Aged & Community Care Providers Association
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10 November 2023

Safety and Quality Advice Centre
Australian Commission on Safety and Quality in Health Care
Level 5, 255 Elizabeth Street,
Sydney NSW 2000
AdviceCentre@safetyandquality.gov.au

Dear Safety and Quality Advice Centre,

RE: Draft NSQHS Standards Guide for Ambulance Health Services

The Aged and Community Care Providers Association (ACCPA) appreciates the opportunity to comment on the draft *Standards Guide for Ambulance Health Services* (Guide).

This response has been prepared from an aged care perspective, specifically to highlight issues pertaining to transition of care of older people (especially those living in residential aged care facilities), to inform the development of this Guide. To this end, ACCPA recommends inclusion of an aged care specific section to support ambulance services to deliver urgent care to older people in the community and in residential aged care facilities (RACFs), specifically during transition of care.

RC1. Include an aged care specific section in the Guide to support ambulance services to deliver urgent care to older Australians and to improve transfer of care arrangements for those living in residential aged care facilities.

Transitions of care from RACF to hospital

ACCPA notes that the Royal Commission into Aged Care Quality and Safety (Royal Commission) heard evidence of several issues with access to hospital services for older people, with multiple difficulties in relation to hospital access identified.

Importantly, this included significant evidence of poor transition arrangements. The evidence highlighted inadequate provision of clinical information between hospitals and RACFs, and disorganisation in relation to the transport between hospitals and RACFs. There is also limited information as to who will accompany the resident, what support is provided once the older person arrives at the hospital and what coordination is in place for an older person being taken to hospital with little idea of what is happening to them.

To this end, ACCPA acknowledges the work currently being done by the Australian Digital Health Agency to integrate Aged Care Transfer Summary (ACTS) into the My Health Record (MHR). The ACTS is a digital solution using MHR that facilitates access to crucial health information relating to an aged care resident to support clinical handover when an individual is transferred from an aged care setting to acute hospital care.[1]

The ACTS will be an addition to MHR and enable residential aged care providers to digitally capture residents' health information for transfer to another health facility, such as hospitals. Aged care providers will be able to send and receive documents through secure messaging.

With the integration of ACTS into the MHR, ACCPA recommends that a guidance be provided for ambulance services on the use of the ACTS and MHR during transitions of care of older people.

[1] ADHA Aged Care Transfer Summary V1.0.

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RC2. Clearly articulate the process for the transfer of patients from a RACF to hospital to support clinical handover during the transfer of care.

RC3. Provide ambulance services with guidance on the use the Aged Care Transfer Summary to support aged care residents during transfer of care.

Transitions of care from hospital back to RACF/Community

The transfer of care process plays an important role in enhancing patient outcomes, reducing re-admissions, improving hospital efficiency and improving patient flow through health services. But it has been noted that when aged care recipients are transitioning back into RACF or the community from hospital, RACF staff and Home Care Package (HCP) providers face challenges as they often receive limited discharge planning/summaries detailing new medication regimes and these may not be understood or accepted.

Appropriate and effective transfer of care arrangements between hospitals and RACFs/HCP providers have substantial benefits.[2] When appropriate and effective transfer of care practices are put in place and followed, this not only minimises adverse events, reduces hospital re-admissions and results in efficiencies, but it also results in the patient, their families, doctors and other health practitioners involved in providing care having a much more positive experience.

In line with Australian Medical Association (AMA) Guidance, ACCPA is of the view that the discharge care planning processes for aged care consumers with complex needs require greater collaboration and planning between hospitals, a patient's general practitioner (GP) and registered nurses in RACFs or HCP providers. This should include:

- Routinely considering undertaking telephone, video conference or face-to-face case conferencing prior to discharge that includes the GP and/or referring doctor and RACF/HCP provider.
- When the patient's condition is complex or follow up needs to be provided urgently, making a phone call to the patient's GP and RACF or HCP provider to notify them about the impending transfer of care and ensure that a post discharge appointment is made with the GP and communicated to the patient at the time of transfer.
- Outpatient appointment/s date/s (if required) are scheduled prior to discharge in consultation with the RACF or HCP provider.
- The ability for expedited re-assessment in the Emergency Department if the patient's medical condition deteriorates and warrants the patient's re-presentation.
- A documented plan of care and support to be provided to the RACF or HCP provider and GP.
- GPs, RACFs and HCP providers should be able to initiate contact with hospital staff to obtain progress reports on their patients while they are in hospital, including anticipating times when their patient will need a post-discharge appointment.
- Post-Acute Care services and other supports are put in place prior to discharge.
- Easy and timely access to hospital-based specialists for GPs for post discharge management discussions, advice and support.
- In addition to transfer of care summaries, direct communication with the patient's GP or GP practice prior to, or on the day of, discharge to a RACF or the community is best practice.
- If a patient that is referred to the hospital by a GP receives unanticipated care or has a significant deterioration of their condition, the patient's GP should be promptly notified.[3]

[2] General Practice/hospitals transfer of care arrangements 2018 | Australian Medical Association (ama.com.au)
[3] General Practice/hospitals transfer of care arrangements 2018 | Australian Medical Association (ama.com.au)

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Importantly, ACCPA notes that Royal Commission Recommendation 66a[4] states that "…The Australian and State and Territory Governments should by 1 July 2022, implement, and commence publicly reporting on compliance with, hospital discharge protocols that ensure that discharge to residential aged care from hospital should only occur once appropriate clinical handover and discharge summary (including medications list) has been provided to and acknowledged by the residential care service, and provided to the person being discharged."

To this end, ACCPA recommends that paramedics/ambulance services should be included in any hospital discharge planning process for aged care consumers with complex care needs to ensure appropriate clinical handover of the patient to the RACF.

R4. Involve paramedics/ambulance services in hospital discharge care planning processes for aged care consumers with complex needs.

Managing medication across transitions of care

Older patients are at increased risk of experiencing medication discrepancies across transitions of care because of possible breakdowns in communication about managing their medications. Medication discrepancies are any inconsistencies between medications as patients move between different environments. These medication discrepancies are often poorly communicated or inadequately documented in patients' medical records.[5]

To reduce medication errors during transitions of care, ACCPA support the use of an Electronic Medication Management system that provides digital capabilities, and which enables aged care staff, prescribers, and suppliers to reduce medication errors and gain greater flexibility and coordination in the way their services are delivered.

To this end, ACCPA notes the Department of Health and Aged Care and the Australian Digital Health Agency have put in place an electronic National Residential Medication Chart (eNRMC) "Transitional Arrangement" which commenced on 1 July 2022. The Transitional Arrangement allows all RACFs to begin adopting and benefiting from eNRMC products as soon as possible.[6]

With the roll out of the eNRMC, ACCPA recommends that a guide is provided for ambulance services on the use of the eNRMC during resident transitions of care to reduce medication errors.

RC5. Provide ambulance service with guidance on how to use the electronic National Residential Medication Chart during transitions of care.

Expanding paramedics' scope of practice to support aged care

The changing nature of healthcare systems and the development of newer models of healthcare delivery that focus on continuity of care for a person within their community setting has seen the emergence of community-based paramedicine (also known as Community Paramedicine - CPN), beyond emergency health responses, to contribute to broader preventative, restorative, palliative and end of life care.[7]

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[4] Royal Commission into aged care quality and safety final report recommendations
[5] Ozavci et al (2021) A systematic reviews of older patients' perception and experience of communication about medications across transitions of care https://www.sciencedirect.com/science/article/abs/pii/S1551741119310897
[6] Department of Health and Aged Care https://www.health.gov.au/resources/publications/electronic-national-residential-medication-chart-enrmc-adoption-grant-opportunity-information-pack?language=en
[7] Safe Care Victoria (2021) The role of paramedics in palliative and end of life care https://www.safercare.vic.gov.au/sites/default/files/2021-09/WAVE%20Scoping%20Report.pdf

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Furthermore, given the identified negative impact of hospitalisation on the elderly population, ways to prevent emergency department (ED) presentation for non-urgent conditions have been suggested, as such condition may be better managed at an older person's place of residence. As ED presentations of the elderly often coincide with ambulance services, this patient population has been associated with increased delays for ambulance services and the ED, leading to negative consequences for both patients and the health system. [8,9,10]

CPN is a new approach (extension of scope of practice) that aims to prevent ED presentation for non-urgent conditions (which might be better managed at place of residence) and other system shortfalls by enabling paramedics to use their knowledge and skills beyond emergency health response. In addition to preventative and rehabilitative health, this may include social programs as part of an integrated healthcare effort, as well as treating minor conditions in the field or referring patients to non-ED health resources. CPN has been proven to have favourable outcomes.[11]

In the context of CPN, ACCPA notes that in 2007, New South Wales Ambulance established Extended Care Paramedic (EPC) and Coordinator of Palliative and End of Life Care roles,[12] and subsequently implemented the Authorised Palliative Care Plan (APCP). The APCP provides NSW Ambulance paramedics with an advance care treatment plan that pre-authorises and supports a paramedic to respond to a patient's end-of-life wishes beyond usual paramedic protocols. Similarly, in 2008, South Australian Ambulance Services established the EPC role, training clinicians to be able to work above the normal scope of paramedic practice, collaborating with other healthcare teams to manage and treat people in their home or RACF.[13]

ACCPA supports CPN that provides paramedics with advance training to practice beyond emergency health response and to support a paramedic to respond to the patient's end-of-life wishes beyond usual paramedic protocols. To this end, ACCPA recommends that CPN be implemented consistently across Australia to support care of the elderly.

RC6. Provide paramedics with advance training so they can expand their scope of practice to include palliative and end of life care to enable them to collaborate with other healthcare teams to manage and treat older people in their home or residential care facility.

RC7. Implement Community Paramedicine consistently across the country to support care of the elderly.

Importantly, and in the context of this Guide, there is a need to provide paramedics with clinical guidelines for people registered with a community palliative care service who present with symptoms, and which are applied to people with advanced incurable disease who express a wish to stay at home. The guidelines must provide instructions for paramedic management of specific symptoms and authorise subsequent care at home, if the appropriate care is available, rather than transportation to a hospital for medical assessment, which practically would reflect an available and

[8] Gulacti U, Lok U, Celik M, Aktas N, Polat H. The ED use and non-urgent visits of elderly patients. Turk J Emerg Med. 2016;16(4):141
[9] Briggs R, Coughlan T, Collins R, O'Neill D, Kennelly SP. Nursing home residents attending the emergency department: clinical characteristics and outcomes. QJM. 2013;106(9):803–8.
[10] Kingswell C, Shaban RZ, Crilly J. Concepts, antecedents and consequences of ambulance ramping in the emergency department: a scoping review. Australas Emerg Nurs J. 2017;20(4):153–60
[11] Vuuren et al. BMC Health Services Research (2021) 21:29 https://doi.org/10.1186/s12913-020-06037-0
[12] NSW Agency for Clinical Innovation https://aci.health.nsw.gov.au/resources/aged-health/building-partnerships/building-partnerships/extended-care-paramedic
[13] Safe Care Victoria (2021) Op Cit.

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appropriate advance care directive, available orders and medication for subcutaneous use and contactable palliative care medical and nursing.[14]

RC8. Include a statement in the Guide that paramedics must be provided with clinical guidelines for people registered with a community palliative care service who present with symptoms and who express a wish to stay at home.

If you have any questions or would like to discuss, please contact Dr Moe Mahat at Mohamad.Mahat@accpa.asn.au

Yours sincerely

Anne Liddell
Head of Policy
Aged & Community Care Providers Association

[14] Safe Care Victoria (2021) The role of paramedics in palliative and end of life care, https://www.safercare.vic.gov.au/sites/default/files/2021-09/WAVE%20Scoping%20Report.pdf