

Non-Weight Bearing Respite Pathway

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1. Overview

Western Health's Division of Aged, Cancer and Continuing Care Services provides quality health care for patients in Oncology, Haematology, Acute Aged Care, Geriatric Evaluation Medicine, Rehabilitation services, Palliative Care, Transition Care Services and Residential Aged Care across six Western Health sites.

The division has an integral role within the health care continuum, providing care from the emergency department and acute wards, through to sub-acute care and into the community. To ensure that patients have appropriate and timely access to these services, the division also provides a Subacute and Non-acute Access and Pathways (SNAP) service to facilitate pathways to the right care setting.

The SNAP team facilitate transfers onto various pathways, including the Non-Weight Bearing Respite Pathway. This NWB Respite Pathway guideline details the requirements for managing patients with Orthopaedic NWB orders from admission to discharge from the pathway. Western Health has partnered with Dousta Galla Residential Aged Care Facility to provide respite care during the NWB Respite Pathway.

2. Applicability

This guideline relates to the transfer of patients from Western Health onto the Non-Weight Bearing Respite Pathway, including discharge from the pathway.

All Western Health employees who are involved in the care of patients with Orthopaedic NWB orders as a part of their employment should be aware of the contents of this guideline.

Additional exclusions to this procedure are detailed in the relevant sections.

3. Responsibility

Department managers are responsible for ensuring staff awareness and compliance of this procedure.

4. Authority

Exceptions to the practices described in this guideline can only be authorised by an Executive, Divisional Director, Clinical Services Director or Geriatric Head of Unit for Aged, Cancer and Continuing Care Services, or Manager Subacute and Non-Acute Access and Pathways (SNAP).

5. Associated Documentation

In support of this procedure, the following Manuals, Policies, Instructions, Guidelines, and/or Forms apply:

Code	Name
OP-GC1	Clinical Handover
	SNAP iPM Waitlist User Guide
EMR Powerform	Subacute Transfer Assessment and Planning Tool
EMR Order	SNAP Order
EMR Functionality	ISBAR Handover Page

6. Credentialing Requirements

Credentials are not applicable for this guideline.

7. Definitions and Abbreviations

7.1 Definitions

For purposes of this procedure, unless otherwise stated, the following definitions shall apply:

Clinical Handover	The transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients to another person or professional group on a temporary or permanent basis.
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iPM	Patient Management System.
Patient	Refers to a patient or client receiving health care and/or treatment from a Western Health service.
Receiving Team	The multidisciplinary team who will be responsible for the provision of care to a patient once transferred to a continuing care or non-acute service.
SNAP Clinician	A health professional assigned to the SNAP Team who is responsible for the review and coordination of patients who are on a pathway to continuing care services.
SNAP Medical Officer	A Senior or Junior Medical Staff member with training in Geriatric or Rehabilitation Medicine who is reviewing a patient referred to SNAP.
SNAP Team	Access and Assessment service to facilitate pathways to continuing care out of acute care, and directly from the community, where clinically indicated
Structured Handover	Handover conducted in a structured format.
Continuing Care Ward	Any ward at Western Health which offers continuing care types of GEM; TCP; Rehabilitation; Palliative Care.
Treating Team	The multidisciplinary team responsible for provision of care to a patient at the time of assessment by SNAP (may be inpatient or community providers).

7.2 Abbreviations

For purposes of this procedure, unless otherwise stated, the following abbreviations shall apply:

ACAS	Aged Care Assessment Service
ACLS	Aged Care Liaison Service
CBR	Community Based Rehabilitation
COTWB	Cup Of Tea Weight Bearing
ED	Emergency Department
EMR	Electronic Medical Record
GEM	Geriatric Evaluation and Management
GEM@HOME	Geriatric Evaluation and Management at Home
ISBAR	Refers to I - Identify, S - Situation, B - Background, A - Assessment , R - Request
NIC	Nurse in charge
NWB	Non-Weight Bearing
NWBC	Non-Weight Bear Coordinator
PWB	Partial Weight Bearing
RACF	Residential Aged Care Facility
RAH	Rapid Allied Health
Rehab	Rehabilitation
TCP	Transition Care Program
TWB	Touch Weight Bearing
VCAT	Victorian Civil and Administrative Tribunal
WH	Western Health

8. Procedure Detail

The procedure is divided into the following sections:

- 8.1 Referral to the NWB Respite Pathway
- 8.2 Assessment of patient
- 8.3 Regular review of patient progress against criteria for transfer
- 8.4 Identification of patient as 'Ready for Transfer'
- 8.5 Patient transferred to the NWB Respite Pathway
- 8.6 Care of the patient whilst on the NWB Respite Pathway at Douutta Galla RACF
- 8.7 Discharge from the NWB Respite Pathway

8.1 Referral to the NWB Respite Pathway

All referrals for patients with Orthopaedic Non-Weight Bearing orders at Western Health are processed and coordinated via the SNAP service.

Any member of the inter-professional team may instigate a referral to the SNAP team for review of appropriateness of the patient for the NWB Respite Pathway. It is recommended however that this occurs following a multidisciplinary team discussion which includes the admitting medical team.

8.1.1 Referral by Treating Team

Completion of an order to SNAP using the EMR.

The SNAP Helpline contact number is 8345 7695 (staffed during business hours). The SNAP helpline offers advice to staff who are considering a referral to SNAP, need to contact a SNAP Clinician to provide a verbal update of patient care, or have queries pertaining to the processes involved.

The Non-Weight Bearing Respite Pathway does not accept patients directly from ED or external referrals.

8.1.2 Referral Acceptance and Screen

On receipt of referral, the SNAP team will review the referral and seek further information from the referrer as required.

The SNAP team will confirm acceptance of referral via registration on iPM SNAP waitlist within 12 business hours of referral.

The referral will be initially triaged to the Geriatric Medicine SNAP medical officer on the roster for assessment.

8.1.3 Referral to Non Weight Bear Coordinator

Contact 0481 054 951 or Andrew.Mangan@wh.org.au if a patient has an altered weight-bearing status and is at risk of an extended hospital stay. Once referred, the NWBC will screen the patient file and gather further information as necessary to support the patient through this particular journey. The NWBC will aim to meet with the patient face-to-face in a timely manner to re-confirm background information, the current situation and future goals.

8.2 Assessment of Patient

Assessment of the patient is to occur in a timely and efficient manner being conscious to avoid unnecessary transfers and admissions.

8.2.1 Medical Assessment of Patient and Development of Criteria for Transfer

To be completed by the appropriate SNAP Clinician within 24 hours of referral. The SNAP Service aims for the Treating team to assess and outline a plan, including identification of the appropriate care type. It is recommended that the patient is offered the opportunity to have additional family members/carers present for the assessment, or to have an interpreter booked if required, to ensure thoroughness of assessment and engagement of the patient in their care plan. Three outcomes of assessment may occur:

1. The patient may be appropriate for a Geriatrician opinion but is not for transfer onto the NWB Respite Pathway. This will result in the appropriate assessment and plan for review as indicated.
2. The patient is not yet appropriate for SNAP assessment due to multiple outstanding assessments/interventions by the treating team. This will result in the referral being declined and the treating team asked to re-refer once appropriate.
3. The patient is appropriate for assessment for a transfer to the NWB Respite Pathway. This will result in a medical assessment and development of criteria for discharge. The medical assessment is clearly documented using the SNAP Assessment and Planning powerform in the EMR, where the care type and criteria for transfer to the NWB Respite Pathway are clearly outlined:

Mandatory criteria for transfer include: Confirmation of diagnosis and management plan; Medical stability on day of transfer in line with clinical markers for the patient.

Inclusion Criteria:	Exclusion Criteria:
<ul style="list-style-type: none"> • Patient is clinically and medically stable and does not require ongoing medical input or management by a multidisciplinary team. • Patient is 65 years old and over. • Patient has NWB/TWB/COTWB orders for a minimum of 2/52 weeks. • Patient is from home and cannot be supported during the NWB period • Patient is eligible for respite approvals • Patient resides within WH catchment area • Patient consents to participate on the NWB Respite Pathway. 	<ul style="list-style-type: none"> • Patient has complex, chronic or multiple health conditions that require treatment and management by a Geriatrician and multidisciplinary team • Patients with complex Orthopaedic issues requiring regular input. • Patients whom are non-compliant with the NWB orders • Patients with active osteomyelitis • Patients requiring to return to theatre, including second or third stage procedures. • Patients care needs and goals are greater than what the pathway can provide • Patient is undergoing VCAT process for the appointment of a decision maker • Patient resides in a residential care facility • Patient lives outside of WH catchment area

8.2.2 Clarification of patient needs to support safe discharge to Dousta Galla onto the NWB Respite Pathway

To be commenced by the multi-disciplinary team and completed by SNAP Clinician and annotated in the SNAP Assessment and Planning powerform. This will include any required equipment, specific care needs and supporting services for safe patient care.

8.2.3 Respite approval process and waitlisting

The multi-disciplinary team are to complete an EMR referral to Social Work to request an assessment for discharge planning to the NWB Respite Pathway. Please refer to the guideline, Residential Care Referral, Assessment and Waitlisting process.

8.3 Regular Review of Patient Progress against Criteria for discharge

The SNAP Clinician is to review all patients on the waitlist daily (or as indicated in the medical assessment) to determine the patient's progress against the criteria for transfer. Documentation of progress is to be annotated on the SNAP Assessment and Planning powerform.

As appropriate, the SNAP Clinician is to have regular communication regarding progress of assessment and pathway with the patient +/-family/carers to ensure that eventual transition is seamless and expectations are managed.

Escalation to the medical staff within SNAP is only to occur in instances where the patient has deteriorated significantly in function, or has developed additional symptoms which impact on completeness of the Criteria for Transfer.

8.4 Identification of Patient as 'Ready for Transfer'

Once the patient has achieved all criteria for discharge as documented on the SNAP Assessment and Planning powerform, SW will organise an admission date with Dousta Galla RACF Manager and communicate this with the MDT.

It is important to provide consistent messaging to patients and their family/carers to ensure the process is clearly understood.

8.5 Patient Transferred to the NWB Respite Pathway

In order to ensure that patient transfers are safe and timely it is important that on the day of transfer to Dousta Galla RACF, the patient is reviewed and relevant handover materials are completed and communicated. Ideally, notification of a transfer is to include 24 hours notice to facilitate timely completion of handover, booking of transportation if appropriate, and communication with patient and family.

8.5.1 Patient Confirmed as Stable for discharge

The treating team must review the patient against clinical markers and then advise the SNAP Clinician who will annotate the SNAP Assessment and Planning powerform and acknowledge that patient is stable at time of discharge, including noting the health professional who completed the assessment.

Deterioration in function which would prohibit a safe discharge must be communicated immediately to the SNAP team via the SNAP Helpline 8345 7695.

8.5.2 Clinical Handover of Patient Status

The treating team must complete the Medical Discharge Summary on the day of discharge to Dousta Galla RACF.

Nursing handover will be coordinated by the discharging ward who are to contact the RACF nurse in charge via a phone call and utilise the EMR ISBAR handover page as the basis of handover.

The Allied Health team are responsible to provide a discharge summary regarding weight bearing orders and exercise plans during the NWB period.

8.5.3 Transportation Arrangements

Transportation is to be booked by the treating ward at the time of notification of an admission date. This must occur in consultation with Dousta Galla RACF with the expectation that transfer is to occur in a timely manner. Transport bookings should be aimed to be completed 24 hours prior to the planned transfer.

Whilst at Dousta Galla RACF, patients may need to attend outpatient appointments, where family are unable to transport and escort patients to these appointments, Dousta Galla RACF may arrange transport and a personal care assistant as approved by the SNAP Manager.

8.6 Care of the patient whilst on the NWB Respite Pathway at Dousta Galla RACF

8.6.1 Management on the pathway

- SNAP CNC to email the ACLS, NWB Co-ordinator and the SNAP team to confirm admission of the patient onto the NWB Respite Pathway at Dousta Galla RACF.
- Initial SNAP CNC follow-up within 48 business hours of admission
- Weekly contact with the SNAP CNC and documentation via EMR.
- The accepting GP is to manage all medical care needs whilst in respite as per facility guidelines.
- Any follow-up radiology and pathology related to the orthopedic plan to be ordered by the Orthopedic team or NWB Coordinator. SNAP CNC to follow-up as needed with the facility.
- Clinical documentation via EMR and patients notes at the facility if indicated.

8.6.2 Follow-up Medical Imaging

The Orthopaedic team often request follow-up medical imaging. Where possible, the patient's next of kin will transport and escort the patient.

Where the patient does not have a next of kin available, Dousta Galla will organise an agency healthcare worker escort to remain with the patient until they return. Western Health will be responsible to cover the costs for the escort. Dousta Galla may organise a taxi if suitable or non-urgent transport if the patients care needs are too high. Western Health will be responsible to cover the costs for the non-urgent transport where the patient does not have appropriate insurance cover or an approved pension cover. The escort and the non-urgent transport will remain with the patient until the medical imaging is complete and return the patient to Dousta Galla.

In some circumstances, mobile radiology services may be preferable. These images can be uploaded onto EMR using DICOM format.

8.6.3 Clinical Deterioration, Escalation and Incident Management at Doudda Galla RACF

Whilst the patient is in Doudda Galla, the facility is responsible for all governance and care. The facility is to follow their policy and procedures for managing a clinical deterioration or medical emergency. Should any incidents occur during the delivery of service, notification of the occurrence is required to be shared with Western Health.

8.6.3 Case Conference

A weekly case conference is held to discuss patient's progress, issues, upcoming appointments and discharge planning. Attending members are, but not limited to Aged Care Liaison Service Team Leader and Registrar, Non-Weight Bear Coordinator, GEM@Home team leader, SNAP CNC, Doudda Galla Care Coordinator and treating Physiotherapist. Case conference notes will be published on EMR weekly.

8.7 Discharge from the NWB Respite Pathway

8.6.3 Discharge pathways

- At the end of the NWB period, the patient will have follow-up radiology as required.
- This is to be followed-up by the Orthopedic team and communicated to the NWB Coordinator.
- SNAP CNC to follow-up with the plan and update the facility Physiotherapist and Nurse In Charge.
- ACLS Medical team will review the patient to confirm medical stability and co-ordinate pathway with the SNAP CNC.
- If inpatient GEM or Rehabilitation is indicated, the SNAP team will organize the next available subacute bed for transfer.

If for direct discharge home, referrals to RAH, CBR or GEM@Home may be considered.

8.6.1 Use of the iPM SNAP Waitlist

The iPM SNAP waitlist is the primary tool to identify referral acceptance, progress and status of patients referred for admission and discharge from the NWB Respite Pathway at Western Health.

The iPM SNAP waitlist is maintained within core business hours.

8.6.2 Communication of the NWB Respite Pathway Performance

Additional communication of the NWB Respite Pathway performance is provided in monthly performance metrics outlined and monitored via the Aged, Cancer and Continuing Care Services Quality and Performance Report and associated meetings.

8.7 Supporting Information

8.7.1 Out of Hours Management

There are no transfers onto the NWB Respite Pathway out of business hours.

9. Document History

Number of revisions: new document

10. References

Nil references

11. Sponsor

Operations Manager- Subacute and Non-acute Access and Pathways (SNAP)

12. Authorisation Authority

Divisional Director of Aged, Cancer and Continuing Care Services