Transition of Patients from Hospital to Residential Aged Care

Melanie Wells and Rachna Kumar

Jingeri

We acknowledge the Traditional Custodians of the land in which we work, live and grow. We also pay our respects to Elders past, present and emerging. We also acknowledge other Aboriginal and Torres Strait Islander people present today.

Transition Pathway for RACH - 1

Mary (77): Presented to Emergency with trouble walking due to arthritis. Her home has stairs, and she wanted to think about RACH. Physio assessed in ED and she returned home with extra supports, information and GP follow-up for aged care planning

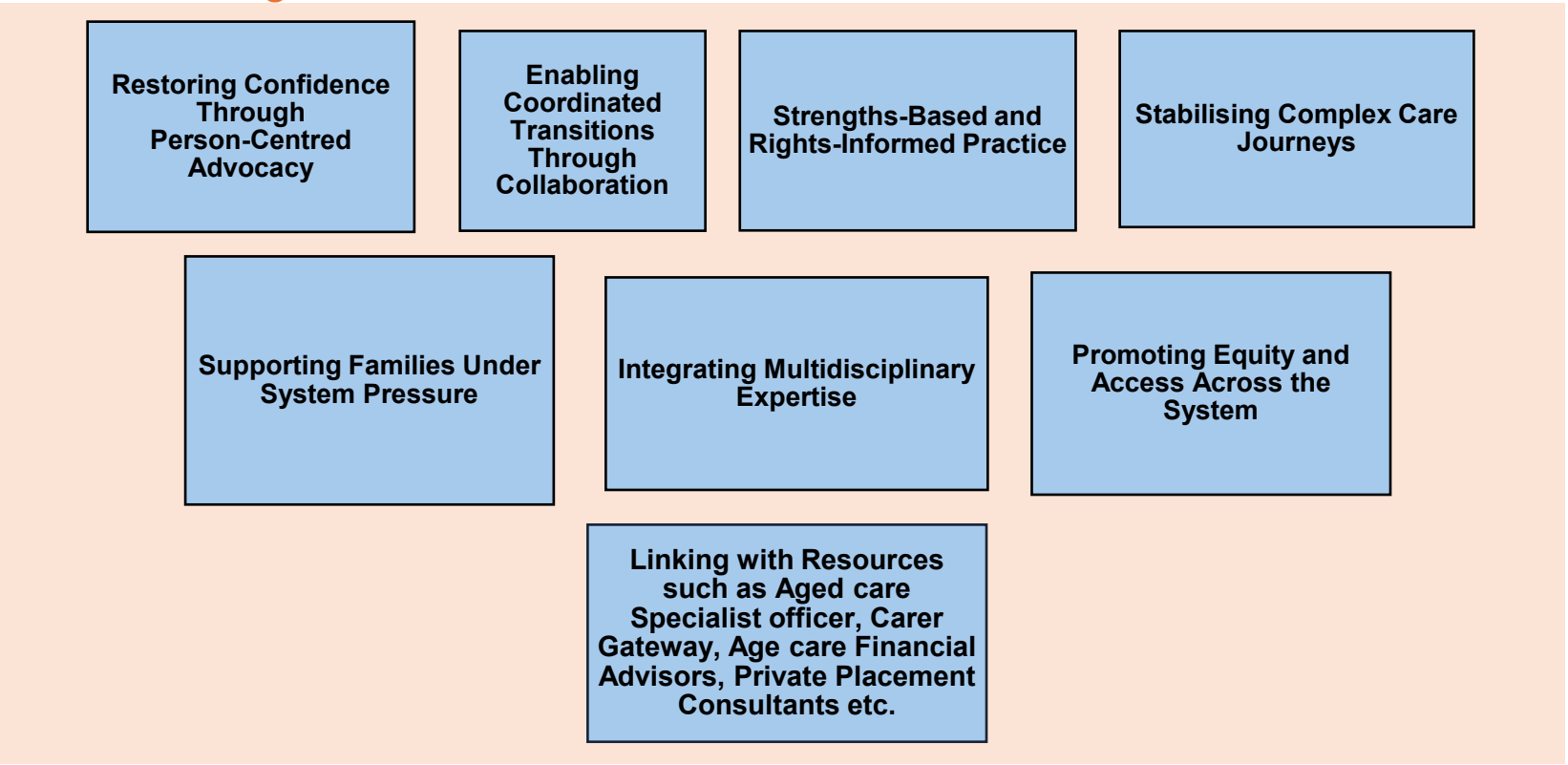
Transition Pathway for RACH - 2

Jack (80): Presented to Emergency after a fall. He was admitted to hospital. His family want him to go and live in RACH. Jack was sent for rehabilitation to improve his functioning. He was able to return home safely to await RACH with additional services and was referred to Tugun Older Person Clinic for assistance with My Aged Care, respite and short-term RACH planning. Jack was able to wait for a bed and relocate to a RACH of his choice

Transition Pathway for RACH - 3

Tom (86): Was brought to the Emergency in crises, with his family unable to cope any longer with Tom's increasing confusion and agitation due to dementia. They has never used planned respite and only had minimal help, they had hoped he would live his days out to home. He was deemed no longer able to safely live at home. Tom was admitted to hospital and had to wait for may months to transition to a RACH. His family were required to pay long stay fees and they were required to take the first bed available which was not the RACH of their choice and was 45 minutes away from home.

How Hospital Social Work Supports Hope and Safe Transitions to Residential Aged Care





Supporting the Journey to Residential Aged Care- Role of Families/Friends/NGOs

1

👀 **Notice Changes Early: Changes in health, mobility, memory, or safety at home**

2

💬 **Start Planning Conversations: Talk with older people and families about future care needs such as EPOA's, Respite, RACH options. Support informed choice and readiness**

3

📞 **Connect with My Aged Care: Share information about aged care options. Help arrange Single Assessment System (SAS) assessment when needs increases**

4

🤝 **Work with Health Services: Link with GPs, aged care services, social workers and Hospitals. Support coordinated care and smooth information sharing**

5

🚪 **Support the Transition: Help plan the move from home to residential aged care. Ensure dignity, respect, and person-centred decision-making**