patient says they do not know) and obtain information on support services, medication, and any other information that would be useful for planning discharge (especially relating to 3 categories of assessment in 5 below).
2. Talk to carer (if there is one) regarding patient's situation and obtain information as above.
3. Phone State DVA Assessment Agency to check if the entitled person has support services and if so temporarily cease them and provisionally re-book on estimated date of discharge.
4. Provide the entitled person (and carer if they have one) with "Tips for Hospital Admission and Discharge" Factsheet, if they did not get one from their LMO/GP at Pre-Admission Clinic.
5. Screening for potential difficulties in discharge. Undertake risk assessment (after discussion with GP and carer) according to 3 major categories:
   (a) living circumstances
   (b) what they are usually like (functional state), and
   (c) what can be expected of them when they leave.

Please tick the flags where they are perceived to exist on admission to the ward.

Patient who lives alone (are they likely to need help at home?)

Patient who is frail and/ or aged

Patient with multiple and poorly managed health problems

Patient who does not have a regular LMO/GP

Patient whose care is shared by a number of different medical practitioners and where communication could be poor

Patient with an ill, frail or incapable carer

Patient who usually cares for someone else (partner, child, family member, friend, pet)

Patient with multiple health problems who did not have prior community health and support services in place

Patient who does not participate in their own discharge plans

Patient who is unrealistic about their ability to manage in the community after discharge

Where there is family conflict about the patient's ongoing independent community living arrangements

Patient who has multiple medications and/ or medical conditions

Patient who exhibits difficulties with compliance in taking medication

Patient who has pain (including chronic) and tiredness

Patient who has reduced mobility and grief regarding loss of ability

Patient who will require equipment at home post discharge

Other potential problems

Specify .....

.....

.....

6. Screening regarding other major issues/risk factors that need to be followed up: physical health (exercise), nutrition, smoking, mental health, etc.

Within 1–2 days of admission

Are patient and carer aware of the expected recovery path? ☐Yes ☐No

If No, take action

Are patient and carer aware of likely changes to health status on discharge? ☐Yes ☐No

If No, specify actions .....

.....

Do you expect the patient to be independently ambulating by the discharge date? ☐Yes ☐No

If No, will the patient be discharged home? ☐Yes ☐No

If Yes, are there management plans for ensuring patient safety? ☐Yes ☐No

If No, specify actions .....

.....

Does the carer live with the patient? ☐Yes ☐No

Is the carer capable and prepared to assist the patient post discharge? ☐Yes ☐No

If No, specify actions .....

.....

Does Veteran's Home Care need to be contacted to give them time to put in place a new service, or to extend an existing service, on the patient's discharge. ☐Yes ☐No

If Yes, specify actions .....

.....

Do you expect the patient to be independent with toileting, showering, dressing and personal ADL? ☐Yes ☐No

If No specify actions .....

.....

At least 2 days prior to discharge

1. Travel

Has suitable transport been arranged from the hospital to the community? ☐Yes ☐No

If No, document action planned and completed.....

.....

Has the distance to be travelled been considered
(i.e. timing, clothing, medications, food and drink, etc) ☐Yes ☐No

If No, document actions .....

.....

Are the travel plans well documented in the notes? ☐Yes ☐No

If No, ensure appropriate documentation .....

.....

2. Moving back home

Have the issues of safe access to the home been considered? ☐Yes ☐No

If No, document actions .....

.....

Have immediate short term home comforts been considered and organised
(cleaning, heating / cooling, food, sleeping arrangements etc) ☐Yes ☐No

If No, document actions .....

.....

Are home modifications / equipment required? ☐Yes ☐No

If Yes, have they been organised? ☐Yes ☐No

If No, document actions .....

.....

If Yes, will they be in place by the day of discharge? ☐Yes ☐No

If No, document actions .....

.....

3. Community health and support services, including Veterans' Home Care

Are health care or support services required in the home? ☐Yes ☐No

If Yes, have they been organised? ☐Yes ☐No

If No, document actions .....

.....

If Yes, will they be in place by the day of discharge? ☐Yes ☐No

If No, document actions .....

.....

4. Information

Have the patient and carer been provided with sufficient information on new / existing medications? ☐Yes ☐No

If No, document actions .....

Have the patient and carer been provided with information on support groups and self help programs? ☐Yes ☐No

If No, is this information required? ☐Yes ☐No

If Yes, document actions.....

Have the patient and carer been provided with emergency contacts to the LMO/GP and hospital? ☐Yes ☐No

If No, document actions .....

On the day prior to discharge

Checking discharge organisation

Are all discharge plans in place? ☐Yes ☐No

If No, what remains to be done? Document actions.....

.....

If discharge plans cannot be implemented by the time of discharge, are there potential ramifications for the entitled person's safety and/ or health? ☐Yes ☐No

If Yes, document actions.....

.....

Medications

Have all relevant medication information and supplies been provided? ☐Yes ☐No

If No, what remains to be done? Document actions.....

.....

Have patient and/ or carer demonstrated their competence with medications? ☐Yes ☐No

If No, what remains to be done? Document actions.....

.....

Equipment

Have all relevant equipment and home modifications been provided/ organised? ☐Yes ☐No

If No, what remains to be done? Document actions.....

.....

Have the patient and/ or carer demonstrated their competence with equipment? ☐Yes ☐No

If No, what remains to be done? Document actions.....

.....

On the day of discharge

Discharge summary

Has the LMO/GP been sent discharge summary by email or fax prior to discharge, or has he/she been phoned to inform him/her that patient is going home and to provide information on major aspects of medication and care management prior to them receiving the discharge summary (mail within 48 hours)? ☐Yes ☐No

If No, document actions .....

.....

Would the patient benefit from a Medication Management Review? ☐Yes ☐No

If Yes, has a recommendation been made to the LMO/GP/ State Office or community pharmacist? ☐Yes ☐No

Has the discharge summary been given to the patient / carer? ☐Yes ☐No

If No, is it appropriate to do so? ☐Yes ☐No

If Yes, document actions and instructions to the entitled person.....

.....

Managing at home

Have there been final discussions with patient and carer regarding short and long term issues of managing at home post discharge? ☐Yes ☐No

If No, conduct discussions as soon as possible.

If Yes, do any further actions need to be taken? ☐Yes ☐No

If Yes, document actions .....

.....

Follow-up appointments

Have appropriate follow-up appointments been made, e.g. GP/LMO; medical specialist, outpatient clinics? ☐Yes ☐No

If No, are they required? ☐Yes ☐No

If Yes, document actions .....

.....

Follow-up action

1. Phone patient next day to check support services are working and check whether they have had any problems managing Care Plan. ☐Yes ☐No

   Do they have problems? ☐Yes ☐No

   If Yes, phone LMO/GP and/or service agency who should have provided service. ☐Yes ☐No

2. Phone patient a couple more times in next two weeks to check on progress.

   First time ..... ☐Yes ☐No

   Second time ..... ☐Yes ☐No

PROMPTS FOR USING THIS KIT

When commencing discharge planning before or after admission to hospital, consider involving the following key individuals or services
- **before admission**
- **following admission**

1. **DVA State Office for entitled person's eligibility.** *(page 1)*
2. **Veteran, or other entitled person, carer and/or family members.** *(page 39)*
3. **Community health and service personnel.**
   - LMO/GP *(page 7)*
   - Community nursing *(page 14)*
   - Veterans' Home Care (VHC) *(page 22)* (for the veteran's patient or carer) *(pages 13, 26, 39)*
4. **Hospital personnel.** *(page 3)*
   - Medical staff
   - Pharmacist
   - Specialist liaison nurse (rural, DVA, etc)
   - Allied health personnel

When implementing discharge plans whilst the entitled person is in hospital or day procedure centre, consider involving the following key individuals and services

1. **Hospital personnel.** *(page 3)*
   - Medical staff
   - Pharmacist
   - Specialist liaison nurse (rural, DVA, etc)
   - Allied health personnel
2. **Entitled person, carer and/or family members.** *(page 39)*
3. **Community health and service personnel.**
   - LMO/GP *(page 7)*
   - Community nursing *(page 14)*
   - Veterans' Home Care (VHC) *(page 22)*
   - Allied health services as appropriate *(page 10)*

When preparing the entitled person for discharge into the community, consider involving the following key personnel or services

1. **Entitled person, carer and/or family members.** *(page 39)*
2. **Community health and service personnel.**
   - LMO *(page 7)*
   - Community pharmacist *(page 6)*
   - Community nursing *(page 14)*
   - Veterans' Home Care (VHC) *(page 22)*
   - HomeFront (page 18)
   - Allied health services as appropriate *(page 10)*
   - Other community services *(page 15)*

If the entitled person *unable* to be discharged independently into the community, consider involving the following key personnel or services

1. **Entitled person, carer and/or family members.** *(page 39)*
2. **ACAT.** *(page 8)*
3. **Community health and service personnel.**
   - LMO *(page 7)*
   - Community nursing *(page 14)*
   - Veterans' Home Care (VHC) *(page 22)*
   - Allied health services as appropriate *(page 10)*

Before admission to day procedure unit OR Before, or on, admission to hospital

Is the veteran or other individual eligible for DVA-funded services?

1. **Check the colour and expiry date of the DVA Repatriation Health Card.**
   See page 33
2. **If the DVA Entitlements Card is White, check the entitled person's eligibility for services by contacting the local DVA State Office.**
   See page 1
3. **Engage the veteran (or other entitled person) in all subsequent discussions regarding his/her discharge from hospital.**
   See page 39, and the factsheet for veterans: 'Tips to Assist with Hospital Admission or Discharge', and find out if they already receive services and, if they or their GP have not already done so, cancel them for the period of hospitalisation and provisionally re-book from the provisional discharge date. If necessary ring DVA and their GP to obtain this information.

Are you familiar with best practice discharge planning principles?

Become familiar with the best practice discharge planning practices and principles outlined
from page 34 onwards.

Have you considered the carer, or whether the veteran or other entitled person is a carer for another person?

Identify whether the veteran (or other entitled person) has a carer, or cares for another person (the entitled person's patient).

- Are there special considerations that need to be taken into account regarding the carer, the entitled person's patient or the entitled person?
  See pages 39, 41

Within one day of admission to hospital

Have you commenced developing the discharge plan?

1. **Nominate and contact the health service providers who can form the multidisciplinary team.** *See pages 3–27*
2. **Use the Discharge Planning Checklist to ensure best practice management.** *See page vi–xi*

   This includes ensuring that a patient risk assessment is undertaken at admission.
3. **Direct queries on availability and access to DVA-funded services to DVA State Office or the DVA website.** *See page 1*

Does the entitled person require assistance with medication?
See page 52

If Yes,

1. **Nominate and contact the relevant health service providers who can assist.** *See pages 3–28*
2. **Ensure that the entitled person has an appropriate supply of medication on discharge and is confident in its use.** *See page 52–56*

Does the entitled person require assistance with transport?

If Yes,

1. **Determine eligibility.** *See pages 29–33*
2. **Organise appropriate transport services.**
   See page 21

Does the entitled person require post-discharge health care or home care services?

If Yes,

1. **Determine eligibility.** *See pages 29–33*
2. **Ensure that the checklist has been completed before discharge, with specific attention paid to the entitled person's requirements in the first 24–48 hours following discharge.**
   See pages vi–xi
3. **Organise services as appropriate giving a provisional discharge date.**
   See pages 3–28 for service provision
   See page 18 for falls prevention

Are there environmental concerns at home that need to be addressed?

On the day of discharge

Have you organised a discharge summary, including medication advice for the LMO/GP?

Ensure that an informative discharge summary, including medication profile is sent to the relevant LMO/GP (This should be sent by email or fax on the day of discharge or the information provided to the GP by phone). A MediList or medication profile should be provided to the entitled person and community pharmacist on, or before, the day of discharge. Ensure that appropriate privacy concerns have been addressed. *See pages 52–56, 61–62, 57*

Have you provided appropriate advice to the entitled person and carer?

The MediList should be provided to the entitled person with advice to the community pharmacist and LMO/GP.

Ensure that appropriate information has been provided to the entitled person and carer regarding community supports, support groups and self help matters (This includes the entitled person or carer agreeing to the follow-on care planned and taking a copy of the discharge summary with them). *See pages 15, 39*

Post-discharge monitoring

Have you considered monitoring your performance in planning entitled person discharge?

1. **Consider using performance indicators to monitor the quality of discharge planning processes (e.g. re-admission rates and length of stay)**. *See page 58–60*
2. **Consider having follow-on phone contact with the entitled person to ensure services planned eventuate and the convalescence proceeds as planned; and consider obtaining feedback on the quality of discharge planning processes and outcomes from community consumers' perspectives.** *See page 39, xi*

1 CONTACT DETAILS

DVA Offices

DVA can be contacted by telephoning, visiting any of the DVA offices, or writing to DVA. You should be able to contact DVA on any of the following numbers for no more than the local call rate.

***NB** The cost of the call may be higher when using a mobile telephone.*

You are advised to use a normal phone (a landline phone) when calling these numbers. Explain the nature of your enquiry to the person who answers the phone and you will be put through to the officer best able to help you with your enquiry.

Telephone numbers

General enquiries **133 254**
Connects callers from anywhere to their capital city State Office.

Non-metropolitan callers **1800 555 254**
Connects non-metropolitan callers only to the capital city State Office.

Dialling from interstate **1300 13 1945**
Allows callers to contact any State Office via a series of voice prompts.

Local Veterans' Affairs Network (VAN) offices **1300 55 1918**
Connects callers with their nearest VAN Office.

Who to contact in DVA

Who you should contact in DVA will depend upon the nature of your enquiry. You can contact DVA through the following:

DVA State Offices – located in capital cities and responsible for health and treatment issues and for assessing claims and reviews of pensions *(see this page)*;

Veterans' Affairs Network (VAN) offices – located in capital cities and regional areas throughout Australia. They provide information and help with DVA matters *(see this page)*;

Other related organisations:

The following organisations can also assist you:

Vietnam Veterans' Counselling Service (VVCS) – offers a free and confidential counselling service for all veterans and their families and has offices throughout Australia (phone **1800 011 046**);

Ex-service organisations – often have welfare or pensions officers who can help and advise you about DVA matters. Ex-service organisations are listed in your local telephone directory.

More Information

If you need more information about any topic in this kit, please contact your nearest DVA office. All DVA fact sheets are available upon request from any DVA State Office or on the DVA website; www.dva.gov.au

Other Useful Contact Numbers For Services for Older People

Commonwealth Carelink Centres	1800 052 222
Aged Care Information Line	1800 500 853
Aged Care Complaints Resolution Line	1800 550 552

Commonwealth Government Departments

Commonwealth Department of Health and Ageing	1800 020 103
Centrelink	
Aged Pension and Retirement	132 300
Disability, Sickness and Carers	132 717
Interpreter services	131 202
Teletype services	1800 810 586
Commonwealth Department of Family and Community Services	1300 653 227
Councils on the Ageing (Head Office)	03 9820 2655
Alzheimer's Associations (National Office) **www.alzheimers.org.au**	02 6254 4233

Carers' Organisations / Services

Carers' Association of Australia	02 6282 7886
Carer Resource Centres	1800 242 636
Carer Respite Centres	1800 059 059

2 KEY HEALTH PERSONNEL WHO CAN ASSIST IN PLANNING FOR DISCHARGE

2.1 Hospital personnel

Medical staff

The salaried medical staff in large public hospitals generally provide services only to inpatients and patients presenting to hospital clinics. They generally operate independently of community medical practitioners. Many large public hospitals do not take direct referrals from community medical practitioners, and DVA entitled persons being admitted to such hospitals do so via the hospital emergency ward or medical clinics. Hospital medical staff in large public hospitals work in a hierarchy in which the medical specialist (consultant) usually decides when the patient will be discharged, while the intern has responsibility for completing discharge processes (such as writing the discharge summary). Thus it is important, in situations where responsibility for admission and discharge is shared among a number of medical staff, that the appropriate medical personnel are consistently involved in planning for patient discharge from hospital. This ensures that decisions are timely and appropriate, and that they take account of the patient and carer's social and medical needs.

In many private hospitals and rural public hospitals, the local general medical officer or medical specialist can have admitting rights to the hospital. Thus the LMO/GP may be discharging the entitled person from the hospital to himself/herself in the community. This may improve communication regarding medical management between hospital and community because it reduces opportunities for late or miscommunication. It may, however, have an adverse effect on quality of discharge planning because the LMO/GP or specialist may fail to recognise the hospital admission as an opportunity to review the entitled person's general health and community independence.

Hospital staff should be aware of the potential for problems in communication between medical staff in the hospital and community, and take appropriate action.

Hospital Allied Health Services

Most public hospitals employ allied health practitioners. Allied health services vary from hospital to hospital. The most common allied health services are physiotherapy, occupational therapy, speech pathology, podiatry, social work and dietetics. Other allied health services can include psychology, prosthetics and orthotics, and audiology. Access to allied health practitioners in public hospitals varies depending on funding agreements, acceptance of community medical referrals, waiting lists, staffing, and availability of specialist services.

In private hospitals, most allied health services are provided by private practitioners who are contracted to the hospital, or who provide private services to admitted patients. Most discharge planners will be able to organise referrals to local allied health practitioners.

Specialist Discharge Planners

Most discharge planning is undertaken by multi-disciplinary teams, comprising Nurse Unit Manager (NUM), clinician, occupational therapist, social worker, physiotherapist, and pharmacist. Some discharge planning is undertaken by staff in individual wards usually coordinated by the NUM. The remainder is centralised through a specialised discharge planner who often does the referrals relating to discharge planning in consultation with the professional team. These are usually nurses who have extensive knowledge of people and services, to ensure that patients are referred appropriately. Some hospitals have a Discharge Planning "Contact" to ensure correct processes, skills/training and materials are in place. Their role is to be coach/trainer, provider of updated information, resource person and monitor of people with a role in undertaking aspects of discharge planning within the hospital, whether it is for DVA entitled persons or general patients.

Some hospitals have a Veteran Liaison Officer, who has information not only about local DVA services, their costs, limitations, key contact people and their contact details, but also about DVA eligibility criteria for services. These people can form a valuable resource regarding specific issues for DVA clients.

Rural Liaison Nurses and General Practitioner Liaison Nurses are also available in some of the larger hospitals. These positions are usually funded from specific grants or by external organisations such as the College of General Practitioners. They have specialist knowledge about service availability in rural areas, or general practitioner issues, and thus provide useful resources when discharging DVA entitled persons to rural areas, or back to their community medical practitioner.

In this manual the term "Discharge Planner" is used to refer to any person who performs a specialist discharge planning role, coordinates discharge planning for a multi-disciplinary team, or who does all aspects of discharge planning.

Hospital Pharmacists

The hospital pharmacist plays an important role in educating hospital staff, entitled persons and carers about medications and their use. In many hospitals, the hospital pharmacist will provide the entitled person with a dedicated education session about new medications, and will advise on safe use of existing medications. Where hospital staff are concerned about DVA entitled persons using multiple medications, or having complex and multiple health problems, the hospital pharmacist can provide an excellent resource for staff and DVA entitled persons alike.

2.2 Community personnel

Some community-based workers provide services specifically for veterans and other entitled persons. Other community workers provide services for all residents in their community. Sometimes a service that is provided for all residents is more appropriate due to hours the service is available, or the range of service components available.

Information about community personnel who provide local services can be obtained through various means including:

- Commonwealth information services as listed in 2.3
- A local government services directory
- Networking with local voluntary organisations. Such agencies can provide:
- Informal health and support services (such as gardening, house cleaning, meal preparation, home maintenance) and
- Volunteers (such as able-bodied older people) who can provide practical assistance by home visiting, undertaking household chores, sitting with patients while carers leave the house, reading the newspaper, writing and posting letters, and other aspects of recuperation that often frustrate patients (Grimmer, Moss and Falco 2004).

Allied Health Practitioners

The usual way in which veterans and other entitled persons consult allied health practitioners is through the private sector. The most common private allied health services used by entitled persons are physiotherapy, chiropractic/osteopathic, podiatry, audiology, speech pathology and occupational therapy. Other allied health services such as dietetics, prosthetics and orthotics may be less frequently available in the private sector and may need to be accessed via the local public hospital.

For enquiries, contact the relevant DVA State Office by calling 133 254 or 1800 555 254.

Specific information on DVA-funded allied health services is provided in Section 2.4, commencing page 10.

Community Nursing Services

DVA provides access to community nursing services under the DVA Community Nursing Program. DVA contracts with community nursing organisations to provide these services in the entitled person's home, upon referral from an appropriate source. Community nursing organisations deliver these services through a mix of registered nurses, enrolled nurses and/or nursing support staff, depending on the care needs of the individual.

Community Pharmacist

The involvement of community pharmacists is essential to best practice discharge planning (Roughead et al 1998a).

It is important that hospitals recognise the role of community pharmacists and direct entitled persons and their carers to their local pharmacy as an ongoing information resource following discharge from hospital. Hospital staff should also routinely supply advice to the entitled person's nominated community pharmacist regarding changes that have been made to medications as a result of the hospital stay. This may be in the form of a MediList or medication profile.

For enquiries, contact the DVA State Office by calling 133 254 or 1800 555 254.

Veterans' Home Care

Veterans' Home Care (VHC) *(see page 22)* is a DVA program to help entitled persons remain in their homes for longer. VHC extends the range of home support services provided by DVA to entitled persons and includes domestic assistance, personal care, safety-related home and garden maintenance and respite care.

Local Medical Officer (LMO)

The Repatriation Commission's health care arrangements place the Local Medical Officer (LMO) at the centre of care for entitled persons (the community case manager). This is in line with the literature that suggests that the general practitioner plays a pivotal role in educating and promoting healthy ageing (Byles 2000, Sims et al 2000). LMOs/GPs are provided with up-to-date information by DVA in the *'Notes for LMOs'* about services that are available to entitled persons. These notes are available on request from the local DVA State Office, or on the DVA web site **www.dva.gov.au.**

Although often not directly involved in admitting patients to city hospitals, LMOs/GPs can offer the admitting hospital valuable information on the entitled person's physical and mental health history, current health status and medication management, and social circumstances (such as the presence of a carer, or whether the entitled person cares for an ill or disabled person).

To ensure continuity of care for entitled persons, hospitals and day procedure centres should involve the LMO/GP in the hospital admission, and provide them as soon as possible after discharge with a discharge summary and MediList, which details discharge plans, community services and medications. See *pages 61–62* for examples of discharge summaries.

LMO and GP Definitions

An LMO is registered with DVA. A General Medical Practitioner (GP) may provide the same service to an entitled person, but is not registered with DVA.

For enquiries, contact a DVA State Office by calling 133 254 or 1800 555 254.

Pre and Post-discharge Responsibility

Following discharge, the LMO/GP is generally deemed to be responsible for managing the entitled person's care. Under the Repatriation Comprehensive Care Scheme, the LMO/GP is clearly established as the patient's care coordinator. DVA's Allied health Arrangements (similar to the Enhanced Primary Care (EPC) items in the MBS schedule at http:www.health.gov.au/internet/wcms/publishing.nsf/Content/health-epc-careplan.htm) allow for greater involvement of the LMO/GP in care coordination. These items support LMOs/GPs to conduct extended consultations with entitled persons, carers and other health care providers, review management, and ensure that the needs of entitled persons, carers, and entitled person's patients are recognised and addressed. Under these items, LMOs and GPs can be reimbursed for contributing to, or organising discharge case conferences and care plans for, people with chronic conditions[1] and multidisciplinary care needs. They can also be reimbursed for health assessments for over 75s.

1 A chronic disease is defined as a disease that lasts (or will last) for at least six months or that is terminal.

Discharge planners are encouraged to familiarise themselves with DVA's Allied Health Arrangements and discuss the entitled person's care with the LMO/GP in terms of these services. As an example, hospital invitations to LMOs to participate in discharge planning meetings should reflect the appropriate EPC schedules.

Arranging health care services both before admission and after hospital discharge is clearly part of the care coordination process and, as such, the LMO should be able to provide valuable patient-specific advice to hospital discharge planning staff.

In many rural and remote localities, some patients do not have consistent access to an LMO/GP. The time and day of discharge must be considered when discharging entitled persons into their local community.

2.3 Commonwealth Initiatives: ACAT and HACC

Aged Care Assessment Teams (ACAT)

Aged Care Assessment Teams (which may have different names in states and territories) (ACATs) are mainly Commonwealth funded but managed by state and territory governments. The teams variably comprise doctors, nurses, social workers and other health professionals who assess and make recommendations regarding the care needs of older people, once they are no longer able to manage at home without assistance. ACATs provide information on suitable care options and can help arrange access or referral to appropriate residential or community care.

ACATs take referrals from, and work closely with, doctors, local health centres and hospitals. They can also take referrals directly from patients and carers. The hospital social work department is an appropriate first contact for local ACATs and further information can be obtained from the Commonwealth Carelink Centre **(1800 052 222)**, the Aged and Community Care Information Line **(188 500 853)** and websites **www.health.gov.au/acc/** or **www.commCarelink.health.gov.au**.

Home and Community Care Programs (HACC)

The Home and Community Care Program (HACC) provides a range of basic maintenance and support services for older people, people with disabilities and their carers, including respite, home help, personal care, food services, transport, home maintenance and modifications, and home nursing. For more information call the Commonwealth Carelink Centre **1800 052 222**, which will connect you with your closest Carelink Centre.

2.4 DVA-funded health and support services

Overview of DVA-funded Health and Support Services

Health and support services funded by DVA are mostly provided at no cost to the entitled person. Access to services is dependent on the availability of the service in the specific local community. In some cases, especially allied health services, some services may not be available locally.

While DVA generally funds allied health services available in the private sector, the entitled person may need to access a service at a public hospital if it is not available privately, or if no private provider can deliver the type of service or level of expertise required by the entitled persons.

Discharge planners and other hospital staff can make enquiries about the availability of specific DVA–funded health and support services by contacting DVA offices at the following telephone numbers.

Summary of DVA Contact Numbers

General enquiries

133 254
Connects callers from anywhere to their capital city State Office.

Non-metropolitan callers

1800 555 254
Connects non-metropolitan callers only to the capital city State Office.

Dialling from interstate

1300 131 945
Allows callers to contact any State Office via a series of voice prompts.

Local Veterans' Affairs Network (VAN) offices

1300 551 918
Connects callers with their nearest VAN office.

A series of one page charts of "DVA funded services in (State)" and a 4–5 page series of sheets of *Entitlements at a Glance* for (State) are available in the "provider" area on this website

Allied Health Services

Purpose: A range of allied health services is available to veterans and other entitled persons under Repatriation health care arrangements including:

Chiropractic and osteopathic – for treatment of conditions arising from injuries to, or disturbances of, the musculoskeletal system. However treatment of organic or visceral disorders such as asthma and deafness by chiropractors/osteopaths is not authorised under Repatriation health care arrangements.

Dietetics – nutritional assessment, disease-specific nutrition therapy, counselling, instruction, design and monitoring of enteral support programs, and health promotion. Dietetic supplements are available through community pharmacies with a LMO/GP authority prescription. To ensure that appropriate equipment is delivered to the patient's discharge address in time, DVA needs at the minimum, two days' notice (weekends not included). The discharging hospital may need to supply the entitled person with sufficient product to last several days as the provider will probably need to order products once it has received the entitled person's authority prescription.

(Appendix 4 (page 63) outlines the procedure for obtaining nutritional supplements.)

Occupational Therapy – to help entitled persons regain physical, psychological, social and vocational abilities that have been disrupted because of accident or illness. Occupational therapists are also integrally involved in the DVA Rehabilitation Appliances Program *(see page 20)* by assessing entitled persons needs and prescribing appropriate aids and appliances. Treatment may involve the assessment of activities of daily living, prescription of rehabilitation appliances and identification and organisation of home modifications. The involvement of an occupational therapist in discharge planning should occur early in the hospital stay, as provision of appropriate treatment may require a pre-discharge home visit which may take time to organise.

Optometry – for optometrical assessments and prescriptions for visual aids.

Physiotherapy – for physical, respiratory and neurological conditions using techniques such as massage, manipulation and exercise and including periodic treatment for acute conditions and maintenance treatment for chronic conditions. Treatment for lymphodema is subject to an annual monetary limit and DVA's prior financial authorisation.

The complete current list of DVA National and State Office contact details can be found on pages 1–5 of this Kit.

Podiatry – diagnosis, routine maintenance, selected soft tissue surgery and physical therapy on the feet. Treatment may also include the prescription of medical grade footwear, footwear modifications and orthotics.

Psychology – treatment of mental health disorders such as depression and anxiety disorders, pain and stress management, adjustment to disability, coping with life-threatening crises and terminal illness, and improving compliance with other treatment. Psychological and neuro-psychological assessments are also provided for assessment of dementia and effects of head injuries, strokes or brain illnesses.

Social Work – to assess personal and family situations and provide information and referrals to appropriate agencies.

Speech Pathology – assessment, diagnosis and treatment of communication and swallowing disabilities and equipment necessary for the treatment of such disabilities. Provision of services and equipment, especially supplies of thickening agents for dysphasia, should always be arranged well before discharge. At least 24 hours may be required for the supply of most equipment, although emergency supplies can be provided when absolutely necessary.

Service delivery: Allied health providers can provide services/treatments at:

- their own rooms;
- the entitled person's home (when there is a genuine need, eg the entitled person is non-ambulatory, bedridden or does not have access to transport);
- residential care facilities (DVA needs to give prior financial authorisation for High Care patients); and
- hospitals (DVA needs to give prior financial authorisation for public hospital visits).

(See page 32 for White Card holder treatment eligibility.)

Referral: Access to these services is based on clinical need and requires a referral from:

- a LMO/GP;
- a medical specialist;
- a treating doctor in a hospital;
- a hospital discharge planner (discharge planners cannot refer to psychologists, chiropractors or osteopaths); or
- from one allied health professional to another within the same health discipline.

Referrals are valid for twelve months with the exception of referrals to physiotherapists, which are for six months. Entitled persons can self refer to optometrists and dentists.

The HIC payment system will recognise only one active referral per treatment type per entitled person in a twelve month period. Upon discharge from hospital, discharge planners should refer entitled persons to the same health professionals who have been treating them prior to admission, where this is appropriate and practicable. Referrers can check referral details with the DVA state office.

Treatment Limits: It is the responsibility of the allied health provider to determine the type, number and frequency of the services/treatments required by the entitled person according to their clinical need. Some allied health services/ treatments are subject to DVA's prior financial authorisation, which can be obtained by contacting the DVA State Office. It is the responsibility of the treating provider to ensure that the entitled person being treated is entitled to treatment at DVA expense.

Discharge planners, medical/hospital staff, LMOs/GPs and allied health providers can seek clinical advice through existing networks, and advice regarding entitled person services by telephoning the DVA State Office on **133 254** or **1800 555 254**.

Further Information: Visit **www.dva.gov.au** fact sheets.

Carer Support Programs

Purpose: DVA provides funding support for some services available to carers of entitled persons.

Referral: No referral is needed to any of these services.

Service delivery: DVA carer support programs vary from State to State and usually include:

- respite care;
- education about caring for someone with dementia;
- videos and books, e.g. *'Dementia: A practical guide for carers*';"Carers Booklet";
- Clubs; and
- information and advocacy.

Sometimes there are carer support groups, newsletters and registers.

A number of support programs are also available through DVA, the Department of Health and Ageing, and Home and Community Care (HACC). These include:

- meals-on-wheels;
- respite care through Commonwealth carer respite centres – National Freecall **1800 059 059**; and
- support for carers through carer resource centres.

Discharge planners, medical and other hospital staff, LMOs/GPs and providers can seek advice regarding carer support from the hospital social work department, through places like Carers Centre, or by telephoning the DVA State Office on **133 254** or **1800 555 254**.

Further information: Visit **www.dva.gov.au** fact sheets.

Community Nursing

Purpose: Community nursing services are provided to entitled persons by DVA-contracted community nursing organisations. Community nursing services meet the clinical and/or personal care needs of an entitled person where personal care needs exceed 1.5 hours per week. They do not include support services such as companionship, shopping, cooking, cleaning, laundry or transport[2].

Referrals: Community nursing services are delivered on referral from an appropriate referral sources, which are:

- the hospital discharge planner;
- the entitled person's LMO or other GP who is treating the entitled person under DVA arrangements;
- a treating doctor in hospital; or
- a Veterans' Home Care (VHC) assessment agency.

The referral is valid for 12 months.

When referring an entitled person to community nursing services, the referrer should provide relevant clinical information in writing to the community nursing organisation. The referrer should obtain the entitled person's consent to the referral and explain to them:

- the reasons for the referral;
- that the referral is for an assessment only for community nursing services; and
- that the referral does not guarantee community nursing services will be provided.

The referral should not stipulate a level of service or a timeframe for service, as the contracted community nursing organisation will undertake a complete nursing assessment to determine the care needs of the entitled person.

The discharge planner should coordinate referrals from hospital providers and treating professionals to ensure that only one assessment for community nursing care is undertaken (not one for Aged Care Packages, one for Community Nursing, and one based on a referral from VHC for personal care).

The referral must be in written form on DVA's request/Referral (D904 form), or the referrer's official letterhead. A referral must include the referrer's provider number. A discharge planner or treating doctor in hospital should use the hospital's provider number.

Personal Care: Personal care can be provided through a DVA-contracted community nursing organisation, if it is assessed that the entitled person requires personal care in excess of 1.5 hours per week, or if the entitled person requires any level of personal care as a component of clinically-required nursing care. If it is assessed that an entitled person has no clinical need for nursing care, but does have a need for personal care at 1.5 hours or less per week, they should access personal care through VHC.

2 These services can be accessed by entitled persons through the Veterans' Home Care program (see page 22), or through Home and Community Care services and Aged Care Packages (see page 8) supplied by State and Federal authorities.

An entitled person should be referred to VHC for an assessment of personal care needs if the referrer considers that there is no clinical need for nursing care, and the need for personal care is likely to be no greater than 1.5 hours per week. The VHC agency will determine the level of personal care required. Refer to *page 22* for further details on VHC services.

Continuity of Care: To ensure continuity of care, DVA expects an entitled person who has previously received community nursing care from a community nursing organisation to return to that organisation for care upon discharge from an acute facility, if the entitled person has been in the acute facility for less than 28 days. In these cases a new referral is not required, as the entitled person has not been discharged from the community nursing care. However, if the entitled person's previous referral expires during their stay in the acute facility, a new referral is required upon discharge. A new referral should also be provided if the entitled person has requested that a new community nursing organisation deliver their community nursing care. A community nursing organisation cannot deliver community nursing care in an acute facility, residential aged care facility, a multipurpose centre, a community centre, or a clinic in any other location.

Discharge planners, medical, other hospital staff, LMOs/GPs and community nursing organisations can seek advice regarding eligibility by telephoning the DVA State Office on **133 254** or **1800 555 254**.

Further Information: Visit **www.dva.gov.au** fact sheets.

Community Support Services

Purpose: Organisations that provide community support services have their own eligibility criteria to determine who will receive them. There is usually strong demand for community support services. Limited funding means that many services will not always be available.

Referrals: As members of the general community, veterans and other entitled persons have the same right of access to general services as all citizens, in considering DVA entitled persons, community support service organisations should apply exactly the same eligibility criteria as they would for all citizens.

Service Delivery: Community support services are sometimes provided free of charge, but usually a small contribution towards the costs is required. Where a fee is payable, the entitled person receiving the service is responsible for paying it. *Such fees are not payable by DVA.*

Where discharge planners have difficulty arranging access for an entitled person to a community support service, contact the DVA State Office on **133 254** or **1800 555 254**. State Veterans' Affairs Network (VAN) staff are keen to extend community links, and can be contacted on **1300 55 1918**.

Further information: Visit **www.dva.gov.au** fact sheets.

Convalescent Care

Purpose: DVA supports convalescent care for entitled persons. This refers to a period of recovery from an acute illness or operation relating to a DVA-approved hospital admission.

Referral: Convalescent care can be organised by medical officers (hospital staff or LMO/GP), discharge planners, or other hospital staff. DVA must provide financial authorisation before convalescent care can be arranged at somewhere other than a public hospital.

Service delivery: Most convalescent care can be provided at home, but in some cases it may be provided in a health care facility.

Gold Cardholders can access a maximum convalescent care period of 21 days each financial year. White Cardholders can access a maximum of 21 days' convalescent care each financial year for an accepted disability or malignant cancer, pulmonary tuberculosis or Post-traumatic Stress Disorder (if these conditions are accepted by DVA). If veterans are from the United Kingdom, New Zealand, Canada or South Africa, they are covered only for the treatment of accepted disabilities.

Convalescent care should be arranged in the most appropriate setting available to meet the entitled person's convalescent needs. It is inappropriate to refer an entitled person for convalescent care where they have been assessed for high level residential care. The use of hospitals for convalescence is considered only in exceptional circumstances where no other option is available. If the entitled person convalesces in a hostel or nursing home, he/she will require an assessment by an Aged Care Assessment Team (*see page 8*). This will be arranged before discharge from hospital.

Discharge planners, medical and other hospital staff, LMOs/GPs and providers can seek advice regarding convalescent care by telephoning the DVA State Office on **133 254** or **1800 555 254**.

Further information: Visit **www.dva.gov.au** fact sheets.

Dental Services

Purpose: Dental services involve the prevention and treatment of oral disease and include general dental services, the filling and crowning of teeth and the construction of dentures.

Referral: Entitled persons can access general dental services by making an appointment with a DVA-registered dentist. Prior financial authorisation is necessary for White Cardholders. Discharge planning from hospital rarely involves the organisation of dental services, unless the admission was specifically for a dental condition. In this instance, access to appropriate dental services would form part of the admission and discharge arrangements. Therefore this Kit does not specifically detail DVA-funded dental services.

There are restrictions for some dental services. Should information on DVA-funded dental services be required, contact the DVA State Office or visit **www.dva.gov.au** fact sheets.

Domiciliary Oxygen

Purpose: Domiciliary oxygen is authorised by DVA strictly in accordance with the guidelines issued by the Thoracic Society of Australia and New Zealand. DVA provides access for entitled persons to domiciliary oxygen supplies and essential accessories where it is medically necessary.

The service is provided by a DVA contractor with equipment supply based on clinical need.

Referrals: Entitled persons must be assessed, during a hospital admission, by a respiratory physician, cardiologist, or oncologist. In remote areas where such specialists are unavailable, this requirement may be waived. All requests for domiciliary oxygen should be submitted to the contracted supplier on a specific application form (available from DVA State Offices)[3]. The form should be completed by a relevant prescriber.

Service Delivery: Specific delivery times (from time of receipt of prescription) are as follows:

- Urgent and emergency orders – 4 hours
- Metropolitan, regional and rural areas (100 km or less from supplier outlet) – 24 hours.
- Remote areas (more than 100 km from supplier outlet) – 48 hours.

Entitled persons may be entitled to a subsidy for electricity used in the operation of oxygen concentrators. When domiciliary oxygen has been provided, DVA should be advised so that subsidy claim forms can be forwarded to the entitled person. The notification to DVA should include the prescribed hours of usage.

Further advice can be provided by contacting the DVA State Office on **133 254** or **1800 555 254**.

Further information: Visit **www.dva.gov.au** fact sheets.

Hearing Services

Hearing services are provided to entitled persons under the Commonwealth Hearing Services Program at no cost. DVA will pay the annual maintenance fee for hearing aids for entitled persons Gold or, relevant White Card eligibility. The LMO/GP can arrange for assessment for hearing aids by completing the *Application for Hearing Services* form and submitting this to the Office for Hearing Services. Contact DVA State Office **133 254** for further details or visit **www.dva.gov.au** fact sheets.

3 In Victoria, requests should be submitted to the Respiratory Medical Department of the Austin Repatriation Medical Centre.

HomeFront (falls prevention)

Purpose: HomeFront is a falls and accident prevention program that provides an environmental assessment of an entitled person's home (including yard) to identify potential falls hazards and recommend appropriate items and modifications where necessary. HomeFront is not designed to respond to urgent needs.

Referrals: All Gold and White Cardholders are eligible for this program. Self-initiated referral is encouraged, however the entitled person can be referred by a Discharge Planner, LMO/GP, other health professional, a carer or family member. The entitled person will need to be available to provide the appropriate registration information.

Service Delivery: The assessment is usually performed by an Occupational Therapist or Community Nurse. The program is a preventive one and is not based on clinical need – that is, rather than focus on the Card holder, it is concerned with the home and surrounding environment. Recommendations made to help prevent a fall or accident might be simply a rearrangement of furniture, or improved lighting, or minor modifications such as non-slip treatment of floor surfaces, or installation of hand rails.

This free assessment, and the contribution of up to $163 towards the cost of recommended items, is available each calendar year.

Literature sent to the householder at the time of the HomeFront assessment provides further information on falls prevention and home safety, including information on medication management, sensory loss and healthy nutrition. The assessor will also leave information on local community services and programs which may be of assistance to the entitled persons in maintaining independent living.

For a HomeFront assessment: Ring **1800 80 1945**.

Further information: Visit **www.dva.gov.au** fact sheets, or contact the HomeFront Coordinator in each DVA State office.

Mental Health Programs

Purpose: DVA provides funding for a range of mental health treatment for entitled persons with mental health problems. Entitled persons hospitalised for mental illness should be referred back to their LMO/GP or treating psychiatrist to consider the most appropriate options.

Counselling and other support programs are also available through the Vietnam Veterans Counselling Service (VVCS) regardless of Gold Card or White Card status.

A range of other programs, support and information is listed below:

Vietnam Veterans Counselling Service (VVCS)

Purpose: VVCS is a free, confidential Australia-wide service with professionally qualified staff skilled in working with life problems faced by veterans and their families. A wide range of programs is available to war and service-related mental health conditions. VVCS is available to all veterans, including peacekeepers and peacemakers as well as entitled family members. It is also available to current ADF members under special referral arrangements.

For contact details of the nearest VVCS centre, call DVA on **133 254** or **1800 555 254**.

Further information: Visit **www.dva.gov.au/health/vvcs or www.dva.gov.au/** fact sheets.

Veterans Line

Purpose: An after hours crisis counselling service provided by the Vietnam Veterans Counselling Service (VVCS). The service is designed to assist veterans and their families in coping with crisis situations outside VVCS office hours.

National telephone contact: 1800 011 046.

Further information: Visit **www.dva.gov.au/health/vvcs/crisis**.

Men's Health Peer Education

Purpose: Trained volunteer peer education facilitators are available to run health education presentations for individuals or groups of veterans or other entitled persons. Clubs, ex-service organisations or other groups that have an interest in men's health can host these presentations. There are a wide variety of subjects to choose from including healthy lifestyles, heart disease and diabetes.

Further advice can be provided by contacting the DVA State Office on **133 254** or **1800 555 254**.

Further information: Call DVA on 133 254 or visit **www.dva.gov.au/health/menshealth/**.

The Right Mix: Your Health and Alcohol

Purpose: Information for the veteran community on health and alcohol issues including standard drinks, alcohol and medications, sleep and mental and other health conditions.

Further advice can be provided by contacting the DVA State Office on **133 254** or **1800 555 254**.

For further information or to order The Right Mix materials, call DVA on 133 254. Visit **www.the right mix.gov.au**.

Palliative Care

Purpose: "Palliative care is about caring for people with a terminal illness as well as their families and friends. Palliative care is care which 'palliates' or relieves pain and other symptoms. It is given when treatment to cure an illness no longer works. It aims to ease the pain, distress and many other physical, emotional and spiritual problems that are present with a terminal illness." (Palliative Care Australia (PCA)).

Using various techniques and knowledge, a team drawn from many health care disciplines including doctors, nurses, allied health workers, chaplains and volunteers, provides coordinated physical, psychological, emotional and spiritual support.

Palliative care aims to make the person feel in control of their treatment and their quality of life. It involves family and friends, recognising that they, too, need to be

prepared for the death of someone they love, as well as being able to offer help and support during the grieving process.

Palliative care adds to the range of medical treatments and services already being provided and works together with the specialists, general practitioners and nursing staff already involved. Sometimes palliative care helps in the decision making about when to stop some treatments.

Palliative care services provide a range of services to patients and their families. These may be nursing, medical care including consultancy with the person's GP, day care, counselling, diet advice, loan of equipment, physiotherapy, occupational therapy, social workers, bereavement support, pastoral care and a wide range of support from trained workers (PCA 2005).

Referral: The veteran or other entitled person's LMO/GP or treating doctor can arrange the appropriate services in the entitled person's local area.

Service delivery: A variety of services may be required to provide optimal care to the palliative entitled person and their family. Most health service areas in Australia have a multi-disciplinary palliative care team made up of specially-trained medical providers, nurses, allied health personnel, counsellors and volunteers. A Veterans' Home Care assessor (*see page 26 for contact details*) can, while the patient is in hospital, assess the need for respite services. Palliative care can prepare and support the entitled person and their family in the management of symptoms and choices of care settings, including acute care hospital, hospice and/or home. It is important to recognise that entitled persons receiving palliative care may move between care settings in response to their changing clinical and emotional needs. Community nurses may provide palliative care nursing and they may also refer the entitled person to specialist palliative care providers, if and when appropriate.

Further information: Contact the DVA State Office on **133 254** or **1800 555 254** for further information.

Pharmaceutical Benefits and Medication Issues

Pharmaceutical benefits and medication issues are outlined in Section 4.4 *(see pages 52–56)*. For further information visit **www.dva.gov.au** fact sheet or contact the local DVA State Office **133 254** or **1800 555 254**.

Rehabilitation Appliances Program (RAP)

Purpose: The DVA Rehabilitation Appliances Program (RAP) provides access to self-help services and rehabilitation items.

Referral and Service Delivery: Provision of services, aids and equipment is based on the entitled person's clinical need and requires assessment by an appropriate health care provider (occupational therapist, physiotherapist or registered nurse). Some RAP items, such as electric scooters are only available to entitled persons with an Accepted Disability that requires that item. The RAP schedule details the appropriate health prescriber, supplier and prior approval requirements. Delivery of aids and equipment varies according to availability, and early involvement of the appropriate health care provider is recommended to ensure timely provision of services and equipment.

Supplementary safety items such as non-slip treatment to floor surfaces, improvement to step definition and improved lighting may be available to entitled persons through HomeFront *(see page 18)*.

Discharge planners, medical and other hospital staff, LMOs and providers can seek advice regarding RAP by telephoning the DVA State Office on **133 254** or **1800 555 254**.

Further information: Visit **www.dva.gov.au** fact sheets.

Residential Aged Care

Veterans and other entitled persons access residential aged care in the same way as other members of the community. DVA does not operate residential aged care facilities.

A range of such facilities is operated by ex-service and other organisations, but entitled persons requiring residential care should not limit themselves to these organisations. They should choose from the complete range of residential aged care facilities available. Options to help them remain in the community should also be considered where practicable.

For admission to residential aged care facilities, an entitled person must be assessed by an Aged Care Assessment Team (ACAT). The ACAT will determine the level of residential care required to meet the person's particular needs and provide advice on the options available. It would generally not be considered appropriate to discharge a high level care needs entitled person into a Supported Accommodation Service. These facilities are ordinarily staffed to care for residents with low level care needs.

Access and information about services in your area can be sought through other sources such as Seniors Information Service, hospital social worker or welfare worker. If an entitled person is a carer and seeking advice for his/her patient, issues of access remain the same.

For further information, *DO NOT* contact the local DVA State Office. Instead, contact the hospital welfare worker or social worker.

Transport and Travel Assistance

DVA may pay travelling expenses for an entitled person to attend the closest practicable health provider to the entitled person's home. The entitled person must travel by the most economical and suitable means of transport available at the time. If an entitled person needs to travel for treatment to a health care facility, he/she may be eligible for an accommodation allowance through the Department.

Transport arrangements will generally be made by the entitled person. However, in certain circumstances, transport may be arranged for the entitled person by DVA. An entitled person who has incurred expenses in relation to travel for treatment must submit a claim to DVA to seek reimbursement. Entitled persons are entitled to travel assistance for treatment in accordance with their Repatriation Health Card. Travel assistance is available to Gold Cardholders for treatment of all conditions, and to White Cardholders for treatment of accepted disabilities only.

DVA will assist entitled persons with travelling expenses for the use of private vehicles or public transport. If either of these modes of transport is not available or is medically unsuitable, they may be able to travel by taxi, community transport, ambulance or air, at DVA's expense. To claim for reimbursement of travelling expenses incurred in relation to treatment, an entitled person must complete a Claim for Travelling Expenses form (D800). The claim must be lodged with the DVA office in the state or territory in which the travel was undertaken, within three months of the date of the first health provider visit claimed. Treating health providers must confirm (on the relevant section of the Claim for Travelling Expenses form) that they are the closest practicable health provider to the entitled person's home.

If an entitled person obtains treatment from a health provider who is more than 50 kilometres from their home, and the health provider has not indicated on the form that he or she is the closest practicable health provider, DVA will pay travelling expenses only for the first 100 kilometres travelled for that visit.

Further information: Visit **www.dva.gov.au** fact sheets.

Veterans' Home Care Program

Purpose: Veterans' Home Care (VHC) is a DVA program providing low levels of home support to assist veterans and other entitled persons to remain living independently in their homes longer. Services include:

- domestic assistance;
- personal care;
- safety-related home and garden maintenance; and
- respite care.

Referral: Entitled persons can be referred for assessment for VHC by their LMO/GP, or the discharge planner, or they can ring **1300 550 450** directly. However, while the entitled person is in hospital, it may be more time-efficient for the discharge planner to make referrals relating to domestic assistance and personal care.

Service delivery: In addition to organisation of the above services, VHC can also refer the entitled person to other services for support. For instance, services such as community transport, social support and delivered meals can be arranged through VHC, through arrangements with State and Territory governments.

VHC provides assistance for entitled persons with low-level care needs. It is not intended to replace higher levels of care such as Community Aged Care Packages (CACPs) or high or low-level residential care. It may, however, provide for a higher level of care to meet short-term post-acute needs or transitional care.

Access to services is not automatic, but is based on assessed need. Assessments are undertaken by VHC assessment agencies contracted with DVA. The agencies then arrange for the services to be provided by authorised service providers contracted with DVA.

The regional coordinator in the assessment agency makes the final decision about the approval of VHC services. Decisions are made in consultation with the Discharge Planner, in accordance with the VHC Guidelines and with regard to

resource allocation for the region. Discharge planners should not raise an entitled person's expectations by suggesting service levels. Service approvals are usually for a defined period. All entitled persons are subsequently reassessed and further approvals are dependent on the outcome of that assessment.

The following sections outline specific issues relating to delivery of Veterans' Home Care services.

Who is eligible for Veterans' Home Care?

To be eligible for a VHC assessment a person must be a veteran of the Australian defence forces, or a war widow(er) or other entitled person, and have a Gold or White Repatriation Health Card.

Commonwealth and Allied veterans who have a White Card may be eligible for respite care, but only where it relates to accepted disabilities.

Partners and cares are not eligible for VHC services unless they have their own Gold or White Card. However, they may be eligible for respite care if they care for an entitled person.

Service providers

VHC assessment agencies are contracted by DVA to undertake assessments for services in 54 regions nation-wide. Approximately 250 service providers are also contracted with DVA to deliver the actual services. Assessment agency contact details can be found on the DVA website at www.dva.gov.au/health/homecare/guidelines/attachi.htm#vh. Alternatively, discharge planners can ring **1300 550 450** to be connected to the assessment agency in their local area.

The assessment agency develops Care and Service Plans for each entitled person. The Care Plan is provided to the entitled person and the Service Plan to the service provider.

At pre-admission or admission

Hospital discharge planners play a key role in transferring entitled persons from an acute care setting to a community setting by ensuring that their needs are coordinated on discharge from hospital. This includes linkages to all DVA programs that can assist them.

It is important that discharge planners commence a discharge plan for entitled persons on their pre-admission or admission to hospital. At this time, details of the entitled person's regional assessment agency and the services currently received should be recorded on the discharge plan, and the VHC discharge planner's referral form *(see page 27)* should be provided to the entitled person's assessment agency as soon as possible after admission.

Referral by hospital discharge planners to VHC

If details of a entitled person's approved VHC services have not been collected before admission to hospital, agencies can be contacted on **1300 550 450**. When ringing this number, the discharge planner will be connected to the appropriate assessment agency in their area, and arrangements can be made for service delivery. Alternatively, the agency can be contacted directly. Contact details can be found on the DVA website at www.dva.gov.au/health/homecare/guidelines/attachi.htm#vhc.

Where an entitled person has been hospitalised in an area outside their usual VHC region, discharge planners can refer to the list of VHC assessment agency contact details on the web to arrange services.

The VHC discharge planner's referral form is designed to assist VHC assessment agencies in assessment and provision of services to entitled persons being discharged from hospital. Discharge planners or other hospital staff should fax the completed form to the entitled person's usual VHC assessment agency. Discharge planners can also provide VHC with information that will allow the agency to organise timely and appropriate services. The following scenarios are examples of how discharge planners can assist VHC:

How Discharge Planners can assist VHC Entitled Persons needing no change to their VHC services

Where an entitled person received VHC services before hospitalisation, and no changes to service provision are required on discharge, the discharge planner should contact the assessment agency on admission to postpone services and to advise that services need to recommence from the date of discharge.

Entitled persons already receiving services who require additional services

Discharge planners should contact the assessment agency to discuss the entitled person's additional service requirements and advise of the date of discharge.

Entitled persons who have never received services

If the entitled person is a Gold or White Cardholder and requires VHC services on discharge, the discharge planner should contact the VHC assessment agency before discharge to arrange an assessment for the entitled person, and fax the discharge planner's referral form *(page 27)* to the agency. The agency may be able to phone the entitled person in hospital to conduct the assessment, or to do it with the carer with power of attorney, so that services can be provided on discharge. The resultant Care Plan could then be discussed with the discharge planner, as the needs of the patient are likely to change as they get closer to discharge. The assessment agency should advise the discharge planner of the outcome of the assessment, including details of the VHC services approved.

Entitled persons requiring long-term, high-level care

VHC is not able to support entitled persons with high-level care needs for a prolonged period of time. Should an entitled person require such care, the discharge planner should organise an assessment by the Aged Care Assessment Team for a CACP before discharge. The VHC assessment agency and DVA Community Nursing programs can arrange community services while the entitled person is waiting for a CACP.

VHC Services

Personal care

VHC provides personal care to entitled persons with basic personal care requirements. Personal care includes assistance with self-care tasks that a person is unable to do because of illness, disability or frailty, including dressing/grooming, assistance with meal preparation and feeding, bathing, showering and toileting, reinforcement/encouragement with mobility and passive exercises. Assistance can also be provided with application of skin-care creams and lotions (non-medicated), pressure area prevention aids, protective bandaging, or fitting of aids/appliances such as splints, calipers, stockings. The assessment agency will refer the entitled person to DVA Community Nursing where required. Community nursing services are provided to entitled persons by DVA contracted community nursing organisations.

Community nursing services meet the clinical and/or personal care needs of a entitled persons where personal care needs exceed 1.5 hours per week. They do not include support services such as companionship, shopping, cooking, cleaning, laundry or transport. *See page 14* for further information.

Discharge Planners need to coordinate referrals from Nursing Unit Managers, Social Workers, and Occupational Therapists to ensure there is only one assessment undertaken for community nursing services (or for personal care services if required at a higher level than VHC can provide). Note that only discharge planners, doctors or VHC agencies can refer to community nursing (however, problems can occur if OTs or SWs refer to VHC who then refers on to community nursing).

Domestic assistance

Domestic assistance provides support with a range of tasks including household cleaning, dish washing, clothes washing and ironing, bed making, bill paying, shopping for the entitled person, cleaning internal windows, and assistance with (but not total preparation of) meals.

Home and garden maintenance

The focus of home and garden maintenance is to minimise environmental health and safety hazards that impact on the entitled person. Keeping the home safe and habitable may involve minor maintenance or repair work, which can be carried out by a handyman, rather than requiring a qualified tradesperson. Tasks may include changing light bulbs and tap washers, installing batteries in smoke alarms, gutter or window cleaning, a general yard clean-up, or other tasks, within the approved hours of services agreed between the entitled person and the service provider.

Home and garden maintenance does not include major repairs or services requiring a qualified tradesperson, such as gutter replacement, major landscaping or garden tasks such as tree-felling or tree removal. Garden tasks such as, branch lopping, lawn mowing and pruning can only be undertaken if an environmental health or safety hazard presents. Routine, cosmetic or ornamental gardening services such as weeding and maintenance of flower beds, pruning of roses, and regular lawn mowing are not available.

Respite care

Respite care is designed to provide temporary relief for a carer who has responsibility for a person requiring on-going care, attention and support. It is provided to entitled person households where the cardholder is the carer of the care recipient. Respite care through VHC may be provided as:

- residential respite when the carer needs a break or there is no carer, and after the entitled person has returned to the community (referral for residential respite is not available from hospital). DVA will only pay residential care costs for the entitled person.
- in-home respite to give the entitled person or their carer a break through flexible arrangements to take over aspects of care.
- emergency short-term home relief when the carer, or entitled person, is suddenly or unexpectedly unable to continue the caring role.

Carer relief needs to be considered a normal part of the carer experience. Thus discharge planners, having discussed this with the carer, should factor in-home respite services into their discussion with the assessment agency *(see carers pages 39–41). For self-carers, while there may be instances to the contrary, it is not generally expected that discharge planners would refer entitled persons to VHC for respite care immediately post-discharge. Entitled persons are to be encouraged to contact the VHC agency for assessment if a need for respite arises at a later date.*

Further information

General information about VHC can be obtained from any DVA State Office on **133 254**, or from the Local Veterans' Affairs Network (VAN) offices **1300 55 1918** or from the VHC link on the DVA web site **www.dva.gov.au/health/homecare/mainvhc.htm. Current VHC Assessment Agency contact details are available on the DVA website at: http:www.dva.gov.au/health/homecare/guidelines/attachi.htm#vhc**

Discharge Planner's Referral

Veterans' Home Care

ACH Veterans' Home Care Assessment & Coordination Agency

DVA File No:……	**Date**: ……/……/……

Veteran's Full Name: Mr / Mrs / Miss / Dr / Rev ……

Address: ……

…… **Postcode**: ……

Telephone number: ……

Anticipated Date of Discharge: ……/……/……

Referrer's Name:	…… **Phone:** ……
Reason for Referral:	…… ……

Current Living Arrangements: Alone ☐ With Partner/Spouse ☐ With family ☐ With Others ☐

What Community Services is the Veteran currently receiving?	**Who provides the Services? (Please include their telephone number)**
……	……
……	……
……	……
……	……

LMO Name: ……

LMO Telephone: ……

Diagnosis: ……

……

……

……

……

Have you referred the veteran to any of these services?

HomeFront ☐ | Dom Care ☐ | Referred to ACAT ☐ **OR** Has current ACAT ☐

Community Nursing ☐ | RAP (DVA Equipt / OT) ☐ | Meal Service ☐

Other: ……

Do you have any relevant recent assessment that can be attached to this referral ?

(eg ACAT, Seniors' Health Assessment) Yes attached ☐ No ☐

Discharge Planner's Referral

Has the Veteran had any recent falls?	In the Home: Yes ☐ No ☐	Outside the Home: Yes ☐ No ☐	

By ticking the appropriate box, please indicate the Veteran's abilty in activities of daily living…

Mobility	Independent ☐	Uses walking aid ☐	Standby ☐	Physical Assistance ☐
Transferring	Independent ☐	Standby ☐	Physical Assistance ☐	Carer assists ☐
Personal Care	Independent ☐	Standby ☐	Physical Assistance ☐	Carer assists ☐
Light housework dishes, dusting	Independent ☐	Requires assistance ☐		Carer assists ☐
Heavy housework vacuuming, bathroom	Independent ☐	Requires assistance ☐		Carer assists ☐
Meals	Independent ☐	Requires assistance ☐	Meal Service ☐	Carer assists ☐
Home Maintenance Taps, light bulbs	Independent ☐	Requires assistance ☐		Carer assists ☐
Gardening light pruning	Independent ☐	Requires assistance ☐		Carer assists ☐

Does the Veteran have any issues relating to continence? Bladder: Yes ☐ No ☐ Bowel: Yes ☐ No ☐

Please Comment ……

……

Does the Veteran provide care to a spouse, partner or family member? Yes ☐ No ☐

Please indicate potential service needs based on your assessment of the Veteran

……

……

……

For further information the VHCA Assessor should contact…

The Veteran: ☐ or

Name:……..

Phone: ……..

Relationship to the Veteran: ……

This statement is to be read to the Veteran/War Widow/Widower: "The information provided on this form will assist in assessment of eligibility for benefits under the Veterans' Entitlements Act 1986. The information may be disclosed to health care providers for the purpose of providing the services a veteran or war widow/widower may need. The information may be provided to the Department of Veterans' Affairs for administration and review purposes".

3 VETERANS/OTHER ENTITLED PERSONS AND DISCHARGE PLANNING

The Department of Veterans' Affairs (DVA) expects that entitled persons will receive best practice planning for discharge. Where possible, this should commence before admission, or as soon as the entitled person is admitted to a hospital or day procedure centre. DVA recognises that the quality of discharge planning has a fundamental bearing on an entitled person's ability to manage independently in the community following hospitalisation.

The DVA Discharge Planning Resource Kit is designed to assist discharge planners and other health care professionals to apply best practice principles when planning entitled persons' discharge from hospitals or day procedure centres.

Nomenclature

Veterans, war widows or widowers and their dependants who are provided with treatment at DVA expense are referred to in this Kit as *entitled persons*. Family, friends or paid carers who are providing assistance to the entitled person after discharge from hospital are referred to as the veteran's, or entitled person's, *carer*.

Definition of a veteran

'Veteran' refers to a Department of Veterans' Affairs treatment beneficiary who is eligible at the time of admission to hospital to receive such a treatment: (a) under Part V of the *Veterans' Entitlements Act 1986*; or (b) under an arrangement made pursuant to section 203 of the *Veterans' Entitlements Act 1986*; and (c) who elects to be treated as such in the hospital facility, and (d) under Part V of the Military Rehabilitation and Compensation Act 2004. In most cases, presentation by the entitled person of a Repatriation Gold Card with his/her name on it will be sufficient evidence of eligibility for treatment. In the case of White Cardholders, possession of the card is not necessarily a guarantee of eligibility for treatment of a particular condition. Where eligibility for a particular service is uncertain, please contact DVA on **133 254** or **1800 555 254** (for non-metropolitan callers).

Note: DVA beneficiaries eligible for treatment under arrangements made pursuant to section 203 of the *Veterans' Entitlements Act 1986* would be veterans of Commonwealth and certain allied countries where those countries have entered into treatment arrangements with the Repatriation Commission.

Veterans' special status

When Australia needed a contribution for war or defence service, the men and women who now comprise our veteran community were prepared to provide it. This call to service sometimes resulted in injury, illness, disease or death, but in all instances it meant an interruption to life, often with permanent consequences. We owe the veteran community a special debt for having successfully defended our way of life and our freedom. Recognition of their personal sacrifices underpins our belief that entitled persons should be provided with health care in an environment of caring, compassionate and understanding support.

As of March 2005, the Department of Veterans' Affairs pays for health services for approximately 318,628 veterans and other entitled persons. The needs of the veteran community are seen as unique and different to those of the general community in recognition of veterans' war experience and war-caused injuries. The Federal Government therefore continues to recognise veterans and other entitled persons as a special needs group and maintains DVA and its programs to address these needs.

Veterans' health needs

The majority of the veteran population is now elderly. Veterans' needs must be considered in context of the known health and social needs of the general aged population (Wang et al 1999). Aged people frequently present to health services for the management of one problem, which sadly is but one of multiple and complex medical problems (Byles 2000). Moreover, their spouses may also be elderly and have specific medical and social needs. This can produce problems for maintaining veteran independence in the community.

Mental health conditions figure prominently in the health of some veterans. Most veterans with an accepted mental health disability also often have physical disabilities, and there may well be a relationship between the veteran's physical and mental health. Thus, planning for discharge from hospital should take account of the veteran and carer, in context of their total health and social needs, and their desired level of independence in the community.

Spouses and dependants of living veterans

Spouses and dependants of a living veteran are generally not eligible for treatment under DVA arrangements. However, some may be eligible because of their own war or defence service and will have their own Repatriation Health Card. Spouses or dependent carers may receive respite care if they provide the primary care for an entitled person.

Spouses and dependants of deceased veterans

The spouse and entitled dependants of a deceased veteran, whose death is accepted by the Repatriation Commission as war-related, are eligible for treatment under DVA arrangements. They will have their own Repatriation Health Card.

Allied veterans resident in Australia

DVA acts as an agent for certain other countries whose eligible veterans reside in Australia. Not all countries have the same treatment entitlements. *If an allied veteran presents for treatment, always check with DVA regarding eligibility for DVA-funded services*. Veterans of these countries may be treated only for conditions accepted by that country as war-related. The procedures for arranging, providing and claiming for treatment of eligible allied veterans are the same as those for Australian entitled persons who hold White Repatriation Health Cards. Further information on DVA Repatriation Health Cards and eligibility for DVA-funded treatment is provided on *page 33*.

Determining eligibility

All eligible Australian entitled persons have been issued with a card (Gold or White Repatriation Health Card). Alternatively, a beneficiary may have written authorisation from DVA specifying his or her entitlement. It should be remembered that possession of the card does not guarantee DVA financial authorisation of a particular episode of care.

All entitled persons are eligible for treatment at Repatriation Commission expense for malignant neoplasia, pulmonary tuberculosis and Post-traumatic Stress Disorder, where DVA has accepted a claim for treatment of these conditions. The DVA Pensioner Concession Card does NOT entitle the holder to any DVA-funded services.

Phone **133 254** or check with the local DVA State Office if there is any doubt about eligibility for services. Further information can be obtained from the DVA web site **www.dva.gov.au**.

Confidentiality

Confidentiality of veterans' and other entitled persons' details must be strictly maintained by all people who have access to their personal information, including discharge planners and other hospital staff. Personal information should be transmitted by post and not by email or fax. However, where post is not practical, fax is the preferred transmission, provided the recipient is advised in advance that a message containing personal information is being sent. Receipt of the information should be confirmed. All persons should be aware of the provisions outlined in the *Privacy Act 1988*, including the *Privacy Amendment (Private Sector) Act 2000*. These are available on **www.privacy.gov.au**. A summary of the *Privacy Amendment (Private Sector) Act 2000* (the National Privacy Principles (NPP) Obligations for Health Service Providers) is provided on *page 57*.

Responsibility for confirming eligibility for DVA-funded services

It is the responsibility of the service provider to ensure that a beneficiary is eligible for services. Thus, where a discharge planner arranges post-discharge services for a veteran or other entitled person, it is ultimately the responsibility of each service provider to confirm the entitled person's eligibility for that service.

Where treatment is provided in a hospital or day procedure centre, it is the treating doctor's responsibility to confirm eligibility for treatment, and the hospital's responsibility to confirm eligibility for the admission itself. Nevertheless, it is useful for discharge planners to have some knowledge of DVA eligibility requirements in order to prevent unnecessary referrals and inconvenience for people who are not eligible.

This Kit provides details on DVA eligibility and contact details for further enquiries.

Reminder

You should verify the eligibility of each White Card holder with DVA before arranging any treatment services. To do this, contact the local DVA State Office (details on *page 1*). You should check the expiry date of both Gold and White Cards as part of the procedure *(page 33)*.

Complaints services

DVA encourages veterans and other entitled persons to identify and comment upon matters relating to their DVA-funded treatment. If the entitled person has a complaint about the standard of health care or any other matter relating to a stay in hospital or day procedure centre, DVA would like to be informed.

Complaints and compliments received from entitled persons about their health care can be sent directly to DVA, to the State Treatment Monitoring Committee or to an Ex-Service Organisation for forwarding to the Department. Entitled persons may also direct their complaint to the State Health Department health complaints officer, or other relevant person in the State. For example in Victoria this is the Health Services Commissioner.

Ex-Service Organisations play a major role in encouraging entitled persons to register complaints and compliments in order to improve services available to entitled persons.

DVA entitlement cards at a glance

The Gold Repatriation Health Card

Gold Repatriation Health Card holders are eligible for DVA-funded services for most of their medical conditions.

The White Repatriation Health Card

White Card holders are eligible for treatment for:

- accepted disabilities (conditions accepted by the Repatriation Commission as war caused);
- malignant neoplasia, pulmonary tuberculosis and post-traumatic stress disorder, where DVA has accepted a claim for treatment for these conditions from the entitled persons or on their behalf; and/or
- anxiety and depression for Vietnam veterans only.

The Orange Repatriation Pharmaceutical Benefits Card

This is a new card introduced on 1st January 2002 for eligible British Commonwealth and allied veterans. This card does not entitle veterans to any medical or health benefits or treatment, and there is no eligibility for admission to hospital under DVA arrangements. It is for pharmaceuticals only.

4 BEST PRACTICE DISCHARGE PLANNING

It should be noted that this Section has only been minimally updated as much of the best practice information is starting to appear on State Health websites (e.g. www.health.vic.gov.au/discharge; www.health.nsw.gov.au/policies/PD/2005; and through the Association of Discharge Planning Nurses (www.dischargeplanning.org.au). However, the following is a useful introduction to the subject.

4.1 Discharge planning: an overview

Regarding the place of discharge planning within overall health care planning it is important to re-iterate what was written in the introduction to this manual:

- Effective discharge planning should be a routine part of health care, and should be a part of an overall health care plan for the person involved, that spans, not only a hospital admission, but their overall care that occurs primarily in the community. This overall approach to health highlights the importance of primary health care and longitudinal rather than episodic care.
- Effective discharge planning should be consistent and standard for all patients receiving care in the health care system, and should not be different for the entitled person community.
- Hospitalisation should be seen as an opportunity to review health status, and make recommendations/take action about ongoing care that needs to be actively managed with the LMO/GP and other community players, including the entitled person and his/her family.
- Effective discharge should result in seamless integration into local community services. It therefore relies on good local knowledge of community services (not only for treatment, but also for psycho-social health) and partnerships with these organisations.
- Effective discharge relies on timely processes and good communication.

Definitions of discharge planning

One of the best definitions of discharge planning is from Armitage & Kavanagh (1995), who suggest that discharge planning is "the systematic identification and organisation of services and supports to assist recently ill people to safely transfer from hospital to the community".

The literature contends that good discharge planning which alerts patients and their carers to the issues of managing independently in the community, decreases downstream health costs by reducing unplanned admissions to hospital and unnecessary provision of community health and support services (Blaylock and Carson 1992, Evans and Hendricks 1993).

DVA supports the provision of best practice discharge planning to facilitate the safe, efficient and effective transition of a veteran or other entitled person from a hospital or day procedure centre into the community. Good discharge planning focuses on the continuity of care for the entitled person, and provides supports for the short and long-term health and social status of the entitled person and carer.

Good discharge planning recognises the entitled person and his/her carer as being integral to the development, implementation and evaluation of discharge plans.

The DVA Discharge Planning Resource Kit presents eight principles of discharge planning. These principles reflect quality standards that are recognised by quality accreditation groups in the healthcare industry such as ACHS EQuIP: (**www.achs.org.au**) and ISO 9000: (**www.unisa.edu.au/orc/isoquality.htm**).

Note: *As these principles are generic to all patients in hospital, the word 'patient' is used in these principles instead of the word 'veteran or entitled person'.*

The principles of discharge planning

Best practice discharge planning principles have been suggested as an integral part of an episode of hospital care. These principles have been formulated from wide-ranging consultation with health care providers, patients and carers (Hedges et al 1999). The principles are that:

1. appropriate and timely discharge planning should be an integral part of every patient's hospital admission;
2. discharge planning is the responsibility of all health care providers involved with the patient, with a specific person designated as being responsible for ensuring that all aspects of discharge planning have been addressed by the time of discharge;
3. a multi-disciplinary approach is most appropriate to the development and implementation of discharge plans. To achieve best practice the multi-disciplinary teams should work collaboratively and in a planned, integrated manner;
4. a documented discharge plan should commence before, or on admission to hospital. The discharge plan should be subject to ongoing assessment throughout the hospital stay to take account of changes in patient and carer health and social status;

5. the patient and carer should be consulted and informed at all stages during the discharge process;
6. at all stages throughout the hospital stay, information and education should be provided to the patient and carer, on all aspects of care which will be required after leaving hospital;
7. discharge from hospital should be timely and, where necessary, linked to appropriate and available local health and community-based services; and
8. ongoing communication and coordination between hospitals and community-based services is essential, to ensure safe, effective and efficient discharge of the patient from hospital to the community.

Planning for discharge

Planning for discharge involves complex and often cyclical processes that:

- take account of the patient's needs in the context of his/her community existence;
- identify the key stakeholders in the patient's discharge and involve them in planning for discharge;
- formulate appropriate plans to address patient needs;
- match the entitled persons needs to available community services and supports;
- develop and implement achievable discharge plans;
- evaluate whether the plans have had the desired effect; and if not, revise and re-implement these plans.

A number of models of planning for discharge are reported in the literature, with the collaborative multidisciplinary model seen to be most effective (Hedges et al 1999). This is where a number of different health professionals have input into the discharge planning process, and where the entire team takes responsibility for the processes of planning, organising and evaluating discharge.

Hedges et al (1999) described these processes of discharge planning in terms of the Total Quality Management Cycle (TQM) as proposed by Anderson and Noyce (1992). This cycle, as it is conceptualised with respect to discharge planning by Hedges et al (1999), is illustrated in Figure 1[4].

The term 'stakeholders' in Figure 1 refers to the key people who may provide input into discharge planning. This group should always include the patient and carer, and may also include health professionals in hospitals or day procedure centres, health professionals and service providers in the community, and where indicated, representatives of funding bodies.

To put this in context with respect to best practice discharge planning for entitled persons, it is the responsibility of relevant hospital staff to identify the stakeholders whose input is required to appropriately deal with the discharge needs of any one patient. Where the patient's health needs have changed significantly as a result of a hospital admission, it is also important to ensure proactive organisation of appropriate services.

4 Permission to reproduce this figure in the DVA Discharge Planning Resource Kit was granted in November 2001 from the Editor of the Australian Journal of Advanced Nursing.

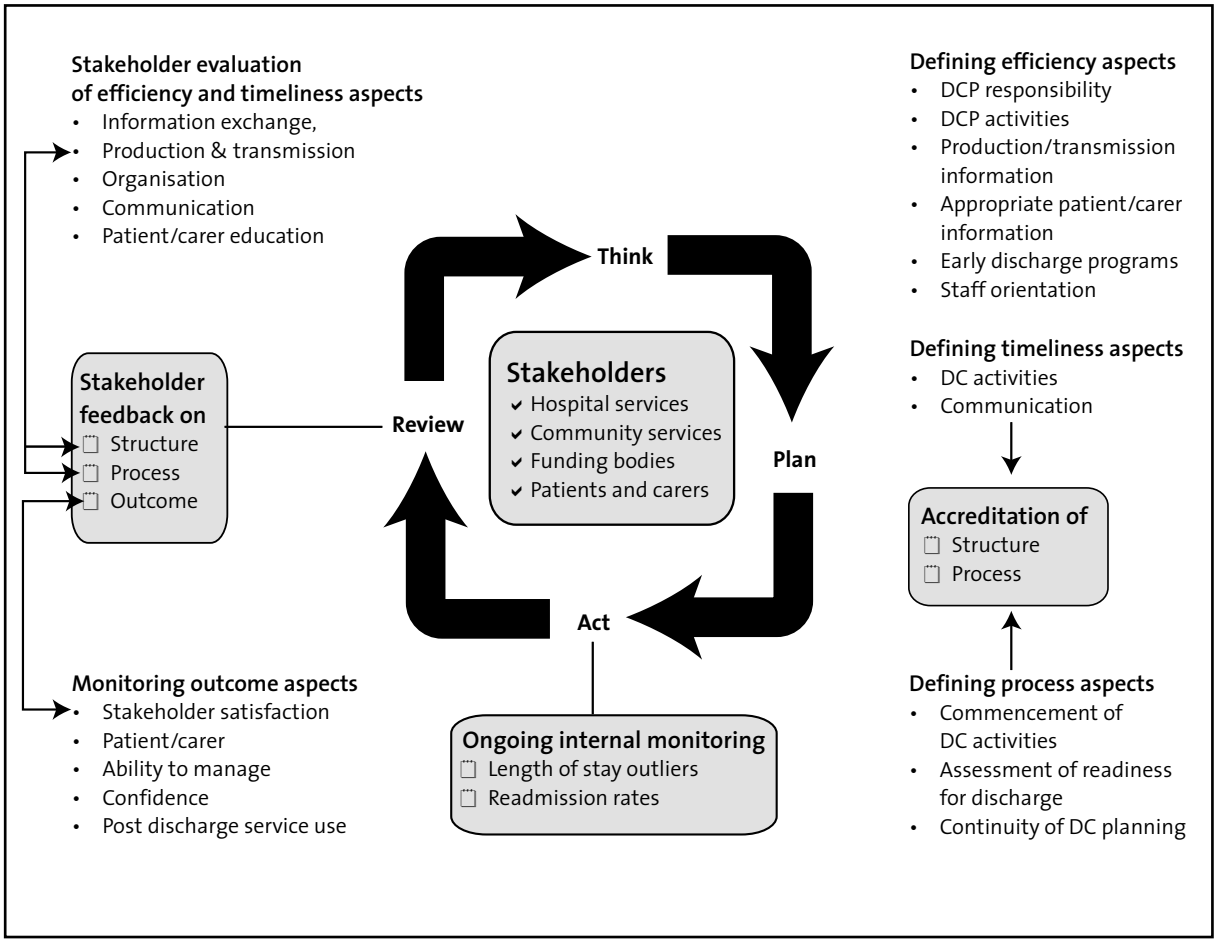

Figure 1. TQM framework for key aspects of performance indicators for discharge planning (reproduced from Hedges at al 1999)

NB. *In this Figure DCP refers to Discharge Planning, and DC refers to Discharge.*

Disclosure of information

To ensure appropriate provision of treatment to patients, it may be necessary to disclose relevant health details to health professionals involved in providing their care. It is important that the entitled person and carer understand that this is happening. Discharge planners are advised to become familiar with the provisions of the *Privacy Act 1988*, including the *Privacy Amendment (Private Sector) Act 2000*. The key provisions of the *Australian Government Privacy Act* are summarised on *page 57*.

DVA health care programs and local health care services

It is essential that DVA health care programs be linked closely with local health care services to ensure that entitled persons and their carers are provided with the most appropriate community services following discharge from a hospital or day procedure centre. Services differ from community to community, and region to region, and service availability within any one area can also change on a week-to-week basis. Thus hospital discharge planners and other health professionals involved in patient discharge need to keep up to date with local service availability to ensure the smooth and efficient organisation of post-discharge supports.

Determining the quality of discharge planning

It is currently far easier to measure the processes of discharge planning than its outcome. That is because good discharge planning and good health status are not necessarily related (Grimmer and Moss 2001, Grimmer et al 2001). Patients may be very unwell following discharge from hospital and yet have received best practice discharge planning. Good discharge planning may not guarantee a quicker recovery, nor significantly improved health status in the short or long term. Furthermore, research has shown that successful transition from hospital to community is only partially dependent on discharge planning and community service provision. Personality, desire for independence, life experience and the support of carers are critical to the entitled person's successful transition from hospital to the community (Anderson and Steinberg 1985, Armitage and Kavanagh 1996a, Grimmer et al 2001). Most research on the quality of discharge planning reports on perceptions of hospital staff. There is very little research from the perspective of consumers (i.e. patients and carers). Only one standardised instrument has been reported in the literature for obtaining feedback on the quality of discharge planning from the community perspective (Grimmer and Moss 2001). This is a set of questionnaires for patient, carer, general medical practitioner and nursing home administrator to be completed within one week of discharge.

A study reporting on experiences of elderly patients regarding independent community living after discharge from hospital: a longitudinal study (Grimmer, Moss and Falco 2004) provides important data on information required by patients in hospital and community organisational supports required.

To assist with quality improvement activities, discharge planners are encouraged to consider obtaining feedback from the consumers of their discharge planning activities, in order to ensure that their discharge planning service is best practice, and that consumers' needs are being met.

Hospital responsibility for discharge planning

It is the treating hospital's responsibility to ensure that the principles of discharge planning are implemented appropriately. In particular, the hospital should ensure the involvement of key stakeholders in planning for discharge.

While there are no specific standards for discharge planning in any of the industry quality standards (ACHS and ISO 9000), the hospital's responsibilities are outlined in some detail in the current ACHS guidelines. Furthermore, responsibilities of private hospitals are specified in the DVA Hospital Services Agreement, the contractual arrangement between the Department and the majority of private hospitals to which entitled persons are admitted. Hospital discharge planners should be aware of these responsibilities and ensure that they consider them in context of DVA entitled person discharge from hospital or day procedure centre.

The DVA Discharge Planning Resource Kit provides a number of examples for discharge planners and other hospital staff regarding best practice principles in implementing and evaluating discharge planning quality:

- Discharge Planning Checklist *(page vi)*;
- suggested performance indicators *(page 58–60)*; and
- medical and nursing discharge summaries *(pages 61–62)*.

Discharge planners and hospital staff are also encouraged to first identify the community consumers of discharge planning, and then seek from them feedback regarding the quality of their discharge planning activities. This exercise will ensure that patients' needs and expectations are being recognised and addressed. Such feedback could be sought by a survey (using a standard instrument, or taking a purpose-built approach such as interviews with consumers).

4.2 Veterans, other Entitled Persons and Carers

The carer

When planning an entitled person's discharge from hospital, it is essential that discharge planners and hospital staff consider the role of the carer. A carer is someone who gives up time to look after another person unable to care completely for himself or herself. A carer may be a wife, husband, son, daughter, other relative or friend. Carers generally have other calls on their time (such as work or family). Much of the success of discharge planning is reliant on their ability and willingness to provide the required level and type of support to the entitled person in both the short and long term.

Before hospital or day procedure centre admission, or where this is not possible, early in the hospital admission, it is important for hospital staff to establish whether the entitled person has a carer. It is then important to establish what roles the carer is prepared to undertake in the entitled person's recovery. For many entitled persons who have never before been ill, their family or friends may never have envisaged themselves in a caring role. Taking on this role may require a dramatic increase in the amount of personal time needed to be spent by the carer with the entitled person, and the assumption of very personal tasks for the entitled person such as hygiene and dressing. It is thus important for hospital staff to clearly outline to carers the roles and tasks that they may be required to undertake for entitled persons on their return home. It is also essential that hospital staff understand that not all designated 'carers' will have the time, skills, physical capacity or confidence to take on all of the caring roles that are required. Appropriate supports for the carer need to be considered, for instance community nursing services for the entitled person, and respite care for the entitled person to give the carer 'time out'. *(see page 26 VHC respite care)*

If a carer agrees to undertake these roles and tasks, it is then important that he/she is consulted during the discharge planning process to ensure that the requisite skills have been learned and that the carer's needs have been considered. There can be an immense and unrecognised burden on carers. Many carers, particularly elderly spouses, have their own health worries and often find the additional workload of caring for an ill partner overwhelming (Brown and Mulley 1997, Fakhoury and McCarthy 1998, Grimmer and Moss 2001). Regular in-home respite, and/or a planned residential respite episode, may prevent a crisis or burn-out situation from arising.

The veteran or other entitled person as a carer for someone else

It is also often overlooked that many entitled persons already care for someone else in the community, sometimes an ill or disabled spouse, sibling or adult child. This Kit refers to this person as the *entitled person's patient*. There may also be other individuals involved in caring for the entitled person's patient (for instance, a child may provide significant assistance to an entitled person who is the primary carer for an ill spouse, or an entitled person and his/her spouse may be jointly involved in caring for a disabled adult child).

It is essential that hospital staff are aware of such arrangements before admission (where possible), or early in the admission, so that plans can be made to ensure the safety and wellbeing of the entitled person's patient and other carers during the entitled person's hospital stay. This will reduce entitled person anxiety, and will assist in accurately determining the required health and support needs of the entitled person, the entitled person's patient and other carers.

The level of care provided by the entitled person, and others, to the entitled person's patient needs to be clearly understood by hospital staff, particularly when the reason for hospitalising the entitled person may prevent him/her from continuing in this role in the short or long term. Hospital staff should also be aware if another carer will be required to undertake more than the usual level of care for the entitled person's patient whilst the entitled person is recovering, and should consider the impact of this burden on the health status of the other carer. To assist in such circumstances, hospital staff should become familiar with services available through the Veterans' Home Care Program *(see pages 22–28)*, other DVA-funded services *(outlined on pages 9–28) and through the Commonwealth Carer Respite Centre*.

To obtain a composite picture of the entitled person in his or her environment, it is essential that discharge planners and other hospital staff involve the entitled's Local Medical Officer (LMO) or GP in planning the admission and discharge. The LMO/GP will undertake entitled person case management before admission, and on discharge to the community, most probably using the MBS Enhanced Primary Care (EPC) items. Such case management is particularly important when the entitled person has complex health needs, if the carer is ill, or when the entitled person has his or her own patient. Discharge planners should be familiar with the EPC MBS items and their purpose *(outlined on page 7)*.

Empowering the entitled person and carer to actively participate in discharge planning

Entitled persons and carers need to be considered by hospital staff within the context of their usual environment when discharge arrangements are being made. Poorly integrated community services can result when different agencies are involved in providing services to entitled persons without considering the entitled person and carer in context (Hall and Dornan 1988). Where hospital staff have concerns about appropriate services for the entitled person and/or carer, it is important to contact the entitled person's LMO/GP and/or the DVA National or State Offices.

It is also essential that hospital staff and discharge planners recognise that entitled persons and carers have specific knowledge about their physical, mental and social needs and their ability to manage in the community. This knowledge is an essential resource for hospital staff when planning for discharge, and should *never* be overlooked or discounted (Lusky 1986).

The importance of entitled persons and carer involvement in planning for discharge is highlighted in the factsheet on this website entitled *Tips to assist with hospital admission and discharge – Checklist for veterans, carers and other eligible persons*. Discharge planners and hospital staff are encouraged to provide this factsheet to every entitled person and their carer before, or on, admission to hospital or day procedure centre. They should also talk through the issues raised in the factsheet with entitled persons and their carers so that their concerns can be addressed before discharge.

A critical element of successful planning for discharge is empowerment of the entitled person and carer to organise aspects of their return to community living (Kennedy et al 1987). This can be achieved by:

- improving their knowledge of their health problems;
- ensuring that they recognise the importance of self-management (eg medications, diet, exercise, etc);
- ensuring that they understand the importance of planned respite care in maintaining carer health and wellbeing, rather than as a response to a crisis of carer exhaustion and burn-out; and
- providing them with the knowledge to self-organise community services and equipment as required.

Constraints on community services in many localities often mean that, after discharge, entitled persons and carers have to assume numerous aspects of day-to-day management without trained assistance. Provided they are empowered to make appropriate decisions, entitled persons and carers have been shown to successfully manage the transition from one health state to another with dignity, independence and confidence (Hall and Dornan 1988, Naylor et al 1984).

4.3 Practicalities of planning for discharge

Checklist

A Discharge Planning Checklist is provided (*pages vi-xi*) to assist in streamlining discharge planning activities.

A) When should you start planning for discharge?

Before admission

Where possible, planning for discharge should commence before the entitled person's admission to hospital. This is particularly important where the admission to hospital or day procedure centre is elective, and/or when it is known that the entitled person is a carer for an ill or disabled person (the entitled person's patient).

Early identification of the patient as an entitled person will assist discharge planners plan for appropriate service provision.

Where possible, written information on the impending hospital stay should be provided, so that the entitled person and carer can consider aspects of planning for discharge in their own time. The entitled person, the carer and, if appropriate, the entitled person's patient, should be included in discussions on discharge planning, and any information given to the entitled person should also be sent to the LMO/GP (for instance, information about medications or community services that are being arranged). The LMO/GP can thus act as an additional resource for the veteran, the carer and/or entitled person's patient.

Issues that can be considered before admission include:

- the nature of the admission;
- what will occur during hospitalisation;
- the expected date and time of discharge;
- transport home following discharge from the hospital;
- the entitled person's likely health status on discharge;
- expected changes in the short and long term to the entitled person's ability to undertake usual aspects of daily living, such as mobility, sleep behaviours, bathing and dressing, obtaining food and organising meals, eating, undertaking usual household chores, and ability to drive or use usual transport;
- the discharge destination and whether it requires modification to accommodate health status changes;
- the role of the carer, including new tasks that need to be undertaken to deal with change in the entitled person's health status;
- current and new medications and entitled person and carer confidence in managing them, including why new medications were prescribed, how they should be taken and possible side effects and contra-indications;
- the entitled person's expected recovery path; and
- environmental safety in and around the home to reduce the risk of falls and accidents.

On, or as soon as possible following, admission

Where planning for discharge before admission is not possible because of the nature of the admission, planning for discharge should commence as soon as possible after admission. The same issues as outlined in the previous section should be considered, with *greater urgency* than when discharge planning has commenced before admission.

Early commencement of discharge planning is particularly important when the admission has been unplanned (i.e., an emergency). In this case, the entitled person's and carer's physical and emotional ability to be involved in planning for discharge may be reduced, and it may take several days to provide answers to questions which ideally should have been asked before admission. Where the entitled person also has a patient, emergency accommodation and/or home care may need to be organised for this person whilst the entitled person is in hospital, and in the immediate post-discharge period.

Where the entitled person is too ill to be included in discussions on discharge plans, the carer should be involved, as the entitled person's primary representative. Should the carer also be too ill, frail or distressed to undertake this role, other family members or friends should be consulted.

The sooner in the hospital admission process that discharge planning is commenced, the more time is available to make the required decisions and arrangements, and to ensure that when the entitled person is discharged, transition from hospital or day procedure centre to the community will be smooth, efficient, effective and sustainable.

Identifying entitled persons who may present difficulties when planning for discharge

The literature suggests the need to 'flag' individuals who may prove difficult to discharge safely, efficiently and/or effectively. Early identification of such individuals will reduce last minute problems in organising and implementing appropriate discharge plans. The involvement of different health professionals in assessing entitled persons' and carers' discharge needs should assist in early identification of problems. This is a distinct advantage of the multidisciplinary team model of discharge planning, compared with a single health professional who undertakes a multitude of tasks.

The basic 3 categories for risk assessment of geriatrics used at RGH Concord are:

- living circumstances
- what they are usually like (functional state); and
- what can be expected of them when they leave.

The philosophy at Concord is that discharge is risk-taking. "If too many fail the approach is too cavalier. If none fail, the approach is too cautious".

Recognised flags for potentially problematic discharge from hospital and day procedure centres include:

- living alone;
- being frail and/or aged;
- having multiple and/or poorly managed health problems;

- having multiple health problems and not having prior community health and support services in place;
- not having a regular LMO/GP;
- when health care is shared by a number of medical practitioners;
- the presence of an ill, frail or incapable carer;
- when the entitled person cares for someone else;
- when entitled persons are unwilling to participate in making discharge plans;
- being unrealistic about ability to manage in the community post-discharge;
- family conflict about the entitled person's ongoing independent community living arrangements;
- when the entitled person is taking multiple medications;
- when there are potential problems with compliance (including impaired cognition or dexterity difficulties),
- chronic pain and tiredness; and
- reduced mobility and grief regarding loss of ability.

The Discharge Planning Checklist (*pages vi–xi*) provides examples of ways in which hospital staff can 'flag' entitled persons who may be potentially problematic to discharge in a timely, effective and sustainable manner. Where such entitled persons are identified early in the hospital stay, timely and appropriate plans can be made to smooth the transition from hospital to community, and to ensure sustainability of entitled person independence in the community following discharge.

B) During the hospital stay

Discussions on expectations of recovery

Before, or as soon as possible after admission, entitled persons and carers should be informed about what to expect during the recovery period, including what will happen in hospital, how long recovery may take following discharge, and how to assist recovery after returning home.

Where necessary, information on the expected recovery path should be given in writing so that the entitled person and carer can refer to it during and after hospitalisation.

Sometimes the actual recovery path differs from that which is expected by the entitled person, carer and family. It is important to provide entitled persons and carers with a realistic recovery path, which clearly spells out expected short-term and ongoing changes to health and lifestyle. Consequently, it is also important to involve the entitled person and carer in discharge planning discussions to ensure appropriate decisions before and following discharge.

Discharge planners should meet with the entitled person and carer throughout the hospital stay to ensure that their needs and concerns have been recognised and addressed. These discussions ensure that both patient and carer have a good understanding of the expected recovery path and their roles and responsibilities in optimising recovery.

Confirming time and date of discharge

It is important to discuss the anticipated date and time of discharge with the entitled person and carer before admission (if possible), and to confirm this with them as soon as possible after admission. Entitled persons often expect to be in hospital longer than they actually are, and may delay making plans for discharge on this basis. Knowing the anticipated discharge date can help to avoid entitled person and carer anxiety, and can prompt entitled persons and carers to become involved in making proactive plans for discharge.

Early identification of the anticipated time and date of discharge from hospital can direct appropriate exchange of information between hospital or day procedure centre and health care professionals in the community. It can also assist in the coordination of appropriate and timely provision of community services.

Discussing self-help strategies

Focusing on self-help strategies, rather than passive receipt of health services, has been shown to be the most effective way of not only involving patients and carers in recovery, but also optimising future health status (Lorig 1991, 1996, Lorig et al 1999). Information about self-help strategies can be provided to entitled persons and carers from the beginning of the hospital stay. This may take the form of brochures informing them about local support groups, or ways in which they can help themselves after discharge from hospital or day procedure centre.

Consideration should be given by hospital staff to designing simple home programs, such as a gentle daily exercise routine, which can be completed by the entitled person as an adjunct to formal rehabilitation programs (such as physiotherapy). The hospital physiotherapist, occupational therapist, health promotion unit or divisional therapist should be able to assist with designing such a program.

Many recently ill people feel better mentally and physically after gentle exercise, and they should be encouraged in hospital to commence their own exercise program as soon as it is safe to do so. Self-help programs could include meditation and relaxation, walking, arm, trunk and leg exercises, deep breathing, self-paced Tai Chi movements or simple line dance steps to music, holding a stable piece of furniture for support.

Where possible, entitled persons and carers should also be reminded that active participation in activities of daily living such as bathing, dressing, gardening, cleaning and cooking can contribute to a useful self-help exercise program, particularly where functional retraining is a necessary element of their rehabilitation program. It has been observed that recently ill people often gain as much functional recovery and confidence from actively assisting with their own activities of daily living (such as bathing and dressing), as they gain from passive receipt of rehabilitation programs delivered by health professionals (Lorig 1996).

Information on support groups

Where the hospital admission has resulted in long-term changes to entitled person health, and/or new or increased responsibilities for the carer, the entitled person and carer should be given information whilst still in hospital about local support groups. Support groups can provide a wealth of information and guidance about

managing a health problem, and can also provide access to others who have had similar experiences. While entitled persons and carers may not be emotionally ready for support group involvement in the early days post-discharge, knowledge about the availability of such groups will empower them to assume self-management when the time is right.

Information on community services

Good discharge planning practices provide entitled persons and carers with written information on local community services, before leaving hospital. While the need for these services may not become apparent to the entitled persons until some time post-discharge, knowledge of their availability will assist in self-determination and self-management. These could include DVA-funded health care or support services. Information is provided in this Kit on a range of service options to assist entitled persons in the community following discharge *(see pages 9–28)*.

Consideration and organisation of how the entitled person will manage after leaving hospital

The key to good discharge planning is to sensibly use the hospital stay to address how the entitled person and carer will manage safely in the community, following discharge. Consequently, discharge planning needs to commence early in the hospital stay. Safety criteria include:

- being ambulant or with stand-by assistance (i.e. not a heavy transfer);
- for those predisposed to falling, minimising the risk of injury;
- returning to a safe home environment;
- having a competent and informed carer; and
- accessing and using appropriate aids and equipment.

Where concerns are held by the entitled person, carer or hospital staff about any of these issues, appropriate health professional(s) should be involved in discharge planning to address specific problems. The section commencing on *page 10* outlines the range of DVA-funded services that will assist entitled persons in safely returning to the community.

When assessing how an entitled person will cope after hospitalisation, family members are sometimes of the view that the patient should go into residential care as they would find it difficult to manage them at home. Often, even if this is agreed by the health care team, appropriate care is not available. It is important that when an appropriate option comes up the person either takes it or is not funded by DVA for further stay in hospital. For example:

- They must accept first offer of a residential bed even if it is not their preference, and wait there for their preference.
- If they are offered a community care package which meets their needs they must take it.

Sometimes convalescent care can be arranged, and sometimes respite care in-home, or in a residential care facility after the patient has been home for a short while. Arranging care for the patient is often a compromise. Patients with complex needs can be managed in the community as long as adequate assessment

and referral is undertaken, so that services are provided that do not cause difficulties for the carer in having the patient at home.

The entitled person's and carer's involvement in the development of discharge plans is essential to assist them to recognise and address issues that may impact on the entitled person's ability to return home independently. Common issues raised with entitled persons and their carers by discharge planners include:

- the expected date of discharge;
- medication management at home;
- the entitled person's prognosis;
- the role of the carer in the short and long term;
- the likely effects, on entitled person and carer, of changes in the short and long term to their physical and emotional health, and social status;
- equipment and other physical supports in the home and community that are required to assist with changed physical health status;
- medical and nursing supports that are required to assist with changed physical and emotional health status;
- community support that is required to assist with changed social and emotional health status;
- transport requirements in the short and longer term, and the impact that this will have on entitled person and carer; and
- provision of a safe home environment to reduce the risk of falls and accidents in and around the home.

Home visits, rehabilitation aids and appliances

Rehabilitation aids and appliances, or home modifications, are often required following an entitled person's hospitalisation. These should be arranged as soon as possible after admission, when the entitled person's and carer's needs are defined, so that they can be installed before discharge, and the entitled person educated about how to use them when he/she goes home. The timing is particularly important where home modifications are required. At all times, appropriately trained health professionals should be involved in home assessments, provision of, and instruction on, the correct use of rehabilitation aids and appliances. This usually requires the input of occupational therapists, physiotherapists, social workers and/or orthotists/prosthetists. For information on the provision of aids and appliances, refer particularly to the section in this Kit on the Rehabilitation Appliances Program (RAP) *(see page 20)*.

Health care services in rural or remote areas

If entitled persons are from country areas, there may be restrictions on the type and availability of local health and support services. Any restrictions should be brought to the notice of the discharging doctor and discussed before discharge with the LMO/GP. Some major city hospitals have a Rural Liaison Nurse who can assist with questions on country service availability.

Medication matters

Medication issues related to discharge planning are outlined in the section commencing on page 52. Hospital and day procedure staff should remember that many entitled persons and carers take time to become familiar with new medications, and thus information on medications should be provided early in the admission to increase confidence in self-management. *It is essential that timely and accurate communication on medication matters occurs between hospital staff and the entitled person's LMO/GP.*

Remember

Discharge planners should remember that many entitled persons use other medications in conjunction with prescription medications, for instance medications purchased over-the-counter (without prescription) and homeopathic remedies. Thus, entitled persons and carers should be actively prompted to discuss their current and future medication management, as well as any concerns they may have about self-management. They should also discuss their medications with their LMO/GP and local community pharmacist following discharge.

C) In the days before discharge

Confirming arrangements

Towards the end of the hospital stay, all discharge plans should have been put in place. Services should be organised and implemented as appropriate, to ensure no delays on the day of discharge, or in service provision following discharge from hospital.

Research has shown that delays in leaving the hospital on the day of discharge have a detrimental effect on patient and carer confidence regarding successfully managing in the community (Hedges et al 1999, Grimmer et al 2001).
The following issues should be considered.

- The person responsible for discharging the entitled person should be aware of discharge date and time to ensure no last minute delays to hospital discharge procedures.
- Just before discharge, the entitled person's LMO/GP should be contacted by hospital staff regarding issues such as changes in health status, medication management, and timing of and reason for follow-up appointments.
  This communication is usually in the form of a written discharge summary. Examples of discharge summaries are provided (see *pages 61–62*). Staff should be aware of the National Privacy Principles Obligations for Health Service Providers regarding confidentiality of health information (summarised on *page 57*) and available in full on **www.privacy.gov.au**.
- Arrangements should be completed for community health and support services. If an assessment is needed for Veteran's Home Care services, this should be organised as soon as possible after admission to ensure services are in place when the entitled person is discharged. Ideally, the entitled person will have a copy of their VHC Plan outlining details of the service/s they will receive. If the entitled person requires immediate support services following discharge, the

services provider should be aware of, and responsive to, the time of discharge, and contact the entitled person to arrange a time for the first visit post discharge.

- Entitled person and carer safety should be considered, from a range of aspects such as medication management, ambulation, hygiene, food preparation, eating, occupational health and safety issues, as well as domestic environmental safety and falls prevention.
- If the entitled person is not independently ambulating, special consideration should be given to suitability of transport home, and the level of assistance required from other people to assist the entitled person to enter and manoeuvre around the home. Transport home should have been arranged, taking into account who will provide the transport, the distance that needs to be travelled and the availability of suitable transport for the patient's condition and health status.
- Equipment should be in place in the home, or supplied to the entitled person in hospital, before the day of discharge. The patient and carer should feel confident about using the equipment.
- Best practice discharge planning principles suggest that all test results should be known and there should be no last-minute changes to discharge plans based on test results.
- Supplies of all new medications should have been organised and sufficient education sessions held with the patient and carer to ensure that they are confident in medication matters.
- Follow-up appointments should have been arranged, and the timing of follow-up appointments with multiple health providers considered in the light of patient and carer health status and distance needed to be travelled for the appointments.

Follow-up appointments

The dates of initial follow-up health reviews and community service appointments should be organised before the day of discharge. The patient and carer should have written information about the time and date of appointments, the name and contact details of the consulting health professional, and the purpose of the appointments. Relevant clinical information should also be provided to any health professionals with whom appointments have been made, in time for the appointment.

Where possible, hospital staff should consider the nature of the follow-up appointment that will incur least physical and emotional stress to the entitled person and carer, for instance, a telephone call or home visit, or organising an appointment with a visiting specialist to a country area, rather than a face-to-face appointment at the hospital or specialist's rooms, where the patient needs to travel long distances.

Where it is considered essential that the patient travels to the follow-up appointment, information about eligibility for travel assistance should be provided to the patient and carer in hospital.

Information is provided on eligibility for DVA-funded transport on *page 21*.

D) On the day of discharge

The discharge summary

On the day of discharge, a discharge summary of the admission to hospital, the outcome of relevant test results, current medication management and reasons for any changes, discharge plans and organisation of community supports should be forwarded to the LMO/GP by fax or email, following discussion with and agreement by the patient/carer. On evenings or weekends an attempt should be made to ring the LMO/GP with the information. If the summary is not ready at discharge a phone call to the LMO/GP can provide essential details. Medication information provided to the LMO/GP and the local pharmacist could also take the form of a medication profile.

Ongoing medical care is provided post-discharge for patients by their LMO/GP, and it is important that this person is made aware of all relevant information regarding the recent hospitalisation. This guarantees continuity of care and appropriate supervision in the immediate discharge period. A contact name and number for the designated hospital staff member responsible for the patient discharge should be provided on the discharge summary for ease of communication.

In cases where the LMO/GP is required to undertake/organise specific tests post-discharge, it is advisable for hospital medical staff to also phone the LMO prior to the patient leaving the hospital to ensure continuity of care.

It is recommended that the method of communication of the discharge summary to the LMO/GP recognise the National Privacy Principles Obligations for Health Service Providers, as summarised on *page 57*. Personal information should ideally be transmitted by post and not fax or email. However, where post is not practical, fax is the preferred transmission provided the recipient is advised in advance that a message containing personal information is being sent. Receipt of the information should be confirmed. In some instances it may be appropriate for the patient to take the discharge summary to the LMO/GP on the first consultation after discharge, although this has the potential for information to be lost or forgotten.

Farewell to the Entitled Person and carer

Good discharge planning practices suggest that on the day of discharge, very little new information should be imparted to the entitled person or carer, and very few community services should remain to be organised.

The entitled person and carer should be ready to leave the hospital at the agreed time. They should be sufficiently prepared to enable them to return to the community with confidence. Their health and social needs have been recognised and services have been put into place as required to assist them in independent living in the community. They should also have the knowledge to organise services for themselves, should they be required after discharge. The patient/carer should be given a copy of the discharge summary to take home.

E) The period immediately following discharge

The first 24–48 hour period after discharge has been identified in research as the critical time in testing patients' and carers' coping ability (Grimmer et al 2001). Problems that arise during this time can have a major impact on patient and carer confidence with respect to managing independently in the community.

Discharge planners and other health professionals need to consider the issues that may worry patients and carers immediately after discharge, and take steps to ensure that this period of transition runs as smoothly as possible. Issues that commonly cause concern include the need for adequate short-term medication supplies, confidence in administering medications, managing the entitled person's patient (if appropriate), adequate food supplies, organising and eating meals, negotiating the home environment safely, sleeping and sitting arrangements, care of pets, changing dressings or undertaking other wound care, and regular dressing and bathing.

Ideas for hospital staff to assist entitled persons and carers in the immediate post-discharge period

The following section outlines ideas for discharge planners and other hospital staff that may assist entitled persons and carers in the immediate post-discharge period.

1. Make regular follow up telephone calls to the patient and carer to discuss their progress and problems.
2. Suggest that a family member or friend stays with the patient for the immediate post-discharge period.
3. Encourage patients and carers to contact their LMO/GP as soon as possible after discharge. Ensure that patients know the name and telephone number of the LMO/GP and have access to a working telephone.
4. Provide the patient's LMO/GP with appropriate information about the patient's current health status and medication requirements on the day of discharge to encourage continuity of care.
5. Ensure that patient's and carers know the emergency contact numbers for ambulance and hospital, and when to use them.

4.4 Medication matters

Medication supplies

On discharge from hospital, all patients should be provided with sufficient supplies of their medication to ensure continuity of treatment until they can visit their LMO, GP or local pharmacist. This is particularly important when patients are discharged before public holidays (when GP's surgeries and community pharmacies may be closed) or are returning to rural areas where there may be variable access to the LMO/GP or pharmacist. Hospital staff should also ensure that the rural community pharmacist has the required medications in stock for follow-up prescriptions. If the patient is being transferred to another hospital, discharge planners should ensure adequate documentation accompanies the patient so that the receiving hospital can provide continuity of medication management.

Where patients and/or carers find it difficult to access the local pharmacy (for instance because of infirmity, restrictions on mobility, or distance), arrangements may need to be made with the local pharmacist, before the patient's discharge from hospital, for the physical supply of ongoing medication. Many pharmacists offer a home delivery service for elderly patients, and will make a home visit where required to discuss medication matters.

Review of medications

If required, entitled persons are entitled to have a medication management review completed following a referral from the LMO/GP. A medication management review may be performed under the DVA-funded model for entitled persons, or alternatively, under the Domiciliary Medication Management Review model which is funded by the Department of Health and Ageing. The discharge planner may make a recommendation to the entitled person's LMO/GP based on a similar identification process as that used to flag entitled persons who may present difficulties when planning for discharge (see *page 43*). This process is recommended for entitled persons who may:

- exhibit or be at risk of non-compliance with instructions;
- lack home support;
- have complex medical conditions; and/or
- have multiple and complex medications.

Pharmaceutical benefits through the Repatriation Pharmaceutical Benefits Scheme

Pharmaceutical benefits are provided to entitled patients through the Repatriation Pharmaceutical Benefits Scheme (RPBS). The Scheme provides a wide range of benefits beyond those available to the general aged pensioner population through the Pharmaceutical Benefits scheme (PBS). A patient contribution exists at the concessional rate. Safety Net provisions remove the patient contribution after 52 prescriptions have been dispensed in one calendar year. From 1 January 2006, the Safety Net threshold will increase by 2 prescriptions per annum up to 60 in 2009.

Treatment Card holders are eligible under the RPBS for pharmaceuticals and other products for the treatment of:

- all conditions in the case of Gold or Orange Card holders; and
- accepted conditions in the case of White Card holders.

Some entitled persons may hold both White and Orange Repatriation Benefit Cards. In this instance the White Card should be used to access pharmaceuticals for accepted conditions *(see page 33)*.

On discharge from hospital, entitled persons should be provided with sufficient medication to ensure continuity of treatment. Medicines provided in private hospitals are supplied under PBS/RPBS arrangements and quantities for either a course or a month.

Further supplies of post-discharge medications should be obtained from a community pharmacy on presentation of the appropriate prescription. Medications require prior approval before they can be prescribed if:

- they are listed as 'authority required' in the Schedule of Pharmaceutical Benefits;
- increased quantities and/or repeats outside Schedule guidelines are required: and/or
- they are not listed in the Schedule.

Prior approval, including *immediate* verbal approval, can be sought by contacting DVA on the toll free number **1800 552 580** (24 hours).

Please note that this contact number is ONLY for the use of doctors and pharmacists.

The address for written prescriptions needing authority or prior approval is:
Reply Paid 372, VAPAC
GPO Box 9998, Brisbane 4001

Medication is often changed as a result of a hospital admission. This can lead to confusion by the entitled person and carer. Misadventures with medication underlie a significant number of hospital admissions for the elderly (Gilbert et al 1993, Roughead et al 1998). It is the responsibility of hospital staff to recognise the potential for this occurring, and to ensure that the period of hospitalisation is used to review *all* medications (prescription and non-prescription) taken by the patient.

The patient, the LMO/GP and community pharmacist should be provided with information by hospital staff about any changes to the medication regimen which have resulted from the hospital admission. This could be in the form of a MediList and/or discharge summary *(see pages 61–62)*.

Extension of the Repatriation Pharmaceutical Benefits Scheme (RPBS)

From January 2002, as an extension of the Repatriation Pharmaceutical Benefits Scheme (RPBS), a new Repatriation Pharmaceutical Benefits Card (BCAL Card) will give eligible British, Commonwealth and allied veterans access to an extended range of prescription medicines and pharmaceutical items. This card is outlined on *page 33*, and is provided to eligible British, Commonwealth and allied veterans.

White Card holders should continue to use this card to obtain treatment and medicines in relation to their accepted disabilities. The BCAL Card can be used to obtain medicines for any other conditions. It does *not* entitle veterans or other entitled persons to any medical or other health care treatment. For further queries please contact the DVA State Office.

Involvement of Local Medical Officer (LMO)

The involvement of the Local Medical Officer (LMO) or GP is crucial in maintaining entitled persons continuity of care.

The LMO/GP is a key resource for the entitled person in the community. The role of the LMO/GP in patient care is outlined on *page 7*. One of the key responsibilities of the LMO/GP is to provide hospital staff with information about the patient's usual medication management before the admission to hospital. Thus, when admitting entitled persons to hospital, and before discharge, hospital staff should contact the patient's usual LMO/GP in a timely and responsive manner. Discharge from hospital should result in appropriate correspondence with the LMO/GP (via discharge summary, MediList or medication profile) outlining, among other things, changes to medication management that have resulted from the hospital stay.

Remember

Hospital staff should ensure that the LMO/GP has this information in time, and in such a format, as to enable the LMO /GP to respond to patient health needs immediately post-discharge.

Patients should also be instructed to take all their current medications (old and new) to their LMO/GP as soon as possible after being discharged. This assists patients to clarify what medications they should be taking, how they should be taking them and why, and establishes a strong link between community and hospital care for the entitled person. It is important to consider that many elderly people can get confused about medication use, especially when changing medications, and thus the involvement of the LMO/GP is vital to avoid confusion, anxiety and potential medication misadventures.

Remember

Hospital staff should remember that some entitled persons consult more than one general medical practitioner (LMO/GP) in the community (usually for different health problems). Hospital or day procedure centre staff should ask the patient to identify the general medical practitioner with whom they should communicate regarding the health problem for which the patient was admitted.

Involvement of a pharmacist

The involvement of pharmacists is essential to best practice discharge planning as they provide professional counselling to entitled persons and their carers regarding safe and effective usage of medications after discharge from hospital. The care by the pharmacist often starts at the hospital and extends into the community in the form of the local (community) pharmacist.

It is important that entitled persons and their carers are aware of the role of the pharmacist in ensuring that they are well informed regarding their medication use. If in doubt regarding everyday usage of medications, entitled persons and their carers should feel confident in approaching a pharmacist for advice.

The local community pharmacist has a key role in assisting patients and carers to understand their medications and how to use them appropriately once they are discharged from hospital. Thus it is important for hospital staff to inform the patient's regular pharmacist about any changes that have been made to medications, most usually in the form of a medication profile or a MediList. Entitled persons should be advised to visit their local pharmacist as soon as possible after discharge with this information.

The key to best practice medication management is communication between all parties. Discharge planners should ensure that appropriate information is exchanged between hospital medical and pharmacy staff, nursing staff, LMO, patient and carer, with the aim of maximising patient and carer confidence, and minimising the potential for medication misadventure.

Instructions provided to entitled persons and carers on medications

Hospital staff should provide clear, unambiguous verbal and written information to patients and their carers regarding the purpose, dosage, frequency and duration of new medication.

As many patients are already taking medication before they enter hospital, hospital staff should also discuss possible adverse effects and interactions of all medication that patients are using *(including old and new prescription medications, and non-prescription medications including homeopathic remedies)*. Patients and their carers should understand the consequences of non-compliance with their medications and should know who to ask for help, if they have concerns.

Patients usually have supplies of medications at home and it is essential that they understand whether they should continue using previous medications. Hospital staff should give clear instructions if a different brand of the patient's regular medication has been provided.

If a patient has discontinued the use of a particular medication, it is important to consider the safe disposal of the remaining supply to minimise medication misadventure (such as returning discontinued medications to the local pharmacy for safe disposal).

One of the most common failings in discharge planning is assuming that patients and their carers understand all about their medication management after one information session. Hospital staff should verify that they do understand by asking for demonstrations, such as requesting patients and carers to demonstrate how they would organise the day's medication.

Issues to consider are whether patients or carers may need assistance with medication organisation, such as using a Dose Administration Aid (DAA). It is important when discussing medications with entitled persons and carers to clarify whose responsibility it is at home to look after the medication management (eg: the patient, carer, family members, community nurse etc). This allows entitled persons and their carers to consider issues of medication self-management whilst in hospital, and to obtain appropriate assistance and advice before discharge.

It is useful to recommend to entitled persons and their carers that they establish contact with their LMO/GP and/or local pharmacy on a *regular basis* for review and advice.

4.5 The entitled person's home – environmental safety

Environmental safety

Providing a safe domestic environment for the discharged patient and his/her carer is critical to preventing falls and accidents and associated injury and disability from occurring once the entitled person returns home. Research has shown that half of the injury-related hospitalisations in the 65+ age group are the result of falls and tumbles, with 48% of these occurring in the home, and most commonly resulting in fractured lower limbs. The higher the age group the greater the risk of injury and death from falls, with an 85+ year old being 40 times more likely to die as a result of a fall than a 65–69 year old (Cripps and Carmen 2001).

Some conditions, such as frailty and dementia, increase the risk of falling. Where the risk of falls is high, appliances such as hip protectors, which reduce the risk and severity of injury, need to be considered in addition to environmental safeguards. DVA provides several programs of assistance for modifying the domestic environment to increase functionality and reduce the risk of falls.

1. Entitled persons meeting the eligibility requirements, and with a clinical need, can access the Rehabilitation Aids and Appliances Program for modifications and appliances *(see page 20)*.
2. All Gold and White Card holders can utilise HomeFront, which provides a free assessment of the home and its surroundings to identify potential falls hazards. DVA makes a contribution of up to $163 towards the cost of recommended items and modifications. Full details are outlined in the HomeFront section *(page 18)*.
3. A Home Support Loan may be an option for those entitled persons who require home modifications to facilitate their change of health status and 'fall proof' their home but who do not meet the eligibility requirements of RAP *(see page 20)*. More details can be obtained by telephoning **1800 722 000**.

APPENDIX 1

Summary of National Privacy Principles (NPP) Obligations for Health Service Providers*

Collecting Information

- Only collect health information necessary for your functions or activities.
- Use fair and lawful ways to collect health information.
- Collect health information directly from an individual if it is reasonable and practicable to do so.
- At the time you collect health information or as soon as practicable afterwards, take reasonable steps to make an individual aware of:
  - why you are collecting information about them;
  - who else you might give it to; and
  - other specified matters.
- Take reasonable steps to ensure the individual is aware of the above points even if you collect information about them from someone else.
- Get consent to collect health information, unless an exemption applies.
- If it is lawful and practicable to do so, give people the option of interacting with you anonymously.

Storage and Maintenance

- Take reasonable steps to ensure the health information you collect, use or disclose is accurate, complete and up-to-date.
- Take reasonable steps to protect the health information you hold from misuse and loss and from unauthorised access, modification or disclosure.
- Take reasonable steps to destroy or permanently de-identify health information if it is no longer needed for any further purposes.

Use and Disclosure of Information

- Only use or disclose health information for the primary purpose of collection unless one of the exceptions in NPP 2.1 applies (for example, if it is for a directly related secondary purpose within the individual's reasonable expectations, if you have consent, or where there are specified law enforcement or public health and public safety circumstances).
- Only adopt, use or disclose an Australian government identifier if particular circumstances apply that allow you to do so.
- Only transfer health information overseas if you have checked that you meet the requirements of NPP 9.

Access (by the individual) to information

- If an individual asks, give them access to the health information you hold about them unless particular circumstances apply that allow you to deny access – these include where there is a serious threat to life or health.

Openness

- Have a short document that sets out your policies on how you manage health information. Make it available to anyone who asks for it.

* *This is a summary only and NOT a full statement of obligations. These are set out in the NPPs themselves. For details, please refer to* ***www.privacy.gov.au***

APPENDIX 2

Performance Indicators for Discharge Planning

a) Each ward or clinical unit should develop formal policies and procedures of discharge planning that recognise stakeholders' needs.

Elements

Evidence should be provided of formal lines of communication between ward staff:

- and patient and family
- and community

Evidence should be provided of the methods employed to educate:

- patient and family
- ward staff
- community health staff

Evidence should be provided of consideration of minimum staffing levels required for safe and efficient discharge

Medications:

- evidence should be provided of educational strategies for patients and family
- evidence should be provided that discharge medications are provided within 2 hours of the decision to discharge the patient
- evidence should be provided of medication information sent to community health services

Evidence should be provided of the appropriate use of standard and reliable documentation:

- in hospital
- within the ward
- between wards
- between ward and community services

Evidence should be provided that regular delays in discharge are:

- recognised, and strategies have been developed to address them

Evidence should be provided that the estimated time and day of discharge are:

- specified at admission, subject to review a couple of days later, and then the revised date achieved, and that any changes to the date are notified to community referral agencies within 24 hours of the changes being agreed.

b) Personnel responsible for planning and facilitating discharge are identified for each ward/functional unit.

Elements

Evidence should be provided of formal designation of roles and responsibilities

Evidence should be provided of functional and efficient lines of communication:

- within ward
- within hospital
- between hospital and community

c) The time spent on formal discharge planning activities should be measured in a standard way, and recorded efficiently and appropriately.

Elements

Evidence should be provided that there is standard documentation of standard tasks

Evidence should be provided of prompt commencement of discharge planning following admission

Evidence should be provided of adequate time to plan discharge

d) Ward-specific mechanisms should be developed to regularly seek relevant information post-separation.

Elements

Evidence of measurement of satisfaction with acute hospital discharge planning by relevant community stakeholders (patient, carer, general practitioner and nursing home administrator)

Evidence of prompt access to required community services

Evidence of prompt and appropriate placement in the community

Evidence of assessment of the patients' ability to manage at home

Evidence of minimisation of hospital costs by application of Best Practice discharge planning principles

There should be evidence of attempts to minimise subsequent health and related costs, e.g.

- readmission
- use of community services
- increase in personal costs

Evidence of attempts to measure health status (if appropriate)

e) Incentives should be developed for hospital staff to ensure positive and ongoing commitment to appropriate discharge planning activities.

Elements

Minimisation of delay in discharge

Achieving time and day of discharge

Achieving requisite levels of stakeholder satisfaction

- Entitled person
- Carer
- LMO/GP
- Nursing Home Administrator

Evidence that quality improvement strategies are implemented to deal with identified problems

APPENDIX 3

NURSING DISCHARGE SUMMARY

U/ R No .....

Surname ..... Other Names .....

Date of Birth ..... Sex.....

Date of admission ..... Ward.....Date of discharge.....

Address .....

Phone..... Primary contact person's name .....

Phone ..... Relationship to patient.....

Notified of transfer Yes/ No

Religion.....

Primary language spoken.....Interpreter Yes/ No

On discharge, will the patient be returning to their home address? Yes/ No

If not, where will the discharge destination be? .....
.....

Diagnosis .....

Procedures .....

Complications .....

Relevant past history .....

Allergies/ sensitivities.....

SUMMARY OF CONDITION ON TRANSFER

Nutrition .....

Skin .....

Mobility and equipment .....

Gastrointestinal .....

Vision ..... Hearing .....

Urinary (eg IDUC, insertion date, incontinence) .....

State of orientation .....

Weight ..... Smoker Yes/ No

Current medication *(included last dose given. Attach a photocopy of the medication changes or attach the patient's medication profile sheet from the discharge drugs pack.)*

Nursing management .....

.....

Jelco insertion date (if applicable) ..... **Allied Health Discharge Letter enclosed** Yes/ No

Doctor's Discharge Summary enclosed Yes/ No **Own X-Rays sent** Yes/ No

Discharge drugs sent Yes/ No **Supplies** Yes/ No

Medical Officer – Print Name Only *Nursing Signature* *Print Name*

Date..... *Telephone number .....*

DISCHARGE SUMMARY

Doctor's Discharge Letter

U/ R No.....

Surname.....

Other Names .....

Date of Birth ..... Sex .....

Consultant .....

Date of admission .....

Date of discharge .....

Discharged to .....

To Doctor ..... Address .....

.....Post Code .....

Copies to .....

Final Diagnosis The chief cause (after study) of the admission

Complications A condition that arises during the hospital stay

Secondary Conditions Any condition that existed at the time of admission or arose during the patient's stay that affected treatment

Significant Operations/ Procedures This Admission

Relevant Past History

Synopsis of This Admission Including relevant investigations/ information to patient's/ relatives (use Continuations Sheet if insufficient space)

Medications (clearly written schedule of medications and scripts provided to patient, and initial scripts provided to community pharmacist (name).

Unplanned Readmission .....**Yes / No**

Services arranged post-discharge (e.g. community nursing, VHC, meals on wheels, OT, physio, ACAT, transport, RAP) - copies of referral provided to patient

- confirmed .....**Yes / No**
- decision pending .....**Yes / No**

Follow-up appointments (e.g. GP/LMO, Medical Specialist, outpatient clinic, podiatrist, other) – copies of appointments provided to patient. .....**Yes / No**

Phone patient notified of phone follow-up by discharge planner or team member to check on progress to occur (twice at least in first week, including day after discharge) and name and number provided. .....**Yes / No**

Summary written by

Signature _____ Name (print) _____

Date.....

☐ Intern ☐ RMO/ Registrar

APPENDIX 4

Procedure for Obtaining Nutritional Supplements

Nutritional supplements are available for entitled persons on an individual patient basis. The supplement must be clinically justified and is supplied as a pharmaceutical item, therefore ordered on a Repatriation Pharmaceutical Benefits Scheme (RPBS) 'authority' prescription. Approval is given for patients who clinically require enteral feeding via a tube, or cancer patients. Patients who do not fall within these categories may be considered on an individual basis. The procedure is as follows:

- Assessment by a dietitian who determines the type and quality of nutritional supplement required by the entitled person. These are not limited and are restricted only by the entitled person's needs.
- The dietitian sends a copy of the "Request for Nutritional Supplementation" form by fax to both the LMO and Veterans Affairs Pharmaceutical Approvals Centre (VAPAC in the Qld State Office, Brisbane). Information required includes name of product required, including pack size, daily usage, diagnosis of the problem requiring nutritional supplements and date of next review.
- A copy of the form, plus explanatory notes is available from VAPAC via fax or electronic copy.

  Contact numbers
  Fax number for VAPAC is **07 3223 8651**
  Phone number for VAPAC is **1800 552 580**

- The LMO calls VAPAC on the 24 hour dedicated 1800 number for approvals. The request will be assessed and if approved, an approval number will be given to the LMO to write on the prescription.
- The quantity approved is one month's supply. Repeats are available in line with the date of the next review (maximum of 5 repeats – six months therapy). It is a requirement that the entitled person is re-assessed by a dietitian at least six monthly (or whatever necessary) to determine their ongoing need, and tolerance of the chosen supplement and a written recommendation is to be re-submitted by the dietitian at that time.
- The prescription is taken to the local pharmacist who will obtain the product for the entitled person. This procedure generally takes 24 hours. The entitled person is charged the concessional patient contribution for prescriptions, and does NOT incur any delivery charges. The pharmacy may contact the DVA Pharmacy Adviser (telephone **133 254** or **1800 555 254**) for assistance in obtaining the product.
- Equipment required to administer the product may be obtained through the Rehabilitation Appliances Program (RAP) **133 254** (see *page 20* of this Kit).
- At present, dietary thickeners can be ordered as above using the same procedure as for nutritional supplements. A specially designed order form "Request for Thickeners" plus explanatory notes is also available from VAPAC via fax or electronic format.

APPENDIX 5

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