



Australian Government

Department of Health

Transition Care Programme Guidelines

Updated March 2022

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FOREWORD

The Transition Care Programme Guidelines 2022 (the guidelines) is an updated version of the Transition Care Programme Guidelines 2015, which were developed by the Australian Government in consultation with all states and territories.

The guidelines are a resource for the state and territory governments, as the approved providers of transition care, as well as service providers, officers of the Department of Health and other interested parties.

The guidelines explain the Australian Government's policy context and operational requirements for the Transition Care Programme, including the clarification of responsibilities of the approved providers under the *Aged Care Act 1997*, and the Aged Care Principles which govern the operation of the programme. Users of these guidelines should be aware that state and territory governments, as the approved providers, may develop jurisdiction specific operational guidelines that complement these national guidelines.

We trust you will find these guidelines a valuable tool that will assist in the provision and operation of transition care.

Australian Government Department of Health

ABOUT THE GUIDELINES

These guidelines are intended to provide general information about the Transition Care Programme (the programme). The guidelines are linked to the *Aged Care Act 1997* (the Act) and, where relevant, the *Aged Care (Transitional Provisions) Act 1997* (the Transitional Provisions Act)¹ through a transition care payment agreement (payment agreement) between the Australian Government and each state or territory government. Compliance with the guidelines is a requirement under the payment agreement.

The guidelines should be read in conjunction with the Act, the Transitional Provisions Act where relevant, the *Aged Care Principles* (the Principles) and the *Aged Care Quality and Safety Commission Act 2018* (Quality and Safety Commission Act). If there are any matters not fully clarified in the guidelines, assistance should be sought from the Australian Government Department of Health (the Department) or the relevant state or territory government, as the approved providers of transition care (approved providers). Independent legal advice should be sought as required on any matter contained within the guidelines.

1.1 What the guidelines contain

The guidelines explain the Australian Government's policy context and operational requirements for the provision of transition care.

1.2 How the guidelines will be updated

The Department will update the guidelines, as required, in consultation with states and territories, to ensure their currency and accuracy.

Please refer to the online version of the guidelines located on the Department's website to ensure you have the most recent version. The footer of each page includes the issue date of the guidelines.

1.3 Feedback

The Department and all state and territory governments welcome any comments on the guidelines. Please provide any comments via email to TCP@health.gov.au.

¹ Under section 1-2A, the Transitional Provisions Act applies only to 'continuing care recipients. Under the Act, a continuing care recipient must have entered a relevant residential, home care, or flexible care service before 1 July 2014, and must not have ceased to be provided with that care for a continuous period of more than 28 days (other than for leave) or have chosen not to opt into the new aged care arrangements. Please note that where these guidelines refer to 'the Act', the Transitional Provisions Act may apply in circumstances which involve the provision of aged care services to a continuing care recipient.

CHAPTER 2 INTRODUCTION

2.1 Transition care in brief

Transition care provides short-term care that seeks to optimise the functioning and independence of older people after a hospital stay. Transition care is goal-oriented, time-limited and therapy-focused. It provides older people with a package of services that includes low intensity therapy such as physiotherapy and occupational therapy, as well as social work, nursing support or personal care to maintain and improve physical and/or cognitive functioning.² Whilst available to eligible permanent residents of aged care homes, the programme seeks to enable older people to, where possible, return home after a hospital stay rather than prematurely enter residential aged care.

Transition care facilitates a continuum of care for older people who have completed their hospital episode, including acute and subacute care³ (e.g., rehabilitation, geriatric evaluation and management), and who may benefit from restorative care and more time and support to make a decision on their long-term aged care options if needed.

The programme is not intended to be a “holding” program for people who are awaiting placement in a residential aged care home or a residential Multi-Purpose Service. The primary function of the programme is therapeutic.

2.2 Roles and responsibilities within the Transition Care Programme

Six key entities have roles and responsibilities within the programme:

- The Australian Government;
- State and territory governments who fulfil the function of approved providers;
- Transition care service providers – regional and/or local managers, including non-government organisations contracted by state and territory governments to deliver transition care;
- Aged Care Assessment Teams (ACATs)⁴;
- Hospitals; and
- Transition care recipients.

The roles of the Australian Government and state and territory governments are outlined below. For the other entities, see sections 3.3 *The role of hospitals*, 3.4.1 *The Aged Care Assessment Team (ACAT)*, 3.5.2 *The service provider*, and 5.3 *Care recipient responsibilities* of these guidelines.

2.2.1 Australian Government

The Australian Government’s roles and responsibilities in relation to the programme are to:

- develop and implement national policies to meet the objectives of the programme in partnership with the state and territory governments as the approved providers;
- administer the programme in partnership with the state and territory governments, including the development of operating guidelines;
- allocate transition care places and account for the programme in a report to the Australian Parliament under the Act;
- provide a subsidy under the Act to each occupied transition care place for care and services;
- collaborate with state and territory governments in the evaluation of the programme and reporting of transition care data;
- manage complaints received by the Aged Care Quality and Safety Commission (the Commission); and
- provide strategic direction.

The Department and the Commission undertake the Australian Government’s role in the programme.

² A detailed list of services to be provided is included in *Schedule 1: Specified care and services for transition care services* of the payment agreement and is provided at [Attachment B](#).

³ Definitions for acute care and subacute care are included in the glossary at the end of these guidelines.

⁴ Note, in Victoria, an ACAT is referred to as an Aged Care Assessment Service (ACAS). Where ACAT is used throughout the Guidelines, it is intended that ACAS is interchangeable.

2.2.2 State/territory governments (approved providers)

State and territory government responsibilities in relation to the programme are broadly defined as follows:

- in partnership with the Australian Government, develop and implement policies;
- manage the day-to-day operations of the programme, including through service providers in their state/territory;
- ensure quality care is provided in accordance with Schedule 4: The Transition Care Programme Quality Improvement Framework, provided at [Attachment A](#) of these guidelines, and the Aged Care Quality Standards;
- manage complaints in their state/territory, and where necessary cooperate with the Commission to resolve complaints received by the Commission;
- collaborate with the Australian Government in the national evaluation of the programme;
- ensure that transition care data is collected and reported to the Australian Government;
- provide proportionate funding towards the operation of the programme;
- establish mechanisms to ensure that the guidelines and the Australian Government's conditions for managing the programme are met, including monitoring the performance and the quality of service delivery of the service providers; and
- ensure that service providers comply with the provisions of the payment agreement and any recipient agreements in place.

State and territory governments, as the approved providers of transition care, are responsible for meeting all approved provider obligations and responsibilities under the Act. The use of sub-contractors does not negate these legal obligations.

2.3 Allocation of transition care places

The Australian Government and state and territory governments have clearly defined roles in relation to the allocation of transition care places.

The Department allocates new transition care places up to a defined limit, under section 14-1 of the Act to state and territory governments who are the approved providers of the programme. The approved providers are responsible for planning the model of transition care based on local need. Where appropriate, the Department should be consulted as part of this process.

Under Part 3.3 of the Act, an approved provider is eligible for flexible care subsidy, provided:

- it holds an allocation of flexible care places;
- the allocated places have taken effect (i.e. have become operational); and
- the approved provider provides flexible care to a care recipient who has been approved as eligible under the Act, the *Approval of Care Recipients Principles 2014*, and *Subsidy Principles 2014*.

2.3.1 Service planning

Prior to each new allocation of transition care places, each state and territory government as the approved provider, will be required to submit a bilateral implementation plan to the Department that details how and where transition care will be delivered in their jurisdiction. Bilateral implementation plans must include, but are not limited to:

- the number of places to be allocated in a particular period;
- the number of care recipients expected to receive these services, including Aboriginal and Torres Strait Islander people;
- the region in which these places are to be located; and
- how transition care will fit with the services provided through the hospital system, particularly subacute care.

A bilateral implementation plan must include a clause recognising that transition care delivered in a residential care setting should not reduce access to allocated residential care places in the area.

To cater for care recipients who require care in either a residential setting or a home care setting, each jurisdiction's bilateral implementation plan must include the expected number of transition care places to be delivered in a home care setting, in a residential setting, or flexibly in either setting (see also section 2.3.2 *Flexible care setting*).

Transition care places are allocated to the approved providers in respect of individual 'transition care services'. Transition care services cannot exceed the number of transition care places allocated to

them. For example, if a service has been allocated ten transition care places, it may only claim flexible care subsidy for up to ten care recipients on any given day.

Where demand for transition care in a particular area of a state or territory is temporarily greater than the number of places available in that area, a service from another area in the same state or territory may provide care into that area, through a brokerage arrangement.

If, however, there are ongoing discrepancies between supply and demand for transition care places in various areas of a state or territory, an approved provider can apply to the Department to move transition care places permanently from one service to another. This move requires a variation to the conditions of allocation (see also 6.3.1 *Conditions of allocation of flexible care places for transition care*).

To apply for a variation to conditions of allocation for TCP places (as per section 17 of the Act), an approved provider should complete the application form available at www.health.gov.au/resources/publications/application-to-vary-conditions-of-allocation and submit it via email, to the Department's respective state or territory office.

Approved providers may assign day-to-day management responsibility to a local service outlet, known as the service provider. Service providers manage the delivery of transition care on behalf of the approved provider. Service providers may enter sub-contracting arrangements with other entities, to deliver required transition care and services.

Where service providers are assigned responsibility for the delivery of transition care, approved providers remain accountable for ensuring all requirements in the Act and the Principles are met (Further information on legislative requirements is in [Chapter 6 Responsibilities of Approved Providers of Transition Care](#)).

2.3.2 Flexible care setting

The flexible care places used for transition care are legislated by the Act, and the Principles. Under section 49-3 of the Act, flexible care is defined as “*care provided in a residential or community setting through an aged care service that addresses the needs of care recipients in alternative ways to the care provided through residential care services and home care services*”.

Section 50-2 of the Act permits the *Subsidy Principles 2014* to specify the types of care for which flexible care subsidies can be paid. For this purpose, section 103 of the *Subsidy Principles 2014* specifies that flexible care includes transition care.

Transition care places may be delivered flexibly in either a residential or a community setting. State and territory governments have the flexibility to determine the mix of care delivery settings in line with local service capacity (including spare residential setting capacity) and individual care recipient needs.

Recipients can move from one setting to another within the same transition care episode, e.g. from residential-based to home care-based transition care. To enable such moves, a service may change the mix of places delivered in a residential or home care setting on a daily basis, or as required, within the limits of the number of places allocated. Such changes must adhere to any jurisdictional protocols set by the approved provider (see also section 3.5.5 *Movement between care settings and services*).

2.3.3 How to participate in delivering transition care services

Organisations seeking to participate in the provision of transition care must contact the relevant state or territory government Department of Health.

2.4 Funding and management of the Transition Care Programme

The Australian Government and states and territories jointly fund the programme.

Australian Government funding for transition care is provided in the form of a flexible care subsidy under the Act. The amount of flexible care subsidy payable in respect of a care recipient per day is determined by the Minister by legislative instrument, in accordance with paragraph 52-1(1)(a) of the Act.

From 1 August 2013, approved providers also receive the dementia and veterans' supplement equivalent amount, in addition to the basic subsidy amount. This additional funding is paid in recognition that service providers may provide care to veterans with an accepted mental health condition and others with higher care needs associated with dementia.

The state and territory funding contributions are made by direct funding and in-kind contributions.

Service providers may request fees from care recipients deemed able to contribute to the cost of their care (see also sections 5.6 *Fees payable by care recipients* and 6.2.5 *Provider responsibilities*).

The arrangements for the payment of Australian Government subsidy are detailed in Chapter 4 of the *Subsidy Principles 2014*. To receive payment of flexible care subsidy for transition care, approved providers must enter into a payment agreement with the Australian Government as required under section 111 of the *Subsidy Principles 2014*.

Approved providers remain responsible for ensuring service providers comply with the provisions of the payment agreement.

To meet their responsibilities, approved providers should enter into service agreements with service providers that mirror the relevant requirements of the payment agreement, including compliance with these guidelines.

The payment agreement also requires the service provider to offer and remain ready at all times to enter into, a recipient agreement with a care recipient. If a care recipient declines to enter into a recipient agreement, the provider must observe the requirements it would otherwise have under a recipient agreement. Section 5.2 of these guidelines details the requirements for recipient agreements. The amount of care recipient fees charged, if any, forms part of the agreement between the care recipient and the service provider (see also section 5.6 *Fees payable by care recipients*).

2.5 Relevant Legislation

Transition care is legislated by the Act and the Principles, and the Quality and Safety Commission Act.

Approved providers and service providers are required to meet all the conditions specified by the legislation, the payment agreement and the recipient agreement, including accountability and quality of care.

Under section 14-5 of the Act, allocations of aged care places can be made subject to conditions. It is a condition of each allocation of a transition care place, and a requirement under section 111 of the *Subsidy Principles 2014*, that each approved provider enter into a payment agreement with the Australian Government.

Throughout these guidelines, specific references are also made to other relevant sections of the Act, the Principles, the Quality and Safety Commission Act and the payment agreement. These references should be referred to when more detailed clarification is required.

Copies of both Acts, the Principles and any amendments to the legislation can be found on the [Federal register of legislation website](#).

The table below sets out the parts of the Act that are of relevance to the programme.

| Chapter | Part |
|---|--|
| Chapter 2 – Preliminary matters relating to subsidies | Part 2.1 – Approval of providers |
| | Part 2.2 – Allocation of places |
| | Part 2.3 – Approval of care recipients |
| Chapter 3 – Subsidies | Part 3.3 – Flexible care subsidy |
| Chapter 4 – Responsibilities of approved providers | Part 4.1 – Quality of care |
| | Part 4.2 – User rights |
| | Part 4.3 – Accountability etc. |
| Chapter 6 - Administration | Part 6.1 – Reconsideration and review of decisions |
| | Part 6.2 – Protection of information |
| | Part 6.3 – Record keeping |
| | Part 6.4 – Powers of officers |
| | Part 6.5 – Recovery of overpayments |

These guidelines should be considered in conjunction with:

- the Act and the Principles;
- the Quality and Safety Commission Act;
- relevant state and territory legislation;
- the payment agreement;
- the service agreement; and
- the recipient agreement.

2.6 Additional National Support

2.6.1 Translating and Interpreting Service (TIS National)

TIS National is an interpreting service provided by the Australian Government Department of Home Affairs for people who do not speak English and for agencies and businesses that need to communicate with their non-English speaking clients.

TIS National provides immediate phone interpreting, pre-booked phone interpreting and on-site interpreting services for Australian Government funded aged care programs, including transition care.

TIS National has access to:

- more than 3,000 contracted interpreters across Australia; and
- interpreters speaking more than 160 languages.

TIS National's immediate phone interpreting service is available 24 hours a day, every day of the year for any person or organisation in Australia who needs an interpreter. Approved providers of government-subsidised aged care, including transition care, can use TIS National for free when discussing care needs, fees, care plans and budgets with clients.

For information on registering with and accessing TIS National, please see the Department's website at: www.health.gov.au/initiatives-and-programs/translating-and-interpreting-service-for-aged-care-service-providers.

2.6.2 My Aged Care

My Aged Care is the entry point to access Australian Government funded aged care services and provides information about the types of aged care services available, eligibility for services, referrals to service providers that meet a client's needs and the contribution they can be asked to pay. The My Aged Care phone line and website can be used to find information about the programme. The My Aged Care contact centre can be contacted on 1800 200 422:

- Monday to Friday 8am – 8pm
- Saturdays 10am – 2pm
- Sundays and national public holidays – Closed

Additional information can be found at the [My Aged Care Website](#).

2.6.3 Services Australia

Services Australia is responsible for processing the payment of transition care subsidies.

Australian Government subsidy (Flexible Care) claims for care recipients receiving transition care are processed in accordance with sub-section 50-1(1) of the Act and the payment agreement between the Australian Government and the approved provider.

Subsidy claims are lodged monthly by TCP service providers via the Aged Care Provider Portal (ACPP), a secure online platform made available to providers of flexible care in late 2020.

The ACPP has integrated features which makes the platform user friendly, including quick links. It allows users to easily manage claims utilising self-service tools, with the capacity to quickly filter details in claim and event screens and to securely search for care recipients and events.

Users with 'organisation' administration access can use provider self-service features to manage which users have access to claim on behalf of a service (or services). Users can also use these features to update key service information online in real-time.

Information regarding the ACPP, including access guidelines and user resources are available at the Services Australia website at: www.servicesaustralia.gov.au/organisations/health-professionals/services/medicare/aged-care-provider-portal.

For claiming and payment enquiries and assistance, approved providers are advised to contact the Services Australia online claiming helpdesk via email: aged.care.liaison@servicesaustralia.gov.au or phone: 1800 195 206.

CHAPTER 3 THE TRANSITION CARE PROGRAMME

3.1 What is transition care?

On 23 April 2004, Health Ministers endorsed the definition of transition care (its role, functions and target group) developed by the Care of Older Australians Working Group. An extract of the definition is contained below.

Aim/Objectives

Transition care provides short-term support and active management for older people at the interface of the acute/subacute and residential aged care sectors⁵. It is goal-oriented, time-limited and targets older people at the conclusion of a hospital episode who require more time and support in a non-hospital environment to complete their restorative process, optimise their functional capacity, and finalise and access their care arrangements.

The potential for further recovery will vary according to the individual. Therefore, the services provided will vary from individual to individual, ranging from those that further improve physical, cognitive and psycho-social functioning thereby improving the person's capacity for independent living, to those that actively maintain the individual's functioning while assisting them and their family and carers to make appropriate long-term care arrangements.

An outcome of transition care is that inappropriate extended hospital lengths of stay and premature admission to residential aged care are minimised. However, it should be stressed that transition care's primary function is therapeutic, rather than administrative.

Mix of Services⁶

Depending on their assessed level of need, transition care will offer eligible older people several, or all the following:

- nursing support or personal care;
- low intensity therapy (such as physiotherapy, occupational therapy) and support (such as social work) to maintain physical, cognitive and psycho-social functioning and to facilitate improved capacity in activities of daily living;
- medical support such as GP oversight; and,
- case management, including establishing community supports and services and where required, identification of residential care options.”

To access transition care, a person must be an admitted patient of a public or private hospital and assessed and approved for transition care by an ACAT. For the purposes of transition care, a person accessing hospital-in-the-home, is deemed to be admitted to a hospital.

A person must enter the programme upon discharge from hospital. Transition care can be delivered in either a facility-based residential setting or in a community setting, e.g. the person's own home. It is possible to receive transition care in a residential setting first and then in a home care setting, or vice versa.

Transition care clients can continue to access the Pharmaceutical Benefits Scheme (PBS) and Medicare. Some people from overseas, however, do not have access to the PBS and Medicare and therefore will need to meet their own medical costs while accessing the programme (see also section 3.2.5 *Older people from overseas*).

3.1.1 Services provided through transition care

Transition care provides older people with a package of services that includes low intensity therapy such as physiotherapy and occupational therapy, as well as social work and nursing support or personal care. Transition care must be provided in accordance with *Schedule 1: Specified care and services for transition care services* (see [Attachment B](#) and *Chapter 4: Transition Care Programme Restorative Care Requirements*).

The care and services to be provided are detailed in Schedule 1, which is divided into three parts:

1. all care recipients;

⁵ While the definition is accurate in terms of specifying the interface between the acute/subacute and the residential aged care sectors, and while the programme applies to older people assessed as otherwise eligible for residential care, it also includes transition care provided in a community setting.

⁶ A detailed list of services to be provided is included in *Schedule 1: Specified care and services for transition care services* of the Payment Agreement and provided at [Attachment B](#).

2. care recipients who receive care in a residential setting; and
3. care recipients who receive care in a community setting.

Schedule 1 sets out the basic level of care that a service provider must be able to provide, if needed by a care recipient.

The services provided as part of the programme are designed to meet a care recipient's daily care needs and provide additional therapeutic care to enable the care recipient to maintain or improve their physical, cognitive and psycho-social functioning, thereby improving their capacity for independent living.

The therapeutic care will vary from person to person, ranging from services that improve a care recipient's capacity for independent living to services that enable a care recipient to enter or remain in residential aged care at an optimum level of physical and cognitive functioning.

Some people entering transition care are likely to have dementia or be experiencing a level of cognitive confusion. Therefore, where needed, therapeutic care should include appropriate cognitive therapy to assist with restoration or stabilisation of cognitive skills.

In providing the transition care specified care and services, the service provider must have systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards, quality standards and guidelines relevant to transition care service provision.

3.2 Eligible care recipients

Division 22 of the Act sets out how a person becomes approved as a care recipient. Section 8 of the *Approval of Care Recipients Principles 2014* states the requirements a person must meet to be eligible for transition care.

To be eligible for transition care, the person must be an admitted patient of a public or private hospital and assessed as eligible for transition care by an ACAT. For the purposes of transition care, an admitted patient includes people receiving hospital-in-the-home. The ACAT may need to assess the person in consultation with the hospital geriatric rehabilitation service or members of the multidisciplinary team treating the person (which may include the treating physician, a registered nurse, occupational therapist, physiotherapist, social worker or a health professional from another allied health discipline), as well as carers, representatives or family members as appropriate.

In assessing a person's eligibility for transition care, the ACAT must use the eligibility criteria listed at section 3.4.3 *Assessment process for transition care*. The ACAT delegate will only approve a person for transition care if the person meets the eligibility criteria, and:

- If transition care is to be delivered in a residential care setting, the person can enter care immediately (within 24 hours) on discharge from hospital.
- If transition care is to be delivered in a home setting, the person can enter care within 48 hours from their date of discharge from hospital. Health services should remain responsible for ensuring safe discharge practices are followed and as such, be confident that the discharging patient will be adequately supported for the period prior to entry into home-based TCP.

Further to specifications included in the below categories, eligibility to access transition care will also be impacted if a person is accessing other forms of aged care assistance. See section 3.5.4 *Existing recipients of residential or home care*.

3.2.1 Aboriginal and Torres Strait Islander people

The expansion of the programme from 2,000 to 4,000 places in 2011-12 included a commitment to improve access to the programme by Aboriginal and Torres Strait Islander people. Approved providers must manage the delivery of transition care to ensure that Aboriginal and Torres Strait Islander people have equitable access to the programme.

An expected outcome of the programme in each state and territory is that the proportion of Aboriginal and Torres Strait Islander people assessed as eligible for transition care who subsequently receive transition care is no less than the proportion of non-Indigenous people assessed as eligible for transition care who subsequently receive transition care.

3.2.2 Older people with dementia

Each person's experience with dementia is unique and some older people with dementia may benefit from tailored care when transitioning from a hospital stay to their usual place of residence or another care setting. People with dementia who are assessed by the ACAT as able to benefit from the therapies and support provided by the programme are eligible to participate in the programme. For

older people with dementia who are unable to express their care goals, the development of care goals should involve the person's family, carer and/or representative (see also section 2.4 *Funding and management of the Transition Care Programme*).

3.2.3 National Disability Insurance Scheme (NDIS) Client Eligibility

For a younger person to access the TCP, there must be no other care facilities or care services more appropriate to meet the person's needs. As a last resort, a younger person (including NDIS participants) may be able to access TCP services, where other services are inappropriate or unavailable.

In this situation, the individual should have evidence that clearly demonstrates that all other options have been tested, including NDIS eligibility where appropriate, or, for existing NDIS participants, they should contact the National Disability Insurance Agency (NDIA) to explore whether their existing NDIS plan could be used to fund supports or whether it requires review.

To be eligible for TCP, an individual will need to be approved by an ACAT and meet the specific eligibility requirements for transition care.

Where people are receiving services under both programs at the same time, it is expected that providers will coordinate care to ensure that there is no duplication of services.

3.2.4 Older people who usually reside interstate

The eligibility provisions for transition care under the Act do not restrict provision of care based on where care recipients live, or where they are assessed. Older people who are not residents of a particular state, territory or region can thus access transition care services in that state, territory, or region in particular circumstances. For example, a care recipient transferred to a tertiary hospital away from their usual place of residence to access specialist care can be discharged to a transition care service in another location, based on their follow-up arrangements with their family, carer and/or representative. It is important that transition care commences immediately on discharge from hospital if the person is entering transition care in a residential care setting, or within 48 hours if the person is to receive transition care in their own home (see also section 3.5.5 *Movement between care settings and services*).

3.2.5 Non-Australian residents and older people from overseas

Non-Australian residents and older people from overseas can access the programme if they are ACAT assessed and approved as eligible using the same criteria as other clients. Importantly, people who are not permanent residents of Australia may not be eligible for the PBS and Medicare and would thus be responsible for meeting their own medical and pharmaceutical expenses while in transition care. There are several countries, however, with which Australia has reciprocal health agreements, and people from these countries may be eligible for Medicare and PBS medicines. Further information is available on the [Services Australia website](#).

Where a person from overseas enters the programme and decides to meet their own expenses as a result of being ineligible for the PBS or Medicare, a service may still claim the flexible care subsidy in respect to the provision of transition care to that care recipient. Services should inform such care recipients of their responsibility to meet these costs before they enter the programme.

These guidelines, including section 5.6 *Fees payable by care recipients*, apply in respect of all people seeking to access TCP.

3.3 The role of hospitals

The role of hospitals in relation to the programme is to:

- provide acute and/or subacute care, including rehabilitation and geriatric evaluation (including dementia assessment) and management prior to referring a patient for ACAT assessment;
- ensure that the patient is medically stable and ready for discharge before they are referred for ACAT assessment;
- ensure that the geriatric and rehabilitation service or members of the multidisciplinary team treating the patient work closely with the ACAT during the assessment process; and
- work with the service provider, the ACAT, the patient and their family or carer to develop a care plan as part of the care recipient's hospital discharge planning process.

3.3.1 Referral process

ACATs accept referrals from several sources. A patient in hospital may self-refer for assessment by the ACAT or may be referred by any member of the multidisciplinary team caring for the patient in

hospital, or by their carer or family member. The ACAT, however, must not assess them until they are medically stable and ready for discharge, (see *section 3.4.3 Assessment process for transition care*). Hospital staff and the ACATs should be informed about the local availability of the programme and the potential benefits and services offered by the programme.

To avoid disappointment, all potential care recipients in hospital and carers or family members should be informed whether transition care is available in the area where the care recipient wishes to access care, i.e. in their own home or in the local area of a carer or family member.

Potential care recipients should also be made aware that access to a transition care place depends on:

- them being assessed and approved as eligible for transition care;
- availability of a vacant transition care place; and
- whether a service provider can meet their care needs and accepts the person as a care recipient.

3.4 Assessment and approval of care recipients for transition care

Divisions 19 to 23 of the Act provide information on the approval of care recipients. Approval of care recipients is also outlined in the *Approval of Care Recipients Principles 2014*.

To access transition care, older people must first be assessed and approved by an ACAT as requiring the type and level of assistance transition care delivers, as set out in section 8 of the *Approval of Care Recipients Principles 2014*.

3.4.1 Assessment: the role of the Aged Care Assessment Team (ACAT)

The role of an ACAT is to conduct a holistic, comprehensive assessment of older people incorporating physical, medical, psychological, cultural, social, environmental and wellness dimensions. The assessment is facilitated by the mandatory National Screening and Assessment Form (NSAF), which has been designed to collect consistent information across these dimensions. This information is used to develop a Support Plan focussing on the client's most important areas of concern and recommendations that address the client's current needs.

Based on the client's eligibility in accordance with the Act, ACATs support the client's access to the most appropriate aged care services, including approval for residential care, home care or flexible care services, such as transition care.

When assessing a client for transition care, the assessment must be conducted while the client is an admitted patient of the hospital and the person must be medically stable and ready for discharge. The ACAT must consult with the hospital geriatric rehabilitation service or equivalent, or members of the treating multidisciplinary team including a registered nurse, physician, occupational therapist, physiotherapist, speech therapist or social worker.

Under section 11-3 of the Act, the ACATs ensure that older people from special needs groups have equitable access to assessment services, including:

- people from Aboriginal and Torres Strait Islander communities;
- people from culturally and linguistically diverse backgrounds;
- people who live in rural or remote areas;
- people who are financially or socially disadvantaged;
- veterans;
- people who are homeless or at risk of becoming homeless;
- care-leavers⁷;
- parents separated from their children by forced adoption or removal;
- lesbian, gay, bisexual, transgender and intersex people; and
- people of a kind (if any) specified in the *Allocation Principles 2014*.

Additionally, ACATs should consider the needs of clients with dementia.

After conducting a comprehensive assessment, an ACAT will send their assessment findings and recommendations to the ACAT delegate. Where a care type under the Act is identified as the most

⁷ A care leaver is a person who was in institutional care or other form of out-of-home care, including foster care, as a child or youth (or both) at some time during the 20th century.

appropriate type of support to meet the client's needs, and the client meets the eligibility criteria, the ACAT assessor will recommend this to the ACAT delegate.

The ACAT delegate will notify the client of the decision to approve or not approve them as a care recipient and if eligible, the ACAT assessor will provide the client with information about aged care services and make the necessary referrals to an appropriate service provider through the My Aged Care system or by issuing a referral code to the client. The referral code enables potential service providers to view the My Aged Care client record, accept the referral, and start organising services.

ACATs and service providers should build and maintain effective working relationships to ensure ACATs are aware of the transition care services that providers offer and can make appropriate timely referrals to the most suitable provider.

Once a service provider is found that can offer the services required, they accept the client's referral in My Aged Care and enter the relevant service information. My Aged Care then transmits client approval information to the Australian Government Services Australia payment system that allows the service provider to claim for Australian Government subsidy against a valid approval for the period of care delivered. Please note the transition care approval is valid on the date the ACAT delegate signs the approval, and then for four weeks (28 calendar days) after the date of signing. The person must enter the programme within this four-week approval 'entry period', and within the specified episode commencement timeframe i.e. immediately upon discharge from hospital if the person is entering transition care in a residential care setting, or within 48 hours if the person is to receive transition care in their own home. Please note that health services remain responsible for ensuring safe discharge practices are followed, and as such, should be confident that the discharging patient will be adequately supported for the period prior to entry into home-based TCP (see also section 3.4.4 *Approval for Transition Care*).

The ACAT is also required to assess a client's need for a transition care extension and other care options as requested by the service provider through the My Aged Care provider portal. The ACAT will use the information provided by the service provider, and other sources such as the client and relevant health professionals as appropriate to assess eligibility for the extension (see also section 3.5.7 *Extensions* and section 3.5.8 *Review of the ACAT extension decisions*).

Further information is available at: [My Aged Care Assessment Manual](#).

During the transition care episode, the ACAT should assist the service provider, if necessary, in reviewing a care recipient's needs, re-assessing appropriate care options or referring to a more appropriate service if needed (see also section 3.5.2 *The service provider*).

3.4.2 Who should participate in an ACAT assessment?

As with all ACAT assessments, where appropriate, and with the care recipient's permission, the assessment must involve:

- the care recipient and their carer, family or representative;
- an interpreter or an Aboriginal or Torres Strait Islander health worker or liaison officer as required, in accordance with the individual's preferences; and
- other health and rehabilitation professionals, as appropriate.

3.4.3 Assessment process for transition care

When considering a person's suitability for transition care, the ACAT assessor must consider the eligibility criteria and several additional factors. The ACAT must ascertain that the person:

- is a public or private hospital admitted patient, or is receiving acute or subacute care under a hospital-in-the-home or equivalent programme where the patient is classified as an admitted patient;
- has completed his/her episode of acute and/or subacute care, is medically stable and ready for discharge at the time of assessment;
- wishes to enter transition care;
- would otherwise be eligible for residential care;
- would have the capacity to benefit from a package of services that includes, at a minimum, low intensity restorative therapy and nursing support and/or personal care; and
- would have the capacity to benefit from goal-oriented, time-limited and therapy-focussed care necessary to:
 - complete their restorative process;
 - optimise their physical and cognitive functional capacity; and
 - assist in making long-term arrangements for their care.

In addition, the ACAT must consider the following factors:

- the intent of transition care is to benefit older people through time-limited, low-intensity therapy and support immediately after a hospital episode;
- transition care is designed to improve older peoples' capacity for independent living and to maintain their functioning, while assisting them and their family and carers to make appropriate long-term care arrangements if needed;
- the therapeutic care provided by the programme will vary from individual to individual, ranging from services that improve a care recipient's capacity for independent living, to services that enable a person to enter residential aged care at an optimum level of physical and cognitive functioning;
- the ACAT, in consultation with the hospital geriatric rehabilitation services or equivalent, and other members of the multidisciplinary team caring for the patient, needs to ensure that the full range of clinical and/or rehabilitation support to be provided by the hospital has been completed before a person enters transition care;
- the cognitive abilities of a person with dementia may fluctuate from day to day, so the extent of a person's dementia may not be immediately obvious at the initial assessment;
- entry to transition care must be immediately upon discharge from hospital (within 24 hours) if the person is entering transition care in a residential care setting, or within 48 hours if the person is to receive transition care in their own home. Health services should remain responsible for ensuring safe discharge practices are followed and as such, be confident that the discharging patient will be adequately supported for the period prior to entry into home-based TCP.
- close co-operation and liaison between the hospital discharge planner, the ACAT and the service provider is required to ensure a transition care place is available in a timely manner, to benefit the care recipient;
- as part of the comprehensive ACAT assessment, the care recipient, and their carer and/or family as appropriate, should be fully informed of the range of other available aged care services that may be appropriate for them. The ACAT should assess the person's eligibility for those options and approve them if clinically appropriate; and
- if the person is only approved as eligible for transition care at the time of the initial ACAT assessment, it is likely that they will need a re-assessment before the completion of their transition care episode, to establish their long-term care requirements. Where this is necessary, the ACAT will consider any changes to the person's care needs and ensure that the long-term care recommendations reflect the revised level of need and the person's preferences.

3.4.4 Approval for transition care

A person must be approved under Divisions 19 to 22 of the Act before an approved provider can be paid flexible care subsidy for the provision of transition care.

Division 23 of the Act deals with how an approval can cease to have effect. Division 85 of the Act deals with reconsideration and review of decisions.

An ACAT approval to enter transition care is valid on the date the ACAT delegate signs the approval, and then for four weeks (28 calendar days) after the date of signing. The person must enter the programme within this four week 'entry period'. If the person does not enter the programme within the four-week period, their approval will lapse and they will need a re-assessment for transition care, if appropriate.

As transition care places may become vacant at short notice, ACATs should approve eligible clients for transition care even if there is not an immediate vacancy at the time of referral.

As with all ACAT approvals, clients should be reminded that approval as a care recipient does not guarantee a place, particularly if a vacancy does not present itself during the person's stay in hospital.

The result of an ACAT assessment, and the decision to approve or not approve a person to receive transition care, must be provided to the person who has applied for the care (or their representative) in writing and provide the reasons for the decision. A decision to reject a person's application for transition care is a 'reviewable decision' under section 85-1 of the Act. The [Aged Care Assessment Manual](#) on reviewable decisions contains further information.

3.4.5 Assessment and approval in a short stay unit of an emergency department

Where appropriate, older people may access the programme from a short stay unit or equivalent in an emergency department, provided:

- they have been admitted to hospital;

- they are medically stable and have been ACAT assessed and approved as meeting all other eligibility criteria for transition care under section 8 of the *Approval of Care Recipients Principles 2014*; and
- it is not more appropriate for the patient to receive subacute care such as rehabilitation or geriatric evaluation and management⁸.

The care provided while the care recipient is an in-patient of the short stay unit should involve discussion between the treating multidisciplinary team, geriatrician, and transition care service staff, as well as a comprehensive assessment by an ACAT to ensure that the person is medically stable and not identified prematurely for the programme.

3.4.6 Hospital and assessment information for care plan development

For those people approved as eligible for transition care, the hospital geriatric rehabilitation service and the ACAT assessment are key information sources for the development of a care plan to guide the physical and cognitive therapy services delivered through transition care. It is important that the ACAT attach a copy of all relevant assessment documentation to the copy of the NSAF given to the service provider.

3.5 Entry to transition care

A care recipient must enter transition care:

- immediately upon discharge from hospital if the person is entering transition care in a residential care setting; or
- within 48 hours of discharge, if the person is to receive transition care in their own home. Health services should remain responsible for ensuring safe discharge practices are followed and as such, be confident that the discharging patient will be adequately supported for the period prior to entry into home-based TCP.

These commencement timeframes are to ensure recipients can derive maximum benefit from a time-limited episode of low intensity therapeutic interventions.

An ACAT approval to enter transition care is valid on the date the ACAT delegate signs the approval, and then for four weeks (28 calendar days) after the date of signing (see also section [3.4.4 Approval for transition care](#)).

Older people who are receiving care under a hospital-in-the-home or equivalent programme cannot commence their transition care episode while they are still classified as admitted patients of the hospital.

Older people who are discharged from hospital and have returned to their usual place of residence without commencing the programme within the required timeframe, are no longer eligible to enter the programme.

3.5.1 Duration of care

Flexible care subsidy will be paid for all recipients up to a maximum of 12 weeks. Where an extension has been granted, up to a further six weeks flexible care subsidy will be paid (see also section [3.5.7 Extensions](#)).

To ensure that the limited resources benefit as many older people as possible, there should not be an assumption that the programme is a 'twelve-week programme' for every care recipient. Care is provided based on each care recipient's care needs. While some care recipients may require the maximum 12 weeks of care and an extension of up to six weeks, not all care recipients will require the maximum period of care.

Additionally, where a recipient transfers between one TCP setting/provider to another during an episode, the recipient may choose to utilise some or all of their episode 'break days'. However, there must be no gap in their ability to access care, i.e. there is no day during which the recipient is not able to be provided transition care services by either their current or new service provider.

3.5.2 The service provider

Service providers manage the day-to-day operations of a transition care service⁹. This includes:

⁸ A definition for subacute care is included in the Glossary at the end of these guidelines.

⁹ Definitions for transition care service, transition care service provider, and service provider are included in the Glossary at the end of these guidelines.

- assisting in the admission of clients to transition care, their return to hospital if required and their transfer to their preferred long-term care option;
- liaising with their local ACAT and/or transition care coordinator and advising of the capacity of the service to accept new care recipients, and any transition care vacancies in the region;
- offering and remaining ready at any time to enter into a recipient agreement with eligible clients (see also section 5.2 *Recipient agreement*);
- having appropriate processes in place to receive, record and resolve complaints and handle them fairly, promptly, confidentially and without retribution (see also section 7.2.1 *Internal complaints processes*); and
- reporting (activity, financial and quality) as per programme and contract requirements to the approved provider.

Service providers are responsible for providing services appropriate to the needs of their care recipients for the period the care recipients are under their care. Transition care must be provided in accordance with *Schedule 1: Specified care and services for transition care services* of the payment agreement also provided at [Attachment B](#), and [Chapter 7: Quality Assurance and Complaints in transition care](#).

The service provider, following consultation with the referring hospital, will make the final decision as to whether the person's care needs can be adequately met by their service and whether they have any places available.

The 12-week duration of the programme equates to 84 calendar days. As it is a time-limited programme, services should be provided according to the care plan on a 7-day a week basis, including weekends and any public holidays falling within the transition care period.

Care planning

The service provider must develop a care plan for a care recipient which incorporates a therapeutic care plan for both their physical and cognitive needs developed through the care recipient's hospital discharge planning, the ACAT assessment process and in consultation with the care recipient, and their carer or family, where appropriate. For older people with dementia who are unable to express their care goals, the development of a care plan may need to involve the person's family and/or carer.

Case management

The service provider has a responsibility to assist in the admission of a client to the programme, in their return to hospital should this be required, and in their subsequent transfer to their preferred long-term care option at the end of their transition care episode. The service provider plays a significant role in the care recipient's case management, including establishing community support and services and, where required, identification of residential care options.

Cooperation with ACATs

To facilitate the best outcome for each care recipient, both during and after the assessment process, service providers should have an effective working relationship with their local ACAT. Specifically, service providers:

- should liaise with the ACAT and keep them informed about the capacity of their service to accept new care recipients, and any transition care vacancies in the region;
- may involve the ACAT in reviewing the care recipient's needs, re-assessing appropriate care options and/or referring the care recipient to a more appropriate service; and
- may also identify care recipients who potentially require an extension to their transition care episode and submit a transition care extension application form to an ACAT for review (see also sections [3.5.7 Extensions](#) and [3.5.8 Review of ACAT extension decisions](#)).

ACATs can work with Dementia Support Australia to ease the transition of clients with dementia to home or residential aged care.

3.5.3 Residential based transition care

Providers of residential based transition care are expected to provide services that reflect the intent of the programme to optimise the care recipient's health and independence. Residential based transition care services should be provided in a more home-like, less institutional environment, including:

- communal living space/living room environment which is separate from sleeping areas and the location of acute/subacute care provision, i.e. a space that encourages family, carers and visitors to spend time with care recipients;
- a dining area and care recipients being encouraged not to eat in bed;

- care recipients being encouraged and supported to dress every day;
- facilities for care recipients to prepare snacks for themselves and their visitors;
- privacy, particularly for personal care and bathing arrangements;
- space for care recipients to move about, especially outdoors;
- physical arrangements which support the involvement of carers in the therapeutic activities; and
- a model of care and staff knowledge that supports the intent of the programme to promote the care recipient's independence and health (including cognitive functioning).

Transition care services may also be provided in rural and remote hospitals when appropriate. The requirements for the more home-like environment may be relaxed on a case-by-case basis in these locations, if relevant (see also the Aged Care Quality Standards and the requirements set out in [Chapter 4: Transition care programme restorative care requirements](#)).

It is not the intention that the programme will reduce access to the number of allocated residential care places. Rather, transition care places are to be considered as additional to other aged care places.

3.5.4 Existing recipients of residential or home care

Existing recipients of Australian Government funded residential or home care services, including recipients of Home Care Packages (HCP) or the Commonwealth Home Support Program (CHSP), may be able to access transition care following an episode of hospital care if they are assessed as eligible.

The Australian Government has created a category of leave (where required) from residential care and home care package services to enable this to occur. The relevant Australian Government subsidy continues to be paid to the original aged care provider during periods of leave for transition care.

It is the responsibility of the care recipient to notify their residential or home care package service provider of their intention to take leave and enter transition care. It is expected, however, the care recipient's residential or home care provider discuss the provision of care with the relevant transition care provider to coordinate care provision and ensure the care recipient's care needs are met.

Existing HCP recipients

People receiving HCP services can access transition care after a hospital stay if they are assessed and approved as eligible by an ACAT and take appropriate leave from their package.

When a HCP recipient takes leave to receive transition care, the home care subsidy is payable at the full basic subsidy rate for up to 28 consecutive days in a financial year for each episode of transition care. After 28 days of leave, the subsidy is payable at 25 per cent of the basic daily subsidy rate.

Further information regarding HCP leave arrangements is available on the Department's website at the following link: www.health.gov.au/initiatives-and-programs/home-care-packages-program/managing-home-care-packages/temporary-leave-from-home-care-packages.

When an existing HCP recipient is accepted into the TCP, the care recipient must be provided with the full package of transition care services to be provided in either a community or residential setting, in accordance with Schedule 1: Specified care and services for transition care services of the payment agreement and provided at [Attachment B](#).

Existing CHSP recipients

People are entitled to receive CHSP and transition care services at the same time, provided they are assessed as being eligible for each program. There are instances where the CHSP may provide the same or similar services to transition care, such as home maintenance or assistance with meals. When planning care, transition care service providers are expected to liaise with their care recipient's existing CHSP provider to ensure there is no duplication of services (see also section 3.5.9 *Accessing long-term care after transition care*).

Existing residential care recipients

Where residents of aged care homes take more than 28 consecutive days of either hospital leave or leave for transition care (which must be preceded by hospital leave), the subsidy to the aged care home drops by 50 per cent for residents who have a classification under the Aged Care Funding Instrument (ACFI) and are being paid the ACFI subsidy. The reduction in subsidy of 50 per cent also applies to residents who have an ACFI classification but are still being paid a grand-parented subsidy rate under the old Resident Classification Scale (RCS).

When an existing recipient of residential care is accepted into the programme, the care recipient must be provided with the full package of transition care services to be provided in a residential setting, in

accordance with *Schedule 1: Specified care and services for transition care services* of the payment agreement, provided at [Attachment B](#).

3.5.5 Movement between care settings and services

To facilitate client-centred transition care delivery, it is possible for care recipients to move from one setting to another within the same transition care episode, i.e. from a residential setting to a community care setting or vice versa. Care recipients do not require an ACAT re-assessment to enable this move.

Where available and appropriate, the step-down from residential to home care-based care within a transition care episode should be encouraged in order to maximise the care recipient's opportunities to return to independent living in the community.

Care recipients are also able to transfer from one setting/service provider to another (within their state or territory, or interstate) during an episode, provided there is no gap in their ability to access care, i.e. there is no day during which the care recipient is not able to be provided transition care services by either their current or new service provider.

A care recipient agreement will need to be developed with the new service provider.

3.5.6 Interrupting a TCP episode – available break days

A recipient can take a break from receiving care for up to seven days in total, during their transition care episode, for hospital or social purposes.

A recipient can take break days at any time after they have commenced their episode. That is, a person must have entered the programme as per the commencement requirements for at least one day, prior to taking a break.

Break days can be taken together in blocks, or individually, throughout a recipient's episode.

Any break days taken will still be counted as available care days and will not extend the maximum duration of a recipient's transition care episode (i.e. up to 12 weeks, with a possible extension of up to another six weeks, where approved).

A service provider will continue to be paid subsidy for any break days taken by a recipient throughout the duration of their episode. Calculation of a recipient's contribution fee is to include any days taken as break days.

Break days only interrupt the delivery of care and services during a recipient's transition care episode. The episode itself is not suspended and then recommenced. As such, providers are not required to report break days via the Aged Care Provider portal, for the purposes of subsidy payment.

Where a recipient is absent from care for more than a cumulative total of seven days, their transition care episode must end. To recommence care, the person will require a valid, current ACAT approval and must enter a new transition care episode directly after another hospital stay, in line with the relevant 'delivery setting' episode commencement timeframe.

Dual recipients taking a break from their transition care remain on 'leave' from their ongoing HCP or residential care facility.

A transition care recipient cannot use their break days for the purpose of accessing residential respite.

Tracking and management of recipient break day balances

Responsibility for managing recipient break day balances sits with TCP providers. Providers are to ensure their services have appropriate processes and systems in place to track and manage recipient break balances and collate break day data.

3.5.7 Readmission to hospital from transition care

A recipient's episode will cease if the recipient is absent from care for more than a total of seven break days during their transition care episode, including if they need to re-enter hospital (see also, section 3.5.6 *Interrupting a TCP episode – available break days*).

To recommence care, a person will require a valid ACAT approval and must enter their new transition care episode directly after another hospital stay, in line with the relevant 'delivery setting' episode commencement timeframe.

A person who is hospitalised and whose episode has ceased, is able to enter a new transition care episode without the need for an additional transition care approval, if the person is subsequently able to be discharged from hospital within their initial ACAT transition care approval's 28 day/four week entry period, if clinically appropriate.

An ACAT re-assessment is only required if the care recipient wishes to re-enter the programme after the four week entry period has expired, or where the ACAT is still valid but the re-admission to hospital may have changed the person's care needs since the last approval for transition care services.

3.5.8 Extensions

In exceptional circumstances, a care recipient may require an extension to a transition care episode where their care will need to exceed the 12-week maximum. To apply for an extension, the service provider must complete a *Transition Care Extension Form* with the care recipient (or representative) within the initial 12-week episode of transition care. Once the service provider has completed the form, they must forward it to an ACAT for review.

ACATs should only grant extensions if care recipients have further therapeutic care needs and wish to receive further transition care to achieve a better outcome. In such cases, an assessment for an extension to transition care, which specifies the duration of the extension, may be undertaken. A transition care episode can only be extended by up to 42 days (6 weeks). It is possible to have more than one extension if the total number of days does not exceed 42 days (6 weeks). For example, if an ACAT has only granted an extension of 20 days, it is possible to grant another extension of up to 22 days.

Based on the information provided by the service provider, and other sources such as the care recipient and relevant health professionals, the ACAT will assess whether the transition care episode should be extended.

It is not necessary for an ACAT to comprehensively re-assess a care recipient if the service provider has identified that the person requires an extension and provides the following information:

- reasons why goals were not achieved in 12 weeks;
- physical, cognitive and psycho-social goals that the care recipient would be working on during the extension;
- team action required to achieve care recipient goals and discharge;
- action required by external services to achieve care recipient goals and discharge;
- relevant information from other sources such as the care recipient (or representative) or health professionals; and
- the proposed number of days of extension.

The ACAT may however, undertake a comprehensive re-assessment of the care recipient if they are not satisfied with the information provided by the service provider. The extension form does not need to be signed by the same ACAT who undertook the initial assessment for eligibility for transition care.

The service provider should allow sufficient time for the ACAT to review the status of the care recipient if it is likely that a more comprehensive re-assessment is required.

3.5.9 Review of ACAT extension decisions

A decision to extend or not extend a care recipient's episode of transition care is not a 'reviewable decision' under the Act. However, the Department offers a right of review to any person whose request for an extension is denied. In the first instance, the decision should be discussed with the ACAT. If after discussing a decision not to extend an episode of transition care with the ACAT, any care recipient seeking to request a review should write to:

The Secretary
Department of Health
Attn: Aged Care Assessment Program
GPO Box 9848
ADELAIDE SA 5001

3.5.10 Accessing long-term care during/after transition care

A person cannot commence both transition care and most other forms of Australian Government funded aged care, such as residential care, respite or a HCP, on the same day. This includes situations where a recipient is taking a break from their transition care.

Pre-entry leave for residential aged care

In accordance with sub-section 42-3(3) of the Act, a person entering residential aged care may take up to seven days 'pre-entry leave' to secure their place in their new aged care home. Older people receiving transition care who are about to be discharged from the programme and enter residential aged care may take pre-entry leave. The only fee that can be charged during pre-entry leave from residential care is the basic daily fee. No subsidy is payable to the aged care provider for pre-entry leave (see also section 5.6.1 *Determining care fees*).

Residential aged care services cannot claim pre-entry leave for an existing residential aged care recipient who is on leave from residential care and is receiving transition care.

Accessing home care

A person cannot commence a new HCP whilst currently accessing transition care. Transition care recipients can only commence home care packages after they have completed their transition care episode, i.e. no Australian Government subsidy is paid to HCP providers until the care recipient has completed their transition care episode.

A person already receiving a HCP can temporarily suspend the provision of their home care whilst accessing transition care, and resume home care services on conclusion of their TCP episode.

For care recipients who have not yet met their physical and cognitive therapeutic goals but wish to end their transition care episode early in order to accept a HCP, their discharge plan should include strategies to help the care recipient and their carer or family to meet these goals after discharge from the programme.

When a person receives notification that they have been assigned a HCP, they have 56 calendar days from the date their package is assigned to find an approved HCP provider, and then with the provider discuss their initial assessment, care planning and establish their Home Care Agreement in preparation for the start of their HCP. The date a person accepts their offer to enter a HCP agreement is considered as the 'commencement' date of their HCP.

If the person requires more time to 'enter' their Home Care Agreement, they can contact the My Aged Care Contact Centre and request a 28-day extension.

In the circumstance where a current TCP recipient has been assigned a HCP, this would therefore mean the person has a total of 56 calendar days (or 84 with an extension) from their HCP assignment notification date, to finish/cease their TCP episode and enter into their Home Care Agreement.

To ensure a TCP recipient has an uninterrupted continuation of care and services when moving from transition care to a HCP, their TCP provider and prospective HCP provider need to coordinate around the timing of the TCP episode end date and the HCP 'commencement' date, in line with HCP acceptance timeframes.

Accessing a Commonwealth Home Support Package (CHSP)

As noted above in section 3.5.4, a person may commence/receive CHSP and transition care services at the same time, provided they are eligible, although a person should not receive duplicate services.

Additionally, a person who meets the eligibility requirements may receive CHSP services after receiving transition care.

CHAPTER 4 TRANSITION CARE PROGRAMME RESTORATIVE CARE REQUIREMENTS

This chapter outlines the restorative care requirements that service providers must comply with when delivering transition care to recipients. A summary of these requirements is at [Attachment C](#).

4.1 Optimising Independence and Wellbeing – Requirement 1

The transition care service optimises the independence and wellbeing of its care recipients.

4.1.1 Assessment processes:

- allow care recipients or their representative, assisted by carers and families as appropriate, to make informed choices between transition care service options to define and set their goals to optimise their independence and wellbeing;
- include an assessment of care recipients' physical and cognitive independence, as well as their psycho-social needs; and
- consider special needs groups, including people from Aboriginal and Torres Strait Islander communities, people from culturally and linguistically diverse backgrounds, and people who have a physical or cognitive impairment.

4.1.2 Care planning is focussed on optimising independence and wellbeing and includes a goal-oriented care plan for the care recipient that:

- responds to the identified needs of the care recipient and targets those goals which optimise independence while taking into consideration the cognitive and psycho-social needs of the care recipient;
- provides the care recipient with required physical and cognitive therapies and treatments designed to teach the care recipient to achieve their own goals; and
- improves the care recipient's functioning by promoting independence and monitors that improvement in consultation with the care recipient and/or their representative, carers and families, clinicians, and therapists.

Note: For further detail on care planning, see outcome 4.2.2.

4.1.3 The transition care service demonstrates that its service:

- provides a coherent and integrated case management process that enables care recipients to meet their goals and takes into consideration the psycho-social situation of the care recipient;
- actively promotes self-management and self-sufficiency by providing interventions that support the care recipient to make the most of their own capacity and achieve their full potential;
- encourages care recipients to seek support from carers and families, community groups and others to foster their independence when required;
- assists care recipients to achieve an optimum level of independence and wellbeing so that care needs are minimised over the longer term;
- provides facility-based residential transition care services in a more home-like, less institutional environment. This may include:
 - a communal living space/living room environment which is separate from sleeping areas and the location of acute/subacute care provision, i.e. a space that encourages carers, families and visitors to spend time with care recipients;
 - a dining area and care recipients encouraged not to eat in bed;
 - care recipients being encouraged and supported to dress every day;
 - facilities for care recipients to prepare snacks for themselves and their visitors;
 - privacy, particularly for personal care and bathing arrangements;
 - space for care recipients to move about, especially outdoors;
 - physical arrangements which support the involvement of carers and family in the therapeutic activities; and
 - a model of care and staff knowledge that supports the intent of the Transition Care Programme to promote the care recipient's health and independence.

Note: Transition care services may also be provided in rural and remote hospitals where appropriate. The requirements for a more home-like environment may be relaxed on a case-by-case basis in these locations, if relevant.

4.2 Multidisciplinary Approach and Therapy Focused Care – Requirement 2

The transition care service provides its care recipients with high quality, evidence-based therapeutic services focussed on maintaining or improving function in line with established goals.

4.2.1 Assessment processes:

- assessment of the care recipient's transition care needs by the multidisciplinary team (MDT) at the beginning of the transition care episode;
- the use of validated assessment tools deemed appropriate by clinicians/therapists*;
- a dementia assessment;
- measurement of a baseline level of functioning using validated assessment tools, and re-assessment of functional performance at pre-determined intervals; and
- evidence of discharge planning throughout the transition care episode.

*Note: The use of the Modified Barthel Index for assessments by the transition care service at entry to and exit from the Transition Care Programme is mandatory for Australian Government subsidy payments.

4.2.2 Care planning processes demonstrate that:

- a goal-oriented physical and cognitive therapy programme is developed by the provider in consultation with the care recipient or representative, carer and family prior to the commencement of therapy or treatment, with input from the MDT of the transferring hospital and the ACAT;
- the therapy programme duration is estimated and informs planning for the care recipient's discharge;
- hospital discharge information is incorporated into the initial care planning process;
- care provision is responsive to the identified needs and goals of the care recipient;
- physical and cognitive therapy goals agreed with the care recipient or their representative/carer are documented and prioritised;
- the care recipient receives timely and appropriate access to therapy, care and equipment during the transition care episode. This is demonstrated by:
 - ensuring aids, appliances, equipment and services required for a care recipient's therapy are provided in a timely manner;
 - providing a broad range of services tailored to meet the care recipient's therapeutic goals to improve or maintain function;
 - providing the care recipient with low intensity therapy from appropriately qualified staff to achieve their individual documented goals; and
 - actively encouraging care recipient, and/or their representative, carer and family participation in all aspects of transition care service provision.
- the care recipient's progress against therapy goals is regularly evaluated throughout their transition care episode and on exit, with changes in physical and cognitive function measured and recorded to demonstrate achievement of the care recipient's goals;
- the care recipient's changing needs are reflected as they move between care settings; and
- care recipient goals are delivered in accordance with the care plan, using an integrated case management approach.

4.2.3 The MDT approach to the planning and review of care recipient care demonstrates that:

- documented procedures and protocols are available to support the multidisciplinary team in the care and review of care recipients. This includes processes for communicating care recipient information to relevant health professionals;
- care planning is carried out by members of the MDT with relevant clinical experience in goal-oriented, low intensity therapy;
- care plan reviews/case conferencing include those members of the MDT involved in the care recipient's treatment and occur at predetermined intervals;
- care is informed by discussions with and between the relevant geriatrician and the care recipient's GP, where possible, and/or other appropriate medical input;
- MDTs have integrated care recipient records;
- the MDT comprises an appropriate mix and level of staff, enabling the provision of effective care recipient services; and

- a coordinator/case manager is in place to oversight and promote effective MDT and inter-agency working.

4.3 Seamless Care – Requirement 3

The transition care service uses a collaborative service delivery model that delivers seamless care.

4.3.1 Assessment processes:

- follow agreed protocols for the effective transfer of care recipient information between primary, community, acute and aged care services;
- recognise and incorporate hospital assessment, care planning and discharge arrangements, including ACAT assessment and approval recommendations;
- enable staff of the receiving transition care service to meet and assess the care recipient's care needs and the transition care service's ability to meet these care needs prior to the care recipient's admission into the service, where possible; and
- provide for a verbal as well as a written handover of care recipient information and status whenever the care recipient moves between or within services, where practical.

4.3.2 The transition care service works within an integrated system of care with other organisations by:

- establishing relationships and communication strategies that govern collaboration between acute/subacute, aged and primary care services, promoting a clear understanding of each other's roles, responsibilities and admission criteria;
- establishing systems for the secure, timely and effective transfer of transition care, care recipient information between service providers;
- strengthening partnerships with GPs and other transition care support services;
- facilitating effective interagency case conferences;
- facilitating the care recipient's entry to and exit from transition care so that the care recipient experiences a seamless move;
- effectively coordinating the care recipient's needs and goals between services;
- keeping the care recipient and/or their representative well informed prior to moving to a new service;
- facilitating education, training, networking and support across sectors and service boundaries in the broader health and aged care community where appropriate; and
- facilitating access to ongoing care and service provision post discharge from the programme, as required.

4.3.3 The transition care service develops systems for the safe discharge of care recipients that help prevent re-admission, including:

- providing transition care service discharge plan information to any subsequent care organisation; and
- providing appropriate discharge documentation to the care recipient, specifying:
 - length of stay in transition care;
 - destination post transition care;
 - goals which care recipient agrees have been achieved or not achieved (with reasons for non-achievement);
 - care recipient physical and cognitive functional levels on discharge from transition care, assessed using the same validated instrument used on admission;
 - care recipient and/or representative, carer and family education and support to improve functioning following discharge;
 - where appropriate all services and equipment to be provided to the care recipient on discharge from transition care, with key supplier contact details;
 - an up-to-date list of prescribed discharge medications; and
 - other follow-up arrangements/referrals such as information for the care recipient's GP, which are the responsibility of the care recipient and/or their representative.

CHAPTER 5 CARE RECIPIENTS

5.1 Charter of Aged Care Rights

Service providers must comply with the [Charter of Aged Care Rights](#) within the *User Rights Principles 2014*. Providers must give care recipients information about their rights and responsibilities in relation to the service.

5.1.1 Provider responsibilities in relation to the Charter

For all transition care recipients, transition care service providers have a responsibility to:

- give the care recipient a copy of the Charter signed by a staff member of the provider;
- give the care recipient information about their rights under the Charter;
- assist the care recipient to understand their rights under the Charter;
- ensure the care recipient, or their authorised person, are given a reasonable opportunity to sign a copy of the Charter;
- keep a record of the Charter given to the care recipient, including:
 - the signature of a staff member of the provider;
 - the date on which the provider gave the care recipient a copy of the Charter;
 - the date on which the provider gave the care recipient (or their authorised person) the opportunity to sign the Charter;
 - the care recipient (or authorised person)'s signature (if they choose to sign); and
 - the full name of the care recipients (and authorised person, if applicable).

The purpose of seeking the care recipient's signature is to allow them to acknowledge they have received the Charter and been assisted to understand it and what their rights are.

Care recipients are not required to sign the Charter and can commence, and/or continue to receive care and services, even if they choose not to sign the Charter.

5.1.2 Resources

To assist providers with these requirements the Department has developed a [Charter of Aged Care Rights Template](#) for signing, which is available in English and a number of other languages to download on the Department's website. Other resources to support the sector are available on the Department's website and the [Older Persons Advocacy Network website](#).

For further details, please also refer to the [User Rights Principles](#).

5.2 Recipient agreement

The payment agreement requires a service provider to offer and remain ready to enter into a formal agreement with the care recipient or their representative.

The recipient agreement must:

- be expressed in plain language that the care recipient or their representative can understand;
- state the range of services, particularly physical and/or cognitive therapies, that the care recipient has been assessed as requiring as per their care plan and how and when they will be provided;
- include a clear statement of the charges payable by the care recipient and how amounts of each charge are to be worked out;
- state a date for the start of the transition care services;
- provide conditions under which either party may terminate the care service;
- provide an exit strategy planned for the care recipient once transition care is completed, including expected date of discharge, where the care recipient is expected to be discharged to, support services to be arranged, carer briefing, and care recipient consent for the discharge strategy;
- provide that any variation to the recipient agreement must be made following adequate consultation and mutual consent of the care recipient and the service provider. The provider must give the care recipient reasonable notice in writing about the variation to the agreement. Any variations to the agreement must be clearly documented in the care recipient notes;
- not be varied in a way that is inconsistent with the *New Tax System (Goods and Services Tax) Act 1999* and the Act;

- provide for the giving of financial information to the care recipient or their representative, including the costs of services, any fees payable, and consideration of the care recipient's financial circumstances;
- state the care recipient's rights in relation to decisions about the service that he or she is to receive;
- include a guarantee that all reasonable steps will be taken to protect the confidentiality, so far as legally permissible, of information provided by the care recipient or their representative, and details of use to be made;
- state the limits of the transition care services to be provided; and
- state that the care recipient (or their representative) is entitled to make, without fear of reprisal, any complaint about the provision of transition care and state the mechanisms for making a complaint. This refers to both internal and external complaints mechanisms (see section [7.2 Complaints](#)).

If a care recipient does not want to formally acknowledge a recipient agreement, the service provider is still required to observe its responsibilities to negotiate and deliver the level and type of care each care recipient needs. It is important in these circumstances that the service provider documents in writing the reasons for not having a signed agreement with the care recipient and the basis on which agreed care is delivered.

The recipient agreement may be subject to modifications over the transition care episode. It is expected that a formal review of the information included in the recipient agreement would be conducted as needed and as requested by the care recipient (or their representative).

As indicated in section 3.5.5 – movement between care settings and services, where a care recipient transfers between service providers within their own state or territory, there is no need to enter into a new recipient agreement. If a care recipient moves to a new service provider in a different state or territory, however, a new recipient agreement must be offered.

5.3 Care recipient responsibilities

The payment agreement between the Australian Government and each state and territory government provides for the care recipient's responsibilities to be included in the recipient agreement between the service provider and the care recipient.

As well as having rights that must be respected, care recipients, or their representatives where appropriate, have responsibilities to the service provider, care staff, other care recipients and themselves.

While the Act and the Principles do not define the responsibilities of care recipients, the Department expects that responsibilities will be agreed between both parties and would not be inconsistent with any requirements of the Act and the Principles. These responsibilities should be clearly articulated in the recipient agreement.

In the spirit of the recipient and the service provider having reciprocal responsibilities, the care recipient's responsibilities include the following:

- respecting the rights of staff and the provider to work in a safe and healthy environment free from harassment;
- respecting the rights and needs of other care recipients (for transition care delivered in a residential setting);
- caring for their own health and well-being, as far as they are capable;
- working to achieve the goals articulated in their agreed individual care plan;
- informing the provider about any required changes to the care plan or agreement;
- providing information to the provider about their wants and needs;
- notifying the provider of any special requirements;
- providing constructive feedback to the provider about the service's performance; and
- contributing to the cost of care where appropriate.

5.4 Advocacy

Part 3 of *Schedule 1: Specified Care and Services for transition care services* attached at the payment agreement and provided at [Attachment B](#) provides for the care recipient to have access to an advocate.

Service providers should present information to care recipients on the role of advocates.

A care recipient has the right to call on an advocate of their choice to represent them as required in the management of their care, including establishing or reviewing their recipient agreement, negotiating the fees they may be asked to pay and in presenting any complaints they may have.

Service providers are also required, under Schedule 1, to accept the care recipient's choice of an advocate.

If care recipients require assistance, the National Aged Care Advocacy Program (NACAP) provides free, independent and confidential advocacy support, education and information. NACAP is provided Australia-wide by the Older Persons Advocacy Network (OPAN). OPAN can be contacted between 8am to 8pm from Monday to Friday and between 10am to 4pm on Saturday on 1800 700 600 (free call) or at www.opan.org.au. An advocate can help care recipients to make informed decisions and support them in raising concerns and working towards a resolution.

5.5 Privacy/confidentiality

Part 6.2 and sections 62-1 to 62-2 of the Act describe the responsibilities relating to the protection of personal information. Section 62-1 imposes obligations on the approved provider relating to the use, disclosure of and keeping of personal information relating to care recipients.

The Australian Government and state and territory governments as the approved providers and service providers (engaged by the approved providers), can only use personal information concerning a care recipient:

- for a purpose connected with the provision of aged care to the care recipient; or
- for a purpose for which the personal information was given by the care recipient to the approved provider (section 62-1(a)), represented by the service provider.

It is the responsibility of each state or territory government as the approved provider to ensure that its service providers protect the privacy of the care recipient and comply with all applicable laws relating to the use of personal information.

Service providers must implement security safeguards to protect personal information relating to care recipients against loss or misuse (section 62-1(c) of the Act).

Service providers should also determine how they meet the *Australian Privacy Principles* in the *Privacy Act 1988* and/or similar obligations contained in state or territory privacy laws.

5.6 Fees payable by care recipients

The payment agreement sets out the maximum amount that can be charged for care recipient fees.

Service providers may ask care recipients to pay a care fee as a contribution to the cost of their care. Any fees should be fully explained to the care recipient and the amount charged should form part of the agreement between the care recipient and service provider. Any fees must be agreed with the care recipient prior to services being provided.

The maximum amount that can be charged is outlined in *section 5.6.2 Maximum fees* and reflected in the payment agreement.

A care recipient's access to transition care should not be affected by their ability to pay fees but should be decided based on their need for care and the capacity of the service provider to meet that need.

Decisions on whether to charge fees are entirely at the discretion of the approved provider and the service provider. The Australian Government recommends that fees be waived for financially disadvantaged care recipients.

Information on the cost of transition care for recipients is outlined on the [My Aged Care website](#).

5.6.1 Determining care fees

The process of setting care fees should be as simple and unobtrusive as possible, respecting the care recipient's right to privacy and confidentiality.

To ascertain a care recipient's ability to contribute to the cost of their transition care, the service provider may only request information that is reasonable to request under the circumstances (i.e. the care recipient is an in-patient of the hospital before entering transition care).

In determining a care recipient's capacity to pay fees, the service provider should consider any exceptional and unavoidable expenses incurred by the care recipient.

A care recipient receiving transition care, who is about to be discharged to residential aged care, can be charged applicable aged care fees for the period of pre-entry leave by the residential aged care service provider (see section 58-1(c) of the Act), although no subsidy is payable to the provider. This is likely to mean that the care recipient's capacity to pay care fees in transition care is diminished.

Similarly, residents who were in residential aged care before entering hospital may continue to be charged fees by their original service whilst receiving transition care services, which may impact on their capacity to pay fees for transition care.

Home care recipients who began their care before 1 July 2014 cannot be charged care fees by the home care provider while they take leave for transition care (see sub-section 130(5) of the *Aged Care (Transitional Provisions) Principles 2014*).

Home care recipients who began their care on and after 1 July 2014 cannot be charged a basic daily fee while they take leave for transition care (see section 68 of the *Aged Care (Subsidy, Fees and Payments) Determination 2014*).

5.6.2 Maximum fees

The care fee for transition care is calculated daily for every day the care recipient receives transition care. The maximum value of the care fee is 85 per cent of the basic daily rate of single pension for care delivered in a residential setting. A care recipient who is an existing recipient of residential care services and is already paying 85 per cent of the basic daily rate of single pension in care fees, cannot be asked to pay the same amount to their service provider.

For home care-based transition care, the maximum care fee is 17.5 per cent of the basic daily rate of the single pension.

The amount paid must be discussed and agreed upon between the care recipient and service provider before transition care is provided (see section 3.5.4 *Existing recipients of residential or home care*).

The above rules on maximum fees apply to both single and married care recipients.

Each March and September when new pension rates are announced, the Department notifies the approved providers of any variations in the rate of the maximum care fees for transition care. The approved providers should then notify all service providers of the new rate. These rates are published on the Department's website at: [Schedule of Fees and Charges for Residential and Home Care](#).

In addition, the basic subsidy amounts for residential, home care and flexible aged care are indexed on 1 July each year; these are published in the [Aged Care \(Subsidy, Fees and Payments\) Determination 2014](#), after approval by the Minister.

5.6.3 Payment of fees in advance

Service providers may ask for fees up to one week in advance. If a care recipient leaves the programme, any payment in advance beyond the date of cessation must be refunded to the care recipient as soon as possible.

5.6.4 Waiving Fees (Financial Hardship)

Service providers can waive care recipient fees in circumstances where a care recipient is experiencing financial disadvantage. Care recipients should discuss their financial circumstances with the service provider before services are provided (see section 5.6.1 *Determining care fees*).

CHAPTER 6 RESPONSIBILITIES OF APPROVED PROVIDERS OF TRANSITION CARE

Section 56-3 of the Act sets out the responsibilities of the state and territory governments as the approved providers and for service providers regarding User Rights.

6.1 Compliance with the legislation

Approved providers are approved under the Commission Act and therefore must comply with the requirements set out in the Act and the Principles. These conditions relate to all activities performed in the context of providing flexible care under the Act and Principles. This chapter identifies the key responsibilities of service providers under the Act and Principles. For the purposes of the Transition Care Programme approved providers are the relevant state and territory governments.

While these guidelines provide additional advice on responsibilities of the approved providers and a measure of policy interpretation, it is strongly recommended that approved providers and service providers become familiar with the Act and the Principles to be fully aware of their responsibilities in all aspects of flexible care in the form of transition care.

6.1.1 Failure to comply

Part 7B and Parts 8, 8A and 8B of the Quality and Safety Commission Act outline the consequences of non-compliance of approved providers.

Failure to meet responsibilities under the Act can lead to the imposition of sanctions on an approved provider under Part 7B of the Quality and Safety Commission Act. Most instances of non-compliance can be resolved without the approved provider incurring any further sanctions.

If, however, the approved provider does not remedy the non-compliance one or more sanctions may be imposed. A decision to impose sanctions is a 'reviewable decision' under Part 8B, Division 2 of the Quality and Safety Commission Act and is subject to appeal to the Administrative Appeals Tribunal.

6.1.2 Serious and immediate health and safety risk management and reporting

The Serious Incident Response Scheme (SIRS) commenced on 1 April 2021.

SIRS sets arrangements for approved providers of residential aged care, including approved providers and residential aged care services delivering transition care in a residential aged care setting, to manage and take reasonable action to prevent incidents with a focus on the safety, health, well-being and quality of life of aged care consumers.

The SIRS have two key components:

- incident management obligations; and
- compulsory reporting obligations.

Incident management obligations

The SIRS require every TCP approved provider delivering transition care in a residential setting to have in place an effective incident management system – a set of protocols, processes, and standard operating procedures that staff are trained to use. This means adopting a systematic approach to minimise the risk of, and response to incidents that occur in a residential care setting. An incident management system is vital in supporting residential aged care services to effectively manage risks to their consumers, visitors and staff.

Responsibility to establish an Incident Management System (IMS) and notify the Commission of a reportable incident, sits with the TCP approved provider.

The approved provider is also responsible for:

- ensuring a staff member of the provider who becomes aware of a reportable incident, notifies the provider's key personnel, supervisor/manager, or the person responsible for notifying those incidents to the Commission; and
- providing to the Commission any required additional/significant information and a final report if requested.

Matters for the approved provider to determine through their Incident Management System (IMS) include:

- how information about an incident moves from the TCP service to the approved provider and/or the Commission;

- how an incident is managed; and
- what information is collected and provided to the approved provider and/or the Commission.

The TCP service may report the information directly to the approved provider, or staff at the TCP service may have their My Aged Care accounts aligned with multiple aged care providers and services, allowing them to submit notifications directly to the Commission.

Compulsory reporting obligations

In addition to managing all incidents, approved providers delivering transition care in a residential setting will be required to:

- report serious incidents involving aged care consumers to the Aged Care Quality and Safety Commission (the Commission) within 24 hours; and
- report serious incidents to the police within 24 hours of becoming aware of the incident if there are reasonable grounds to do so (where the incident is of a criminal nature).

SIRS reporting is facilitated through the My Aged Care Provider Portal. Specific guidance and resources for providers on reporting incidents through the My Aged Care Provider Portal, can be found by visiting the resources page on the [Department of Health website](#).

SIRS expand the types of reportable incidents and removes the previous exemption for resident-on-resident incidents where there is an assessed cognitive impairment. This reporting includes incidents that occur or are alleged or suspected to have occurred and will include incidents involving a care recipient with cognitive or mental impairment (such as dementia).

Approved providers are required to report all 'priority 1' reportable incidents within 24 hours of the provider becoming aware of the incident.

From 1 October 2021, approved providers will also be required to report all 'Priority 2' incidents to the Commission within 30 days of becoming aware of the incident.

While the 24-hour timeframes to report incidents to the Commission and the police commence from the point in time that the approved provider becomes aware of the incident, staff members of approved providers (any individual who is employed, hired, retained or contracted by the approved provider or a TCP service provider, whether directly or through an employment or recruiting agency) who become aware of a reportable incident must notify the approved providers as soon as possible.

For example, if a person working for a third-party organisation is caring for a person in bed-based TCP and there is an unexpected death (SIRS incident category) of that person on a Friday night, that person must notify the approved provider's key personnel as soon as possible. If the approved provider becomes aware on Friday night, they will still need to comply with timeframes and report the incident to police and the Commission within 24 hours (by Saturday night).

Regardless of the approach defined in the approved provider's IMS, the Aged Care Provider Portal SIRS notification 'Your details' tab, should reflect the information of the approved provider. Further detail such as the service/facility that the incident occurred at, can be provided in free-text responses to later questions in the form.

Approved providers are to check the Commission's website at [aged care quality.gov.au/sirs](https://agedcarequality.gov.au/sirs) for further SIRS information, including provider resources. Alternatively, the Commission can be contacted by emailing sirs@agedcarequality.gov.au or calling on 1800 081 549.

Serious and immediate health and safety risk reporting requirements for TCP providers delivering services in community / home settings

SIRS will be extended to apply to approved aged care providers delivering care in a community/home setting by 1 July 2022.

While the requirements under the SIRS do not currently apply to care delivered in community or home settings, please note that in accordance with Standard 8 of the Aged Care Quality Standards, all providers must have effective risk management systems and practices that include (among other things) identifying and responding to abuse and neglect of consumers.

These requirements ensure that those affected receive timely help and support, and that operational and organisational strategies are put in place to prevent the situation from occurring again. Such strategies help maintain a safe and secure environment for care recipients. (Additionally, see [Attachment A – Schedule 4: Transition Care Programme Quality Improvement Framework, Essential Transition Care Quality Components, Safety](#)).

6.1.3 Minimising the use of restraints

Legislative requirements regarding the use of physical and chemical restraints are contained in the *Quality of Care Principles 2014 (Principles)*.

Whilst these requirements currently do not apply to TCP providers (regardless of care setting) it is considered good practice that TCP providers meet the restraint requirements and continue to apply the guidance contained in the Decision-Making Tool: Supporting a Restraint Free Environment in Community Aged Care, available on the Commission's website at www.agedcarequality.gov.au/providers/assessment-processes/minimising-restraints.

6.2 Specific legislative requirements

In addition to the general responsibilities, approved providers under the Act have several specific areas of responsibility they and their service providers are required to meet.

6.2.1 Accountability

Division 63 of the of the Act deals with the accountability requirements for approved providers and service providers. The requirements set out in Division 63 of the Act include such responsibilities as maintaining and retaining records relating to the service and complying with any conditions of allocation to which the places included in the service are subject. The requirements set out in Division 63 also include other responsibilities that are specified in the *Accountability Principles 2014*, such as the requirement for all staff and volunteers to have a current police certificate (section 48 of the *Accountability Principles 2014*).

6.2.2 Flexible care subsidy

Divisions 49 to 52 of the Act state the requirements which must be satisfied to claim subsidy, the basis on which it will be paid and how the rates will be set. The conditions under which subsidy may be claimed are established under section 50-1 of the Act. The *Subsidy Principles 2014* set out the arrangements for payment of flexible care subsidy to approved providers.

6.2.3 Record Keeping

Divisions 88 to 89 of the Act cover the types of records approved providers and service providers are required to keep in relation to the administration of the service and regarding care recipients. They also cover the issues of false and misleading records and the penalties that may apply. The *Records Principles 2014* focus on records relating to care recipients. Approved providers should also ensure that service providers maintain the health records of individual care recipients in accordance with the local state or territory legislation and policy guidelines, as appropriate.

6.2.4 Quality of care

Section 54-1(1) of the Act outlines the responsibilities of the approved providers (and their service providers) in relation to the quality of the care provided. Approved providers are required to ensure that service providers have a workforce that is sufficient, and appropriately skilled to provide safe, respectful and quality care and services. Approved providers must also comply with the Aged Care Quality Standards set out in Schedule 2 of the *Quality of Care Principles 2014*. Further, the TCP Payment Agreement states that approved providers must ensure transition care is provided in accordance with the *Transition Care Programme Quality Improvement Framework (Attachment A)*.

6.2.5 Provider responsibilities

Section 56-3 of the Act describes the responsibilities of the approved providers in relation to flexible care recipients. The requirements in section 56-3 of the Act address matters such as the charging of fees, the resolution of complaints, the requirements for recipient agreements, and the protection of personal information.

6.2.6 Notification of material change: key personnel

Section 9-1 of the Act requires approved providers to notify the Aged Care Quality and Safety Commissioner of changes that materially affect their suitability to provide aged care within 28 days after the change occurs.

A material change is one that is substantial or considerable in nature. For example, the approved provider:

- is no longer an incorporated organisation;
- is unable to meet any of the Aged Care Quality Standards;

- is unable to manage its financial responsibilities including subsidies and care recipient's fees and payments;
- makes a change which may affect the rights of aged care recipients;
- makes substantial changes to its organisational or governance structure such as:
 - entering a sub-contract arrangement for delivery of clinical care;
 - use of a management company to manage the day-to-day operations of the organisation; or
 - change to key personnel.

See the below process steps for updating approved provider material / key personnel details:

| | |
|---------------|---|
| Step 1 | Register the new personnel on PRODA (Provider Digital Access system). PRODA is the online identity verification and authentication system, needed to access the Aged Care Provider Portal www.servicesaustralia.gov.au/organisations/business/services/proda-provider-digital-access |
| Step 2 | Submit a Notification of a Material Change form to the Aged Care Quality and Safety Commission (as part of its notification processing, the Commission will update NAPS) Process and requirement information: www.agedcarequality.gov.au/notifying-material-changes-approved-providers Form: here |
| Step 3 | Submit a <i>Register, amend or remove users for Aged Care Provider Portal</i> form (AC004) to Services Australia to enable updates to the ACP (and the payments system). Information and form link: here |
| Step 4 | If required, update the My Aged Care provider portal with new user details and deactivate previous users – see section 1.5 and 2.5 of the My Aged Care Provider Portal User Guide Part 1: Administrator Functions |
| Step 5 | Send notification email with new material/key personnel details to TCP@health.gov.au (the Department will then ensure the relevant state or territory office is notified). |

6.2.7 Notification of deceased TCP recipient

Where a current TCP recipient passes away, the responsible TCP service provider is to update the client's record in the My Aged Care system. Several processes are triggered to inactivate a client record when the client status is marked as deceased, and these will importantly, prevent the client or their representative from receiving further correspondence from My Aged Care (which can understandably be upsetting when the client has passed away).

This is in addition to the standard service provider requirements in respect to ensuring accurate claims reporting, including selection of the 'deceased' discharge code.

In the unfortunate instance that a TCP service provider is first to discover a care recipient is deceased when delivering care and services, it is expected that the service provider would follow the approved provider's guidance protocols in relation to notifying emergency services and the appropriate key contact person for the recipient, and any other reporting and notification processes the approved provider has in place. For approved providers delivering transition care in a residential setting, all unexpected deaths are considered Priority 1 reportable incidents under the SIRS and must be reported to the Commission within 24 hours (for more information on SIRS, see 6.1.2 *Serious and immediate health and safety risk management and reporting*).

6.3 Transition care payment agreement

Paragraph 111(3)(a) of the *Subsidy Principles 2014* sets out the requirements for a payment agreement to be in place for an approved provider to be eligible for flexible care subsidy. For payment of flexible care subsidy to be made, approved providers are required to enter into a payment agreement with the Secretary of the Department. Adherence to the payment agreement forms one of the conditions of allocation of flexible care places for transition care. The payment agreement sets out the requirements and specifications of the recipient agreement.

6.3.1 Conditions of allocation of flexible care places for transition care

An allocation of flexible care places for transition care may be subject to conditions in respect to the allocation of places generally or allocations of places of a specific kind. Sections 14-5 and 14-6 of the

Act set out the requirements in relation to conditions of allocations. The Department allocates transition care places to approved providers of transition care, in respect of specific transition care services, under the Act. These conditions can be specific in terms of determining the area in which the places are to apply or the target group for places. They also cover general conditions such as meeting the requirements of the Act and the Principles, such as entering into a payment agreement with the Australian Government, reporting and provision of information to the Department and specific matters including those outlined below.

6.3.2 Provision of information to the Department

Approved providers must participate in any monitoring and evaluation programmes undertaken by the Department. As such, approved providers must provide the Department with any relevant information when requested, including items specified in the payment agreement.

6.3.3 Insurance

As set out in the payment agreement, approved providers must ensure that their service providers maintain appropriate insurance while providing transition care. Service providers should be aware of any relevant state or territory legislation regarding insurance requirements and standards that may affect the delivery of transition care services.

6.3.4 Compliance with the laws of the Australian Government, states and territories

Approved providers and their service providers must comply with the provisions of any relevant statutes, regulations, by-laws and requirements of any Australian Government, state, territory or local authority.

6.3.5 Publishing of TCP material

Requirements in relation to the publication of information relating to an approved provider's provision of transition care, and the use of a Commonwealth logo, including those used by the Department, are outlined in clause 16 of the payment agreement. These extend to both TCP service providers, and any contracted third-party suppliers, given they are managing / delivery of the programme on behalf of the approved provider.

CHAPTER 7 QUALITY ASSURANCE AND COMPLAINTS IN TRANSITION CARE

7.1 Aged Care Quality Standards

The Aged Care Quality Standards apply to all aged care services including residential care, home care, short-term restorative care, transition care, the National Aboriginal and Torres Strait Islander Flexible Aged Care Program, Multi-Purpose Services and services under the CHSP. There is flexibility in the way the new Standards are applied to different services. For example, Standard 5 (Organisation's service environment) would not apply to a transition care service that only offers services to care recipients in a community setting. Further guidance is available on the Commission's website at

[https://www.agedcarequality.gov.au/sites/default/files/media/Guidance %26 Resource V14.pdf](https://www.agedcarequality.gov.au/sites/default/files/media/Guidance%26ResourceV14.pdf).

The Aged Care Quality Standards focus on quality outcomes for consumers rather than provider processes. This will make it easier for consumers, their families, carers and representatives to understand what they can expect from a service. It will also make regulation simpler for providers working across multiple aged care services, and encourage innovation, excellence and continuous improvement.

The Aged Care Quality Standards, including information for consumers and specific guidance and resources to assist Providers and aged care services with implementing and maintaining compliance with the Standards, are available on the Commission's website at

www.agedcarequality.gov.au/providers/standards.

7.2 Complaints

The payment agreement requires service providers to state the mechanisms available for making a complaint. This includes informing care recipients (or their representatives) in the recipient agreement of internal and external mechanisms for addressing complaints made by, or on behalf of, the care recipient.

7.2.1 Internal complaints processes

If care recipients have concerns, they should be encouraged to approach the service provider in the first instance. In most cases, the service provider is best placed to resolve complaints and alleviate concerns of care recipients. Service providers must handle any complaints fairly, promptly, confidentially and without retribution.

Complaints should be used positively to monitor and improve the quality of services provided by the service provider. Actively encouraging care recipients to provide feedback, both positive and negative, and duly considering this feedback will improve services and provide continuous improvement.

Service providers must also provide information in the recipient agreement about external complaint mechanisms and relevant contact information, such as telephone numbers of state/territory or Australian Government complaints bodies.

7.2.2 External complaints processes

If care recipients (or their representatives) cannot resolve their dispute with the transition care service provider, they may choose to direct their complaints to either the Commission (see section [7.2.3 Australian Government Aged Care Quality and Safety Commission](#)), or alternatively, the relevant state/territory 'Health Complaints Agency' outlined in the table below.

| Jurisdiction | Health Complaints Agency |
|-----------------|---|
| New South Wales | Health Care Complaints Commission |
| Victoria | Health Complaints Commissioner |
| Queensland | The Office of the Health Ombudsman |
| South Australia | Health and Community Services Complaints Commissioner |

| Jurisdiction | Health Complaints Agency |
|------------------------------|---|
| Western Australia | Health and Disability Services Complaints Office |
| Tasmania | Health Complaints Commissioner Tasmania |
| Northern Territory | Health and Community Services Complaints Commissioner |
| Australian Capital Territory | ACT Human Rights Commission |

7.2.3 Australian Government Aged Care Quality and Safety Commission (the Commission)

The Aged Care Quality and Safety Commission replaced the Australian Aged Care Quality Agency and the Aged Care Complaints Commissioner on 1 January 2019. The Commission's role is to protect and enhance the safety, health, well-being, and quality of life of people receiving aged care. The Commission provides a free service that handles concerns or complaints about service providers and can also provide support with information and options to resolve aged care concerns and complaints.

The Commission can be contacted as follows:

Free Call: 1800 951 822 9am – 5pm Monday to Friday

Mail: Aged Care Quality and Safety Commission
GPO Box 9819
In the capital city and state/territory transition care is being provided

Email: info@agedcarequality.gov.au

Attachment A SCHEDULE 4 – TRANSITION CARE PROGRAMME QUALITY IMPROVEMENT FRAMEWORK

The Transition Care Programme Quality Improvement Framework was developed in 2010-11 by the cross-jurisdictional Transition Care Working Group (TCWG) as a strategic approach to achieving the goals of the programme and improving the quality of care and service delivery for transition care recipients nationally. The TCWG oversaw the expansion of the transition care programme from 2,000 to 4,000 places from 2008 to 2012 and reported to the Australian Health Ministers’ Advisory Council until 30 June 2013.

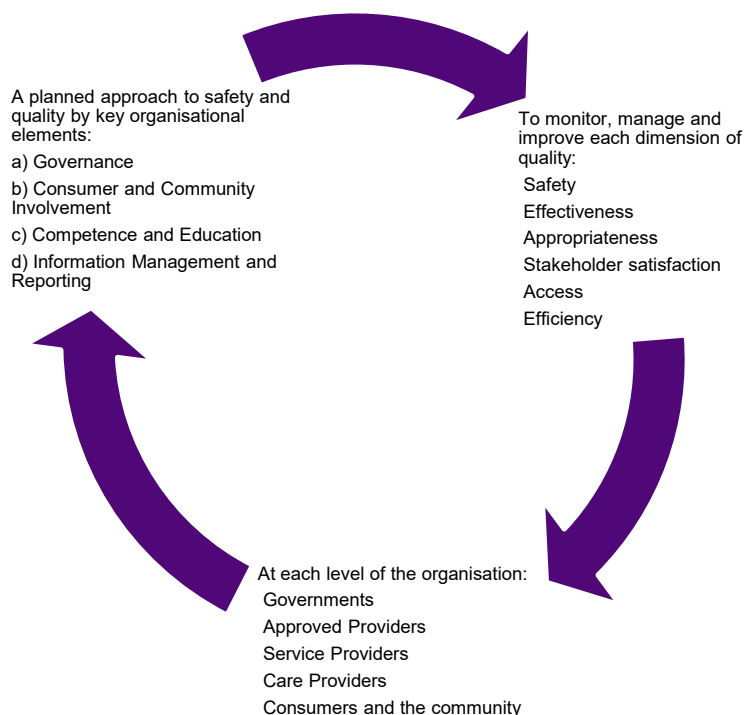
The Quality Improvement process provides the opportunity to change for the better. The underlying ethos of any quality improvement framework is one that fosters improvement and performance. The results are improved client outcomes, as well as efficiency and ease of compliance with Australian Government requirements, in particular the Aged Care Quality Standards which were introduced on 1 July 2019, and state/territory legislation and requirements.

The Framework is relevant to transition care services of any size, and to stakeholders at each level of the transition care programme, namely:

1. Governments – Australian and state/territory (approved providers);
2. Transition care service providers – regional and/or local managers;
3. Hospitals; and
4. Transition care recipients.

Framework Dimensions

The Framework describes the dimensions of quality and the cross dimensional organisational elements that underpin effective safety and quality improvement.



Essential Transition Care Quality Components

1 Organisational Elements

The Framework is based on four organisational elements¹⁰ critical to quality improvement:

- I. Governance and leadership
- II. Consumer involvement

¹⁰ Ibid.

- III. Competence and education
- IV. Information management

In the context of transition care, the four organisational elements critical to quality improvement refer to:

I. Governance and leadership

- Corporate governance exercised by Australian and state/territory governments and their respective structures and processes which ensure fulfilment of strategic, statutory and financial obligations.
- Clinical governance refers to the accountability of approved providers and authorised service providers for monitoring, supporting, evaluating and continuously improving the safety and quality of care and service delivery.

II. Consumer involvement

- Consumers need to be involved at two levels, either:
 - as people who either directly or indirectly make use of transition care services, predominantly older people and their families and carers; or
 - as representatives of the community or population served by the service they are attending.

III. Competence and education

- Competence needs to be assured at all levels of the Programme and requires the provision of education and training to ensure understanding of the quality framework to foster compliance. Regular review and follow-up action is also required to ensure maintenance of skills and knowledge appropriate to all levels of service provision.

IV. Information management

- There needs to be accurate, relevant and timely collection, analysis and reporting of data, supported by appropriate software and hardware and the capacity to convert the data into information which can be used to support and to enable continuous improvement in practice.

2 Dimensions of Quality

Each of these organisational elements intersects with six commonly recognised dimensions¹¹ of quality:

- I. Safety
- II. Effectiveness
- III. Appropriateness
- IV. Stakeholder satisfaction
- V. Access to services
- VI. Efficiency

These dimensions form the basis for monitoring, managing and reporting on the quality of transition care services provided nationally. There is significant overlap and interdependence between them, therefore making it important for all dimensions to be included in a system designed to improve the quality of care and services being provided.

Components of the six dimensions of quality as they pertain specifically to the provision of transition care include, but are not limited to, the following activities:

I. Safety

- Management and reduction of risks
 - (i) Transition care service providers must have up-to-date policies and procedures to manage and reduce risks, including falls, incidents of abuse of older people and other adverse events.
 - (ii) Transition care service providers delivering care in a residential setting must comply with all requirements mandated by the SIRS, which include incident management and compulsory reporting obligations (see 6.1.2 of the guidelines Serious and immediate health and safety risk management and reporting).

¹¹ Ibid.

- Police checks
 - (i) All transition care staff and contractors who have or are reasonably likely to have access to care recipients of a transition care service must undergo a national criminal history record check every three years.
 - (ii) This includes volunteers who have unsupervised access to care recipients (see also part 6 of the Accountability Principles 2014 and section 63-1 of the Act).
- Buildings used for the provision of residential based transition care must comply with the relevant state/territory building regulations.
- Credentialing/professional registration/accreditation of service providers
 - (i) Allied health, medical and nursing staff who provide transition care services must have current national registration or be a member of the appropriate professional association, a Department of Veterans' Affairs (DVA) approved provider or a Registered Medicare Provider.
- Environmental safety checks
 - (i) Transition care service providers must meet appropriate environmental standards, including food handling and hotel services in residential based transition care services.

II. Effectiveness

- Transition care service provision should include:
- quality improvement reviews and studies, both quantitative and qualitative, including robust monitoring, reporting and response systems;
- consumer satisfaction surveys and other feedback mechanisms; and
- monitoring of functional improvement using an endorsed or validated tool*.

*Note: The use of the Modified Barthel Index for assessments by the transition care service at entry to and exit from the transition care programme is mandatory for Australian Government subsidy payments.

III. Appropriateness

- Transition care service provision should include outcome monitoring in accordance with principles of transition care, including returning home to live in community (or previous care setting) and admission to residential care rates, and re-admission to hospital during a transition care episode.
- Service settings should be suitable for meeting transition care outcomes, including provision of a more home-like, less institutional environment in residential services and space available for therapy (see Requirement 4.1, Outcome 4.1.3 in Chapter 4 – Transition Care Programme Restorative Care Requirements).

IV. Stakeholder Satisfaction

- Transition care service provision must have internal and external processes for monitoring and managing complaints.
- Complaints processes should be informed by stakeholder consultation and feedback, including satisfaction surveys, focus groups and interviews with internal and external stakeholders at all levels.¹²

V. Access to services

- Transition care service provision must comply with admission/eligibility criteria governing access to services, including utilisation of services by target groups, including Aboriginal and Torres Strait Islander people, and special needs populations.
- This should include reviews of the utilisation of services encompassing target groups and special needs populations to optimise access.

VI. Efficiency

- Transition care service provision should be guided by systemic reviews and updating of policies and procedures to ensure consistency at national, state and local levels. This should include:

¹² NSW Health, 1999. *A Framework for Managing the Quality of Health Services in New South Wales*, NSW Department of Health, Sydney.

- (i) transparent data analysis and reporting on performance, including occupancy rates, lengths of stay and re-admission rates; and
- (ii) regular benchmarking and comparing of organisational performance.

3 Operating Environment

There are several key external and internal safety and quality drivers impacting on the environment in which the Transition Care Programme Quality Improvement Framework operates:

VII. Compliance with legislative and regulatory requirements.

VIII. Compliance with quality standards.

IX. An internal self-assessment and reporting system.

X. Local quality improvement plans which address operational priorities and implications for safety and quality are reviewed and updated annually or in line with requirements of the approved provider and the relevant external accreditation agency.

I. Compliance with legislative and regulatory requirements

- Transition care approved providers and services are required to comply with all Australian Government and/or state/territory legislative and regulatory requirements.

II. Compliance with quality standards

- Transition care must comply with the Aged Care Quality Standards, regardless of whether they are accredited under the Aged Care Quality Standards or the National Safety and Quality Health Service (NSQHS) Standards.

III. Internal self-assessment and reporting system

- Transition care service provision must include an internal reporting and self-assessment system.

IV. Local quality improvement plans

- Transition care service provision must have a culture that promotes continuous quality improvement. This should include, but not be limited to, local quality improvement plans which address operational priorities and implications for safety and quality and are reviewed and updated annually or in line with requirements of the approved provider and the relevant external accreditation agency. The local plans must:
 - (i) reflect an organisational or service level culture which fosters safety and quality improvement;
 - (ii) enable individual transition care services to draw on appropriate organisational structures, processes and resources (including technical support and information) to monitor, manage and improve service delivery; and
 - (iii) utilise a simple quality improvement methodology, comprising:
 - a) a feedback loop which ensures that data and information are collected, analysed and acted on, with the results of action review for effectiveness and all parties concerned kept informed of progress;
 - b) improvements that could be adopted by individual organisations or services;
 - c) improvement tools and techniques that could be utilised and chosen locally and which are consistent with the environment in which the transition care service operates; and
 - d) the involvement of people who are directly impacted by change because of improvement activities. These people could be staff, consumers, the community, and other stakeholders.

4 Review of the Framework

This Framework should be reviewed from time to time to ensure it remains current and consistent with new developments in health and aged care, and to facilitate changes identified through growing experience with the programme.

The review should be undertaken by a group which includes representatives from the department with portfolio responsibility for the programme and state/territory approved providers to ensure the perspectives of all jurisdictions are considered.

Attachment B SCHEDULE 1 – SPECIFIED CARE AND SERVICES FOR TRANSITION CARE SERVICES

The Transition Care Payment Agreement provides that the care and services listed in Schedule 1 are to be provided in a way that meets the Aged Care Quality Standards.

The following lists of care and services are not intended to be exhaustive or to limit the range of care and services provided. They indicate the basic level of care that transition care service providers must be able to provide, if required by a recipient of transition care, for receipt of flexible care subsidy for that recipient. The use of telehealth and telecare devices should be considered where medically indicated and appropriate to the care recipient’s goals. The availability and adoption of this equipment may be subject to adequate infrastructure to support the transmission of data and images.

Part 1 Care and services that must be provided, when required, to transition care recipients in a residential setting

| Col.1 | Column 2 Service | Column 3 Content |
|-------|--|---|
| 1.1 | Maintenance of all buildings and grounds | Adequately maintained buildings and grounds. |
| 1.2 | Accommodation | Utilities such as electricity and water. |
| 1.3 | Furnishings | Bed-side lockers, chairs with arms, containers for personal laundry, dining, lounge and recreational furnishings, draw screens (for shared rooms), care recipient wardrobe space, towel rails, over-bed tables. |
| 1.4 | Bedding materials | Beds and mattresses, bed rails (if appropriate), bed linen, blankets and absorbent or waterproof sheeting, incontinence sheets, ripple mattresses, sheepskins, tri-pillows, and water and air mattresses appropriate to each care recipient’s condition. |
| 1.5 | Cleaning services, goods and facilities | Cleanliness and tidiness of the entire service. Excludes: a care recipient’s personal area if the care recipient chooses and is able to maintain it himself or herself. |
| 1.6 | General laundry | Heavy laundry facilities and services, and personal laundry services, including laundering of clothing that can be machine washed. Excludes: cleaning of clothing requiring dry cleaning or another special cleaning process, and personal laundry if a care recipient chooses and is able to do this himself or herself. |
| 1.7 | Toiletry goods | Bath towels, face washers, soap, toilet paper, sanitary pads, tissues, toothpaste, toothbrushes, denture cleaning preparations, mouthwashes, moisturiser, shampoo and conditioner, shaving cream, disposable razors and deodorant. |
| 1.8 | Meals and refreshments | Preparing nutritious meals that are culturally appropriate and of adequate variety, quality and quantity for each care recipient, served each day at times generally acceptable to both care recipients and management, and generally consisting of 3 meals per day plus morning tea, afternoon tea and supper. Special dietary requirements, having regard to either medical need or religious or cultural observance. Food should include fruit of adequate variety, quality and quantity, and non-alcoholic beverages, including fruit juice. Assisting care recipients in eating meals. For care recipients requiring enteral feeding in residential based transition care, the transition care service provider is responsible for providing the enteral feeding formula at no extra cost to the care recipient. See also 3.3 of this Schedule regarding the provision, care and maintenance of tubes for enteral feeding. |
| 1.9 | Emergency assistance | At least one responsible person is continuously on call in the facility in which transition care is delivered to provide emergency |

| Col.1 | Column 2 Service | Column 3 Content |
|-------|--|---|
| | | assistance. In a medical emergency, which requires immediate action, appropriate medical assistance must be sought, e.g. by dialling 000. |
| 1.10 | Treatments and procedures with respect to ongoing medical management | <p>Treatments and procedures that are carried out according to the instructions of a health professional, such as a GP or a representative for assessing a care recipient's personal care needs, or undertaken according to the care recipient's wishes, including supervision and physical assistance with taking medications, and ordering and reordering medications, subject to requirements of state and territory law.</p> <p>It is expected that the provision of primary medical care to a transition care recipient would be undertaken by a GP and that the services provided by the GP in the residential setting would be covered by Medical Benefits Schedule (MBS) rebates, as is currently the case in residential aged care services.</p> <p>Where GPs are asked to provide different medical services or a higher volume of services than specified in the MBS requirements, then funding of these additional services should occur through the Transition Care Programme.</p> <p>For the purpose of monitoring the care recipient's health status, telehealth and telecare devices may be used where medically indicated and appropriate to the care recipient's goals.</p> |
| 1.11 | Assistance in obtaining health practitioner services | Arrangements for aural, community health, dental and oral health, medical, psychiatric, optometry and other health professionals to visit care recipients whether the arrangements are made by care recipients, relatives or other persons representing the interests of care recipients or are made direct with the practitioner. |
| 1.12 | Goods to assist care recipients to move themselves | <p>Crutches, quadruped walkers, walking frames, walking sticks, wheelchairs and off-the-shelf aids to assist with upper limb function, should be available as required for the duration of a care recipient's stay.</p> <p>Excludes: motorised wheelchairs and custom-made aids.</p> |
| 1.13 | Goods to assist staff to move care recipients | Medical devices for lifting care recipients, stretchers, trolleys should be provided as required for the duration of a care recipient's stay. |
| 1.14 | Goods to assist with toileting and incontinence management | Includes the provision as required of absorbent aids, commode chairs, disposable bed pans and urinal covers, disposable pads, over toilet chairs, shower chairs, urodomes, catheter and urinary drainage appliances, and disposable enemas. |
| 1.15 | Basic medical and pharmaceutical supplies and equipment | <p>Includes analgesia, anti-nausea agents, bandages, creams, dressings, laxatives and aperients, ointments, saline, swabs, urinary alkalisating agents, and anti-diarrheals.</p> <p>Non-prescription pharmaceutical goods should always be administered to a care recipient only as the result of a clinical decision and be recorded on the care recipient's medical chart.</p> <p>Excludes: any goods prescribed by a health practitioner for a particular care recipient and used only by the care recipient. In this case, the medication would be covered, as is normal, under the Pharmaceutical Benefits Scheme (PBS).</p> |
| 1.16 | Medications | Medications subject to requirements of state or territory law. |

Part 2 Care and services that must be provided, when required, to transition care recipients in a community setting

| Col.1 | Column 2 Service | Column 3 Content |
|-------|------------------------|---|
| 2.1 | Bedding materials | Provision of absorbent or waterproof sheeting, incontinence sheets. |
| 2.2 | General laundry | Assistance with laundry. |
| 2.3 | Meals and refreshments | <p>Arrange, where required, transport to help a person shop.</p> <p>Assistance with nutrition, hydration and preparing and eating meals. The definition of preparing and eating meals assumes that the care recipient is responsible for providing and paying for the food, including enteral feeding formula, if required. See also 3.3 of this Schedule regarding the provision, care and maintenance of tubes for enteral feeding.</p> <p>However, where Meals on Wheels is required, it is important that the payment arrangements for Meals on Wheels services are clearly described in the care recipient agreement between the service provider and the care recipient.</p> <p>Assistance with special dietary requirements, having regard to either medical need or religious or cultural observance.</p> |
| 2.4 | Emergency assistance | <p>Having at least one responsible person or agency, approved by the organisation providing the community care, in close proximity and continuously on call to give emergency assistance when needed.</p> <p>For example, this could be through a personal alert system or a phone number to a mobile or land line which is staffed 24 hours per day.</p> <p>In a medical emergency, which requires immediate action, appropriate medical assistance must be sought, e.g. by dialling 000.</p> <p>Each transition care service provider must develop a protocol for emergency situations and this protocol must be reflected in the service provider's policies and procedures.</p> |
| 2.5 | After hours assistance | <p>As part of each care recipient's care plan, the service provider must manage the risk of the care recipient requiring after hours assistance. The possible risk factors for each care recipient should be identified and management strategies implemented for these risk factors.</p> <p>Where the need for after-hours assistance has been identified, there should be 24 hour on call access to at least one responsible person or agency in reasonable proximity who is familiar with the care plan and who has given consent to be included in the care plan as contact. The responsible person may be a relative, friend or neighbour who is located close to the care recipient and who will organise after-hours assistance or emergency assistance when required.</p> <p>The service provider may also have their own staff on call (i.e. from a nearby aged care service) to go to the care recipient's home after hours. Should the care recipient not nominate a person as a contact, the transition care service provider must provide the after-hours assistance.</p> <p>If the care recipient requires 24 hour on call assistance and access to an emergency call system, this must be provided. If a care recipient requires access to an emergency call system on a long-term basis, the care recipient should be given the option of</p> |

| Col.1 | Column 2 Service | Column 3 Content |
|-------|--|--|
| | | having an emergency call system of their choice installed at their own cost. |
| 2.6 | Home help | Assistance with home help including domestic assistance. This includes assistance with cleaning or the provision of cleaning services, goods and facilities, if required. |
| 2.7 | Home maintenance and functional safety | <p>Home maintenance reasonably required to maintain the home and garden in a condition of functional safety and provide an adequate level of security.</p> <p>Efforts to ensure functional safety must also include identifying and addressing any Occupational Health and Safety issues that might have an adverse effect on care staff working in the home.</p> <p>If a care recipient requires home modifications, such as the installation of grab rails, hand rails and ramps to enable the care recipient to continue living at home, service providers, in their role as case manager, should confirm eligibility of the care recipient for home modification services provided under the Commonwealth Home Support Programme or Veterans' Home Care Programmes and availability of the required home modifications through these Programmes. For care recipients who are not eligible for services under these Programmes, the care recipient or their representative is responsible for arranging the home modifications and meeting the cost involved.</p> <p>As a follow-up, unless otherwise advised in the discharge plan (i.e., referral to have external follow up), the prescribing therapist should liaise with the care recipient after the transition care episode to ensure that the care recipient's functional needs have been met once the home modifications are complete or the necessary equipment has been supplied. The follow-up by the relevant therapist could be a home visit or a phone assessment as appropriate, depending on what type of home modification has been undertaken and the needs of the care recipient.</p> |
| 2.8 | Treatments and procedures with respect to ongoing medical management | <p>Control and administration of medication prescribed by a medical practitioner, subject to legal restrictions on providing the medication. Administration of treatment such as eye drops, pressure care, dressings and urine tests, subject to legal restrictions on providing treatment.</p> <p>Telehealth and telecare devices may be used where medically indicated and available for monitoring the care recipient's health status, especially for those who live in rural, remote and outer metropolitan areas.</p> |
| 2.9 | Assistance in obtaining health practitioner services | Transport to help a care recipient visit a medical practitioner or assistance in arranging a home visit by a medical practitioner. |
| 2.10 | Goods to assist care recipients to move themselves | <p>Service providers may need equipment to assist in the provision of transition care services and meet care recipients' needs (e.g. a wheelchair for assistance with mobility or a personal alert system to provide on-call emergency assistance). Transition care service providers using Australian Government subsidies may purchase such equipment and, where appropriate, this equipment may be loaned temporarily to individual care recipients.</p> <p>When purchasing equipment for the service, ownership of the equipment vests with the service provider. Any equipment loaned to individual care recipients should be returned to the provider at the conclusion of the transition care episode, for use by other care recipients. It is important to note that the provider is purchasing the equipment for use in service provision.</p> |

| Col.1 | Column 2 Service | Column 3 Content |
|-------|---------------------|--|
| | | If a care recipient requires aids and equipment on an ongoing basis, service providers should, in their role as case manager, seek equipment from such places as state/territory government equipment schemes or equipment loan services. For care recipients who are not eligible for services under these equipment schemes or equipment loan services and the required services are not available, the care recipient or their representative is responsible for the cost of the equipment. |
| 2.12 | Other | Other services required to maintain the person at home as agreed with the care recipient. |

Part 3 Common care and services that must be provided, when required, to all transition care recipients

| Col.1 | Column 2 Service | Column 3 Content |
|-------|----------------------------------|--|
| 3.1 | Administration and care planning | General operation of the transition care service, including care recipient documentation and care planning and management. When an older person is in a transition care service, initial and ongoing assessment, planning and management of care will be undertaken by appropriately qualified and trained staff members or others (including external practitioners) with expertise in geriatric and/or therapeutic management, with the involvement of the care recipient (or the representative), and his or her carer, where appropriate. |
| 3.2 | Case management | <p>The transition care service provider should ensure that appropriate case management is available to recipients of transition care, to coordinate and monitor all aspects of their care and their movement from hospital, through transition care and back into the community or to their normal care arrangements, and act as a central point of contact for everyone involved in the care of the recipient.</p> <p>This will include:</p> <ul style="list-style-type: none"> ensuring that a comprehensive care plan is available at the time of discharge from hospital; ensuring that all aspects of the care plan are carried out, monitoring progress against the care plan goals and adjusting the plan where necessary; identifying any changes to a recipient's care needs that occur during transition care and arranging for appropriate adjustments to the services provided; liaising with and organising all care requirements provided by external service providers (including GPs and specialists); and arranging for appropriate care, if required, following transition care or managing the return of the recipient to the community or their normal care arrangements. <p>Throughout the time spent in transition care and with respect to any subsequent arrangements, the case management role includes ensuring that the individual lifestyle choices of the care recipient are taken into account and that everything possible is done to enable social contact between the care recipient and their family and friends.</p> |
| 3.3 | Specialised clinical services | Clinical care provided as part of the transition care programme, where required, is to be carried out by a registered nurse, or under the direct or indirect supervision of a registered nurse or other professional appropriate to the service delivery and in |

| Col.1 | Column 2 Service | Column 3 Content |
|-------|---------------------|--|
| | | <p>accordance with professional standards and guidelines. These services may include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • assessment for pain and a plan implemented to keep the care recipient as free from pain as possible; • provision and care and maintenance of tubes, including enteral feeding, naso-gastric and tracheostomy tubes etc; • establishment, review and maintenance of urinary catheter care and/or stoma care programme; • complex wound management; • enema administration or insertion of suppositories; • suctioning of airways and tracheostomy care; • oxygen therapy requiring ongoing supervision because of a care recipient's variable need, including the provision of oxygen and oxygen equipment at no additional cost to the care recipient; • appropriate medication management; • appropriate nursing services; • appropriate dementia support; • taking appropriate action to prevent falls among care recipients; • on-call access to specialist nursing services, if required; and • specialised swallowing management. |
| 3.4 | Therapy services | <p>The therapeutic care to be delivered through the transition care programme includes low intensity therapy such as physiotherapy, occupational therapy, podiatry, dietetics¹³, speech pathology, counselling and social work to maintain and improve physical and cognitive functioning and to facilitate improved capacity in activities of daily living. This care is to be provided by appropriately qualified and trained staff or consultants and in accordance with any levels of care specified under the recipient's care plan, developed as specified in section 3.1.</p> <p>Recreational activities and diversional therapy are provided that are suited to the care recipient, including lifestyle, cognitive and general exercise programs. Participation in the activities is encouraged and access to recreational equipment facilitated.</p> <p>Psychological or counselling services may also be required to provide emotional support and to assist care recipients deal with their psychological and emotional states as they experience changes to their circumstances and confront alterations to their dependency levels, their normal accommodation etc. For example, this may be the case where, following a period in hospital followed by transition care, a care recipient requires a higher level of ongoing care than previously.</p> <p>Support for care recipients with cognitive impairment may be required, including individual therapy, activities and access to specific programmes designed to prevent or manage a particular condition or behaviour, enhance quality of life and provide ongoing support.</p> <p>A key component of the transition care programme is the therapeutic services that care recipients can receive. These services are not a substitute for the subacute care delivered through the hospital sector. Hence eligibility for transition care</p> |

¹³ Day to day diabetes education and management forms part of 'dietetics' and is to be undertaken by a qualified diabetes educator who oversees and manages diabetes therapy where clinically appropriate, according to the care recipient's needs and care plan.

| Col.1 | Column 2 Service | Column 3 Content |
|-------|------------------------------------|--|
| | | <p>includes an ACAT assessment that concludes that, where appropriate, a care recipient has already received hospital based subacute rehabilitation care and/or geriatric evaluation and management where necessary (or will have received it prior to discharge).</p> <p>The therapy services do not include acupuncture and as such, the cost of the provision of acupuncture is not covered by the transition care programme.</p> |
| 3.5 | Daily living activities assistance | <p>Personal assistance, including individual attention, individual supervision and physical assistance with:</p> <ul style="list-style-type: none"> • bathing, showering, personal hygiene and grooming; • maintaining continence or managing incontinence, and using aids and appliances designed to assist continence management; • eating and eating aids, and using eating utensils and eating aids (including actual feeding if necessary); • dressing, undressing and using dressing aids; • moving, walking, wheelchair use and using devices and appliances designed to aid mobility, including the fitting of artificial limbs and other personal mobility aids; and • communication, including to address difficulties arising from dementia, impaired hearing, sight or speech, or lack of common language (including the fitting of sensory communication aids). |
| 3.6 | Social activities | <p>Arranging social programs and activities or providing/coordinating transport to socialisation activities/functions at a reasonable frequency. Encouraging transition care recipients to take part in social activities.</p> <p>Providing other services that help to prevent social isolation and promote and protect the dignity and well-being of recipients.</p> |
| 3.7 | Religious and cultural activities | Provide support to the care recipient in accessing religious and cultural activities. |
| 3.8 | Advocacy | Advocacy services to help protect the care recipient's interests. |
| 3.9 | Support | Support services to maintain personal affairs. |
| 3.10 | Waste disposal | Safe disposal of organic and inorganic waste material. |

Attachment C SUMMARY OF TRANSITION CARE RESTORATIVE CARE REQUIREMENTS

| Requirement | Assessment Process | Planning Process | Requirements which transition care services must demonstrate |
|--|--|--|--|
| <p>1. Optimising Independence and wellbeing</p> <p>The transition care service optimises the independence and wellbeing of its care recipients</p> | <p>Assessment processes:</p> <ul style="list-style-type: none"> allow care recipients or their representative, assisted by carers and families as appropriate, to make informed choices between transition care service options to define and set their goals to optimise their independence and wellbeing; include an assessment of care recipients' physical and cognitive independence, as well as their psycho-social needs; and consider special needs groups, including people from Aboriginal and Torres Strait Islander communities, people from culturally and linguistically diverse backgrounds, and people who have a physical or cognitive impairment. | <p>Care planning is focussed on optimising independence and wellbeing and includes a goal-oriented care plan for the care recipient that:</p> <ul style="list-style-type: none"> responds to the identified needs of the care recipient and targets those goals which optimise independence while taking into consideration the cognitive and psycho-social needs of the care recipient; provides the care recipient with required physical and cognitive therapies and treatments designed to teach the care recipient to achieve their own goals; and improves the care recipient's functioning by promoting independence and monitors that improvement in consultation with the care recipient and/or their representative, carers and families, clinicians, and therapists. <p><i>Note: For further detail on care planning, see outcome 4.2.2.</i></p> | <p>The transition care service demonstrates that its service:</p> <ul style="list-style-type: none"> provides a coherent and integrated case management process that enables care recipients to meet their goals and takes into consideration the psycho-social situation of the care recipient; actively promotes self-management and self-sufficiency by providing interventions that support the care recipient to make the most of their own capacity and achieve their full potential; encourages care recipients to seek support from carers and families, community groups and others to foster their independence when required; assists care recipients to achieve an optimum level of independence and wellbeing so that care needs are minimised over the longer term; provides facility-based residential transition care services in a more home-like, less institutional environment. This may include: <ul style="list-style-type: none"> a communal living space/living room environment which is separate from sleeping areas and the location of acute/subacute care provision, i.e. a space that encourages carers, families and visitors to spend time with care recipients; a dining area and care recipients encouraged not to eat in bed; care recipients being encouraged and supported to dress every day; facilities for care recipients to prepare snacks for themselves and their visitors; privacy, particularly for personal care and bathing arrangements; space for care recipients to move about, especially outdoors; physical arrangements which support the involvement of carers and family in the therapeutic activities; and |

| Requirement | Assessment Process | Planning Process | Requirements which transition care services must demonstrate |
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| | | | <ul style="list-style-type: none"> ○ a model of care and staff knowledge that supports the intent of the Transition Care Programme to promote the care recipient's health and independence. <p><i>Note: Transition care services may also be provided in rural and remote hospitals where appropriate. The requirements for a more home-like environment may be relaxed on a case by case basis in these locations, if relevant.</i></p> |
| <p>2. Multidisciplinary Approach and Therapy Focused Care</p> <p>The transition care service provides its care recipients with high quality, evidence-based therapeutic services focused on maintaining or improving function in line with established goals</p> | <p>Assessment processes:</p> <ul style="list-style-type: none"> • assessment of the care recipient's transition care needs by the multidisciplinary team (MDT) at the beginning of the transition care episode; • the use of validated assessment tools deemed appropriate by clinicians/therapists*; • a dementia assessment; • measurement of a baseline level of functioning using validated assessment tools, and re-assessment of functional performance at pre-determined intervals; and • evidence of discharge planning throughout the transition care episode. <p><i>*Note: The use of the Modified Barthel Index for assessments by the transition care service at entry to and exit from the Transition Care Programme is mandatory for Australian Government subsidy payments.</i></p> | <p>Care planning processes demonstrate that:</p> <ul style="list-style-type: none"> • a goal-oriented physical and cognitive therapy programme is developed by the provider in consultation with the care recipient or representative, carer and family prior to the commencement of therapy or treatment, with input from the MDT of the transferring hospital and the ACAT; • the therapy programme duration is estimated and informs planning for the care recipient's discharge; • hospital discharge information is incorporated into the initial care planning process; • care provision is responsive to the identified needs and goals of the care recipient; • physical and cognitive therapy goals agreed with the care recipient or their representative/carer are documented and prioritised; • the care recipient receives timely and appropriate access to therapy, care and equipment during the transition care episode. This is demonstrated by: <ul style="list-style-type: none"> ○ ensuring aids, appliances, equipment and services required for a care recipient's therapy are provided in a timely manner; ○ providing a broad range of services tailored to meet the care recipient's therapeutic goals to improve or maintain function; ○ providing the care recipient with low intensity therapy from appropriately qualified staff to achieve their individual documented goals; and | <p>The MDT approach to the planning and review of care recipient care demonstrates that:</p> <ul style="list-style-type: none"> • documented procedures and protocols are available to support the multidisciplinary team in the care and review of care recipients. This includes processes for communicating care recipient information to relevant health professionals; • care planning is carried out by members of the MDT with relevant clinical experience in goal-oriented, low intensity therapy; • care plan reviews/case conferencing include those members of the MDT involved in the care recipient's treatment and occur at predetermined intervals; • care is informed by discussions with and between the relevant Geriatrician and the care recipient's GP, where possible, and/or other appropriate medical input; • MDTs have integrated care recipient records; • the MDT comprises an appropriate mix and level of staff, enabling the provision of effective care recipient services; and • a coordinator/case manager is in place to oversight and promote effective MDT and inter-agency working. |

| Requirement | Assessment Process | Planning Process | Requirements which transition care services must demonstrate |
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| | | <ul style="list-style-type: none"> ○ actively encouraging care recipient, and/or their representative, carer and family participation in all aspects of transition care service provision. ● the care recipient's progress against therapy goals is regularly evaluated throughout their transition care episode and on exit, with changes in physical and cognitive function measured and recorded to demonstrate achievement of the care recipient's goals; ● the care recipient's changing needs are reflected as they move between care settings; and ● care recipient goals are delivered in accordance with the care plan, using an integrated case management approach. | |
| <p>3. Seamless Care</p> <p>The transition care service uses a collaborative service delivery model that delivers seamless care</p> | <p>Assessment processes:</p> <ul style="list-style-type: none"> ● follow agreed protocols for the effective transfer of care recipient information between primary, community, acute and aged care services; ● recognise and incorporate hospital assessment, care planning and discharge arrangements, including ACAT assessment and approval recommendations; ● enable staff of the receiving transition care service to meet and assess the care recipient's care needs and the transition care service's ability to meet these care needs prior to the care recipient's admission into the service, where possible; and ● provide for a verbal as well as a written handover of care recipient information and status whenever the care recipient moves between or within services, where practical. | <p>The transition care service works within an integrated system of care with other organisations by:</p> <ul style="list-style-type: none"> ● establishing relationships and communication strategies that govern collaboration between acute/subacute, aged and primary care services, promoting a clear understanding of each other's roles, responsibilities and admission criteria; ● establishing systems for the secure, timely and effective transfer of transition care, care recipient information between service providers; ● strengthening partnerships with GPs and other transition care support services; ● facilitating effective interagency case conferences; ● facilitating the care recipient's entry to and exit from transition care so that the care recipient experiences a seamless move; ● effectively coordinating the care recipient's needs and goals between services; ● keeping the care recipient and/or their representative well informed prior to moving to a new service; ● facilitating education, training, networking and support across sectors and service boundaries | <p>The transition care service develops systems for the safe discharge of care recipients that help prevent re-admission, including:</p> <ul style="list-style-type: none"> ● providing transition care service discharge plan information to any subsequent care organisation; and ● providing appropriate discharge documentation to the care recipient, specifying: <ul style="list-style-type: none"> ○ length of stay in transition care; ○ destination post transition care; ○ goals which care recipient agrees have been achieved or not achieved (with reasons for non-achievement); ○ care recipient physical and cognitive functional levels on discharge from transition care, assessed using the same validated instrument used on admission; ○ care recipient and/or representative, carer and family education and support to improve functioning following discharge; ○ where appropriate all services and equipment to be provided to the care recipient on discharge from transition care, with key supplier contact details; ○ an up-to-date list of prescribed discharge medications; and |

| Requirement | Assessment Process | Planning Process | Requirements which transition care services must demonstrate |
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| | | <p>in the broader health and aged care community where appropriate; and</p> <ul style="list-style-type: none"> • facilitating access to ongoing care and service provision post discharge from the programme, as required. | <ul style="list-style-type: none"> ○ other follow-up arrangements/referrals such as information for the care recipient's GP, which are the responsibility of the care recipient and/or their representative. |

GLOSSARY

| Term | Meaning |
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| ACAT (ACAS) | <p>Aged Care Assessment Teams (ACATs) (Aged Care Assessment Service (ACAS) in Victoria) are multidisciplinary teams of health professionals who provide assessment, information, advice and assistance to frail older people to gain access to the types of services most appropriate to meet their care needs. This includes responsibility for determining eligibility for entry to Australian Government subsidised residential aged care, home care and flexible care (including transition care) as and when appropriate.</p> <p>ACATs conduct a comprehensive assessment of the restorative, physical, medical, psychological, cultural and social dimensions of a person's needs, and/or promote their independence as and when appropriate. ACATs refer clients to services that are appropriate and available to meet their needs.</p> <p><i>Aged Care Assessment Manual, June 2018.</i></p> |
| ACUTE CARE | <p>Acute care in the context of transition care is care provided to hospital in-patients in which the clinical intent or treatment goal is to:</p> <ul style="list-style-type: none"> • cure illness or provide definitive treatment of injury; • perform surgery; • relieve symptoms of illness or injury (excluding palliative care); • reduce severity of an illness or injury; • protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function; or • perform diagnostic or therapeutic procedures. |
| ADVOCATE | <p>A person who acts on behalf of another party. In the absence of a carer, an independent advocate could be a general practitioner, legal representative, person appointed by the guardianship board or another person who can represent the interests of the care recipient adequately.</p> <p>Department of Health and Ageing, 2006, Aged Care Assessment and Approval Guidelines, Canberra.</p> |
| ADVOCACY SERVICE | <p>An advocacy service is an independent, confidential service provided free of charge in each state and territory. If a person receives Australian Government-subsidised aged care services, advocacy services can help them exercise their rights by representing them, and providing information, advice and support to them, their carer, family or friends.</p> <p>See the Older Persons Advocacy Network (OPAN).</p> |
| AGED CARE ACT 1997 (the Act) | <p>The Act is the Australian Government legislation that relates to Australian Government funded residential, home care and flexible aged care services.</p> |
| AGED CARE (TRANSITIONAL PROVISIONS) ACT 1997 (the Transitional Provisions Act) | <p>The Transitional Provisions Act is the Australian Government legislation that applies to 'continuing care recipients', i.e. people who have entered aged care before 1 July 2014, and have not ceased to be provided with aged care for a continuous period of more than 28 days (other than leave), and have not have chosen to opt into the new arrangements. Where these guidelines refer to 'the Act', the Transitional Provisions Act may apply in circumstances which involve the provision of aged care services to a continuing care recipient.</p> |
| AGED CARE FUNDING INSTRUMENT (ACFI) | <p>ACFI is the classification instrument underpinning the funding model to pay care subsidies to Australian Government funded residential aged care services. The ACFI is used to assess core care needs as a basis for allocating funding.</p> |
| AGED CARE QUALITY AND SAFETY COMMISSION (the Commission) | <p>The Commission is established under the <i>Aged Care Quality and Safety Commission Act 2018</i>. The Commission's role is to protect and enhance the safety, health, well-being and quality of life of people receiving aged care. In fulfilling this role, the Commission provides a free service that handles concerns or complaints that have not been resolved by talking to the service</p> |

| Term | Meaning |
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| | provider. The Commission can provide support, with information and options, to resolve aged care concerns with service providers. |
| AGED CARE SERVICE | An undertaking through which aged care is provided in the form of residential, home care or flexible care. See Schedule 1 of the Act. |
| APPROVED PROVIDER | Approved provider means a person or body in respect of which an approval under Part 2.1 of the Act is in force, and, to the extent provided for in section 8-6 of the Act, includes any state or territory, authority of a state or territory or local government authority. See Schedule 1 of the Act. |
| AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE (ACSQHC) | The ACSQHC leads and coordinates key improvements in safety and quality in health care across Australia in partnership with patients, clinicians, the Australian, state and territory governments, the private sector, and health care organisations. The ACSQHC's functions include: <ul style="list-style-type: none"> • developing national safety and quality standards; • developing clinical care standards; • coordinating work in specific areas to improve outcomes for patients; and • providing information, publications and resources about safety and quality. |
| AUSTRALIAN PRIVACY PRINCIPLES (APPs) | The APPs took effect from 12 March 2014 as a result of changes to the <i>Privacy Act 1988</i> (Cth). These new principles relate to the National Privacy Principles and the Information Privacy Principles (IPPs) (except for ACT agencies who continue to be covered by the IPPs). The APPs: <ul style="list-style-type: none"> • deal with all stages of the processing of personal information, setting out standards for the collection, use disclosure, quality and security of personal information; and • provide obligations on agencies and organisations subject to the <i>Privacy Act 1988</i> concerning access to, and correction of, an individuals' own personal information. |
| CARE PLAN | A plan developed by the transition care service provider in consultation with the care recipient. The care plan describes the goals of transition care agreed with the care recipient, the type of services to be provided, the frequency and hours of actual service provision, the location at which the service will be provided and the respective responsibilities of the service agency, its staff and the care recipient. The care plan for transition care should be informed by the hospital geriatric rehabilitation service and the ACAT. |
| CARE RECIPIENT/ CLIENT | A person receiving transition care services. |
| CARER | Carers can include family members, next of kin, friends or neighbours who have been identified as providing regular and sustained care and assistance to the care recipient. Carers frequently live with the person for whom they are caring. A carer may also be the care recipient's advocate. |
| COMMONWEALTH HOME SUPPORT PROGRAMME (CHSP) | The CHSP provides entry-level home support for older people who need assistance to keep living independently at home and in their community. Carers of these clients will also benefit from services provided through the CHSP. |
| DEMENTIA | Dementia is an umbrella term describing a syndrome associated with more than 100 different diseases that are characterised by the impairment of brain functions, including language, memory, perception, personality and cognitive skills. Although the type and severity of symptoms and their |

| Term | Meaning |
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| | pattern of development varies with the type of dementia, it is usually of gradual onset, progressive in nature and irreversible. |
| DEPARTMENT | The Australian Government Department of Health. |
| FLEXIBLE CARE | Flexible care means care provided in a residential or community setting through an aged care service that addresses the needs of care recipients in alternative ways to the care provided through residential care services and home care services. See section 49-3 of the Act. |
| FLEXIBLE CARE SUBSIDY | Flexible care subsidy is a payment by the Australian Government to approved providers for providing flexible care to care recipients. Further information on flexible care subsidy is included in Part 3.3 of the Act and the <i>Subsidy Principles 2014</i> of the Aged Care Principles. |
| GP | General Practitioner. |
| HOME CARE PACKAGE (CONSUMER DIRECTED CARE) | A Home Care Package is a coordinated package of services tailored to meet a person's specific care needs. Consumer Directed Care provides the consumer with added flexibility and choice in the delivery of care and services under your home care package. It allows greater control in determining the types of care and services you receive, who delivers them, and when. |
| HOME-LIKE ENVIRONMENT | <p>Providers of residential based transition care services are expected to provide services that reflect the intent of the Transition Care Programme and meet the following criteria for a more home-like environment (see the Transition Care Programme Restorative Care Requirements at Attachment C).</p> <p>Residential transition care services are provided in a more home-like, less institutional setting, with the setting including:</p> <ul style="list-style-type: none"> • communal living space/living room environment completely separate from sleeping areas and location of acute/subacute care provision, i.e. a space that encourages family/carers and visitors to spend time with care recipients; • a dining area so care recipients are encouraged not to eat in bed; • care recipients being encouraged and supported to dress every day; • facilities to prepare snacks etc. by the care recipient themselves or visitors; • privacy particularly for personal care and bathing arrangements; • space for care recipients to move about especially outdoors; (cont.) • a model of care and staff knowledge that supports the intent of the transition care programme to promote the care recipient's health and independence. <p>Transition care services may also be provided in rural and remote hospitals where appropriate. The requirements for the more home-like environment may be relaxed on a case by case basis in these locations, if relevant.</p> |
| IN-PATIENT HOSPITAL EPISODE | <p>In relation to a care recipient, means a continuous period during which the care recipient:</p> <ol style="list-style-type: none"> a) is an in-patient of a hospital; and b) is provided with acute care or subacute care or both. <p>See section 4 of the Subsidy Principles 2014.</p> |
| LOW INTENSITY THERAPY | <p>In relation to a care recipient, means therapy that:</p> <ol style="list-style-type: none"> a) maintains the care recipient's physical and cognitive functioning; and b) facilitates an improvement in the care recipient's capacity in relation to activities of daily living. <p>Examples include:</p> |

| Term | Meaning |
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| | <ol style="list-style-type: none"> 1. Occupational therapy; 2. Physiotherapy; 3. Social work. <p>See section 4 of the Subsidy Principles 2014.</p> <p>The therapy services that transition care service providers must be able to provide, if required by a care recipient, are detailed under item 3.4 Therapy services of <i>Schedule 1: Specified care and services for transition care services</i> at Attachment B.</p> |
| MINISTER | The Australian Government Minister with portfolio responsibility for Ageing. |
| MULTIDISCIPLINARY TEAM (MDT) | An MDT is a care team made up of three or more health care disciplines, e.g., general practitioner, geriatric, nursing, pharmacy, physiotherapy, dental, podiatry, nutrition, optometry, psychology, occupational therapy, social work, and speech pathology. |
| NATIONAL SAFETY AND QUALITY HEALTH SERVICE STANDARDS (Second Edition) (NSQHS Standards) | The NSQHS Standards provide a nationally consistent statement about the level of care people can expect from health services. |
| NATIONAL SCREENING AND ASSESSMENT FORM (NSAF) | <p>The NSAF is an approved form for a person to apply to be approved as a care recipient of aged care under sub-section 22-3(3) of the Act. This care includes residential care, home care and flexible care.</p> <p>The NSAF supports ACAT's to conduct a comprehensive assessment based on the person's needs, record the client's story within their assessment, support planning processes as well as displaying the assessment and support plan information, including to the aged care providers. The NSAF replaces the Aged Care Client Record.</p> <p>Aged Care Assessment Program Manual, June 2018.</p> |
| OLDER PEOPLE | For the purposes of aged care planning, older people are regarded as those aged 65 years and over or 50 years and over if Aboriginal and Torres Strait Islander people. The Act does not specify an age when a person becomes an aged person. |
| OLDER PERSONS ADVOCACY NETWORK (OPAN) | <p>OPAN is an Australia-wide network that provides a free advocacy services for care recipients, their families and carers in relation to Australian Government funded aged care services, including transition care.</p> <p>OPAN can be contacted on 1800 700 600 between 8.00am and 8.00pm from Monday to Friday. Further details about OPAN are available at www.opan.com.au.</p> |
| REHABILITATION | <p>Rehabilitation, in the context of transition care, is a form of subacute care as outlined in section 4 of the <i>Subsidy Principles 2014</i> - see 'Subacute Care' below.</p> <p>Transition care is not a substitute for rehabilitation and should only commence after completion of the care recipient's rehabilitation care episode.</p> |
| REPRESENTATIVE | <p>A representative of a care recipient is:</p> <ol style="list-style-type: none"> a) a person nominated by the care recipient as a person the care recipient wishes to participate in decisions relating to his or her care; or b) a *partner, carer, or *close relation of the care recipient; or c) a person who holds an enduring power of attorney given by the care recipient to decide the health care and other kinds of personal services the care recipient is to receive; or d) a person appointed by a state or territory guardianship board (however described) to decide the health care and other kinds of |

| Term | Meaning |
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| | <p>personal services the care recipient is to receive.</p> <p>Section 44-26B of the Act defines the following:</p> <p>Partner, in relation to a person, means the other member of a couple of which the person is also a member.</p> <p>Close relation, in relation to a person, means:</p> <ul style="list-style-type: none"> (a) a parent of the person; or (b) a sister, brother, child or grandchild of the person; or (c) a person included in a class of persons specified in the <i>Subsidy Principles 2014</i>. |
| RESIDENTIAL AGED CARE | <p>Residential aged care is personal and/or nursing care that is provided to a person in a residential facility in which the person is also provided with accommodation that includes appropriate staffing, meals, cleaning services, as well as furnishings, furniture and equipment for the provision of that care and accommodation. Residential care does not, however, include care provided to a person in the person's private home; care provided in a hospital or in a psychiatric facility; or care provided in a facility that primarily provides care to people who are not frail and aged.</p> <p>See section 41-3 of the Act.</p> |
| SANCTIONS | <p>Penalties may be imposed by the Secretary of the Department under Part 4.4 of the Act on an approved provider for not complying with one or more of the responsibilities under Part 4.1, 4.2 or 4.3 and under Section 3-4 of the <i>Aged Care (Transitional Provisions) Act 1997</i>. Certain procedures must be followed for sanctions to be imposed.</p> |
| SECRETARY | <p>The person filling, or temporarily filling, the position of Secretary of the Department.</p> |
| SPECIFIED CARE AND SERVICES FOR TRANSITION CARE SERVICES | <p>Services to be provided for all transition care recipients who need them. They are listed at Attachment B of these guidelines.</p> |
| SUBACUTE CARE | <p>Subacute care means medical or related care or services provided to a care recipient who is not in the acute phase of an illness. Examples include:</p> <ol style="list-style-type: none"> 1. Rehabilitation; 2. Palliative care; 3. Psychogeriatric care; and 4. Geriatric evaluation and management. <p>See section 15.3 of the <i>Flexible Care Subsidy Principles 1997</i>.</p> <p>Note: To be eligible for transition care, a care recipient must have completed their acute and/or subacute episode of care.</p> |
| TRANSITION CARE | <p>Transition care is a form of flexible care that:</p> <ul style="list-style-type: none"> (a) is provided to a care recipient: <ul style="list-style-type: none"> (i) at the conclusion of an in-patient hospital episode; and (ii) in the form of a package of services that includes at least low intensity therapy and nursing support or personal care; and (b) can be characterised as: <ul style="list-style-type: none"> (i) goal-oriented; (ii) time-limited; (iii) therapy-focussed; (iv) targeted towards older people; and (v) necessary to complete the care recipient's restorative process, optimise the care recipient's functional capacity and assist the care recipient, and his or her family or carer (if any), to make long-term arrangements for his or her care. |

| Term | Meaning |
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| | See section 106 of the <i>Subsidy Principles 2014</i> . |
| TRANSITION CARE PAYMENT AGREEMENT | An agreement between the Australian Government and each state and territory government as the approved provider of transition care which details the arrangements for the payment of flexible care subsidy by the Australian Government to the approved provider. |
| TRANSITION CARE RECIPIENT AGREEMENT | An agreement between a transition care recipient and a transition care service provider which details services to be delivered by the service provider, charges payable by the care recipient to the service provider, the external complaint mechanisms and how to access these and other arrangements. |
| TRANSITION CARE SERVICE TRANSITION CARE SERVICE PROVIDER SERVICE PROVIDER | An aged care service operated by a state or territory government as the approved provider to deliver transition care, or an organisation engaged by the approved provider to deliver transition care. |