Department of Health

Queensland Government

MEMORANDUM

To: Hospital and Health Board Chairs

Copies to: Chief Executives, Hospital and Health Services
Co-Chairs, Statewide Older Persons Health Clinical Network
Co-Chairs, Statewide General Medicine Clinical Network

From: Kathleen Forrester, Deputy Director General, Strategy, Policy and Planning Division

Contact No: 3405 5773

Fax No:

Subject: Long Stay Older Patients Steering Committee

File Ref: ST000560

I am writing to you in relation to the work of the Queensland Health Long Stay Older Patients Steering Committee. As you may be aware three Board Chairs nominated to form the Steering Committee to address the important issue of older people remaining in hospital for a residential aged care place or community support package despite being ready for discharge.

The focus of the Steering Committee is to identify practical solutions to reduce the unnecessary stay of older people in acute care settings. The Steering Committee members are Mr Michael Horan, Chair, Darling Downs Hospital and Health Board; Mr Tony Mooney, Chair, Townsville Hospital and Health Board; Mr Terry Mehan, Administrator, Cairns and Hinterland Hospital and Health Board; and I am a member and chair of the Steering Committee.

At the second meeting of the Steering Committee on 18 January the Committee invited a number of key stakeholders to discuss projects currently under development in Hospital and Health Services to address Long Stay Older Patients (please see attached Meeting Notes for your information, Attachment 1). The Steering Committee would like to share the presentations on the strategies with all Board Chairs, for your consideration when forming solutions appropriate to your HHSs.

The presentations attached are:

- *The Stranded Patient Project,* presented by Professor Ian Scott, Co-Chair Statewide General Medicine Clinical Network (Attachment 2). Plus Professor Scott's research paper *Stranded: causes and effects of discharge delays involving non-acute in-patients requiring maintenance care in a tertiary hospital general medicine service* (Attachment 3).

- *QCAT Guardianship Process Initiative* presented by Mr Mitchell Potts, Project Manager, and Ms Mary Humphrey, Social Work Coordinator (Attachments 4 & 5).

Plus QCAT Guardianship Process Flowchart, Guidelines and Applicant Responsibilities (Attachments 6, 7 & 8).

- *Watching our Waiting initiative (*Attachment 9*).*

Further to these projects, the Steering Committee, Clinical Excellence Division and Professor Scott will work together over the coming months to identify further initiatives which are evidence based, and could be targeted for local or system-wide implementation. These will be provided in the final report from the Steering Committee.

If you have any questions or would like further information regarding long stay older patients, please contact Emily Cross, Principal Policy Officer, Strategic Policy, on telephone 3234 1056 or email: StrategicPolicy@health.qld.gov.au.

K. Forrester

Kathleen Forrester
Deputy Director-General
Strategy, Policy and Planning Division
23/2/17

Long Stay Older Patients Steering Committee

Meeting Notes

Queensland Health Long Stay Older Patient Steering Committee

Date: Wednesday 18 January 2017
Time: 3.30pm – 5.00pm
Venue: Level 17 Conference Room, Queensland Health Building, 147 Charlotte Street, Brisbane
Teleconference:

Attendees	
Kathleen Forrester (Chair)	Deputy Director General, Strategy, Policy and Planning Division
Terry Mehan	Administrator, Cairns and Hinterland Hospital and Health Board
Michael Horan	Chair, Darling Downs Hospital and Health Board
Tony Mooney	Chair, Townsville Hospital and Health Board
Graham Kraak	A/Executive Director, Strategic Policy and Legislation Branch
Michael Zanco	Executive Director, Healthcare Improvement Unit
Professor Ian Scott	Co-Chair, Statewide General Medicine Clinical Network
Dr Robert O'Sullivan	Co-Chair, Statewide Older Persons Health Network
Mary Humphrey	Social Work Coordinator, QCAT Guardianship Process Initiative
Mitchell Potts	Project Manager, QCAT Guardianship Process Initiative
Apologies	
Robert McCarthy	Chair, Torres and Cape Hospital and Health Board
Dr John Wakefield	Deputy Director-General, Clinical Excellence Division (Invitee)
QH LSOP Project Team (Strategic Policy Team)	
Stephen Stewart	Manager
Emily Cross	Principal Policy Officer

Long Stay Older Patient Steering Committee

Key Messages and Actions

1. Following the first meeting of the Steering Committee in September 2016 to examine the results of the 2016 Long Stay Older Patients Census, the purpose of this meeting was to examine current projects being trialled in Hospital and Health Services (HHSs) to reduce the number of long stay patients and ensure patients receive the care they need in the right place.
2. Dr Ian Scott presented on the Stranded Patient Project, as well as possible strategies to reduce discharge delays as published in the research paper: *Stranded: causes and effects of discharge delays involving non-acute in-patients requiring maintenance care in a tertiary hospital general medicine service.*
3. Mitchell Potts and Mary Humphrey presented on the QCAT Guardianship Process Initiative and its successful implementation in Metro North HHS reducing the average wait for a QCAT hearing from 66 days to less than 30 days.
4. Following the presentations the Steering Committee discussed:
    a. Long stay patients are common across the acute health system.
    b. With an ageing population the issue of long stay older patients will continue to be important to HHSs.
    c. Significant Commonwealth reforms, particularly to the Aged Care Funding Instrument and My Aged Care, will continue to impact the relationship between hospitals and Residential Aged Care Facilities (RACFs).
    d. An undersupply of residential aged care places is not the most significant cause of discharge delays (for example, Cairns HHS has decreased the number of long stay older patients but has the lowest ratio of residential aged care places to population).
    e. Central coordination and oversight of long stay patients in the hospitals is important, particularly in building relationships with RACFs and increasing visibility of vacant residential aged care places (e.g. Metro North Nurse Navigator roles).
    f. There are models of care in practice where hospitals outreach to private RACFs to support more challenging patients to stay in the RACF.
    g. Some Queensland Health RACFs specialise in accommodating patients with challenging behaviours who have not been able to be placed in a private RACF (e.g. Redlands Residential Care). Redlands Residential Care has also supported other local RACFs to manage patients with challenging behaviours.
    h. The focus of the Steering Committee is to ensure older people receive the right care in the right place.

5. The Committee identified that some solutions proposed in the presentations would be relatively simple to implement while others are more complex and may need to be supported by collective action and additional funding.
6. Opportunities may exist to identify the evidence on initiatives that have been previously trialled, have positive patient outcomes and a known return on investment, such as the Stranded Patient Project or the QCAT Guardianship Process Initiative.
7. Key actions:
    a. Send a memo (Attachment 1) from the Steering Committee to Board Chairs and HHS Chief Executives with the outcomes from the meeting including copies of Stranded Patient Project presentation by Professor Scott (Attachments 2 & 3); QCAT Guardianship Process Initiative presentation (Attachments 4 & 5), plus QCAT Guardianship Process Flowchart, Guidelines and Applicant Responsibilities (Attachment 6, 7 & 8); and information on the 'Watching our Waits' initiative (Attachment 9). The cover letter will request Board Chairs and CE's consider the identified strategies in the presentations relevant to their HHSs.
    b. Mike Horan will provide an update at the next Board Chairs forum in February on the outcomes of the second Steering Committee meeting.
    c. Clinical Excellence Division will work with Professor Scott to identify the top five to ten initiatives to be targeted for local or system-wide implementation.
    d. The agenda for the next meeting of the Steering Committee will focus on solutions for managing challenging behaviours in older patients e.g. patients with dementia. A guest speaker will be invited from Metro South HHS to present on the Redlands Residential Care model and have an aged care industry representative for a joint discussion and identification of solutions.

The Stranded Patient

Ian Scott

Director of Internal Medicine and Clinical Epidemiology,

Princess Alexandra Hospital

Associate Professor of Medicine

University of Queensland

Longer Stay Older Patients Steering Committee

18/1/17

The challenge

HHS	LSOPs 2014	LSOPs 2016 (Acute Facilities Only)
Cairns & Hinterland	56	19
Central Queensland	15	22
Darling Downs	24	29
Gold Coast	15	14
Mackay	< 5	
Metro North	40	42
Metro South	29	35
North West	0	< 5
South West	< 5	< 5
Sunshine Coast	11	19
Torres and Cape	0	< 5
Townsville	22	71
West Moreton	13	18
Wide Bay	11	9
Mater Health Service		7
Grand Total	**238**	**296**

24% increase

HHS	Total OBD	
	2014	2016*
Cairns & Hinterland	5,182	947
Central Queensland	500	1,365
Darling Downs	1,782	4,624
Gold Coast	363	631
Mackay	112	97
Metro North	523	1,335
Metro South	823	1,453
North West	0	47
South West	12	539
Sunshine Coast	126	255
Torres and Cape	0	129
Townsville	2,253	11,573
West Moreton	302	575
Wide Bay	222	122
Mater Health Service	na	82
Grand Total	**12,200**	**23,774**

95% increase

The challenge

- 8% of all OBDs in general medical beds in Qld public hospitals in 2015 occupied by stranded patients
  - 1 in 13 beds permanently occupied

- LOS has extended from average length of occupied bed days of 54 days in 2014 to 80 days in 2016

- Estimated costs of 'maintenance care' patients in general medicine units of 24 largest hospitals has risen from $28.3m in 2010 to $42.2m in 2015

The challenge

Reason for Delay in Discharge	LSOPs	% of Total	OBD#	% of OBD	Average OBD
Waiting for residential care bed	156	53	12,831	54	82
Difficult to place due to behaviour/dementia	43	14	3,899	16	91
Family to select facility	29	10	797	<5	27
Waiting for guardianship decision	23	8	1,271	5	55
Waiting asset test/financial assessment	< 10	3	412	<5	52
Wait home care package	< 5	1	13	<0	7
Other or Blank	35	12	4,551	19	130
Total	**296**	**100**	**23,774**	**100**	**80**

The challenge

CSIRO PUBLISHING
Australian Health Review
http://dx.doi.org/10.1071/AH15204

Stranded: causes and effects of discharge delays involving non-acute in-patients requiring maintenance care in a tertiary hospital general medicine service

Armi Salonga-Reyes[1] MBBS, Advanced Trainee in General Medicine
Ian A. Scott[1,2,3] MBBS, FRACP, MHA, MEd, Director of Internal Medicine and Clinical Epidemiology

131 general medicine patients with non-acute LOS ≥28 days

Rank according to OBDs	Cause of delay	OBDs
1	Wait for RACF beds	2372 (43.8%)
2	Administrative delays external to hospital (QCAT, Public Trustee, Adult Guardian, funding decisions (DSQ, insurance companies))	1377 (25.4%)
3	Patient or family refusal of care options	552 (10.2%)
4	Delays in assessments internal to hospital (ACAT, social worker, geriatrician or psychiatrist reviews, EPOA identification)	405 (7.5%)
5	Delays in delivery of home support (domiciliary care, home equipment or modifications)	385 (7.1%)
6	Wait for investigations or resolution of undefined medical condition in clinically stable patient not receiving acute care	177 (3.3%)
7	Management of acute medical complications	152 (2.8%)
	Total	5420

The challenge

- Changes to ACFI as from 31/7/14 - dementia supplement for people in RACFs removed

- Leading Age Services Australia (LASA) and Aged and Community Services Australia (ACSA):
  - in metropolitan Brisbane area changes to ACFI - withdrawal of $1.7 billion federal funding over 4 years
  - reduces per patient funding by 11%
  - may cause up to 20% of nursing homes to close, and reductions in staffing levels and skill in others

- Ansell strategic analysis - from January 2017
  - average 80-bed facility would lose about $439,000 per year
  - less than 13% of residents classified as having high complex health care (CHC) needs vs 44% currently
  - average daily funding for the care of CHC needs would fall from the current $45.84 to $30.80

- Requirement of RACFs to be guaranteed of secure finding: in cases where there is no EPOA a guardianship application needs to be made and public trustee then overseeing finances before acceptance, even if all next of kin are in agreement to pay for care
  - has led to a spike in QCAT applications

- More prolonged assessment of income
  - if you have <$100,000 you are 'poor' and will receive full government subsidy; if you have >$500,000 you are considered rich and will be able to pay; if you have between $100,000 and $500,000 delays will ensue as your assets are closely scrutinised.

The challenge

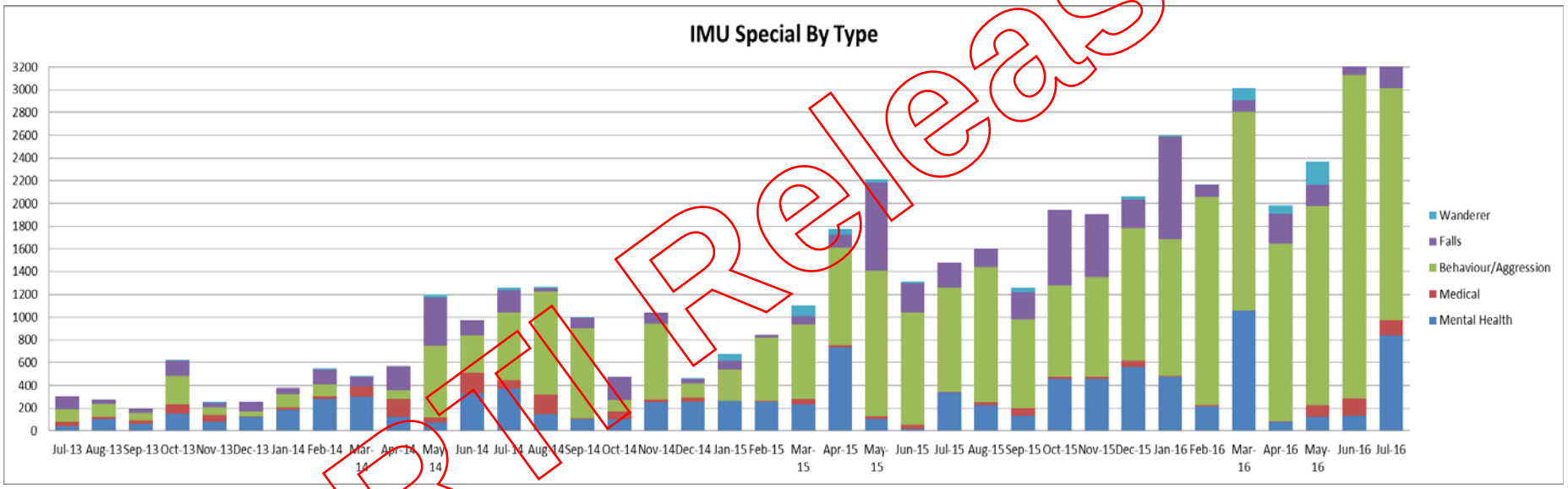
- Initiation of NDIS has also led to increased requests for QCAT applications for same reasons as above

- Increased occupational violence towards hospital staff from patients with BPSD, intellectual disability and other challenging behaviours, often occurring during times of redirection or restriction of patients who would be better managed and less prone to aggression if cared for in designated RACF rather than acute hospital bed
  - risk of losing nursing staff (60% considering leaving in recent OV survey of ward 5A staff)

- Costs of 24/7 security personnel and nurse specials for patients requiring ongoing supervision - $million dollar patients

- No additional DSQ care packages

The challenge



Stranded Patient Project

Project Rep

June 2016

- Paucity of patient-level quantitative data on QCAT/other agency processes and delays
- Inconsistent communication practices between hospitals and key stakeholders
  - frequently arbitrarily determined by individuals who had the ability to network harmoniously
- No single point of contact between hospitals and key stakeholders
- Lack of shared understanding between respective services of internal pressures, compliances and constraints within each service and which contributed to reactive versus planned interventions
- Inconsistent processes – both within and between hospitals and external agencies and varying levels of staff expertise
- No accountability for timely outcome
- Discharge planning processes tend to be serial rather than parallel and collaborative
- Little recognition of increased complexity of decisions for people entering residential aged care following aged care reforms
- No escalation processes for stalled interactions between agencies or between hospitals and residential aged care facilities

Initiatives

- Long Stay Executive Committee (LSEC) established in all hospitals reporting to SE

- Hospital-wide monitoring and reporting system for LSPs which collates both qualitative and quantitative data on progress and delays

- Queensland Health (QH) led high-level Long Stay Executive Committee involving all key stakeholders aimed at developing and implementing strategies that overcome barriers to patient discharge
  - Inter-agency, inter-jurisdictional committee

Suggestions

Cause of delay	Potential remedial strategies
Wait for RACF or supported accommodation beds	Access to more interim care or respite care beds Access to more transitional care programs providing half-way options between hospital and RACF More RACF beds or supported accommodation for patients with special needs: • dementia with or without wandering behaviour or behavioural and psychological symptoms • mental health problems • intellectual impairment • bariatric patients • homeless • other patient groups requiring greater supervision but not eligible or suitable for RACF More direct communication between hospital and RACF staff in deciding patient eligibility for transfer: • electronic transmission of hospital data • videoconferences allowing visualisation of patients Dedicated RACF placement officers or brokers Low or no entry fees or bonds Sanctions against RACFs that fail to accept patients meeting entry criteria
Long Stay Nurse Navigators (RBWH/TPCH)	
Long stay patient social worker to target long stay patients awaiting nursing home	

Suggestions

Cause of delay	Potential remedial strategies
Administrative delays in decisions relating to applications to external agencies (QCAT, Adult Guardian, Public Trustee, funding decisions (DSQ, MASS, Centrelink, insurance companies))	Dedicated agency officers for hospital applications Agency liaison officer on hospital campus Greater interagency collaboration and harmonisation of assessment and decision processes Single, direct communication channels for hospital staff to different agencies, with weekly QCAT meetings Mandated decisions within stipulated periods after lodgement of applications Ability to fast-track decisions on the basis of clinical urgency Sanctions for non-decisions beyond stipulated periods where agencies perceive hospitals as 'safe havens' with no sense of urgency to act Tracking systems that regularly report status and progress of patients with non-acute stays exceeding 4 weeks to all relevant stakeholders

Suggestions

Cause of delay	Potential remedial strategies
Patient or family refusal of care options	Formal letters from hospital administration requesting acceptance of care options if mediation efforts fail Mandatory attendance at family meetings convened to discuss future management Financial impost or legal sanctions for inordinate delays in accepting recommended options and/or providing RACF listings Mandated acceptance of first available interim care or RACF bed pending transfer to facility of first choice at a later date when vacancy arises
Delays in assessments internal to hospital (ACAT, social worker, geriatrician or psychiatrist reviews, identification of EPOA or SDM)	Single common assessment process Ability to undertake decisions in medically stable patients despite ongoing prolonged courses of active treatment (e.g. intravenous antibiotics for osteomyelitis or endocarditis) Higher frequency of ACAT assessment rounds (especially over public holiday periods) Reduced turnaround times for ACAT decisions Request to families to nominate EPOA or SDM early in admissions More social workers

Suggestions

Cause of delay	Potential remedial strategies
Delays in delivery of home support (domiciliary care, home equipment or aids or modifications)	Hospitals to hire home equipment for a limited period while undergoing trial in hospital or RACF, pending completion of the MASS application for final approval Extra funding to occupational therapists to complete equipment trials in hospital, community or RACFs Hospital preferred provider of home equipment and home modifications In-house supply and rental service of assistive appliances (e.g. walking frames or wheelie-walkers, crutches, orthotic aids etc.) Local or regional professional teams to coordinate care packages More diversified range of home care packages and services Reinstatement of state-level public funding for home care services Contractual requirement for community-based support agencies to provide flexible patient-centred services

Liverpool experience

Targeted Case Management (extreme LOS):

- MDT case management review for all current patients with LOS >100 days
- Active support from Executive and clinical teams for complex discharges

Introduction of Weekly Ward Reporting

- Long Stay Committee re-established to review LOS >30 days weekly
- Reporting template for AMO/NUM to provide detail on management plans

Appropriate Quality Care Plans:

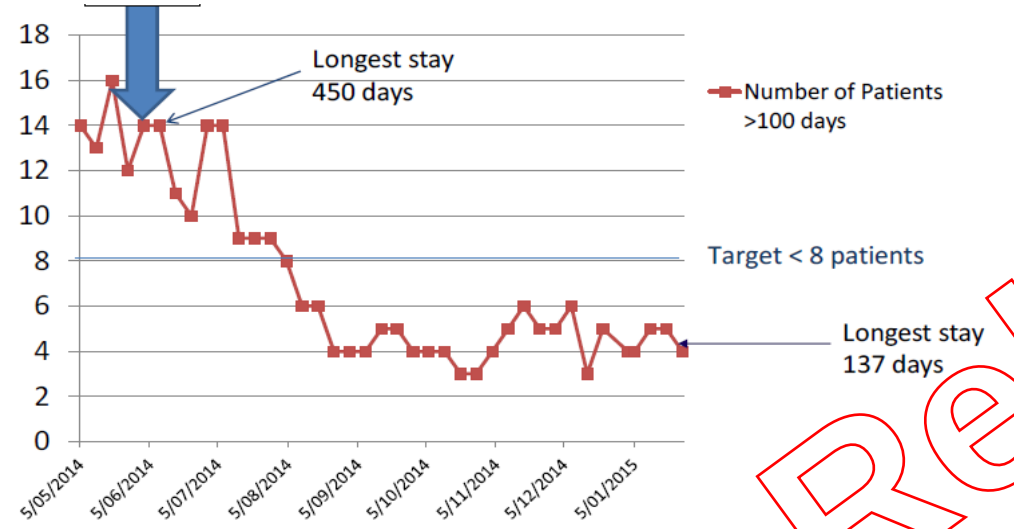
- NUM and MDT education and feedback on patient management plans
- Ward visits support and enable teams to promote a culture of problem solving

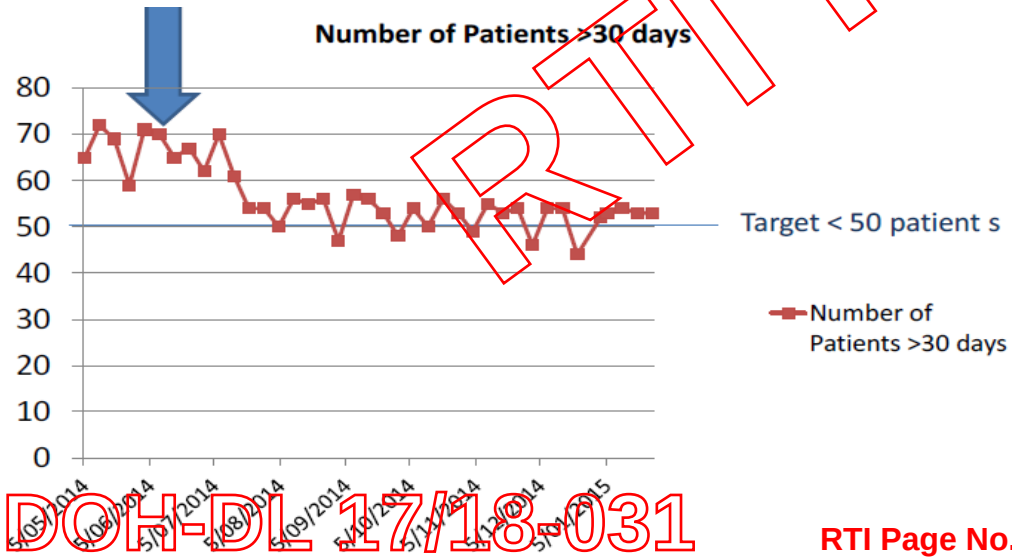
Monitoring and escalation process

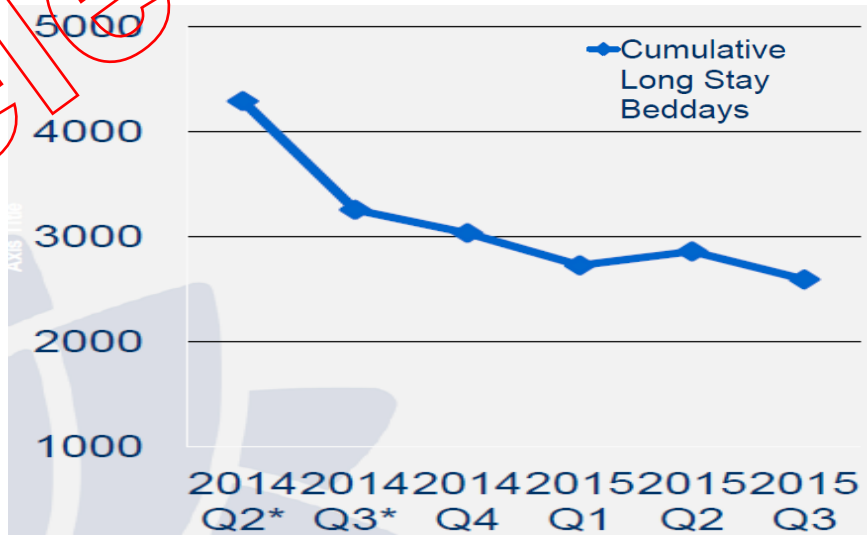
- Monitoring tool to track LOS >30 days and identify discharge barriers early
- Local ward escalation, bed meeting, DMU and committee processes

Jennings 2015
Liverpool Hospital NSW

Liverpool experience







Jennings 2015
Liverpool Hospital NSW

Watching Our Waits IT tool

Watching our waits

Watching our Waits is a tool for capture and tracking of long stay patients.

Please enter your Novell username and password.

Username

Password

Sign In

Enter your Novell ID and password to access the system.

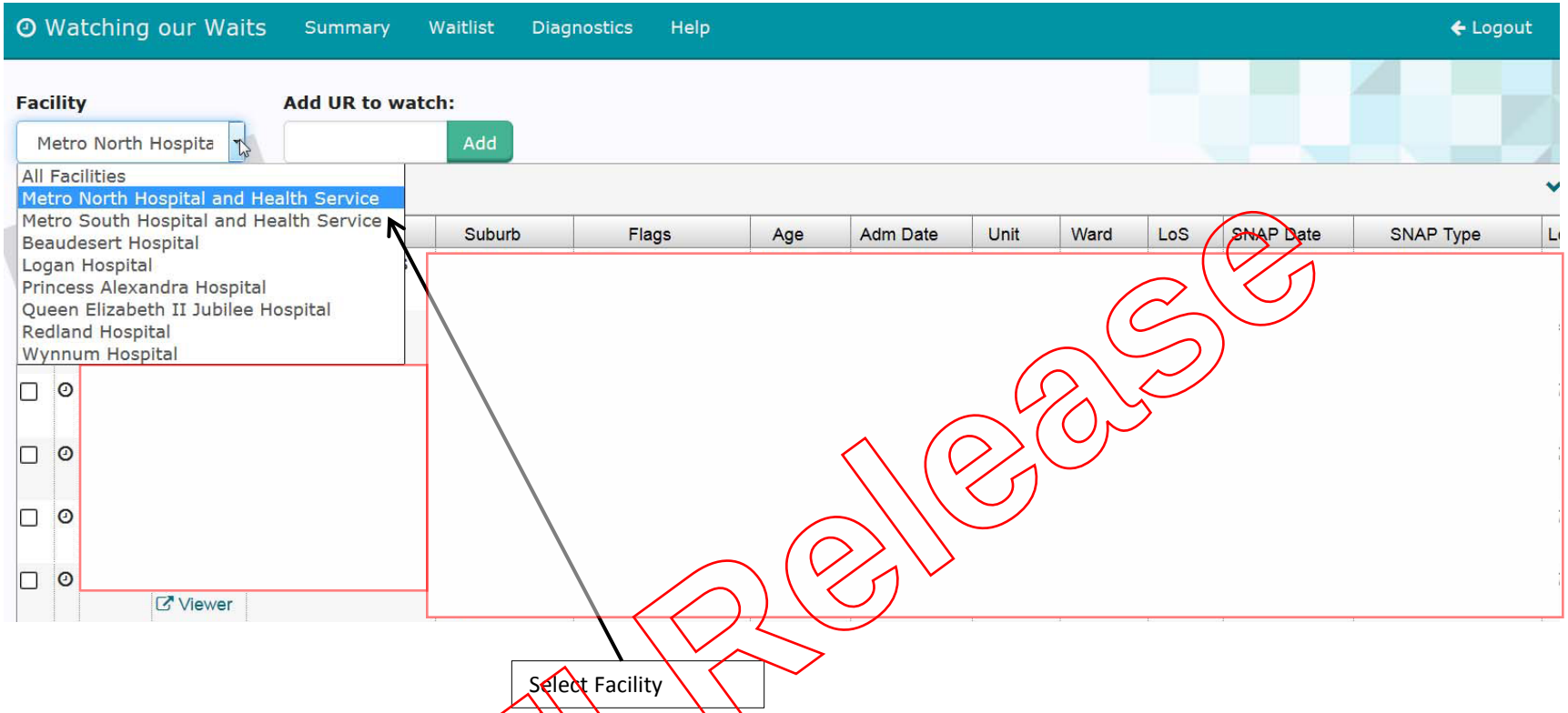
System permissions are granted by requesting access via the Online IT support service

Detailed auditing capacity is utilised to confirm records are accessed appropriately.

If you have forgotten your Novell username or password please contact the InfoService Centre on 1800 198 175 for assistance.

Users accessing this application are reminded of their responsibilities under the Queensland Health Code of Conduct. In particular:

- You should only access a patient's record when it is part of your duties, it is a legal requirement, or when specific consent is given
- Patient information **must not** be made available to any person or authority other than those staff responsible for the health care of the patient, unless legislation and standards
- Users should not leave this application unattended - always "logout"
- Users **must not** share passwords.


Watching our Waits
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Waitlist
Diagnostics
Help
Logout
Facility
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Metro South Hospital and Health Service
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Logan Hospital
Princess Alexandra Hospital
Queen Elizabeth II Jubilee Hospital
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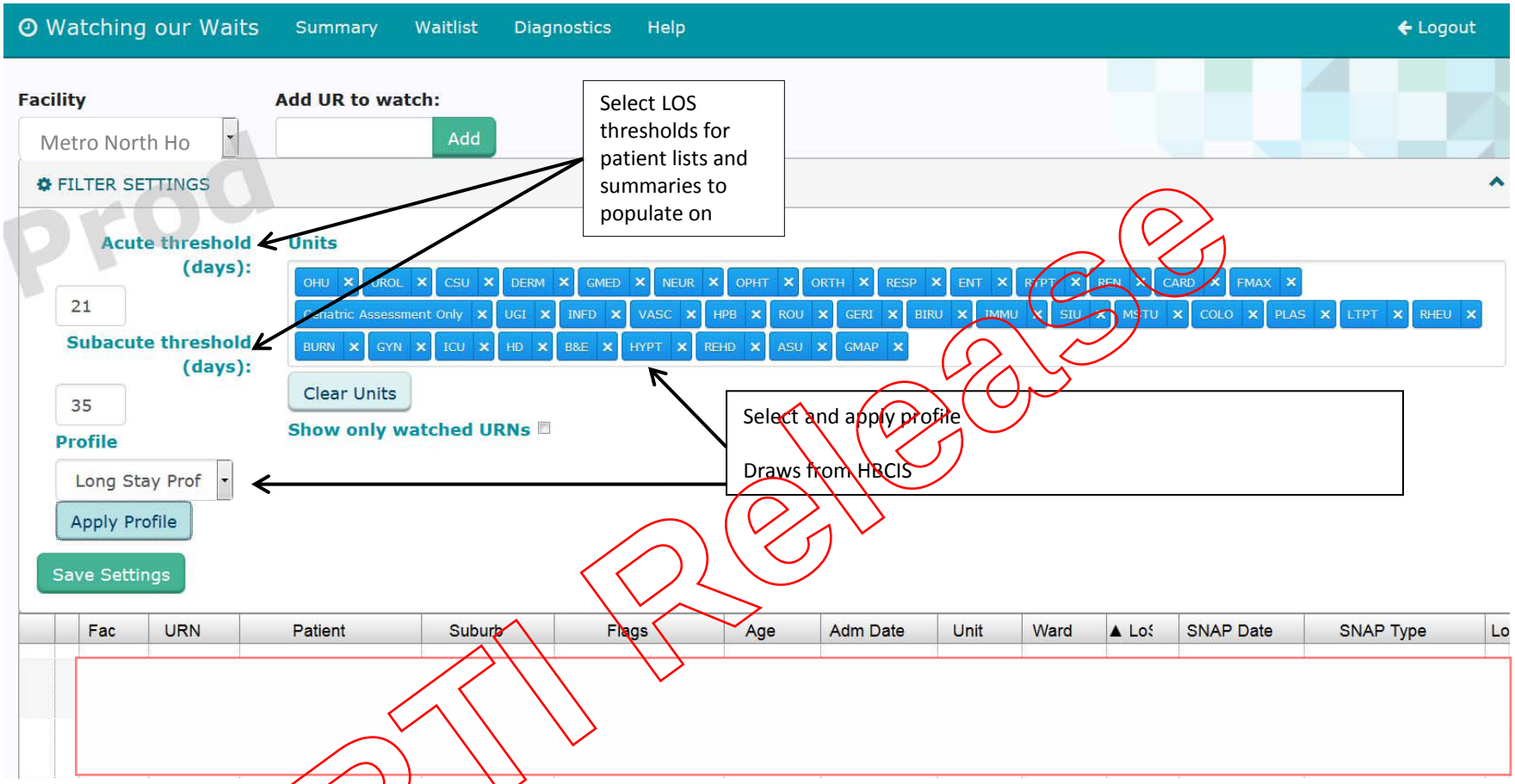
Watching our Waits
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Subacute threshold (days):
35
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NEUR
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GYN
ICU
HD
B&E
HYPT
REHD
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GMAP
Clear Units
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Long Stay Prof
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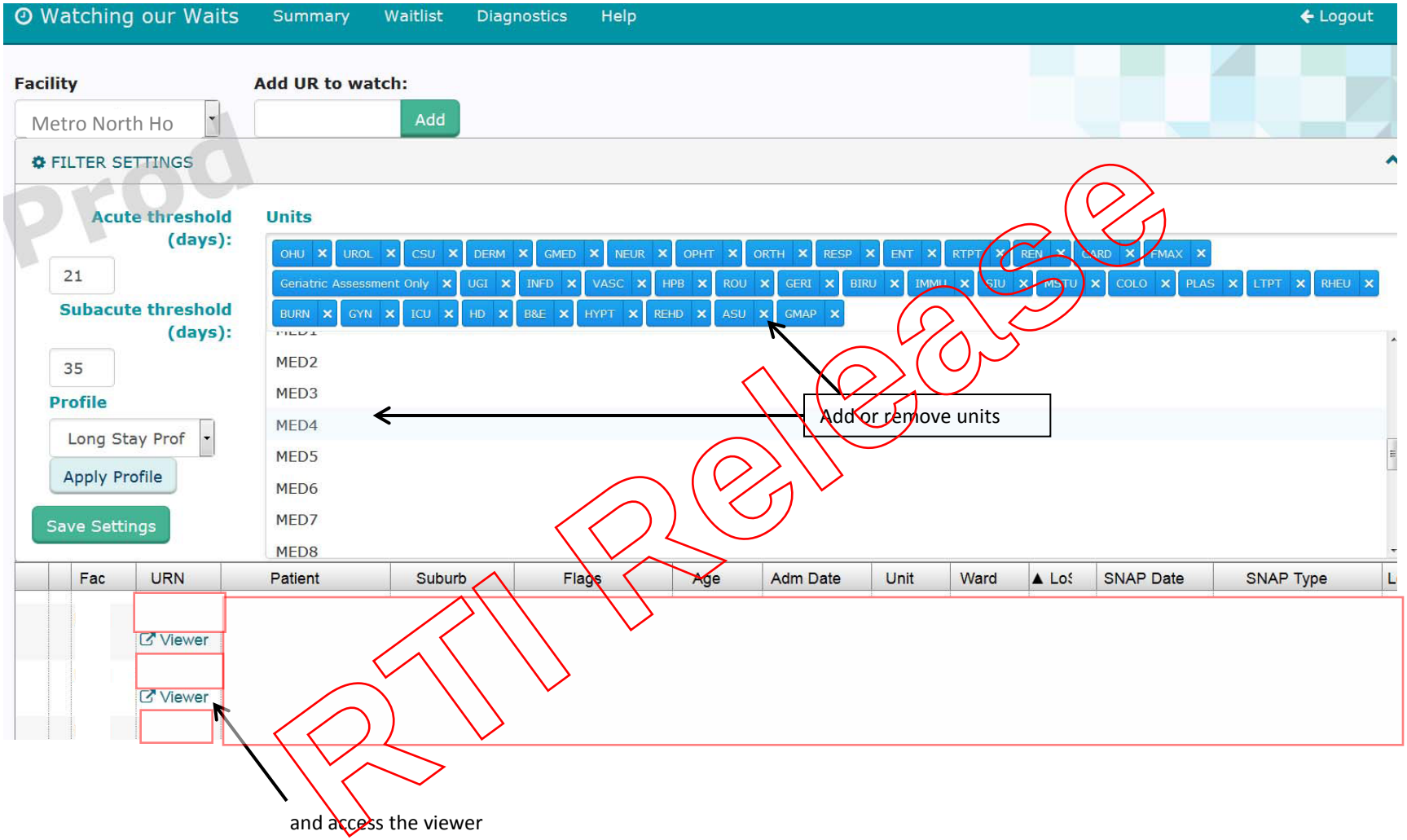
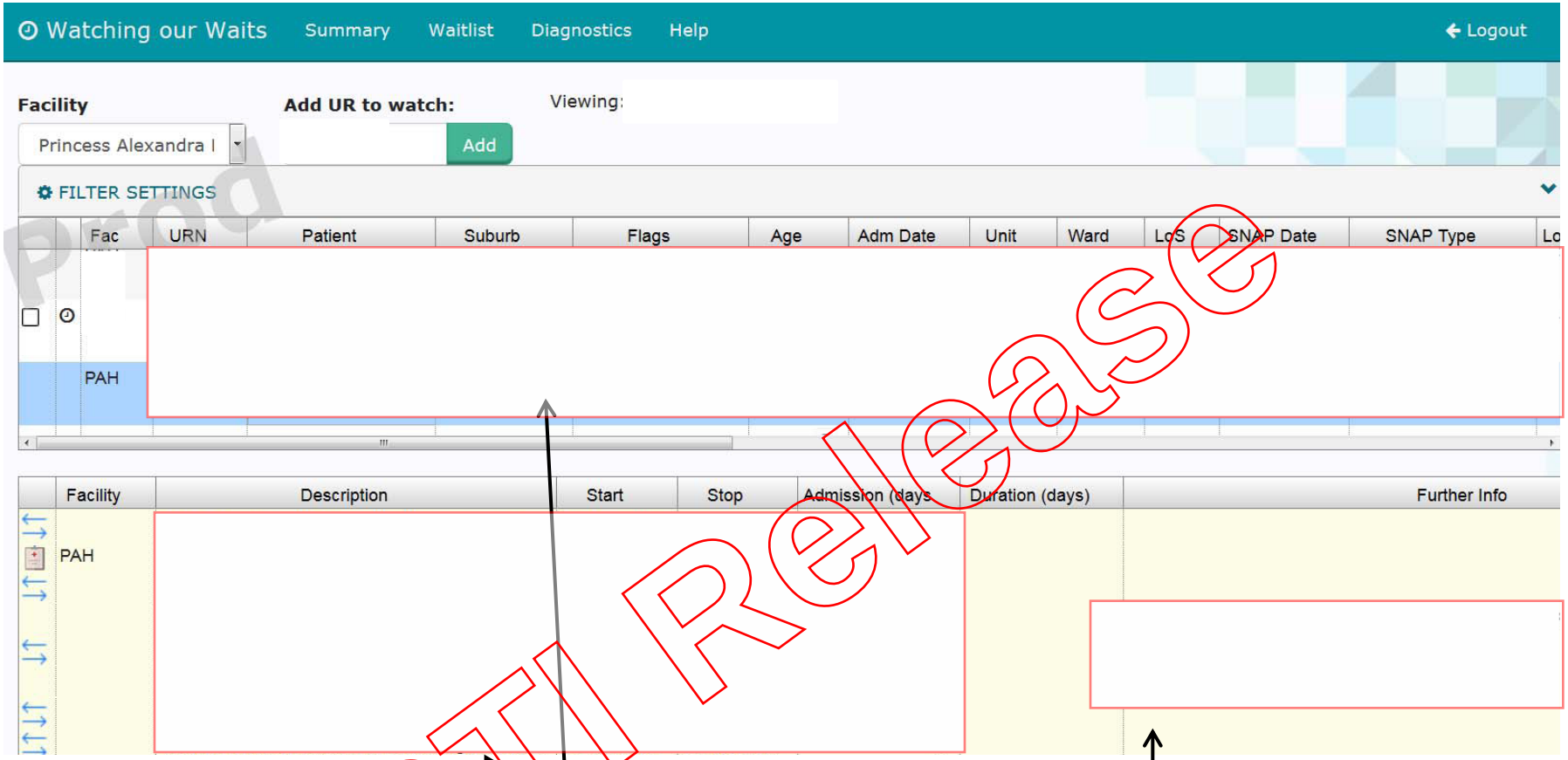


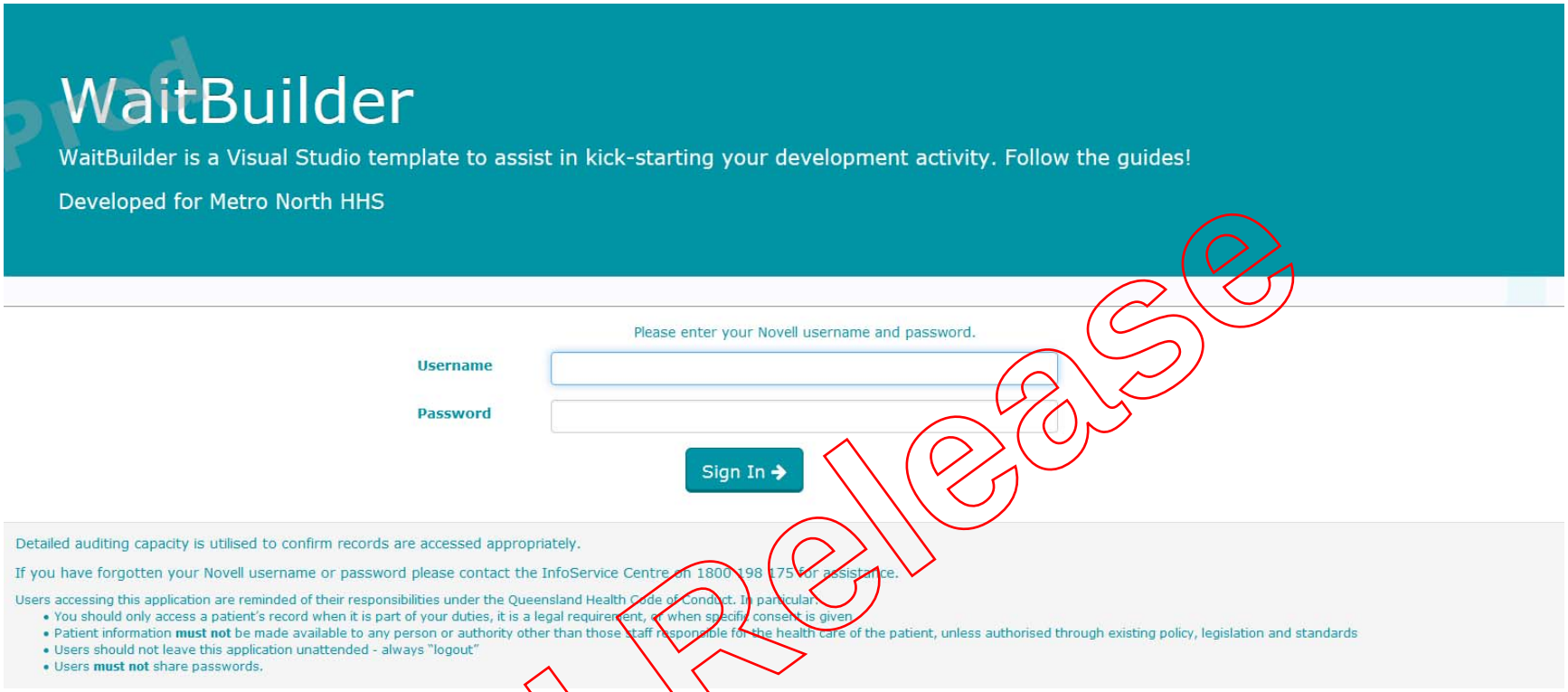


Click on a patient to see further information about the patient journey, encounters, episode of care change, readmission data including accumulated LOS

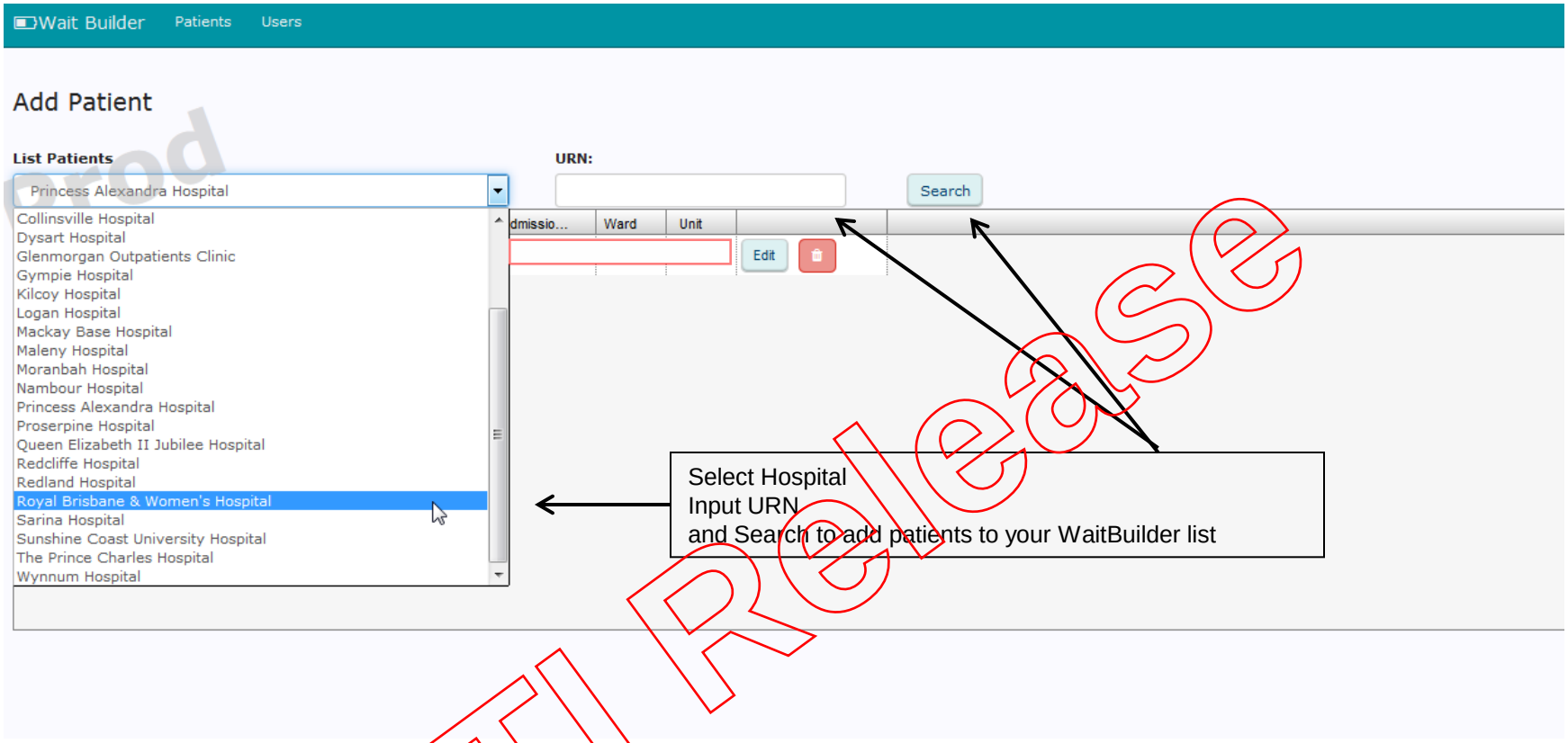
Information of any wait reasons will generate here i.e waits for assessments or external agency decisions v 1.0

This information will be generated from Wait Builder app – allowing S/W, direct care clinicians and other who already input this information into various spreadsheets to input into one Long Stay program to collate and generate summaries and dashboard.

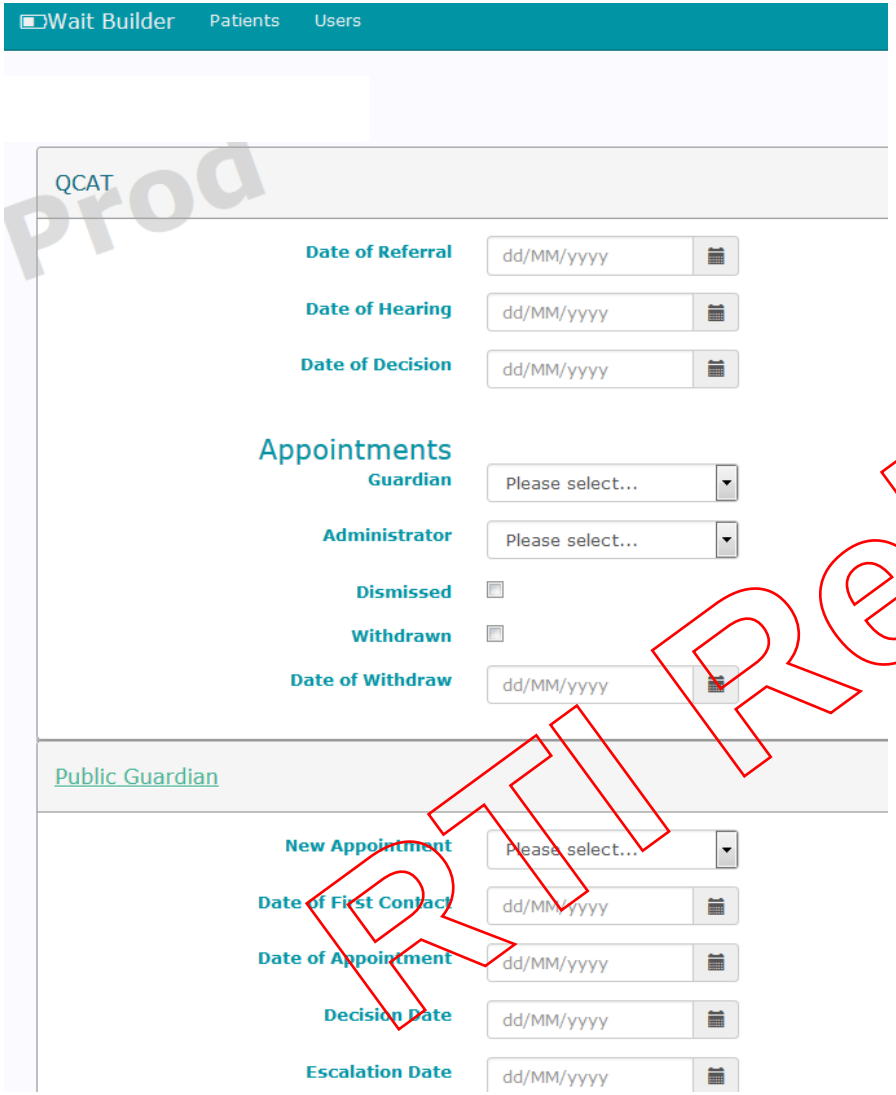
V2.0 will focus on acute internal discharge barrier metrics



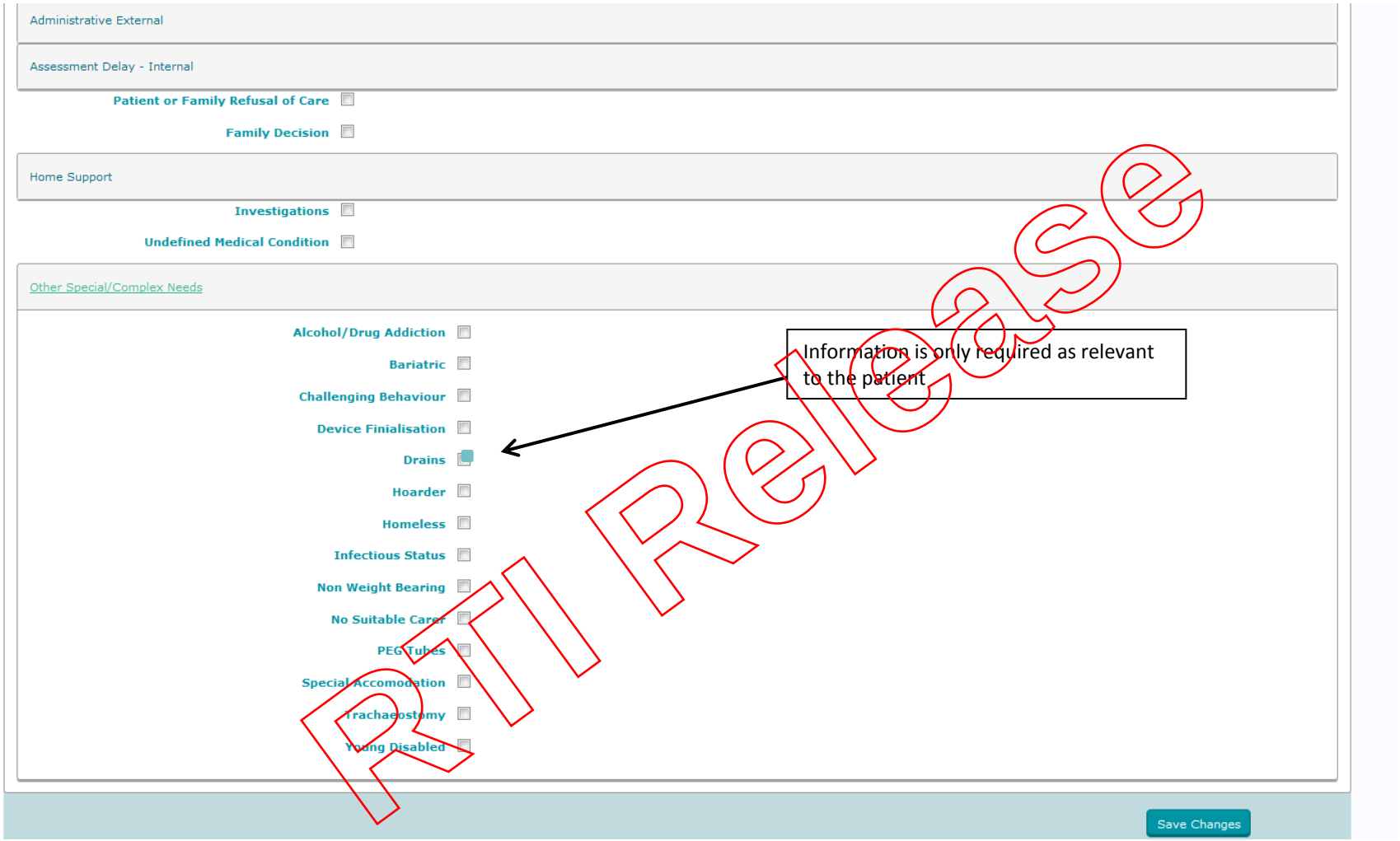
The WaitBuilder app allows input of wait variables which feeds the WoW system

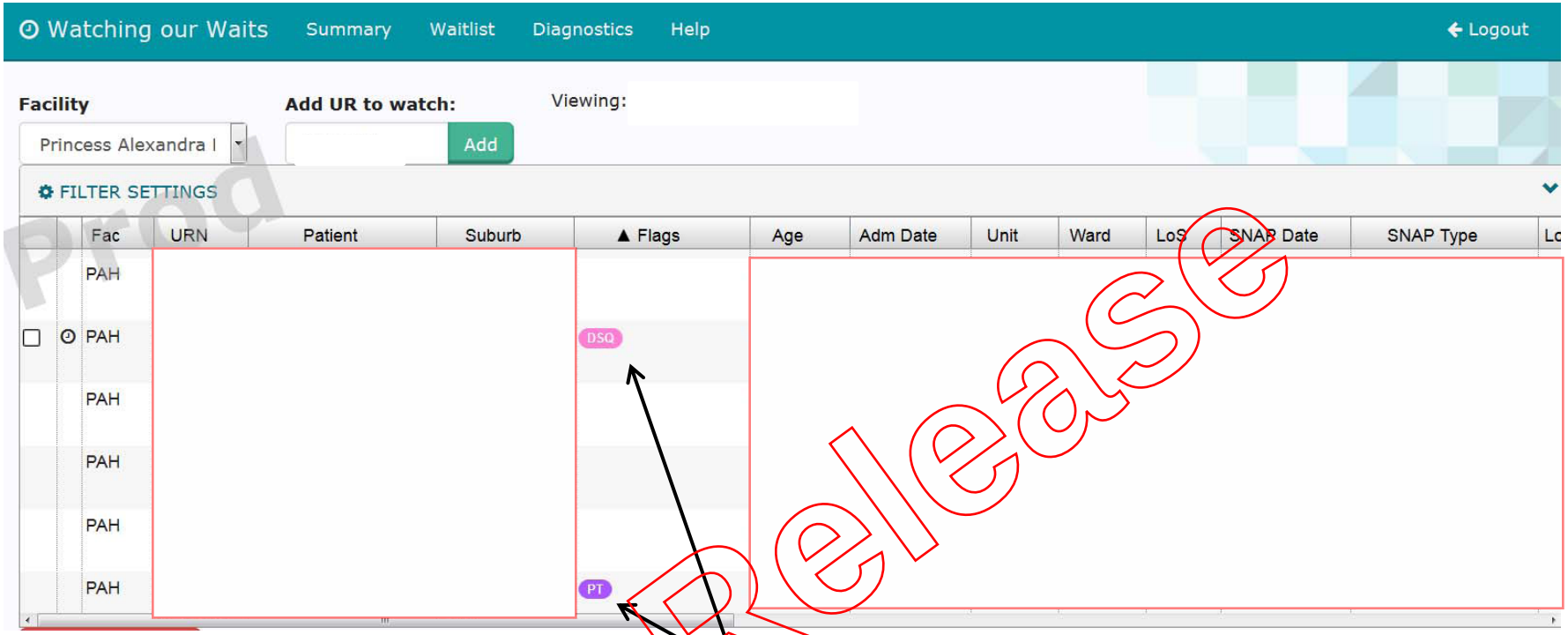


Editing a patient in WaitBuilder will provide the following pathways for wait inputs

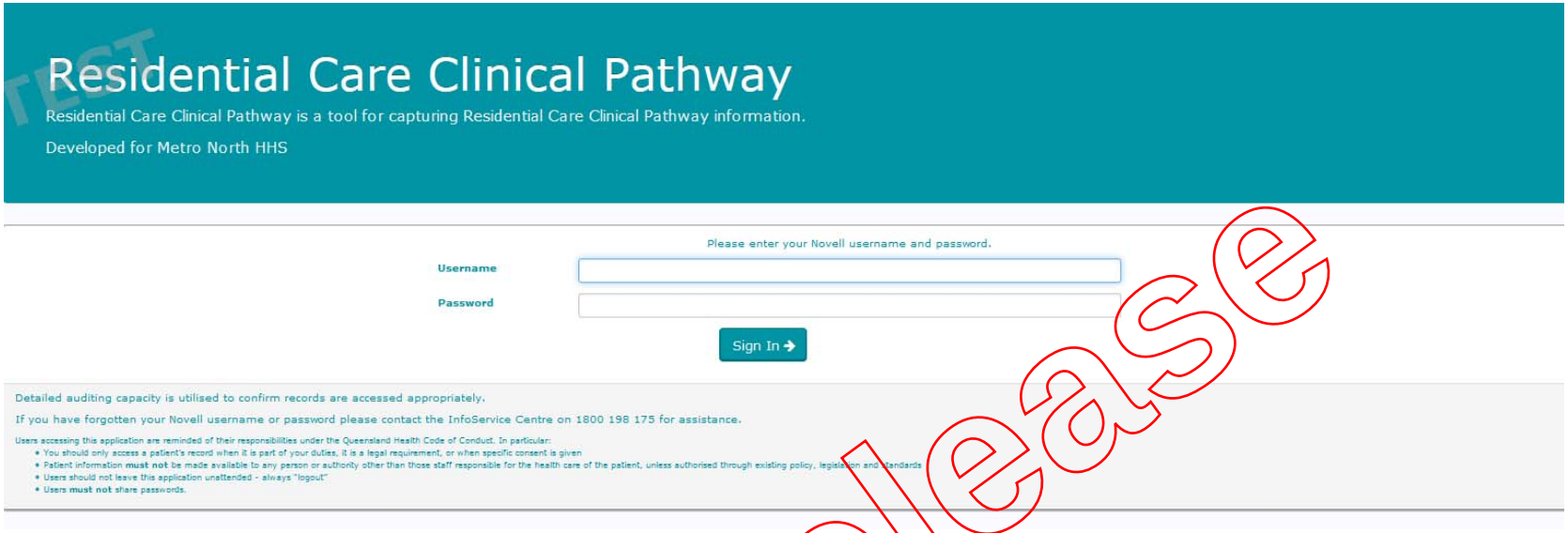


Wait category pathways have been built into the system under each of variables listed

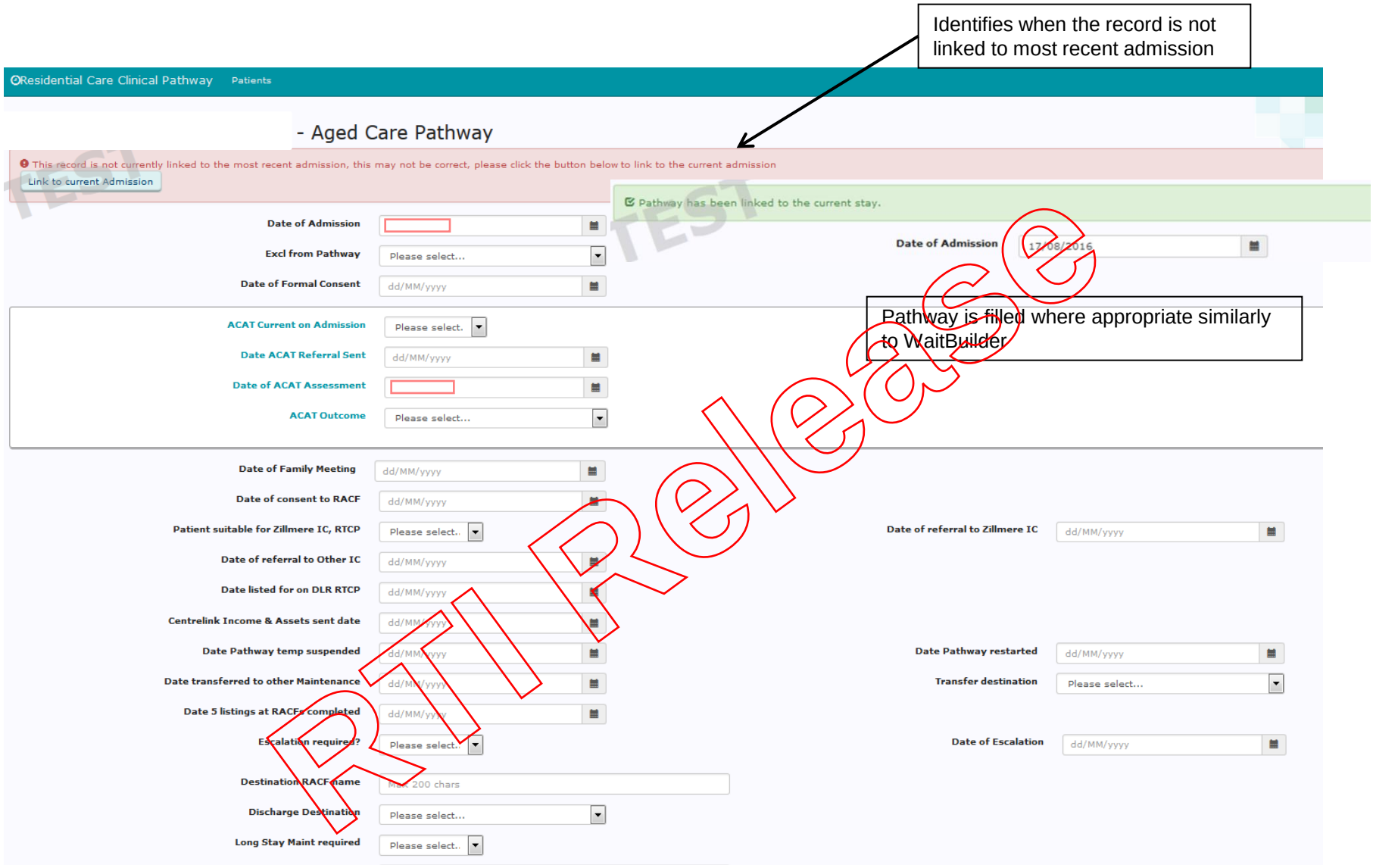

Administrative External
Assessment Delay - Internal
Patient or Family Refusal of Care
Family Decision
Home Support
Investigations
Undefined Medical Condition
Other Special/Complex Needs
Alcohol/Drug Addiction
Bariatric
Challenging Behaviour
Device Finialisation
Drains
Hoarder
Homeless
Infectious Status
Non Weight Bearing
No Suitable Carer
PEG Tubes
Special Accomodation
Tracheostomy
Young Disabled
Information is only required as relevant to the patient
Save Changes



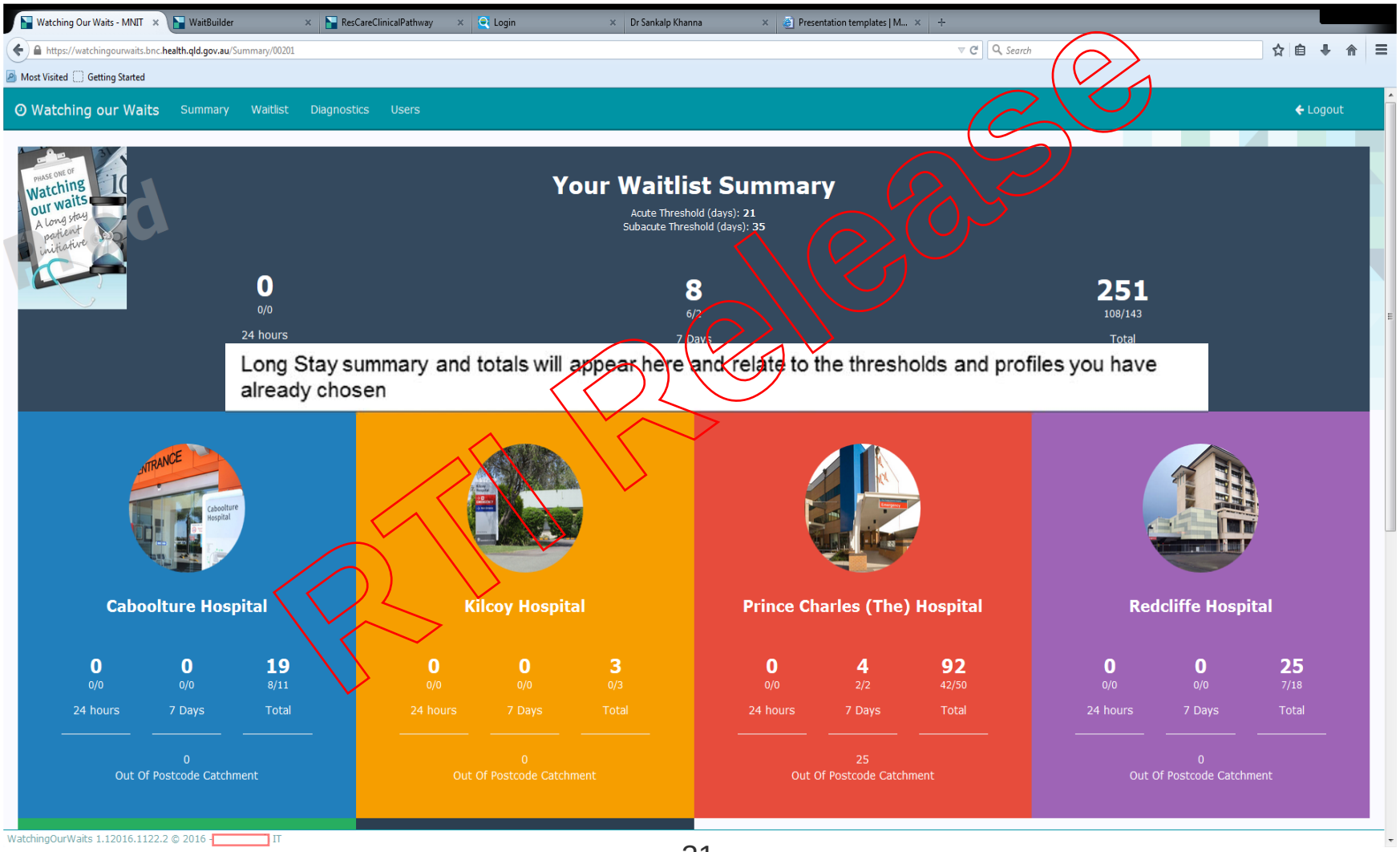
Waits identified in WaitBuilder then feed across back into the WoW waitlist



RCCP tool feeds into WoW system similarly to WaitBuilder


Identifies when the record is not linked to most recent admission
Residential Care Clinical Pathway
Patients
- Aged Care Pathway
This record is not currently linked to the most recent admission, this may not be correct, please click the button below to link to the current admission
Link to current Admission
Pathway has been linked to the current stay.
Date of Admission
Excl from Pathway
Please select...
Date of Formal Consent
dd/MM/yyyy
Date of Admission
17/08/2016
Pathway is filled where appropriate similarly to WaitBuilder
ACAT Current on Admission
Please select..
Date ACAT Referral Sent
Date of ACAT Assessment
ACAT Outcome
Date of Family Meeting
Date of consent to RACF
Patient suitable for Zillmere IC, RTCP
Date of referral to Zillmere IC
Date of referral to Other IC
Date listed for on DLR RTCP
Centrelink Income & Assets sent date
Date Pathway temp suspended
Date Pathway restarted
Date transferred to other Maintenance
Transfer destination
Date 5 listings at RACF completed
Escalation required?
Date of Escalation
Destination RACF name
Max 200 chars
Discharge Destination
Long Stay Maint required
RTI Release

Summary Screen



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Stranded: causes and effects of discharge delays involving non-acute in-patients requiring maintenance care in a tertiary hospital general medicine service

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Abstract

Objectives. The aims of the present study were to identify causes of prolonged discharge delays among non-acute in-patients admitted to a tertiary general medicine service, quantify occupied bed days (OBDs) and propose strategies for eliminating avoidable delays.

Methods. A retrospective study was performed of patients admitted between 1 January 2012 and 31 May 2015 and discharged as non-acute cases requiring maintenance care and who incurred a total non-acute length of stay (LOS) >7 days and total hospital LOS >14 days. Long-stay patients with non-acute LOS ≥28 days were subject to chart review in ascertaining serial causes of discharge delay and their attributable OBDs. Literature reviews and staff feedback identified potential strategies for minimising delays.

Results. Of the 406 patients included in the present study, 131 incurred long-stays; for these 131 patients, delays were identified that accounted for 5420 of 6033 (90%) non-acute OBDs. Lack of available residential care beds was most frequent, accounting for 44% of OBDs. Waits for outcomes of guardianship applications accounted for 13%, whereas guardian appointments, Public Trustee applications and funding decisions for equipment or care packages each consumed between 4% and 5% of OBDs. Family and/or carer refusal of care accounted for 7%. Waits for aged care assessment team (ACAT) assessments, social worker reports, geriatrician or psychiatrist reviews and confirmation of enduring power of attorney each accounted for between 1% and 3% of OBDs. Of 30 proposed remedial strategies, those rated as high priority were: greater access to interim care or respite care beds or supported accommodation, especially for patients with special needs; dedicated agency officers for hospital guardianship applications and greater interagency collaboration and harmonisation of assessment and decision processes; and formal requests from hospital administrators to patients and family to accept care options and attend mediation meetings.

Conclusions. Delayed discharge of non-acute maintenance care patients results principally from impaired access to residential care, administrative delays involving external agencies and patient or family refusal of care. Proposed remedial actions require concerted interjurisdictional advocacy.

What is known about this topic? Delays in discharge of non-acute patients requiring maintenance care can occur for many reasons and incur inordinately long hospital stays.

What does this paper add? The present detailed chart review of 131 long-stay non-acute patients identified causes of serial discharge delays and quantified their prevalence and attributable bed days. Waits for residential care accounted for less than half the bed days, administrative delays involving decisions by agencies external to the hospital accounted for one-quarter and patient or family refusal of care options accounted for one-tenth. Strategies are proposed that may minimise these delays.

What are the implications for practitioners? Delayed discharge of non-acute patients requiring maintenance care threatens to consume an ever-increasing proportion of acute hospital bed days. Remedial action is required from stakeholders both within and outside hospitals to reverse this trend.

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Introduction

Hospitals frequently experience delays in the discharge of older patients who, despite being medically stable, occupy beds as non-acute patients pending the availability of home support or beds in a residential aged care facility (RACF). Up to one-third of hospital bed days relate to patients receiving non-acute care.[1,2] The causes of these delays are multiple, can occur at several points in the patient trajectory (see Box 1)[1,3] and be associated with inordinately long hospital stays.

The rising numbers of acute presentations to emergency departments (EDs), the advent of '4-h' national emergency access targets (NEAT) mandating rapid transit of patients from the ED to vacant in-patient beds, and constant pressure for more elective surgery all bring a focus on minimising discharge delays (or exit block) for patients no longer requiring acute care in hospital beds. Knowing the types, prevalence, bed occupancy and resource utilisation pertaining to different causes of delayed discharge of non-acute patients may allow health professionals, hospital administrators and care agencies to consider targeted strategies for overcoming such delays.

The aims of the present study were to: (1) identify the causes and prevalence of prolonged discharge delay among older patients admitted to a general medicine service of a tertiary hospital who no longer required acute care; (2) quantify the occupied bed days (OBDs) and estimated bed day costs incurred; (3) define acute medical complications with onset during the non-acute stay; (4) estimate resource utilisation; and (5) elicit, from relevant literature review and surveys of health professionals, possible strategies for eliminating avoidable delays.

Methods

Design, participants and setting

The present study was a retrospective study of patients admitted via the ED to the general medicine service of Princess Alexandra Hospital in Brisbane (Qld, Australia), a tertiary hospital serving a catchment population of 600 000, between 1 January 2012 and 31 May 2015, and who satisfied the following criteria: were discharged as non-acute cases; required community home support or care packages or placement in an RACF (i.e. non-acute category of maintenance care); and incurred a total non-acute length of stay (LOS) of >7 days and total hospital LOS of >14 days. Patients meeting these criteria were identified from the hospital health information management system and medical charts, either paper or electronic, retrieved for detailed analysis. For patients with multiple admissions during the study period, the admission corresponding to the first non-acute discharge was chosen as the index stay. Patients were divided into two groups: (1) long-stay patients with non-acute LOS ≥28 days, who were subject to detailed chart review; and (2) short-stay patients with non-acute LOS <28 days, for whom only administrative data were collected for purposes of comparison in identifying patient characteristics associated with longer non-acute LOS.

The general medicine service of the study hospital in 2014–15 admitted 3975 patients to seven general medicine units with a total mean and median LOS of 7.4 and 3.4 days, respectively. Approximately 12% were discharged as non-acute patients who incurred a mean and median non-acute LOS of 21.8 and 12.8 days, respectively, accounting for 10 765 OBDs (37% of all OBDs) in 2014–15, a 55% increase compared with 6927 OBDs (25%) in 2009–10. The proportion of these OBDs accounted for by maintenance care patients had risen from 31% (2175 OBDs) in 2009–10 to 50% (5352 OBDs) in 2014–15.

Over this 6-year period, the general medicine service averaged an acute LOS of <5 days (median 3.0 days) and, according to Health Roundtable data, ranked within the most efficient tertiary hospital general medicine units in Australia. Timely reclassification of patients to non-acute is performed on consultant ward rounds and at multidisciplinary case conferences. The nominal 76-bed service is staffed by 3 full-time equivalent (FTE) physiotherapists, 3 FTE social workers, 1.5 FTE occupational therapists and 1.5 FTE community health integrated care program (CHIP) nurses.

Data collection and ascertainment of delays in discharge

For long-stay patients subject to chart review, data were extracted into a spreadsheet relating to patient characteristics, presenting diagnosis, co-morbidities, acute and non-acute LOS, final discharge destination and occurrence of acute complications during the non-acute stay. Progress notes for each patient were searched in a forward direction, from 7 days after being classified as non-acute to the time of death or discharge, for entries from doctors, nurses and allied health professionals that indicated serial delays to discharge. Indicative words and phrases such as 'waiting for', 'pending', 'anticipated', 'indefinite' and 'uncertain' were assumed to mark the start of a delay related to a specific cause when first stated, with 'approved', 'received',

Box 1. Categories of discharge delays

- Waits for reviews from geriatricians or psychiatrists in deciding eligibility for alternative categories of care (rehabilitation or mental health care)
- Waits for social worker assessments of patients and convening of family meetings
- Waits for results of outstanding investigations or resolution, recovery or diagnosis of medical condition in non-acute patients that are required before aged care assessment team (ACAT) assessments and/or other formal assessments can proceed (e.g. prolonged delirium, plateau of recovery in patient with disabling stroke or depression or other mental health problems)
- Waits for assessment by ACAT in determining eligibility for residential care or transitional care package
- Waits for outcomes of applications to Queensland Civil and Administrative Tribunal, Adult Guardian or Public Trustee, Medical Aids Subsidy Scheme and Centrelink in determining patient decision-making capacity, guardianship appointments, stewardship of personal finances or eligibility for public or private funding of care or support
- Waits incurred by refusal of patient and/or family or carers to accept offered care options
- Waits in procuring a bed in a residential aged care facility
- Waits in procuring home equipment or home modifications, domiciliary care or nursing support
- Waits incurred by managing acute medical complications arising during non-acute stay

'resolved', 'finalised', 'confirmed', 'accepted' and 'established' assumed to mark the end of the delay.

Discharge delays were attributed by a single researcher (AS-R) to each of the causes listed in Box 1. Because some delays could be attributed to more than one concurrently operating factor, the factor serving as the immediate bottleneck requiring resolution before further processing of patient care could proceed was deemed the dominant cause to which the days of delay spanning its duration were attributed. For example, the outcome of a Public Trustee application regarding a patient's financial affairs, upon which any further action regarding RACF placement depended (dominant factor), became known 12 days after lodgement, but it took another 7 days for the family, who from early in the admission were reluctant to accept the need for residential care, consented to RACF placement. Therefore, the delay attributed to the Public Trustee application was the first 12 days and that attributed to family refusal was the subsequent 7 days. The total non-acute OBDs secondary to each delay was the sum of the individual delays.

In determining inter-rater reliability of the method used to categorise delays, the second researcher (IAS) independently reassessed 48 instances of delay categorisation derived from a random sample of 10 patients (8% of the study cohort). Agreement was seen for 44 instances (92%).

Resource utilisation

The annual use of beds by non-acute patients was determined by converting non-acute OBDs into the number of occupied beds on the basis of 90% bed occupancy. Fixed in-patient costs of non-acute stays was estimated by multiplying OBDs by the average hospital bed day cost.

Potential remedial strategies

A list of potential strategies for minimising non-acute stays was derived from a review of literature published between 1990 and 2014 using PubMed and search terms 'discharge OR transfer delay' combined with 'hospital', and included additional reports cited in retrieved articles. Articles were selected if they referred to non-acute patients. This list and the summary results of the study were provided to attendees at a multidisciplinary meeting of the general medicine service and emailed to those unable to attend. Each recipient was asked to rank the strategies, grouped according to cause, in order of decreasing importance.

Statistical analysis

Continuous variables are presented as the mean ± s.d. or as the median with the interquartile range (IQR) in parentheses for normally and non-normally distributed data, respectively. Fisher's exact test and the Kruskal–Wallis test were used to compare mean and median values. Chi-squared tests were used to compare categorical variables. Analyses were performed using GraphPad v2 (GraphPad Software Inc., San Diego, CA, USA) and Excel (Microsoft, Redmond, WA, USA) statistical packages. Because the present study was a retrospective analysis of routinely collected data on completed episodes of care with reporting of anonymised data and no need for patient contact, ethics approval was waivered by the Metro South Hospital and Health Service (MSHHS) Director of Clinical Governance.

Results

Patient characteristics

In all, 406 patients were included in the study, of whom 131 had long stays (non-acute LOS ≥28 days) and 305 had short stays (non-acute LOS <28 days). Patient characteristics of the two groups are listed in Table 1. Patients with long non-acute stays were slightly younger and had longer acute LOS than those with short non-acute stays. The frequency of admission diagnoses did not differ between the groups, except for falls occurring more often and infections less often in the former compared with the latter group.

Causes of discharge delay

The median acute and non-acute LOS for long-stay non-acute patients were 7 and 40 days, respectively, accounting for 1456 (17%) and 6950 (83%) OBDs of a total of 8409 for the group. After subtracting from the total non-acute stay the first 7 days chosen as the lead-in period ($n = 917$ OBDs), delays were identified that accounted for 5420 (90%) of 6033 non-acute OBDs. Individual delays, ranked according to decreasing numbers of attributable OBDs, are listed in Table 2 and illustrated in three case studies in Box 2. Lack of available RACF beds was the most frequent cause of delay, affecting 91 patients (69%) and accounting for 44% of attributable OBDs. Second in both frequency and attributable OBDs were waits for Queensland Civil and Administrative Tribunal (QCAT) applications regarding guardianship of patients with impaired decision-making capacity, which involved 18 patients (14%) and was responsible for 13% of OBDs, with an average (median) wait for each application of 38 (34) days. Family and carer refusal of recommended care involving 15 (11%) patients accounted for 7% of OBDs. Waits for Adult Guardian appointments, delivery of domiciliary care, Public Trustee applications and funding decisions (mainly related to Disability Services Queensland (DSQ)) each consumed between 4% and 5% of OBDs. Waits for Aged Care Assessment Team (ACAT) assessments, social worker reports, geriatrician or psychiatrist reviews and confirmation of people who had enduring power of attorney (EPOA) each accounted for between 1% and 3% of OBDs. Waits related to resolution or diagnosis of undefined medical conditions (e.g. prolonged delirium or plateau of recovery following disabling stroke) affected four patients destined for residential care and management of acute medical complications affected nine patients already classified as non-acute, with each responsible for 3% of OBDs. Of note, an additional 62 patients suffered 69 acute medical events that were not considered prime causes of delay, the majority (87%) being infections and the remainder falls and adverse drug reactions.

In identifying delays that could be targeted for minimisation strategies, causes were aggregated into seven groups (Table 3), comprising lack of RACF beds (44% of OBDs), administrative delays external to hospital processes (24%), patient or family refusal of care options (10%), delays in assessments internal to the hospital (7%), delays in delivery of home support (7%), waits for investigations or resolution of undefined medical conditions (3%) and management of acute medical complications (3%).

Table 1. Patient characteristics

Data are given as the mean ± s.d. (for age), *n* (%) or as median values with the interquartile range in parentheses. LOS, length of stay; OBDs, occupied bed days

	Non-acute patients requiring maintenance care		*P*-value
	Long-stay patients (*n* = 131)	Short-stay patients (*n* = 305)	
Age (years)	74.7 ± 12.3	78.8 ± 12.5	0.003
No. men	75 (57%)	156 (51%)	0.438
Living situation before admission			0.167
Lives in community	107 (81%)	232 (76%)	
Lives in residential care	24 (18%)	73 (24%)	
Admission diagnosis			
Progressive dementia	31 (24%)	53 (17%)	0.145
Falls	25 (19%)	12 (4%)	0.001
Cerebrovascular accident	21 (16%)	29 (10%)	0.098
Cardiovascular disease	14 (11%)	27 (9%)	0.592
Delirium	7 (5%)	10 (3%)	0.295
Infection or sepsis	6 (5%)	54 (18%)	<0.001
Syncope	2 (2%)	2 (1%)	0.587
Other	25 (19%)	118 (39%)	0.004
Acute LOS (days)	7.0 (3.0–14.0)	5.0 (2.0–9.0)	<0.001
Acute OBDs (% total OBDs)	1456 (17%)	2234 (23%)	
Non-acute LOS (days)	40.0 (29.0–60.0)	16.0 (11.0–26.0)	<0.001
Non-acute OBDs (% total OBDs)	6950 (83%)	7330 (77%)	
Total LOS (days)	49.0 (38.0–70.0)	23.0 (16.0–34.0)	<0.001
Total OBDs	8409	9564	
Discharge disposition			
Residential care facility	92 (70%)	190 (62%)	0.186
Lives in community	37 (28%)	107 (35%)	0.73
In-hospital death	2 (2%)	8 (3%)	

Table 2. Causes of delay in discharge: frequency and attributable occupied bed days (OBDs)

Data for OBDs show the number of OBDs attributable to the delay, with the percentage of total non-acute OBDs in parentheses. RACF, residential aged care facility; QCAT, Queensland Civil and Administrative Tribunal; ACAT, aged care assessment team; EPOA, enduring power of attorney; LOS, length of stay; IQR, interquartile range

Rank according to OBDs	Cause of delay	OBDs	Frequency[A]	Median (IQR) non-acute LOS
1	Wait for RACF beds	2372 (43.8%)	91	21 (22)
2	Wait for QCAT applications	683 (12.6%)	18	34 (27)
3	Family refusal of care options	356 (6.5%)	15	14 (21)
4	Wait for Adult Guardian appointments	253 (4.6%)	8	22 (27)
5	Wait for delivery of domiciliary care	247 (4.5%)	5	21 (56)
6	Wait for Public Trustee applications	234 (4.3%)	10	25 (8)
7	Wait for funding decisions	207 (3.8%)	4	21 (34)
8	Patient refusal of care options	196 (3.6%)	2	98 (42)
9	Wait for resolution, recovery or diagnosis of non-acute medical condition	172 (3.1%)	4	38 (32)
10	Wait for ACAT assessments	154 (2.8%)	14	9 (5)
11	Management of acute medical complications	152 (2.8%)	9	10 (9)
12	Wait for social worker reports	120 (2.2%)	9	14 (10)
13	Wait for delivery of home equipment	110 (2.0%)	4	28 (26)
14	Wait for geriatrician or psychiatrist review	71 (1.3%)	6	12 (4)
15	Wait for EPOA identification and confirmation	60 (1.1%)	3	21 (6)
16	Wait for home modifications	28 (0.5%)	1	28 (0)
17	Wait for results of investigations	5 (<0.09%)	1	5 (0)
	Total	5420	204	

[A]The frequency (number of occasions) may not equal the number of patients affected because the same cause of delay may occur more than once in the same patient.

Box 2. Case studies of discharge delays

Case 1

Ms A.K., an 87-year-old woman admitted from home, lived alone and had poor social support. She was admitted with recurrent falls and delirium secondary to urinary tract infection; this was on a background of newly diagnosed Alzheimer's dementia, type 2 diabetes, Parkinson's disease and osteoarthritis of the right knee. After a 5-day acute length of stay (LOS), Ms A.K. was seen by geriatricians a week after referral and was assessed as having no capacity to make health and financial decisions. She proceeded to have an aged care assessment that was completed 5 days later and recommended residential care (first delay = 5 days). Application was made for appointment of a public guardian and public trustee, which was finalised after 3 weeks (second delay = 23 days), and the patient then stayed in hospital until transfer to an interim nursing care facility (third delay = 11 days).

Case 2

Ms C.P., a 64-year-old woman with C6 quadriplegia, lived alone and presented with a urinary tract infection following a recent admission with fractures of her right patella and tibia managed conservatively with a Richard's splint. Her medical comorbidities included obesity, osteoporosis, epilepsy and venous thromboembolism requiring long-term warfarin. Ms C.P. had significant support needs, being wheelchair bound, requiring two-assist with hoist transfers and dependent for most activities of daily living. Prior to admission, funding for 40 h per week was being provided for by community services, with an additional unfunded 20 h to meet her needs. Her acute LOS was 2 days, and the following 7 non-acute days involved allied health and rehabilitation team assessments of her ability to maintain living in the community. The opinion of these assessments was that her significant decline in function and need for 24/7 care necessitated nursing home placement. However, Ms C.P. and her advocate refused this option and consequently, after a 3-week stalemate (first delay due to patient refusal = 20 days), a concerted effort was made to find a community care service willing to accept her despite her complex needs and lack of funding. It was not until approximately 4 months later that the social worker was able to negotiate a transfer home with additional home support (second delay = 115 days). While in hospital, the patient suffered recurrent symptomatic urinary tract infections requiring intravenous antibiotics, complicating a suprapubic catheter.

Case 3

Mr M.R., an 82-year-old man who lived alone, was found wandering in the streets, confused and disoriented. His medical history included vascular dementia, ischaemic heart disease, hypertension, dyslipidaemia and seizure disorder. He had episodes of aggression and wandering while in hospital, requiring regular risperidone. After an initial acute LOS of 2 days during which reversible causes for confusion were investigated, an aged care assessment team (ACAT) reassessment was requested and completed within 7 days following discussion with his enduring power of attorney. Mr M.R. then waited a further 10 weeks (delay = 68 days) before transfer to a secure dementia unit in a nursing home prepared to accept him. While awaiting placement, Mr M.R. had seizures provoked by hospital-acquired pneumonia which required intravenous antibiotics.

Table 3. Causes of delay in discharge: groupings and attributable occupied bed days (OBDs)

Data for OBDs show the number of OBDs attributable to the delay, with the percentage of total non-acute OBDs in parentheses. RACF, residential aged care facility; QCAT, Queensland Civil and Administrative Tribunal; DSQ, Disability Services Queensland; ACAT, aged care assessment team; EPOA, enduring power of attorney

Rank according to OBDs	Cause of delay	OBDs	Frequency
1	Wait for RACF beds	2372 (43.8%)	91
2	Administrative delays external to hospital (QCAT, Public Trustee, Adult Guardian, funding decisions (DSQ, insurance companies))	1377 (25.4%)	40
3	Patient or family refusal of care options	552 (10.2%)	17
4	Delays in assessments internal to hospital (ACAT, social worker, geriatrician or psychiatrist reviews, EPOA identification)	405 (7.5%)	32
5	Delays in delivery of home support (domiciliary care, home equipment or modifications)	385 (7.1%)	10
6	Wait for investigations or resolution of undefined medical condition in clinically stable patient not receiving acute care	177 (3.3%)	5
7	Management of acute medical complications	152 (2.8%)	9
	Total	5420	204

Resource utilisation

Assuming a bed occupancy of 90%, the 6950 OBDs expended on non-acute care of our long-stay patient sample over the 41-month study period equates to 2034 OBDs per annum equivalent to six beds or 8% of the nominal 76-bed service. Assuming an average acute hospital bed day cost of A$1500, the nominal expenditure incurred by this sample of non-acute stays equals A$10.4 million, or A$3.1 million per annum. This does not include additional costs, such as nurses ('nurse specials') or security staff being assigned to monitor one-on-one aggressive or wandering patients for extended periods of time.

Potential remedial strategies

The literature search retrieved five review articles,[1,4–7] all from the UK, that yielded several potential strategies for minimising delays, as listed in Table 4. These data and the results listed in Table 3 were provided to 55 recipients (26 doctors, 10 nurses, 19 allied health professionals) within the general medicine

service. Thirteen (24%) recipients responded and ranked each group of strategies according to their perceived level of importance from 1 (most important) to 7 (least important).

Discussion

The present study defined causes of, and quantified bed usage resulting from, discharge delays pertaining to long-stay non-acute general medical patients in a tertiary hospital. Although lack of RACF beds delayed the discharge of 70% of patients, it only accounted for 44% of non-acute OBDs. One-quarter of OBDs were secondary to administrative delays external to hospital processes, with applications to QCAT and appointment of Adult Guardians accounting for more than half. Patient or family refusal of care options accounted for another 10% of OBDs, whereas delays related to internal hospital assessment processes accounted for just under 8%. Hospital-acquired acute medical complications affected half the sample and accounted for 7% of OBDs. For the most part, when comparing characteristics of long-stay and short-stay non-acute patients, longer delays were independent of patient age or clinical or residential status on admission.

Study limitations

The patient sample was small, limited to one tertiary hospital, and involved only patients categorised as requiring maintenance care, and therefore the results may not be generalisable to other institutions or patient populations. The method used by treating consultants to classify patients as non-acute was not prospectively validated, but periodic audits by the hospital coding unit indicated few violations of accepted criteria (Maria O'Neil, pers. comm., 2015). The method for attributing OBDs to specific causes of delay relied on subjective review of medical records and could not attribute a cause for 10% of non-acute OBDs. Delays secondary to acute nosocomial complications during the non-acute stay were not subtracted as acute OBDs, because earlier discharge may have circumvented these acute events. The response rate for the staff survey was low, with most respondents comprising individuals unable to attend the multidisciplinary meeting.

Comparison with other studies

The few contemporary studies attempting to identify contributors to non-acute hospital stays in general medicine patients based on chart reviews have yielded variable results. In a study of 200 consecutive admissions to general medicine wards of two regional Tasmanian hospitals in 2010, 33% of total OBDs were for non-medical reasons,[8] most attributed to poor access to community care services and residential care. A Canadian snapshot study of two hospitals in 2009 revealed that 33% of acute beds were occupied by non-acute patients, most with dementia.[9] In a cross-sectional study of approximately 2500 discharges from a large UK hospital over 12 months from April 2001,[10] 4029 OBDs were attributed to delays in social service assessments of care needs and financial eligibility (38%), restricted access to domiciliary care (18%), residential care (24%) or rehabilitation (5%) and family induced delays (15%). Among 88 patients discharged from a UK tertiary hospital, 21% of OBDs were attributed to delays, with patient refusal of care and impaired access to residential or rehabilitation beds being major causes.[11]

Potential strategies for minimising delays in discharge

In minimising delayed discharges of non-acute patients, literature reviews proposed various strategies (Table 4), although very few have been subjected to rigorous analysis of effectiveness. Our respondents nominated improved access to residential care beds as a priority, especially for patients with special needs, such as those with dementia and behavioural problems,[12] mental health disorders[13] or patients with intellectual impairment.[14] The MSHHS has fewer residential care beds per population in its catchment (86.3 per 1000 over 70 years of age) than the national average (112.0 per 1000).[15] Additional funding for, and licensing of, appropriately configured and staffed residential care beds is a neglected need in many jurisdictions.[16] Expansion of fast-track community-based dementia outreach services and dementia-specific assessment and subacute care units feature in the recent MSHHS Dementia Services Strategy.[17] Other strategies include rapid two-way communication between hospital and RACF staff in deciding patient suitability for transfer to specific institutions,[18] using electronic transmission of hospital data combined with videoconferences for direct patient visualisation. Dedicated placement consultants or brokers, and greater access to interim care beds (pending final RACF destination), were also strongly endorsed.

Administrative delays associated with guardianship, financial stewardship and care funding applications were often associated with inordinate delays. In one report, guardianship applications incurred a median prolongation of hospital stay of 53 days,[19] compared with 22 days in the present study. Agencies such as QCAT and Adult Guardian may consider fast tracking applications originating in hospitals by employing a dedicated hospital approval processor. More efficient interagency collaboration in assessment and decision processes relating to specific patients could be afforded by all agencies agreeing to a single representative or mediator participating in multidisciplinary case conferences and exchanges with social workers, conducted through a single agreed communication channel (telephone, email or videoconference, as appropriate). In this way multiple agencies could receive and process relevant requests concurrently and, in so doing, promote greater harmonisation of their procedures. Delays in internal assessments by social workers, geriatricians and ACATs could be reduced by using common assessment procedures coupled with more staff trained in performing such assessments.

Family and/or patient refusal to accept recommended care often relates to unrealistic denial of the need for care[20] and can be difficult to negotiate. To date, no studies have been reported that offer a framework for assisting appropriate decision making.[21] In its absence, persistent refusal to accept care and/or provide listings of preferred RACFs beyond a reasonable time frame (e.g. 14 days) may prompt formal letters of request to do so from hospital administrators and mandatory attendance at family conferences to discuss and resolve outstanding issues.

Hospitals or funding agencies, such as the Medical Aids Subsidy Scheme (MASS), should consider hiring equipment, such as hoists or pressure mattresses, for a limited period (e.g.

Table 4. Suggested strategies and order of importance as perceived by hospital staff respondents

Rankings are shown in decreasing order of importance. OBDs, occupied bed days; QCAT, Queensland Civil and Administrative Tribunal; DSQ, Disability Services Queensland; ACAT, aged care assessment team; EPOA, enduring power of attorney; SDM, substitute decision maker; RACF, residential aged care facility; HITH, hospital in the home; MASS, Medical Aids Subsidy Scheme

Ranking	Cause of delay	Potential remedial strategies
1	Wait for RACF or supported accommodation beds	Access to more interim care or respite care beds Access to more transitional care programs providing half-way options between hospital and RACF More RACF beds or supported accommodation for patients with special needs: • dementia with or without wandering behaviour or behavioural and psychological symptoms • mental health problems • intellectual impairment • bariatric patients • homeless • other patient groups requiring greater supervision but not eligible or suitable for RACF More direct communication between hospital and RACF staff in deciding patient eligibility for transfer: • electronic transmission of hospital data • videoconferences allowing visualisation of patients Dedicated RACF placement officers or brokers Low or no entry fees or bonds Sanctions against RACFs that fail to accept patients meeting entry criteria
2	Administrative delays in decisions relating to applications to external agencies (QCAT, Adult Guardian, Public Trustee, funding decisions (DSQ, MASS, Centrelink, insurance companies))	Dedicated agency officers for hospital applications Agency liaison officer on hospital campus Greater interagency collaboration and harmonisation of assessment and decision processes Single, direct communication channels for hospital staff to different agencies, with weekly QCAT meetings Mandated decisions within stipulated periods after lodgement of applications Ability to fast-track decisions on the basis of clinical urgency Sanctions for non-decisions beyond stipulated periods where agencies perceive hospitals as 'safe havens' with no sense of urgency to act Tracking systems that regularly report status and progress of patients with non-acute stays exceeding 4 weeks to all relevant stakeholders
3	Patient or family refusal of care options	Formal letters from hospital administration requesting acceptance of care options if mediation efforts fail Mandatory attendance at family meetings convened to discuss future management Financial impost or legal sanctions for inordinate delays in accepting recommended options and/or providing RACF listings Mandated acceptance of first available interim care or RACF bed pending transfer to facility of first choice at a later date when vacancy arises
4	Delays in assessments internal to hospital (ACAT, social worker, geriatrician or psychiatrist reviews, identification of EPOA or SDM)	Single common assessment process Ability to undertake decisions in medically stable patients despite ongoing prolonged courses of active treatment (e.g. intravenous antibiotics for osteomyelitis or endocarditis) Higher frequency of ACAT assessment rounds (especially over public holiday periods) Reduced turnaround times for ACAT decisions Request to families to nominate EPOA or SDM early in admissions More social workers
5	Delays in delivery of home support (domiciliary care, home equipment or aids or modifications)	Hospitals to hire home equipment for a limited period while undergoing trial in hospital or RACF, pending completion of the MASS application for final approval Extra funding to occupational therapists to complete equipment trials in hospital, community or RACFs Hospital preferred provider of home equipment and home modifications In-house supply and rental service of assistive appliances (e.g. walking frames or wheelie-walkers, crutches, orthotic aids etc.) Local or regional professional teams to coordinate care packages More diversified range of home care packages and services Reinstatement of state-level public funding for home care services Contractual requirement for community-based support agencies to provide flexible patient-centred services

(*continued next page*)

Table 4. (*continued*)

Ranking	Cause of delay	Potential remedial strategies
6	Wait for investigations or resolution of undefined medical condition in clinically stable patient not receiving acute care	Cancellation of tests ordered by non-general medicine specialists viewed as unnecessary for management Ability to initiate assessment and care or placement processes in the absence of a specific diagnosis (e.g. patients with prolonged delirium of unknown cause, psychological or behavioural problems)
7	Management of acute medical complications	Early initiation of advance care planning in eligible patients with poor prognosis More proactive use of HITH teams in providing active treatment of medical condition in non-hospital settings

maximum 4 weeks) while being trialled in hospital and, if found suitable, transferred with the patient to community or RACF. This could expedite discharge pending completion of the MASS application approving final purchase. Extra funding or resources may be given to occupational therapists to complete equipment trials in a timely manner, either in hospital or in nursing homes and private residences. A list of preferred providers of home equipment and modifications could be developed based on cost and responsiveness to requests. More scope to transfer or discharge patients to respite care while equipment trials or home modifications are being undertaken would also assist. The hospital could consider funding several beds held in trust by external agencies, such as the Lions Club, and hired out for a limited period of time to facilitate discharge while private funding is arranged for final purchase.

Calls were also made for a more diversified and flexible range of care packages and home services, reinstatement of state-level public funding for home care services (removed following federal reforms to Home and Community Care funding in 2013), reduction or even abolition of bonds having to be paid to gain entry to residential care and improved access to housing for homeless people and to supported accommodation for patients with needs but who are ineligible for residential care.

Because hospital-acquired medical complications prolong hospital stays,[22] preventive efforts should be enhanced, coupled with advance care plans that state the indications for conservative care in patients with poor prognosis and quality of life.[23]

Finally, tracking systems that regularly report the status and discharge planning of patients with non-acute stays exceeding 4 weeks to all relevant stakeholders may encourage more concerted efforts to expedite discharge.[24,25]

Although all the patients in the present study had been admitted acutely via the ED, half had an acute LOS of 7 days or less, suggesting a short-lived acute medical problem precipitated decompensation of a long-standing situation of diminishing capacity and insufficient home care. Our experience, and that of others,[26] suggests that older patients and their families often fail to access additional support or residential care despite evident need. Interdisciplinary teams, including general practitioners, that closely monitor frail older patients in the community and promptly mobilise resources, including ACAT assessments, in response to rising medical or social needs can reduce hospital admissions of such patients by up to 50%.[27,28]

Operationalising many of these strategies will require negotiation over time between different agencies across different jurisdictions (health and social services). In the short term, hospital and health services could collaborate with all relevant non-acute care stakeholders within their catchment in developing an integrated governance structure aimed at making best use of all local resources for non-acute care. Such an intersectoral approach appears to improve clinical outcomes[29] and may reduce the number of non-acute patients in hospitals subjected to discharge delays by up to 50%.[30]

Conclusion

Delayed discharges of non-acute patients threaten to consume an ever-increasing proportion of bed days in acute hospitals, with knock-on effects on compliance with NEAT, elective surgery targets and patient throughput, and unnecessary exposure of vulnerable patients to hospital-acquired medical complications. Efforts are required to contain and reverse this challenge on the part of stakeholders, both within and outside hospitals.

Competing interests

None declared.

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References

1 Glasby J, Littlechild R, Pryce K. All dressed up but nowhere to go? Delayed hospital discharges and older people. *J Health Serv Res Policy* 2006; 11: 52–8. doi:10.1258/135581906775094208

2 Flintoft VF, Williams JI, Williams RC, Basinski AS, Blackstien-Hirsch P, Naylor CD. The need for acute, subacute, and nonacute care at 105 general hospital sites on Ontario. *CMAJ* 1998; 158: 1289–96.

3 New PW, Cameron PA, Olver JH, Stoelwinder JU. Inpatient subacute care in Australia: perceptions of admission and discharge barriers. *Med J Aust* 2011; 195: 538–41. doi:10.5694/mja10.11361

4 Bryan K. Policies for reducing delayed discharge from hospital. *Br Med Bull* 2010; 95: 33–46. doi:10.1093/bmb/ldq020

5 Manzano-Santaella A. Disentangling the impact of multiple innovations to reduce delayed hospital discharges. *J Health Serv Res Policy* 2010; 15: 41–6. doi:10.1258/jhsrp.2009.009049

6 Baumann M, Evans S, Perkins M, Curtis L, Netten A, Fernandez JL, Huxley P. Organisation and features of hospital, intermediate care and social services in English sites with low rates of delayed discharge. *Health Soc Care Community* 2007; 15: 295–305. doi:10.1111/j.1365-2524.2007.00697.x

7 Hubbard G, Huby G, Wyke S, Themessl-Huber T. Research review on tackling delayed discharge. Edinburgh: Scottish Executive Social Research; 2004.

8 Buist MD, Jaffray L, Bell E, Hanna L, Weinstein P, Kumar S, Grimmer K. Utilisation of beds on the general medical unit by 'non-acute medical' patients: a retrospective study of incidence and cost in two Tasmanian regional medical hospital units. *Intern Med J* 2014; 44: 171–7. doi:10.1111/imj.12335

9 McCloskey R, Jarrett P, Stewart C, Nicholson P. Alternate level of care patients in hospitals: what does dementia have to do with this? *Can Geriatr J* 2014; 17: 88–94. doi:10.5770/cgj.17.106

10 Bryan K, Gage H, Gilbert K. Delayed transfers of older people from hospital: causes and policy implications. *Health Policy* 2006; 76: 194–201. doi:10.1016/j.healthpol.2005.06.005

11 Hendy P, Patel JH, Kordbacheh T, Laskar N, Harbord M. In-depth analysis of delays to patient discharge: a metropolitan teaching hospital experience. *Clin Med* 2012; 12: 320–3. doi:10.7861/clinmedicine.12-4-320

12 Marks L, Flannery RB Jr, Spillane M. Placement challenges: implications for long-term care of dementia sufferers. *Am J Alzheimers Dis Other Demen* 2001; 16: 285–8. doi:10.1177/153331750101600504

13 Poole R, Pearsall A, Ryan T. Delayed discharges in an urban in-patient mental health service in England. *Psychiatr Bull* 2014; 38: 66–70. doi:10.1192/pb.bp.113.043083

14 Devapriam J, Gangadharan S, Pither J, Critchfield M. Delayed discharge from intellectual disability in-patient units. *Psychiatr Bull* 2014; 38: 211–15. doi:10.1192/pb.bp.113.044388

15 Australian Bureau of Statistics (ABS). Population by age and sex, regions of Australia; hospital and health services. Catalogue No. 3235.0. Canberra: ABS; 2014.

16 Jansen I. Residential long-term care: public solutions to access and quality problems. *Healthc Pap* 2011; 10: 8–22. doi:10.12927/hcpap.2011.22186

17 Metro South Hospital and Health Service (MSHHS). Dementia services strategy. Brisbane: MSHHS; 2015. Available at: https://metrosouth.health.qld.gov.au/sites/default/files/dementia_services_strategy.pdf [verified 26 February 2016].

18 Wilkinson TJ, Kiata LJ, Peri K, Robinson EM, Kerse NM. Quality of life for older people in residential care is related to connectedness, willingness to enter care, and co-residents. *Australas J Ageing* 2012; 31: 52–5. doi:10.1111/j.1741-6612.2010.00503.x

19 Chen JJ, Finn CT, Homa K, St Onge KP, Caller TA. Discharge delays for patients requiring in-hospital guardianship: a cohort analysis. *J Healthc Qual* 2015; in press.

20 van Bilsen PM, Hamers JP, Groot W, Spreeuwenberg C. Demand of elderly people for residential care: an exploratory study. *BMC Health Serv Res* 2006; 6: 39. doi:10.1186/1472-6963-6-39

21 Gravolin M, Rowell K, de Groot J. Interventions to support the decision-making process for older people facing the possibility of long-term residential care. *Cochrane Database Syst Rev* 2007; 3: CD005213.

22 Lagoe RJ, Johnson PE, Murphy P. Inpatient hospital complications and lengths of stay: a short report. *BMC Res Notes* 2011; 4: 135–9. doi:10.1186/1756-0500-4-135

23 Scott IA, Rajakaruna N, Shah D, Miller L, Reymond E, Daly M. Normalising advance care planning in a tertiary hospital general medicine service: an exploratory study. *Aust Health Rev* 2015; doi:10.1071/AH15068

24 Gamble KH. Connecting the dots. Patient flow systems are being leveraged to increase throughput, improve communication, and provide a more complete view of care. *Healthc Inform* 2009; 25: 27–9.

25 Maloney CG, Wolfe D, Gesteland PH, Hales JW, Nkoy FL. A tool for improving patient discharge process and hospital communication practices: the 'Patient Tracker'. AMIA Annual Symposium Proceedings 2007; Oct 11: 493–7.

26 Coleman C, Smith J, Frank JC, Min S-J, Parry C, Kramer AM. Preparing patients and caregivers to participate in care delivered across settings: the care transitions intervention. *J Am Geriatr Soc* 2004; 52: 1817–25. doi:10.1111/j.1532-5415.2004.52504.x

27 Beland F, Bergman H, Lebel P, Clarfield AM, Tousignant P, Contandriopoulos A-P, Dallaire L. A system of integrated care for older persons with disabilities in Canada: results from a randomized controlled trial. *J Gerontol A Biol Sci Med Sci* 2006; 61: 367–73. doi:10.1093/gerona/61.4.367

28 Markle-Reid M, Browne G, Gafni A. Nurse-led health promotion interventions improve quality of life in frail older home care clients: lessons learned from three randomized trials in Ontario, Canada. *J Eval Clin Pract* 2013; 19: 118–31. doi:10.1111/j.1365-2753.2011.01782.x

29 Eklund K, Wilhelmson K. Outcomes of coordinated and integrated interventions targeting frail elderly people: a systematic review of randomised controlled trials. *Health Soc Care Community* 2009; 17: 447–58. doi:10.1111/j.1365-2524.2009.00844.x

30 Andersson G, Karlberg I. Integrated care for the elderly. The background and effects of the reform of Swedish care of the elderly. *Int J Integr Care* 2000; 1: 1–10.

QCAT Guardianship Process Initiative

Project description and outcomes as at January 2017

The QCAT Guardianship Process initiative was developed to improve patient flow and create additional capacity in MNHHS by addressing delays associated with engagement with the Queensland Civil and Administrative Tribunal (QCAT).

The initiative has more than halved the average wait time from date of application to date of hearing for MNHHS patients who require an alternative decision-maker to be appointed by QCAT. Enhanced governance and communication arrangements between MNHHS and QCAT have improved the application and hearing scheduling process. Patients have benefited from more timely transfer to more appropriate care environments.

The initial 12-week trial (July – September 2016) was funded by the Department of Health as a Winter Bed Management Strategy. A further 12 months of funding to September 2017 was subsequently sourced from the Integrated Care Innovation Fund (ICIF).

The Challenge

- A cohort of approximately 200 people per annum who are inpatients of MNHHS facilities and who lack the capacity to make their own personal and/or financial decisions so require an alternative decision-maker to be appointed by QCAT. Two thirds of this cohort is aged over 65, with a median age of 73.
- This cohort of inpatients are subjected to long and increasing waits to access QCAT hearings, an average wait of 66 days for MNHHS inpatients accessing hospital-based hearings between January and June 2016.
- These lengthening waits are medically unnecessary, meaning that whilst patients continue to receive care, an acute hospital ward is not the most appropriate environment, and that scarce bed days are being utilised by patients who have no acute medical reason to occupy them.
- The large and increasing numbers of applications are placing constraints on QCAT's limited resources and are contributing to lengthening delays.

The Model

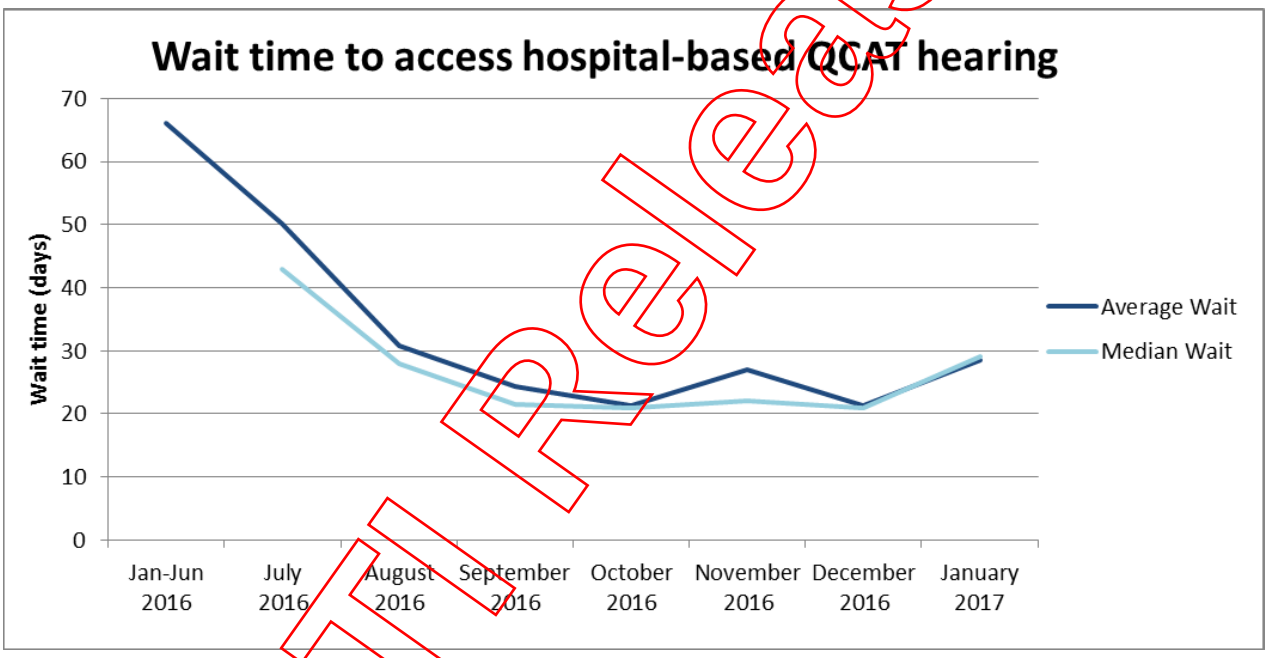
1) Established a dedicated QCAT Social Work Coordinator role to act as a single point of escalation within MNHHS for matters relating to QCAT, and to act as a single point of contact with QCAT's hospital case management team.
2) Purchased additional hospital-based hearing days from QCAT, with the cost of purchase to be more than outweighed by the benefits in terms of bed capacity creation through reduction in length of medically unnecessary hospital stays.
3) Developed guidelines and educational materials to assist MNHHS staff to navigate the QCAT application process.

The Outcomes

- Reductions in average wait from date of QCAT application to date of hearing to 35 days during the trial period. This is compared to an average of 66 days in the six months preceding the trial. This average has been further reduced to 25 days during the post-trial period (October 2016 – January 2017).

Monthly Average wait times from date of application to date of hearing - MNHHS

Month	Hospital Hearings	Average Wait (days)
January – June 2016	21	66
July 2016	14	50
August 2016	20	31
September 2016	10	24
Initial Pilot Totals	**44**	**35**
October 2016	10	21
November 2016	23	27
December 2016	9	21
January 2017	17	28
Post-Pilot Totals	**59**	**25**
Project Totals	**103**	**30**



- During the initial pilot period, an estimated 1,247 bed days of additional capacity were created due to the reduction in bed days occupied by patients awaiting QCAT hearings.
- An externally-prepared evaluation report estimates project return on investment of **402%**. This is based on an assessment of the value of additional bed days created, a conservative 90/10 estimate of bed mix of created capacity (subacute vs acute) and internal MNHHS data on cost per bed day for the 2015/16 financial year.
- MNHHS clinical stakeholders have indicated their satisfaction with the outcomes of the project, in particular the improvement in communication between MNHHS and QCAT.

The Future

- During 2017, the project team will work with the Department of Health to explore the sustainability of the model, as well as its potential portability to other HHSs.
- Under ICIF funding, the project scope has been expanded to also examine potential process improvement initiatives between MNHHS and the Office of the Public Guardian (OPG). Negotiations are underway for a senior OPG employee to be based in MNHHS and to act as the alternative decision-maker for MNHHS inpatients requiring the appointment of the Public Guardian.

Social Work Co-ordinator Role – whilst there is no single purpose for this role, one of the aims of the pilot was to centralise the guardianship process which has been misaligned, inconsistent and reliant on a localised model developed to suit the needs of individual hospitals. Historically, there has been no HHS wide focus on this cohort and therefore, the "QCAT-guardianship problem" has been largely perceptive rather than measured. The co-ordinator position required a person with contextual, empirical and local know of the process, and with relevant established networks across and beyond the HHS.

The role has provided a single point of contact between the HHS and the other agencies involved in the guardianship process.

It has also provided a means to support and advise clinicians across the district and a medium to identify the internal systemic practices and issues which frequently lead to counter-productive processes, practices and relationships between the HHS, QCAT, Public Trustee and the Office of the Public Guardian and less than optimal outcomes for the patients.

This delivered an opportunity to develop resources and tools to support health professionals with the QCAT application process and in their interactions with the guardianship processes, address the knowledge gaps, and improve the standard and consistency of applications and practices.

With regard to the inter-agency processes, the pre-pilot model was one in which respective agencies tended to operate with siloed – serial processes focused on their internal priorities. This approach was non-collaborative and where the patient's rights and needs were over-shadowed by organisational imperatives.

Social Work is a Values based profession underpinned by social justice and human rights. The role has thus ensured that the adult – patient remains at the centre of the guardianship process. Activities with and between the HHS and other agencies have shifted towards a partnership model and patient outcomes, in the context of the guardianship process, are now more timely and appropriate and more increasingly, arrived at through inter-agency collaboration.

The social work contribution to the role can be summarised as follows:

Social Work Profession

- Social Justice Framework/Human Rights – "do what is right"
- Convention on the Rights of Persons with Disabilities
- GAA General Principles & Health Care Principle
- hospitals are for sick people

- patients have the right to say no

Clinical

- Patient –centred care : right care, right place, right time
- Liaison point for social workers/health professions to provide advice and guidance with process

Operational

- Facilitating patient flow
- Centralising communications
- Point of escalation between HHS and external agencies
- Collecting and maintaining data
- Aligning and streamlining inter-agency guardianship processes

Strategic

- inter-agency collaboration, networking internal and external to HHS and Health
- this has led to a gradual shift in culture of siloed, serial approach by all agencies involved in care of patients in the cohort

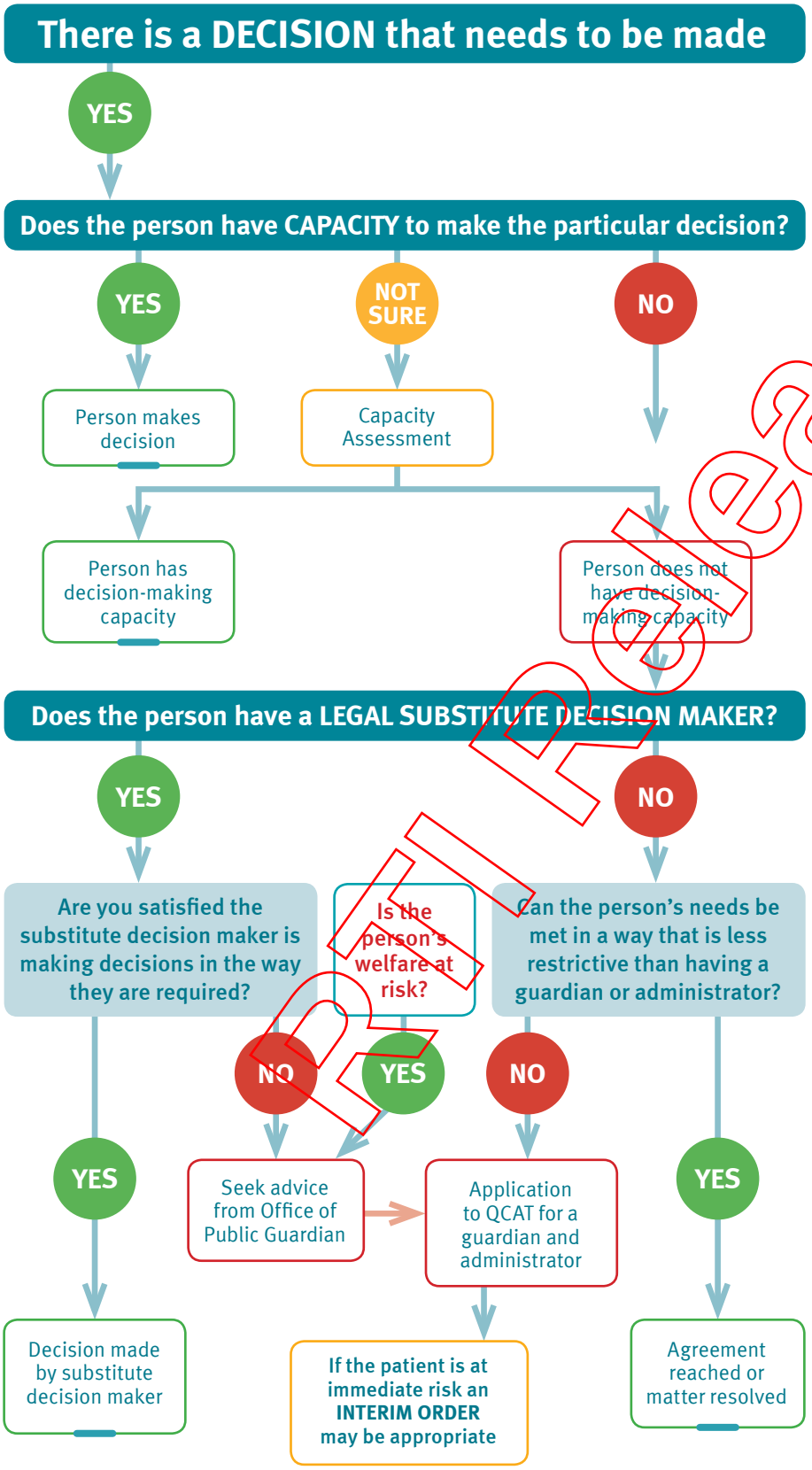
Safety & Quality –

- developed resources intended to provide health professionals a single source of information when faced with prospect of applying to QCAT ► optimising the quality of QCAT applications
- addressing knowledge gaps in the guardianship process / legislative requirements
- minimising interim orders to ensure they meet criteria outlined in legislation- now rarely dismissed

Metro North Hospital and Health Service

QCAT Guardianship and Administration Process

A flowchart to guide the decision-making process when considering an application to QCAT



NEED:

Does it appear that decisions need to be made in regards to the patient's welfare?

TYPES OF DECISIONS:

Personal and health decisions: there are a range of decisions that can be made on behalf of a patient without the need for the appointment of a guardian by the Tribunal. Most health care decisions can be made by members of the patient's existing support network. QCAT will only appoint a guardian if there is nobody in the patient's life or conflict exists within the patient's support network.

Financial: most financial institutions, aged care facilities and service providers require a formal authority to enable someone to make financial decisions on behalf of a patient. These institutions will require a formal authority such as an EPA or QCAT order.

CAPACITY:

Does the patient appear to exhibit a lack of capacity to make decisions with regard to their welfare?

Capacity – capacity for a person for a matter means the person is capable of:
(a) Understanding the nature and effect of decision about the matter; and
(b) Freely and voluntarily making decisions about the matter; and
(c) Communicating the decision in some way. If a person needs to make a decision and is unable to carry out any part of this process, they have impaired decision-making capacity.

ENDURING POWER OF ATTORNEY:

Is an important legal document allowing someone else to make personal and/or financial decisions on a person's behalf. Generally, if a person has made an EPA and the appointed attorney(s) are willing to act, an application to QCAT is not required.

APPROPRIATENESS:

Does the patient already have, or now requires a formal decision maker?

Guardian and/or administrator appointed by QCAT – in the absence of a formal decisionmaker, or conflict exists within a patient's network, QCAT is able to appoint a guardian and /or an administrator for the patient. If you believe a patient needs to have decisions made on their behalf and no authority exists to make those decisions, then you should make an application to QCAT. You should notify the patient of what you intend to do.

INTERIM ORDER:

If the tribunal is satisfied there is some evidence of impaired decision-making capacity and there appears to be an immediate risk of harm to health, welfare or property of the adult concerned in an application, including risk of abuse, exploitation, neglect or self-neglect, the tribunal may make an interim order.

Applying for a guardian or administrator?
For application forms and further information visit QCAT at: www.qcat.qld.gov.au/

Seeking advice from Public Guardian?
Email: adult@publicguardian.qld.gov.au
Phone: 1300653187

V1. Effective: Dec 2016 Review: Dec 2017
Adapted from Guardianship and Administration © www.publicadvocate.vic.gov.au

Queensland Government

Metro North Hospital and Health Service *Putting people first*

Organisational Development, Strategy & Implementation

Metro North Hospital and Health Service

QCAT* Application Guidelines for Adult Inpatients

Queensland Government

Published by the State of Queensland (Metro North Hospital and Health Service), July 2016

For more information, contact:
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Contents

1. Introduction

The purpose of this guideline is to assist health professionals in Metro North Hospital and Health Service have a better understanding of the QCAT application process for adult patients with impaired decision-making capacity who need the appointment of a substitute decision maker during their hospitalisation.

The guideline provides information to support the following processes:

1. Introductory information on Queensland Civil and Administrative Tribunal (QCAT) and guardianship and administration in Queensland
2. Introductory information on the definition of legal capacity in Queensland
3. Outline of the General Principles that inform the QCAT application process
4. Guidelines to determine when/if a person may require a QCAT application
5. Guidelines and links to support the application process
6. Links to current legislation pertinent to QCAT guardianship and administration matters

This document has been reviewed and endorsed by QCAT and is supported by the Office of the Public Guardian and the Public Trustee.

1.1 Queensland Civil and Administrative Tribunal (QCAT)

QCAT is an independent tribunal which can make decisions about decision-making for adults with impaired capacity. This includes, whether a person will be made subject to guardianship and/or administration appointment, whether less restrictive alternatives can be used and whether existing orders are continued or revoked[1].

The Tribunal will only appoint a guardian or administrator if it is satisfied that:

- The adult has impaired capacity;
- There is a need for a guardian or administrator;
- If a guardian or administrator is not appointed, the adult's needs will not be adequately met or their interests will not be adequately protected.[2]

Guardianship is a serious intervention as it removes the rights of the represented person to make decisions for themselves about their own life and gives this responsibility to another person.

When lodging a QCAT application seeking the appointment of an Administrator and/or Guardian, as applicants, health professionals must provide the Tribunal with sound evidence and reports that satisfy the Tribunal's criteria as described in the *Guardian and Administration Act 2000*[3]. They must also demonstrate that there are no informal workable decision making processes in place that are adequate to protect the adult, or that a dispute cannot be resolved informally. Informal decision making is consistent with the least restrictive approach to a person's rights.[4]

In keeping with the General Principles of the *Act*[5], applications on behalf of persons who identify as Aboriginal and Torres Strait Islander, or persons from a cultural and linguistically diverse background (CALD) must be embedded in respect for the pertinent cultural and social values of the adult and the impact on how a person's decision making ability is perceived.

1.2 About decision-making capacity

The Queensland Law Society Handbook for Practitioners on Legal Capacity (2014)[6] outlines the basic principles of Legal Capacity in the following way:

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[1] Office of the Public Advocate, 'Decision-making support and Queensland's guardianship system
[2] *Guardianship and Administration Act 2000*: Part 1, 12
[3] Ibid, 3
[4] Ibid, 4, Part B:5, p37
[5] *Guardianship and Administration Act 2000*, sch 1, Principles, 9, p, 145
[6] Queensland Law Society, 2014, *Queensland Handbook for Practitioners on Legal Capacity*, p.19-23

1.2.1 Presumption of capacity

At common law a person's legal capacity is presumed. In Queensland this is upheld by the *Guardianship and Administration Act 2000* and the *Powers of Attorney Act*.[7]

If an adult[8] loses capacity and has not made an enduring power of attorney, the *Guardianship and Administration Act* provides a mechanism for decisions to be made on behalf of an adult if they lose capacity due to accident, illness, undue influence or age.[9]

There are three elements to making a decision:

1. Understanding the nature and effect of the decision;
2. Freely and voluntarily making a decision; and
3. Communicating the decision in some way[10].

An adult is presumed to have capacity for a matter unless it can be shown otherwise. [11] If an adult needs to make a decision and is unable to carry out any part of the decision-making process, they have impaired decision-making capacity.

Furthermore, the Office of the Public Advocate[12] emphasises the importance of the manner in which capacity is assessed because: *"legal capacity sets the threshold for individuals to take certain actions that have legal consequences";* and

> *"A finding of impaired capacity for a matter means that a person can no longer exercise their legal capacity for that matter; that is, the law will not recognise the decisions that the person makes in relation to that matter. If a person is found to lack capacity for a matter, a substitute decision-maker such as a guardian or administrator may be appointed to make decisions for them, or an enduring power of attorney may be activated. A finding such as this has an obvious and significant impact on a person's autonomy."*[13]

1.2.2 Capacity is time-specific

Capacity fluctuates over time and a person may lack capacity for a particular decision temporarily – for a short period of time or for a long period of time[14]. Whether a person has decision-making capacity may also depend on environmental factors such as the time of day, location, noise or who is present. Capacity may be affected by personal stress or anxiety levels, medication, infection, drugs or alcohol. Therefore, when one or more of these factors are removed or remedied, a person may regain and even increase their capacity in relation to a decision.

1.2.3 Capacity is domain-specific

There is no single test for capacity; the test depends on the subject matter of the decision to be made. A "domain" refers to the general category of subject matter that the decision falls into.[15] The Queensland Law Society highlights that the entire structure of the *Guardianship and Administration Act 2000 (Qld), Powers of Attorney Act 1998 (Qld*) and *Public Guardian Act 2014 (Qld)* recognises that a person may only have impaired capacity for one 'matter", but at the same time retain capacity in relation to every other 'matter."[16]

Whether a person has decision-making capacity is decided according to the law. In different areas of life there are different legal tests for whether a person has the capacity to make a decision. For example, the test for capacity to

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[7] *Guardianship and Administration Act 2000*(Qld) sch1, pt 1 principle 1*; Powers of Attorney Act 1998* (Qld) sch 1, pt 1, principle 1

[8] Adult is defined in Sch 1 *Acts Interpretation Act 1954 (Qld)* as an individual who is 18 or more

[9] Public Trustee: http://www.pt.qld.gov.au/disability-and-aged-support/guardianship-and-administration.html

[10] *Guardianship and Administration Act 2000* (Qld) sch 4*; Powers of Attorney Act 1998* (Qld) sch 3.

[11] Queensland Law Society, 2014, *Queensland Handbook for Practitioners on Legal Capacity*, p.12

[12] Australian Law Reform Commission cited in *Decision-making support and Queensland's guardianship system*, 2016, Office of Public Advocate (Qld), p.54

[13] Office of the Public Advocate (Qld) 2016, *Decision-making support and Queensland's guardianship system,* p.54, http://www.justice.qld.gov.au/__data/assets/pdf_file/0010/470458/OPA_DMS_Systemic-Advocacy-Report_FINAL.pdf

[14] Ibid, 6, p.19

[15] Ibid, 6, p.20

[16] See, e.g., *Guardianship and Administration Act 2000*(Qld) s 12, sch 2 (list of matters); *Powers of Attorney Act 1998* (Qld)s 32, sch 2 (list of matters)

make a will is different from the test for capacity to make a medical decision. These tests also vary depending on the State or Territory.[17]

1.2.4 Capacity is decision-specific

The level of mental competence necessary to have capacity to make a particular decision depends on the nature and complexity of the decision in question. The *Guardianship and Administration Act 2000*, states:

> '*the capacity of an adult with impaired capacity to make decisions may differ according to… the type of decision to be made, including, for example, the complexity of the decision to be made'.*[18]

For example an individual may have capacity to decide where they live, pay their bills and buy groceries, but may not be able to make investment decisions about their money or sell their house. They may be able to make a simple medical decision to have a blood test but lack the capacity to decide about complex medical decisions such as amputations.

1.2.5 Capacity to decide must be distinguished from the decision itself

Capacity should not be determined purely by examining the content of a person's decisions. 'Capacity does not require a person to always make decisions that are objectively correct or in their own best interests or in the best interests of certain others'.[19] The *Guardianship and Administration Act 2000*, states that "the right to make decisions includes the right to make decisions with which others may not agree".[20]

1.2.6 No assumption of incapacity due to appearance, age, behaviour or disability

'Capacity should not be assessed solely on the basis of a person's appearance, their age, the manner in which they behave and communicate or any (physical or intellectual) disability or impairment they may have'.[21]

While a person may have a disability or medical condition, this does not mean that they lack decision-making capacity. For example, a diagnosis of Alzheimer's disease or other dementia, mental illness, intellectual or other cognitive disability or acquired brain injury does not automatically mean a person cannot make their own decisions.

1.2.7 Capacity may be increased with appropriate support

Often there are easy ways to assist or support people to make their own decisions. For example: getting an interpreter, using plain language and simple sentences when communicating, using pictures or photos, writing things down, using technology ,or finding a quiet comfortable place.

1.2.8 Substituted decision making is a last resort

According to the *Guardianship and Administration Act 2000*, 'the right of an adult with impaired capacity to make decisions should be restricted, and interfered with, to the least possible extent'.[22]

Failure to take into account a person's wishes and include their support network in decision making can lead to the removal of the substituted decision maker by the Tribunal.

2. Exclusions

Persons under eighteen years of age are excluded from the *Act* and this application process. It is noted that Section 13 of the *Guardianship and Administration Act 2000* [23]allows the Tribunal to make an "Advance appointment" when

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[17] http://capacityaustralia.org.au/about-decision-making-capacity/

[18] *Guardianship and Administration Act 2000*(Qld) s 5 (c)(ii)

[19] Queensland Law Society, 2014, *Queensland Handbook for Practitioners on Legal Capacity, p.21*

[20] *Guardianship and Administration Act 2000*(Qld) s 5(b)

[21] Ibid, 16

[22] Ibid, s 5(a)

[23] Ibid, s 13.

the individual is 17 years and 6 months. These appointments come into effect when the individual turns 18 years of age.

3. General Principles

The principles guiding the application process are consistent with the *General Principles*[24] described in the *Act* as follows:

Presumption of capacity

1. An adult is presumed to have capacity for a matter.

Same human rights

2. (1) The right of all adults to the same basic human rights regardless of a particular adult's capacity must be recognised and taken into account.

(2) The importance of empowering an adult to exercise the adult's basic human rights must also be recognised and taken into account.

Individual value

3. An adult's right to respect for his or her human worth and dignity as an individual must be recognised and taken into account.

Valued role as a member of society

4. (1) An adult's right to be a valued member of society must be recognised and taken into account.

(2) Accordingly, the importance of encouraging and supporting an adult to perform social roles valued in society must be taken into account.

Participation in community life

5. The importance of encouraging and supporting an adult to live a life in the general community, and to take part in activities enjoyed by general community, must be taken into account.

Encouragement of self-reliance

6. The importance of encouraging and supporting an adult to achieve the adult's maximum physical, social, emotional and intellectual potential, and to become as self-reliant as practicable, must be taken into account.

Maximum participation, minimal limitations and substituted judgement

7. (1) An adult's right to participate, to the greatest extent practicable, in decisions affecting the adult's life, including the development of policies, programs and services for people with impaired capacity for a matter must be recognised and taken into account.

(2) Also, the importance of preserving, to the greatest extent practicable, an adult's right to make his or her own decisions must be taken into account.

(3) So for example –

- The adult must be given any necessary support and access to the information, to enable the adult to participate in decisions affecting the adult's life; and
- To the greatest extent practicable, for exercising power for a matter for the adult, the adult's views and wishes are to be sought and taken into account; and
- A person or other entity in performing a function or exercising a power under this Act must do so in the way least restrictive of the adult's rights.

(4) Also, the principle of substituted judgment must be used so that if, from the adult's previous actions, it is reasonably practicable to work out what the adult's views and wishes would be, a person or other entity in performing a function or exercising a power under this Act must take into account what the person or other entity considers would be the adult's views and wishes.

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[24] *Guardianship and Administration Act 2000*, sch 1, Principles, p 143-144

(5) However, a person or other entity in performing a function or exercising a power under this Act must do so in a way consistent with the adult's proper care and protection.

(6) Views and wishes may be expressed orally, in writing or in another way, including, for example, by conduct.

Maintenance of existing supportive relationships

8. The importance of maintaining an adult's existing supportive relationships must be taken into account.

Maintenance of environment and values

9. **(1)** The importance of maintaining an adult's cultural and linguistic environment, and set of values (including any religious beliefs), must be taken into account.

(2) For an adult who is a member of an Aboriginal community or a Torres Strait Islander, this means the importance of maintaining the adult's Aboriginal or Torres Strait Islander cultural and linguistic environment, and set of values (including Aboriginal tradition or Island custom), must be taken into account.

Please refer to Multicultural health for information and resources to assist patients from culturally and linguistically diverse backgrounds.

Please refer to Aboriginal & Torres Strait Island Health for information on Indigenous Hospital Liaison Services.

Appropriate to circumstances

10. Power for a matter should be exercised by a guardian or administrator for an adult in a way that is appropriate to the adult's characteristics and needs.

Confidentiality

11. An adult's right to confidentiality of information about the adult must be recognised and taken into account.

Guardians must also apply the health care principle[25] by making sure that whenever they are called upon to make a decision about health care that:

- The health care is necessary and appropriate to maintain or promote the adult's heath or well-being;

And

- Is in the adult's best interests and to greatest extent possible, reflects the adults' views.

The *Act* aims to seek a balance between the right of an adult with impaired decision making capacity to maintain an independent role in their decision making and their right to adequate and appropriate decision making support.

4. Patient rights and the right to take risks

All adult patients regardless of their age have a right to be involved in decision-making on where they should go after hospital. Hospitals have a duty of care to manage risks relative to discharge planning and can make recommendations about discharge plans for patients but they do not make this decision. Older people may make decisions which hospital staff and/or their carers do not agree with but this does not necessarily mean it is a wrong decision.[26]

The Australian Charter of Healthcare Rights sets out the key rights of patients when seeking or receiving healthcare services anywhere in Australia, including public and private hospitals.

More detailed information can be found at Australian Charter of Healthcare Rights[27].

[25] The Health Care Principle: http://www.publicguardian.qld.gov.au/__data/assets/pdf_file/0011/269309/OPG-Fact-Sheet_The-Health-Care-Principle.pdf

[26] https://www.carersvictoria.org.au/Assets/Files/cvic-guardianship%20and%20administration%20applications.pdf

[27] http://www.safetyandquality.gov.au/publications/about-the-australian-charter-of-healthcare-rights-a-guide-for-healthcare-providers/

5. When QCAT may not be necessary[28]

Alternative arrangements are available to adults with impaired decision making capacity who have family, friends and a support network to help them deal with important choices.

- **Enduring power of attorney**

While an adult still has capacity they can appoint someone to make decisions on their behalf by making an enduring power of attorney. An enduring power of attorney remains in effect until the death of an adult. It does not lapse when the adult loses decision-making capacity. Adults can cancel their enduring power of attorney whist they still have capacity. For financial matters, an enduring power of attorney begins whenever the adult wants. An adult can choose to give an attorney immediate power or determine a time when the power starts. If an adult loses capacity to make decisions before the enduring power of attorney takes effect, then the enduring power of attorney begins as soon as the attorney is notified of the adult's condition.

- **General power of attorney**

While an adult still has capacity they can appoint someone to make financial decisions on their behalf when they are absent, viz. overseas. A general power of attorney ceases when an adult loses capacity.

QCAT can make a declaration about whether an adult has capacity to make an enduring power of attorney; and can also make a declaration about the validity of an appointment or an administrator's /guardian's actions.

- **Statutory health attorney**[29]

A statutory health attorney is someone with automatic authority to make health care decisions on an adult's behalf when an adult has impaired capacity, either permanently or temporarily, to make health care decisions.

A statutory health attorney can act if an adult has not:

i. set out relevant directions for medical treatment in an advance health directive

ii. appointed an attorney for personal matters under an enduring power of attorney

iii. had a guardian appointed for health care matters by QCAT

Powers of Attorney Act 1998 (s 63)[30] describes who is the statutory health attorney for health matters in a listed order according to who is readily available and culturally appropriate to exercise power for the matter –

(a) a spouse of the adult if the relationship between the adult and the spouse is close and continuing;

(b) a person who is 18 years or more and who has the care of the adults and is not a paid carer for the adult;

(c) a person who is 18 years or more and who is a close friend or relation of the adult and is not a paid carer for the adult.

The *Act* also notes:

> "If there is a disagreement about which of 2 or more eligible people should be the statutory health attorney or how the power should be exercised, see the Guardianship and Administration Act 200, section 42 (Disagreement about health matter)."

More information about enduring powers of attorney can be found at:

- Public Trustee;
- Office of the Public Guardian.

[28] QCAT, Alternative arrangements, http://www.qcat.qld.gov.au/matter-types/guardianship-for-adults-matters/alternative-arrangements
[29] Statutory health attorney, http://www.publicguardian.qld.gov.au/adult-guardian/health-care-decisions/statutory-health-attorney
[30] *Powers of Attorney Act 1998*, s 63, p45

5.1 What should you do when a patient has an existing enduring power of attorney?

When issues of impaired decision making capacity are identified, the social worker or other health professional involved should:

- Check if there is an existing enduring power of attorney
- Request a copy of the notarised document to be filed in the patient's chart
- Check that the document has been witnessed in accordance with the legislative requirements for who can be an eligible witness[31]
- Any issues or concerns relating to the witnessing of an enduring power of attorney should be directed to the Office of the Public Guardian for advice.

6. When is it appropriate to apply to QCAT on behalf of an adult patient for guardianship or administration?

Applying for guardianship and/or administration during a patient's hospital stay maybe triggered by the following factors;

I. There is a ***specific need*** for a decision to be made; *and*

II. The patient has impaired-decision making capacity; *and*

III. There is no substitute decision-maker to make the decision; *or*

IV. There are concerns the substitute decision maker is not making appropriate decisions; *or*

V. There is evidence the patient has impaired decision-making capacity, and there appears to be an immediate risk of harm to the health, welfare and property of the patient concerned, including risk of abuse, exploitation, neglect or self-neglect; *and*

VI. There is no less restrictive way the patient's needs are able to be met.

6.1 Types of decisions

Decisions are categorised as either personal and health decisions or financial decisions.

I. *Personal and health decisions* –

There are a range of decisions that can be made on behalf of a patient without the need for the appointment of a guardian by the Tribunal. Most health care decisions can be made by members of the patient's existing support network. QCAT will only appoint a guardian if there is nobody in the patient's life or conflict exists within the patient's support network. Personal and health care decisions may include[32]:

- Accommodation decisions – where and with whom a person lives
- Health care and medical treatment
- Access to services
- Restriction or prohibition on who may visit a person
- The approval of containment and seclusion in certain limited circumstances #
- The approval of chemical, physical or mechanical restrain t#
- Restricting access to objects #
- Other day-to-day issues

[31] *Powers of Attorney Act 1998*, Chapter 3, Part 1, 31.
[32] http://www.qcat.qld.gov.au/matter-types/guardianship-for-adults-matters

(# note these types of decisions only apply to adults subject to the disability Restrictive Practice regime[33])

II. *Financial decisions –*

Most financial institutions, aged care facilities and service providers require a formal authority to enable someone to make financial decisions on behalf of a patient. These institutions will require a formal authority such as an EPA or QCAT administration order. Financial decisions may include[34]:

- Paying bills
- Maintaining property
- Managing property
- Undertaking a real estate transaction.

Click the link to read about QCAT guardianship and administration decisions.

7. QCAT Application Process[35]

7.1 Things to do before making an application

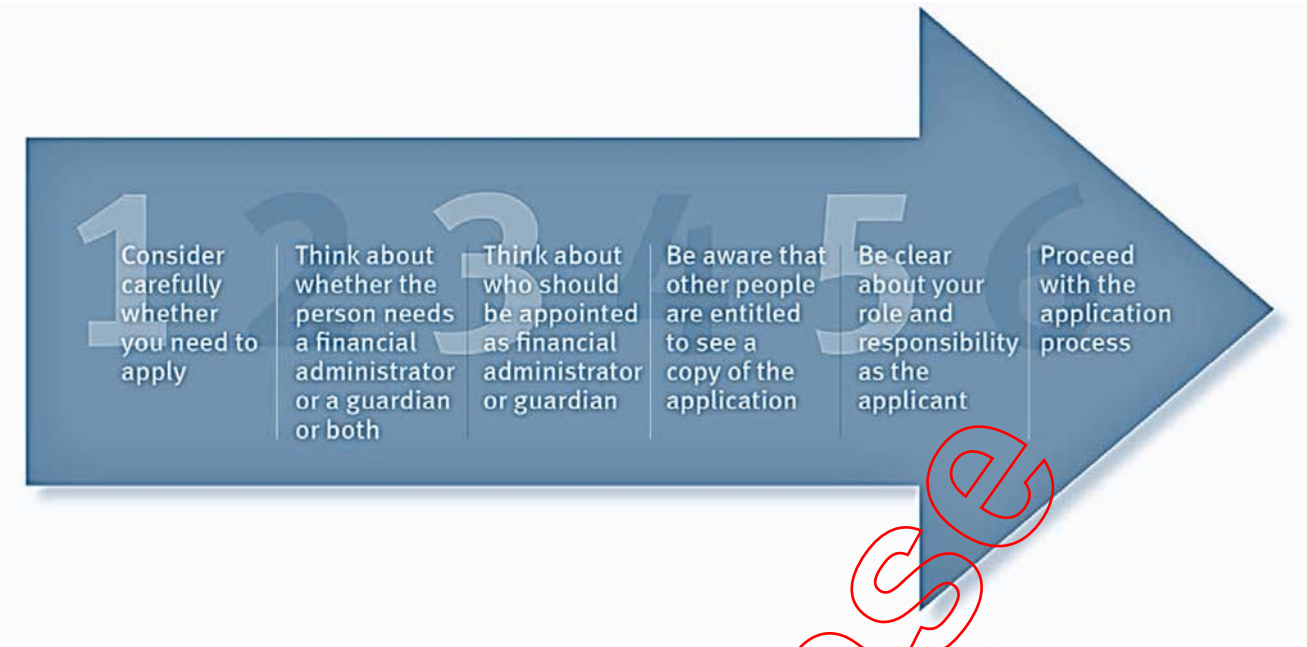
Before making an application for guardianship or administration or both, you:

- must be able to demonstrate to QCAT that there is a specific need for the appointment and that the existing arrangements for decision making are inadequate
- should notify the adult concerned about what you intend to do
- must check whether the adult has given anyone power under an enduring document and if there is such an appointment, prior to lodging the application you must inform the person appointed under the enduring document about what you intend to do
- must obtain details of people who have a close and continuing relationship with the patient
- must ensure that all comprehensive multidisciplinary assessments to establish the patient's decision-making capacity and the level of risk are current and completed. This includes investigation of the decision-making capacity of the person in respect of their physical, cognitive, social, cultural and environmental domains of function which impact on the type and complexity of the decision the person has to make. *The medical opinion to substantiate that the patient has impaired decision-making capacity must be clearly documented in the patient's hospital chart/record*
- must follow your local hospital QCAT application process
- in matters of conflict you may need to seek advice from the Office of the Public Guardian[36]

[33] *Guardianship and Administration Act 2000,* 5B;
[34] http://www.qcat.qld.gov.au/matter-types/administration-for-adults-matters
[35] http://www.qcat.qld.gov.au/matter-types/guardianship-for-adults-matters/application-process

[36] http://www.publicguardian.qld.gov.au/adult-guardian

Before proceeding with an application please consider the following:



The QCAT – Guardianship and Administration Flow Chart may assist you in making the decision to proceed with an application. **REFER Appendix 1**

7.2 Forms to use for the appointment of a guardian or administrator

To apply for the appointment of a guardian and/or administrator, complete and lodge:

Form 10 – Application for administration/guardianship appointment or review – *Guardianship and Administration Act 2000*

AND

A financial management plan for proposed administrators – *Guardianship and Administration Act 2000*

AND

Report by medical and related health professionals – *Guardianship and Administration Act 2000*

7.3 Interim Order

Applying for an interim order is only necessary when there is ***an immediate risk*** of harm to the health, welfare or property of the adult concerned in the application, including because of the risk of abuse, exploitation or neglect or self-neglect by the adult.[37]

A request for an interim order should not be used to facilitate the placement of an adult into residential care.

An interim order may not include consent to special health care[38].

An interim order has effect for the period specified in the order and has a maximum period of 3 months.[39]

Form 54 – Application for interim order – *Guardianship and Administration Act 2000*

A Form 10 and a Report by medical and related health professionals must be included when applying for an interim order.

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[37] *Guardianship and Administration Act 2000*, Chapter 7, s129,ps.122-123
[38] *Guardianship and Administration Act 2000*, Chapter 7, s129, p.123
[39] Ibid, 23

7.3.1 Reporting Abuse

A person being harmed may not be able to report the abuse or be in a position to report it. When you think someone is being abused, report it immediately.

The Queensland Government provides a 6-step guide for health professionals to assess and respond to Elder abuse.

The Office of the Public Guardian can also assist due to its powers to investigate allegations of abuse, neglect or exploitation of adults with impaired capacity. This includes investigating concerns regarding the appropriateness of actions and decisions a substitute decision maker is making on behalf of a person with impaired capacity.

7.4 Other matters

To make an application for the tribunal to decide whether a person has capacity to make a particular decision e.g. executing an enduring power of attorney use:

Form 11 – Application for a declaration about capacity – Guardianship and Administration Act 2000

7.5 Confidentiality

In cases where the applicant has concerns about the risk of harm or injustice by another party should that party have access to the application, they may request the restriction of access by another party to a relevant document or information through a confidentiality order. Should QCAT not grant a request for confidentiality, it may, on request, allow the applicant to retract information.

7.6 Who can apply?

Family members, close friends, health professionals (for example, social workers, medical practitioners, allied health professionals, nurses) or anyone who has a genuine and continuing interest in the welfare of an adult with impaired decision-making capacity can apply for a guardian and/or administrator to be appointed. Adults with impaired decision-making capacity can also apply on their own behalf.[40] [41]

Applicants must be over 18 years of age.

7.7 Who can be appointed as guardian or administrator?

Appointees must be over 18 years of age and not a paid carer for the adult. A paid carer performs services for the adult's care and receives remuneration other than a carer payment or benefit from the Commonwealth or State Government.

When there is no one close to the adult who is willing to accept responsibility; or there is dispute about who should act as guardian or administrator; or there are concerns about the suitability or competence of a proposed guardian. QCAT may appoint the Public Guardian as guardian, or the Public Trustee of Queensland or a private trustee company _ as administrator, to act on the adult's behalf.

7.8 Assessments

To hear and decide a matter in a proceeding, the tribunal must ensure that as far as practicable, it has all relevant information and material.[42] Therefore assessments should include investigations into the decision-making capacity of a person in respect of their physical, cognitive, social, cultural and environmental domains of function which impact on the type and complexity of a decision the person has to make. Consideration must also be given to the way information about the decision is conveyed or communicated to the person and any prevailing undue influences within the person's environment.

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[40] http://www.qcat.qld.gov.au/matter-types/guardianship-for-adults-matters/who-can-apply-for-the-appointment-of-a-guardian

[41] For a case example refer to Queensland Law Society,2014, Queensland Handbook for Practitioners on Legal Capacity, p.46 , http://www.qls.com.au/Knowledge_centre/Ethics/Resources/Client_instructions_and_capacity/Queensland_Handbook_for_Practitioners_on_Legal_Capacity

[42] *Guardianship and Administration Act 2000*, Chapter 7, 130, 123

The medical team may need to consult with a Geriatrician, Psychiatrist or a Neuropsychologist to seek advice, diagnosis, or specialist report that supports a determination of impaired decision-making capacity.

Multidisciplinary assessments may include but are not limited to the following:

- Comprehensive bio-psychosocial assessment
- Mini-Mental State Examination (MMSE)
- Rowland Universal Dementia Assessment Scale (RUDAS)
- Montreal Cognitive Assessment (MOCA)
- ACAT Assessment (if applicable)
- Barthel Index of Activities of Daily Living
- Geriatric Depression Scale
- Kessler Psychological Distress Scale (K10)
- Risk Screening Tool (if applicable)
- Drug and Alcohol service assessment
- Caregiver Strain Index
- Carer and family input

In cases which are **complex**, where there is **evidence of family conflict**, **abuse or exploitation**, or that relate to a **patient's capacity to consent to or refuse medical treatment** the following services are available for consultation:

- Metro North Legal Services
- Office of the Public Guardian
- Office of the Public Advocate

7.9 Providing Documents

Providing all relevant documents helps your application to be processed as smoothly as possible.

Doctors and social workers play a pivotal role in hospital-initiated QCAT applications.

The medical teams are responsible for:

- Referring patients for review to expert clinicians (e.g. Geriatrician, Psychiatrist, Neuropsychologist, Neurology Specialist) for advice and assessments to determine capacity
- Preparing and submitting a medical report in a timely manner.

Social workers are frequently the applicant and may also have the role of supporting families who are seeking a private appointment[43]. This requires them to:

- Co-ordinate the applications process
- Provide the Tribunal with pertinent background collateral that supports the intention of the application;
- Where the social worker is the applicant, ensuring that the application together with all supporting documentation is completed and lodged online;
- Where a social worker is not the applicant, liaising with the applicant to facilitate timely application.

For local practices and procedures please refer to the process outlined by your Social Work Department.

All applications for guardianship and administration must be accompanied by a Report by medical and related health professionals – *Guardianship and Administration Act 2000.*

Without the inclusion of this document the application is incomplete and cannot be processed by QCAT.

[43] See Table 1, p. 15 for definition

7.9.1 Administration Order

You will need to provide –

- Form 10 Application for administration/guardianship appointment or review
- Report by medical and related health professionals
- Financial management plan – proposed administrator

If your application nominates the Public Trustee as administrator, you will need to provide the following information to the Tribunal by the time of the hearing. Providing this information will assist the Public Trustee expedite the commencement of the role when an Order is made, and this will facilitate timely discharge for the adult.

- Centrelink Customer Reference Number (CRN) and an Centrelink Income and Assets statement
- Copy of Bank ATM and Credit Card
- Copy of Medicare Card and Pension Card
- List of and contact details of any professional advisors such as: accountants, solicitors, financial planners etc.
- Tax File Number
- Details of assets/liabilities including account numbers or references
- List of expenditure items such as: property utilities, regular charges and know debts etc.

7.9.2 Guardianship Order

- Form 10 Application for administration/guardianship appointment or review
- Report by medical and related health professionals

If your application nominates the Public Guardian as guardian, you will need to provide the following information to the Tribunal by the time of the hearing. Providing this information will assist the Public Guardian in their decision making process when an Order is made and this will facilitate timely discharge for the adult.

- What is the adult's view (currently or previously expressed) in relation to their future care and support arrangements?
- Does the adult have family or friends that can assist with decision making? If so details of the nature/closeness of their relationship with the adult (e.g. do they already provide day-to-day support?)
- What are the views of interested parties in regard to the adult's future care and support arrangements?
- If there are no known interested parties, what attempts have been made to locate family or friends
- If the adult is unable to return home, what alternative accommodation options have been identified or considered (e.g. residing with family)
- Provide details if any work has been undertaken with the person in regard to Advance Care Planning?
- ACAT assessment – please attach (if applicable)
- Functional OT assessment – please attach
- Has the adult had a trial at home? Please provide details (if applicable)
- Does the adult have approval for a home care package or any other form of funded in-home supports? Please provide details
- Status of Disability Services assessment and contact details for Disability Services location
- Medical history
- Accommodation history, including: type, length, reason for break-down
- Letter from the treating team stating that the adult is unable to return home (if applicable)

The Office of the Public Guardian's policy position on aged care placement is available at:
http://www.publicguardian.qld.gov.au/adult-guardian/our-decisions/residential-aged-care-decisions

7.10 Applicant Responsibilities

- Applicant to keep QCAT updated with adult's contact details e.g. new address if adult is discharge from hospital
- QCAT requires the applicant to provide contact details for any interested parties to enable QCAT to send written notification advising any interested parties of the application
- When a matter is listed for a hearing before QCAT, all parties involved in the application are expected to attend the tribunal in person
- If the applicant wishes to attend the hearing via phone, they will need to first discuss this with the QCAT case manager for the matter. If approval is given for the applicant to attend by phone, then it is the applicant's responsibility to provide a contact phone number at least three business days prior to the hearing[44].
- It is always important that the applicant complete the attendance advice and return this to QCAT even if they are attending in person.
- Prior to the hearing, QCAT may need to discuss the application with the applicant. The applicant should be available, or nominate a proxy, should this be necessary.
- When the adult is a hospital patient, and the applicant has been made by family member or others, QCAT may wish to discuss the case with the health professionals involved in the care of this patient. Medical staff, social workers and other health professionals should make themselves available to QCAT should this be necessary.

7.11 Withdrawing an application

An applicant may make application to withdraw their application at any point in the proceeding. However consent of the Tribunal pursuant to s46 of the *Queensland Civil and Administrative Act (Qld) 2009*[45] is required.

- The applicant is required to make an application on the approved form (Form 40 – Application for miscellaneous matters) and complete the relevant section.
- In some instances the tribunal will also accept a written request to withdraw either via an email or letter.
- The applicant should provide reasons as to why they now believe the adult no longer requires a substitute decision maker as well as any updated capacity information.
- The tribunal will either approve the withdrawal of the application or not approve and thus directing the matter to proceed to hearing.

[44] http://www.qcat.qld.gov.au/going-to-the-tribunal/attending-by-phone
[45] *Queensland Civil and Administrative Act (Qld) 2009, s46*

7.12 Lodgement

For QCAT to proceed with a matter, all forms and supporting documents must be received by QCAT, in person, electronically, or by mail.

Email to: enquiries@qcat.qld.gov.au

All applications and forms must be signed, scanned and then emailed.

By Mail:

QCAT

GPO Box 1639

Brisbane Qld 4001

In person:

QCAT

Level 9

Bank of Queensland Building

259 Queen Street

Brisbane Qld 4000 or at any Magistrates Court (excluding Brisbane)

If you require an onsite hospital hearing, *at the time of application*, you will need to notify by email the MNHHS QCAT Coordinator with details of the application including:

Patient UR

Patient date of birth

Date of application

Name/s of applicant

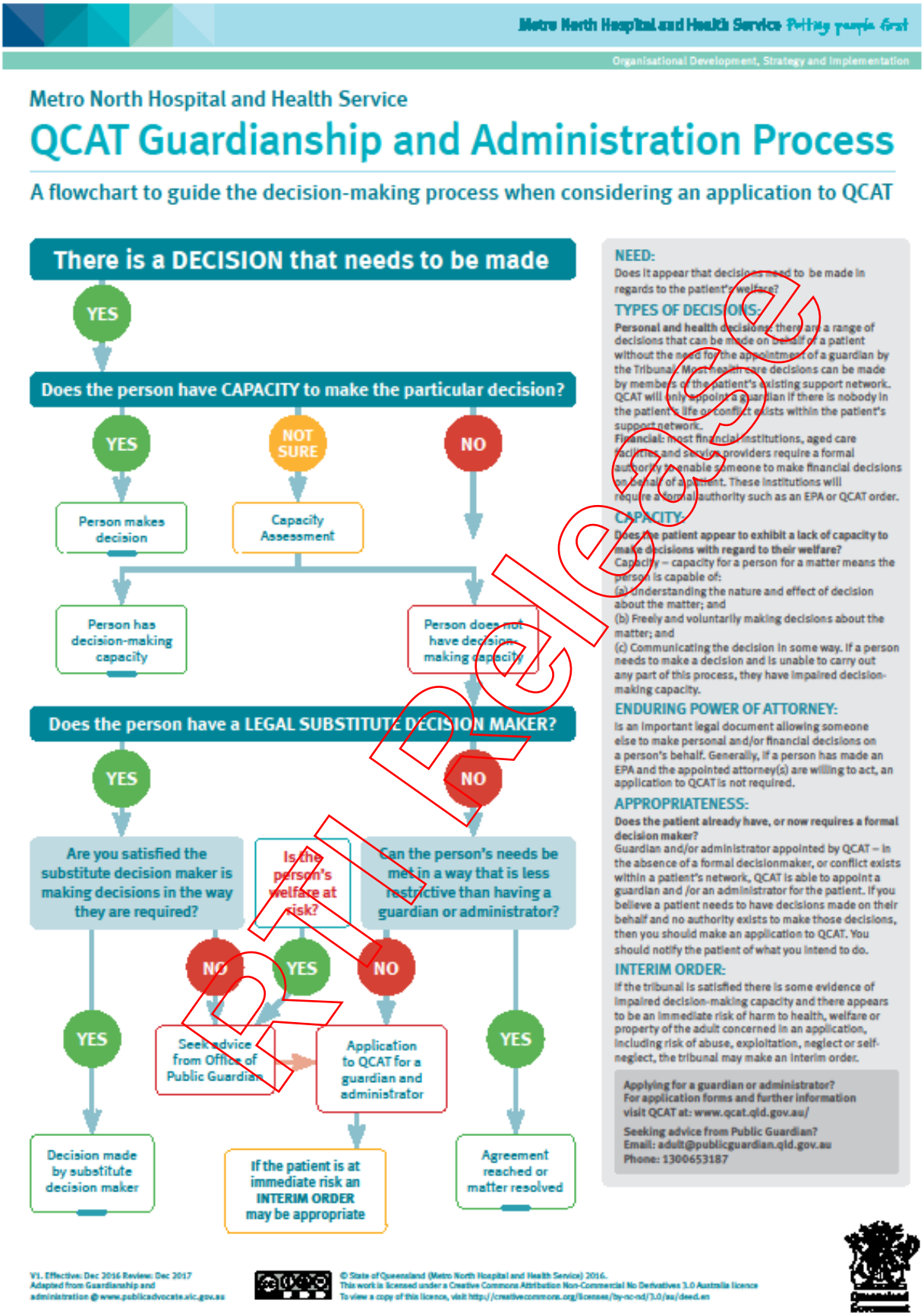
Please email this to: MNHHS_QCAT@health.qld.gov.au

Table 1: Glossary of Terms and Definitions

Act	**A law made by Parliament; also known as an Act of Parliament, legislation or law.**
administrator	A person appointed by QCAT to assist with impaired decision-making capacity by making certain financial and legal decisions on their behalf
Adult	A person who is 18 years of age or older
advance health directive	While an adult still has decision-making capacity they can record their wishes about their health and any medical treatment and appoint an attorney for personal and health matters.
appeal	A procedure which in certain circumstances, a party may request a higher decision-maker to reconsider a decision made. Often leave (or permission) to appeal is required before a decision is reconsidered.
appeal tribunal	This is the internal appeal tribunal in QCAT where most appeals against decisions of QCAT are heard.
appellant	The person or organisation appealing a decision.
applicant	The person who has submitted an application to QCAT requesting assistance in resolving a dispute, grievance or other issue.
capacity	Capacity is specific to a particular decision and means the health practitioner has assessed the person is capable of: (a) understanding the nature and effect of decisions about the matter; and (b) freely and voluntarily making decisions about the matter; and (c) communicating the decisions in some way. It also includes the health practitioner's assessment of the patient's ability to retain the information and process it to reach a decision.
competence	A legal term meaning that the patient has the capacity to make a particular decision.
decision-maker	The patient or other person with the authority to make a particular decision.
enduring power of attorney	Legal document a person can prepare to give someone else the power to make personal or financial decisions on their behalf.
evidence	The facts, circumstances or documents that parties present to the tribunal to prove their case. Evidence must be given orally or in writing and if required under oath or by affidavit.
guardian	A guardian is a person appointed to help adults with impaired decision-making capacity by making certain personal and health care decisions on their behalf.
hearings on paper	When the hearing takes place without the parties being present and the tribunal only considers written material provided by the parties.
impaired capacity	The inability of a person to go through the process of reaching a decision

	and putting it into effect based on three elements: • Understanding the nature and effect of the decision • Freely and voluntarily making a decision • Communicating the decision in some way.
interim order	Any order that is not a final order of the tribunal. It may protect a party's position while the proceeding is running, or provide for something to be done to make sure that any final decision of the tribunal can be effective.
jurisdiction	The legislative power to hear and determine certain matters.
legislation	Written law made by the Parliament or by a delegate of the Parliament such as the Governor in Council.
member	Professionally qualified QCAT decision-makers appointed by the government to hear and determine disputes in the tribunal.
natural justice	The principle that requires the tribunal to conduct a fair and proper hearing without bias.
order	A direction or instruction from the tribunal that a party do a certain, named thing.
private appointment	The person/persons appointed by the tribunal as guardian and/or administrator who is not the Public Guardian or Public Trustee
procedural fairness	Part of natural justice. The obligation to ensure that parties are given the opportunity to put their case to the tribunal, including being able to respond to another party's case.
reasons for a decision	The explanation of why a member made a decision. Reasons can be given either at the hearing or at a later time. If the reasons are given verbally at the hearing a person can apply to have a copy of the reasons given to them at no cost. The tribunal must provide a copy of the reasons within 45 days of the request.
remote conferencing	When the hearing is heard by video-conferencing/audio conferencing/telephone conferencing.
QCAT Rules	Rules set out the practical procedural requirements for QCAT and are made by Governor in Council after being approved by the Rules Committee (not just the President). For example, the rules provide for how an application is served on another party.
Tribunal	An independent body established by legislation that hears and determines disputes between parties.

Appendix 1 QCAT Application Flow Chart



Appendix 2 Resources

Relevant Legislation

(i) ***Guardianship and Administration Act 2000***

https://www.legislation.qld.gov.au/legisltn/current/g/guardadmina00.pdf

(ii) ***Principles of the Act***

http://www.qcat.qld.gov.au/matter-types/guardianship-for-adults-matters/principles-of-the-act

(iii) ***Powers of Attorney Act 1998***

https://www.legislation.qld.gov.au/LEGISLTN/CURRENT/P/PowersofAttA98.pdf

(iv) ***Public Guardian Act 2014***

https://www.legislation.qld.gov.au/LEGISLTN/CURRENT/P/PublicGuardianA14.pdf

(v) ***Disability Services Act 2006***

https://www.legislation.qld.gov.au/LEGISLTN/CURRENT/D/DisabServA06.pdf

(vi) ***Mental Health Act 2000***

https://www.legislation.qld.gov.au/LEGISLTN/CURRENT/M/MentalHealthA00.pdf

(vii) ***National Disability Insurance Scheme Act 2013***

https://www.legislation.gov.au/Details/C2013A0002

Forms

FORM 10: Appointment of a guardian, administrator or to review the appointment of a guardian or administrator

http://www.qcat.qld.gov.au/__data/assets/pdf_file/0005/100868/Form-10-Application-for-Administration-Guardianship.pdf

REPORT by medical and related health professionals- *Guardianship and Administration Act 2000*

http://www.qcat.qld.gov.au/__data/assets/pdf_file/0005/101111/report-by-medical-and-health-professionals.pdf

A financial management plan for proposed administrators – *Guardianship and Administration Act 2000* :

http://www.qcat.qld.gov.au/__data/assets/pdf_file/0017/101357/financial-management-plan-for-proposed-admin.pdf

FORM 12: Miscellaneous matters - confidentiality order

http://www.qcat.qld.gov.au/__data/assets/pdf_file/0006/100896/form-12-app-for-misc-matters.pdf

FORM 54: Application for interim order – *Guardianship and Administration Act 2000*

http://www.qcat.qld.gov.au/__data/assets/pdf_file/0009/168543/form-54-app-interim-order-guardianship.pdf

FORM 11 - Application for a declaration about capacity –*Guardianship and Administration Act 2000*

http://www.qcat.qld.gov.au/__data/assets/pdf_file/0005/100895/form-11-app-for-dec-about-capacity.pdf

FORM 40 – Application for miscellaneous matters

http://www.qcat.qld.gov.au/__data/assets/pdf_file/0007/129670/Form-40-application-for-miscellaneous-matters.pdf

Fact Sheets

Adult administration

http://www.qcat.qld.gov.au/__data/assets/pdf_file/0017/101168/admin-for-adults.pdf

Adult guardianship

http://www.qcat.qld.gov.au/__data/assets/pdf_file/0003/101199/Guardianship-for-adults.pdf

Decision-making for adults

http://www.qcat.qld.gov.au/__data/assets/pdf_file/0011/442982/decision-making-for-adults.pdf

Contact Information

MNHHS QCAT Coordinator

Phone: **36462177**

Email: MNHHS_QCAT@health.qld.gov.au

QCAT – Brisbane

Address:	Level 9, BOQ Centre, 259 Queen Street, Brisbane, 4000
Post:	GPO BOX 1639 Brisbane Qld 4001
Phone:	1300753228
Email:	enquiries@qcat.qld.gov.au
Website:	www.qcat.qld.gov.au

Organisations

Office of the Public Guardian
1300 653 187
http://www.publicguardian.qld.gov.au/adult-guardian
Public Trustee
1300 360 044
http://www.pt.qld.gov.au/
Aboriginal and Torres Strait Islander Legal Services (Qld) Ltd
1800 012 255
http://www.atsils.org.au/
Anti-Discrimination Commission Queensland
1300 130 670
https://www.adcq.qld.gov.au/
Alzheimer's Queensland
1800 639 331
https://www.alzheimersonline.org/
Seniors Legal and Support Service
07 3214 6333
https://caxton.org.au/sails_slass.html
Elder Abuse Prevention Unit
1300 651 192
http://www.eapu.com.au/
Australian Association of Social Workers
https://www.aasw.asn.au/
Carers Queensland
1800 242 636
http://carersqld.asn.au/
Office of Public Advocate (Qld)
07 3224 7424
http://www.justice.qld.gov.au/public-advocate
ADA Australia (QADA)
1800 818 338
http://adaaustralia.com.au/
Office of Health Ombudsman
133 646
http://www.oho.qld.gov.au/
Australian Human Rights Commission
https://www.humanrights.gov.au/
Centre for Cultural Diversity in Ageing
http://www.culturaldiversity.com.au/

Further Reading

Bennett, H. and Hallen, P, 'Guardianship and financial management legislation: what doctors in aged care need to know'. *Internal Medicine Journal*, vol .35, 2005, pp.482-487.

Carlos, A., Rodriguez-Osioio, & Guillermo, Domingues-Cherit, 'Medical decision making:' Paternalism versus patient-centred (autonomous) care'. *Current opinion in critical care,* vol.14, 2008, pp.703-713.

Convention on the RIGHTS of PERSONS with DISABILITIES: http://www.un.org/disabilities/convention/conventionfull.shtml

Crampton, Alexandra, 'The Importance of Adult Guardianship for Social Work Practice'. *Journal of Gerontological Social Work*, vol.43 (2/3), 2004. http://www.haworthpress.com/wef/JGSW

Dastidar, Joyeeta G., Odden, Andy, 'How Do I Determine if My Patient has Decision-Making Capacity? *'The Hospitalist*', August 2, 2011: http://www.the-hospitalist.org/article/how-do-i-determine-if-my-patient-has-decision-making-capacity/

Field, Ms Sue & Professor Colleen Cartwright, 'Dementia and Your Legal Rights': https://www.fightdementia.org.au/sites/default/files/NATIONAL/documents/Dementia-and-your-legal-rights.pdf

Gibson, Laura, "Giving Courts the information Necessary to Implement Limited Guardianships: Are We There Yet?" Journal of Gerontological Social Work, http://dx.doi.org/10.1080/01634372.2011.604668

Lai, James M and Karlawish, Jason, M.D. "Assessing the Capacity to Make Everyday Decisions: A Guide for Clinicians and an Agenda for Future Research". *American Journal Geriatric Psychiatry*, February 2007, vol.15, 2, pp.101-111

Mills, Margaret, 'Dementia and Guardianship: Challenges in Social Work Practice'. *Australian Social Work*, 2016, http://dx.doi.org/10.1080/0312407X.2016.1168463

Parker, Malcolm (ed), Patient competence and professional incompetence: Disagreements in capacity assessments in one Australian jurisdiction, and their educational implications. Journal of Law and Medicine, 2008, 16 25-35

Pinsker, Donna M., Pachana, Nancy A., Wilson, Jill, Tilse, Cheryl and Byrne, Gerard, J., 'Financial Capacity in Older Adults: A Review of Clinical Assessment Approaches and Considerations'. *Clinical Gerontologist*, vol. 33, 2010, pp. 332-346.

Snow, Hayden A, & Fleming, Bill R, Consent, capacity and the right to say no'. *Medical Journal of Australia,* vol. 201, 8, October 2014, pp. 486-488.

Taylor, Brian J, 'Risk Management Paradigms in Health and Social Services for Professional Decision Making on the Long-Term Care of Older People'. *British Journal of Social Work*, vol. 36, 2006, pp.1411-1429.

Wilson, J, Tilse, C, Setterlund, D, & Rosenman, L, 'Older People and Their Assets: A Range of Roles and Issues for Social Workers'. *Australian Social Work*, vol.62, 2, 2009, pp.155-167.

QCAT Hospital Application: Applicant Responsibilities

If you are the applicant you have several responsibilities:

1. Keep QCAT updated with adult's contact details e.g. new address if adult is discharged from hospital or subacute setting
2. QCAT requires the applicant to prove contact details for any interested parties to enable QCAT to send written notification advising any interested parties of the application
3. When a matter is listed for a hearing before QCAT, all parties involved in the application are expected to attend the tribunal in person
4. If the applicant wishes to attend the hearing via phone, they will first need to discuss this with the QCAT case manager for the matter. If approval is given for the applicant to attend by phone, then it is the applicant's responsibility to provide a contact phone number at least 3 business days prior to the hearing
5. It is always important that the applicant complete the attendance advice and return this to QCAT even if they are attending in person
6. Prior to the hearing, QCAT may need to discuss the application with the applicant. The applicant should be available, or nominate a proxy on their behalf, in the event QCAT wish to discuss the application.
7. When the adult is a hospital patient, and the application has been made by family or others, QCAT may wish to discuss the case with the health professionals involved in the care of this patient. Medical staff, social workers and other health professionals should make themselves available to QCAT should this be necessary.
8. Prior to the hearing QCAT may request in writing, additional information about the adult's decision making capacity.
   The tribunal has general powers under the *Guardianship and Administration Act 2000*, s130 (1), s130 (2) s76 (3), s76 (7), s76 (8)[1] and the National Privacy Principle 2.1(g) [2]to request and obtain relevant information or material from a health provider who is treating the adult.

Withdrawing an application

An applicant may make application to withdraw their application at any point in the proceeding. However consent of the Tribunal pursuant to s46 of the *Queensland Civil and Administrative Act (Qld) 2009*[3] is required.

1. The applicant is required to make an application on the approved form (Form 40 – Application for miscellaneous matters) and complete the relevant section.
2. In some instances the tribunal will also accept a written request to withdraw either via an email or letter.
3. The applicant should provide reasons as to why they now believe the adult no longer requires a substitute decision maker as well as any updated capacity information.

The tribunal will either approve the withdrawal of the application or not approve and thus directing the matter to proceed to hearing.

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[1] *Guardianship and Administration Act 2000*, https://www.legislation.qld.gov.au/legisltn/current/g/guardadmina00.pdf
[2] https://www.oaic.gov.au/privacy-law/privacy-archive/privacy-resources-archive/privacy-fact-sheet-2-national-privacy-principle
[3] https://www.legislation.qld.gov.au/LEGISLTN/CURRENT/Q/QldCivAdTrA09.pdf

Watching Our Waits

A MNHHS and MSHHS collaborative assisting teams in the monitoring, management and early escalation of discharge barriers relating to long stay patients

https://watchingourwaits.bnc.health.qld.gov.au/Account/Login

Background and Proposal

In 2015 a project proposal to address long stay patients "waits" was submitted to the Department of Health: Healthcare Improvement Unit by lead clinicians in the Statewide General Medicine Clinical Network comprising:

- Kevin Clark
- Dr Jeff Rowland
- A/Professor Ian Scott
- Dr Elizabeth Whiting

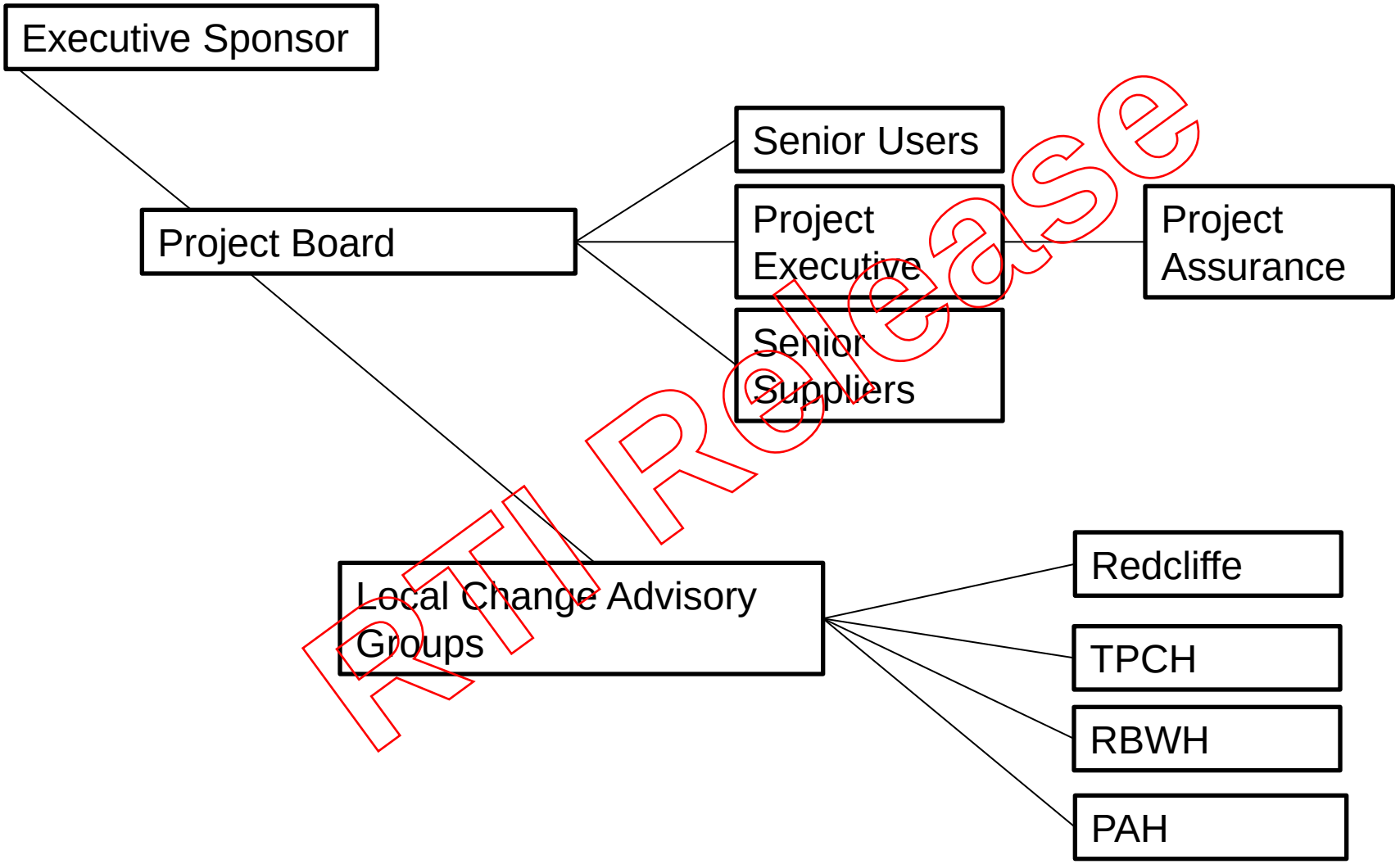
The proposal incorporated 2 main aims: [1]

1) Develop a Queensland Health "Watching our Waits (WoW)" IT functionality that could both track and quantify delays to discharge;
2) Develop, implement and evaluate strategies for reducing these waits as informed by the WoW IT system.

System design, implementation and reporting would provide sustainable measures in regards to the monitoring, management and early escalation of discharge barriers to executive action of long stay patients.[1]

Approval was received in July 2016 and team establishment and work commenced.

Project Governance and Membership



Project Deliverables

Phase 1

- Establish Business Requirements
- ICT development Watching Our Waits v1
- Embed sustainable escalation and monitoring

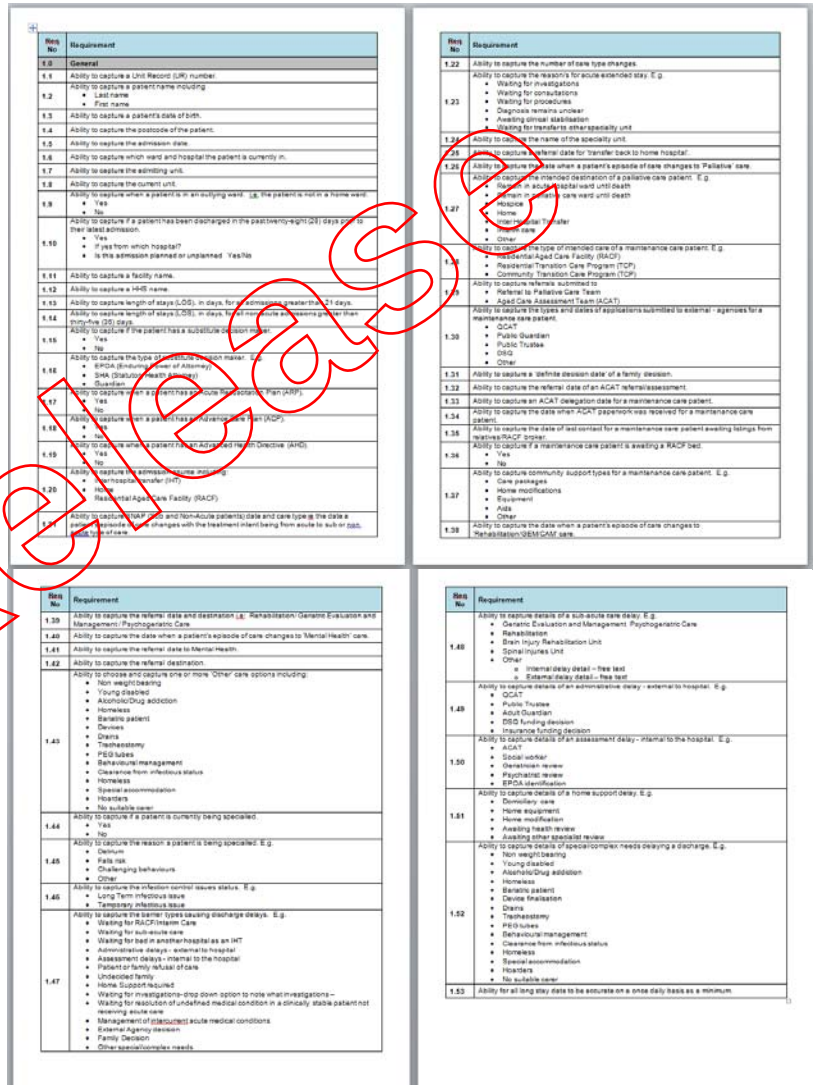
Phase 2

- Establish Phase 2 Data set inclusions – Focus on Acute waits
- Ongoing system refinement
- Measure and report

Business Requirements : Wait Barrier Metrics

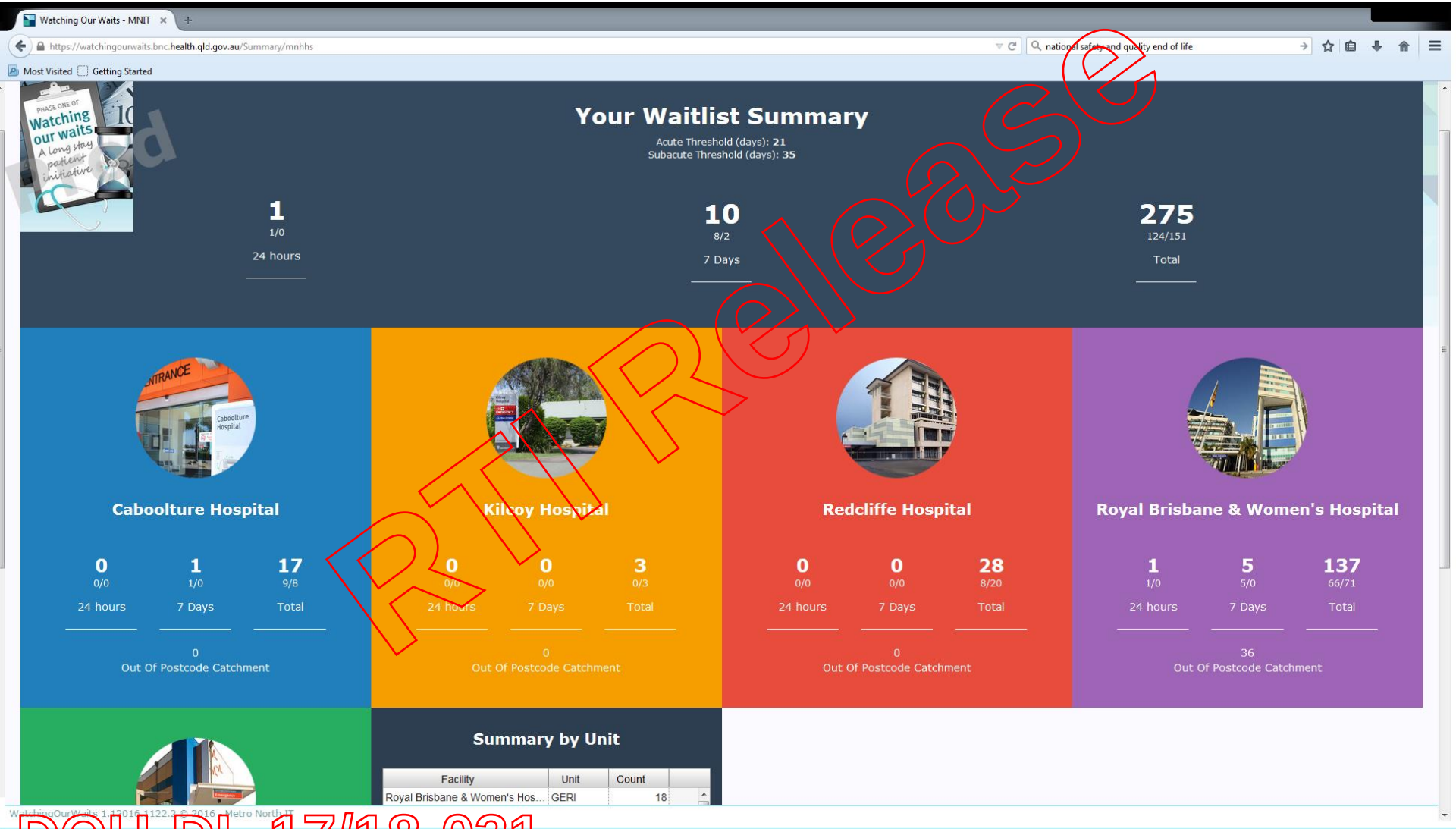
Establishment of BR : Wait Barrier Metrics included

- Literature reference [3,4]
- The PAH Bed Occupancy Audit Tools identified waits
- Review of current Long Stay facility information and reporting measurements
- Consultation with key senior medical executives and committees at a local level
- Collaboration with the project Board and Metro North IT to determine capabilities of inclusions



IT functionality and solution

Summary and Dashboard



Anticipated Business Benefits

- Improve team communication, care planning and care coordination processes.
- Enable a sustainable escalation and monitoring process for patients with extended length of stay
- Identify load requirements on external agencies
- Improve team communication, care planning and care coordination processes.
- Improve patient and carer experience.
- Improve patient safety and clinical outcomes by reducing unnecessary long stays in hospital, associated with increased morbidity and mortality.
- Improve access and efficiency through decreased bed day use and reduced length of stay (LoS).
- Reduce risk of complications or adverse events associated with long LoS, including:
  - hospital-acquired infections
  - falls and pressure injuries
  - de-conditioning and functional decline
  - psychological effects including loss of confidence and independence

Project Challenges

From a multi site – cross HHS approach:

- Data access requirements and authorisation
- Definitions and bed type terminology
- Organisational culture approach to buy in and roll out
- Allocation of resource and cost centre management
- Schedule maintenance

Project Opportunities[2]

- Provides a structured, uniform approach to tracking and quantifying delays “waits” across MNHHS and MSHHS
- Identifies and measures clinician- and system - related factors, both internal and external to HHS, that impact on “waits”
- Provides information to engage external providers and government agencies as well as internal clinical teams in developing, changing, or enhancing service processes and models of care with the aim of eliminating delays

References

1. Clark, K. (2015) Clinical Networks Project Proposal Watching our Waits including Barrier – metrics.
2. Harrison N. (2016) Watching our Waits Project Initiation Document: IT Delivery Phase 1
3. Queensland Health. Stranded Patient Project Report. June 2016
4. Salonga-Reyes A, Scott IA. (2016) Stranded: causes and effects of discharge delays involving non-acute in –patients requiring maintenance care in a tertiary hospital general medicine service. *Australian Health Review.*