Metro South Health | Better together

Long Stay Patients

RACF Leadership Engagement Stakeholder Feedback Report

May 2025

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Contents

Executive Summary

Residential aged care facilities (RACFs) face escalating difficulties accepting new residents transitioning from prolonged hospital stays, particularly those with complex behavioural, cognitive, and clinical needs. Extensive stakeholder engagement across Metro South highlights the critical need for a robust, co-designed transition-of-care model. Such a model must focus on enhancing resident experiences during initial admissions, improving safety, and alleviating pressures on acute hospital services.

A central issue identified by stakeholders is the inadequacy of current funding instruments, specifically the Australian National Aged Care Classification (AN-ACC) model. This funding framework inadequately addresses the financial realities facing RACFs, particularly in managing residents with high cognitive complexity but lower physical dependency. Stakeholders emphasise the risk that RACFs will inevitably prioritise residents whose care needs align more favourably with funding incentives, creating a mathematically unavoidable situation where hospitals increasingly absorb demand that aged care facilities cannot sustainably meet.

Furthermore, stakeholders unanimously advocate for mandatory face-to-face clinical handovers between hospital clinicians, RACF teams, residents and families at the time of a new admission. This is to ensure the effective communication of critical information, such as behavioural support strategies, medication regimens, and advance care directives. The first 72 hours of a new RACF admission are critical for prescribing, planning, and care matching. Wrap-around care models encompassing comprehensive medication reconciliation, tailored behavioural management, specialist referrals, and enhanced advance care planning are also strongly supported.

To address these systemic challenges comprehensively, a dedicated working group comprising senior RACF consumers, clinical managers, aged care executives, hospital clinicians, and primary care representatives is proposed. Executive-level endorsement of this group will be crucial to co-designing, implementing, and evaluating an effective transition-of-care model. This collaborative approach will directly address identified barriers, ensure regulatory compliance under the new Aged Care Act 2024, and adapt to the evolving Aged Care Quality Standards.

This report proposes a model of care that represents a transformative opportunity to realign hospital discharge practices with the operational realities of aged care, optimising resource allocation, enhancing resident outcomes, and fostering a sustainable, collaborative healthcare continuum.

Introduction

Background

Public hospitals in Queensland are experiencing a rise in the number of long-stay patients who remain in acute beds despite being medically fit for discharge. These “long-stay” patients often have complex care needs and lack a suitable discharge destination. A significant subset consists of older adults awaiting placement in Residential Aged Care Facilities (RACFs). The Queensland Health *“Putting Patients First 2024-25”* plan highlights a $186.5 million investment aimed at moving long-stay patients out of hospitals into more suitable care settings[(1)]. Nationally, the Australian Medical Association has highlighted the scale of this issue, reporting that over 19,600 hospital patients were stranded in 2020–21 due to discharge “exit blocks,” totalling 286,000 bed days occupied by people awaiting aged care placement[(2)]. Locally at MSHHS on ***May 20, 2025, 118 patients were seeking a RACH for discharge, 87 for permanent placement, 3 for respite care, and 24 were awaiting an ACAT***. These prolonged hospital stays strain the healthcare system’s capacity, contribute to access blocks (such as ambulance ramping and Emergency Department delays), and postpone care for others. Reducing long-stay hospital admissions – especially for patients awaiting RACF entry – has therefore become an urgent priority for health services like Metro South Hospital and Health Service (MSHHS) in Brisbane.

Aged Care Policy Changes and Industry Context

The aged care sector is undergoing major reforms in the wake of the Royal Commission into Aged Care Quality and Safety. Recent policy changes are transforming how aged care providers operate, which in turn affects hospital discharge pathways. A landmark development is the introduction of the new rights-based Aged Care Act 2024, passed by Parliament in November 2024 and commencing on 1 July 2025. The new Act replaces the outdated Aged Care Act 1997 (deemed "no longer fit for purpose" by the Royal Commission due to its provider-centric focus) and puts older people's rights and needs at the centre of care. Accompanying the Act is a strengthened regulatory and quality framework, including overhauled Aged Care Quality Standards and a new funding model. In line with the Royal Commission's recommendations, the Quality Standards have been reviewed to address critical areas, including dementia care, nutrition, diversity, governance, and clinical care. Stricter standards will take effect on July 1, 2025, to drive improved care outcomes.

Image 1: New Aged Care Act infographic

At the same time, **tighter rules on restrictive practices** in aged care have been implemented, responding to community concerns about the overuse of restraints. It's essential to **note that hospital-based restraint is not subject to the same restrictions**. Legislative amendments in 2021 introduced requirements to minimise the use of chemical and physical restraints, ensure informed consent, and strengthen reporting obligations. Providers are now held to higher expectations regarding behaviour management and safeguarding residents' rights, which can add complexity when admitting individuals with severe cognitive or behavioural issues. Additionally, aged care funding has been reformed. In October 2022, the government replaced the old Aged Care Funding Instrument (ACFI) with the new Australian National Aged Care Classification (AN-ACC) case-mix funding model. AN-ACC aims to match funding to each resident's care needs and was a direct response to the Royal Commission's calls for a more equitable, needs-based funding instrument. It also came with mandated care staffing levels – for instance, as of October 2023, providers must deliver an average of 200 minutes of care per resident per day, including 40 minutes from an RN, with further increases scheduled.

Collectively, these reforms have profound implications. They promise higher-quality care and safety for residents, but they also place aged care operators under greater regulatory scrutiny and increased resource

pressure. Many facilities are adapting to new standards and funding rules while also contending with workforce shortages, a suboptimal skills mix, and rising costs. The aged care industry's capacity and willingness to accept hospital discharges is evolving in this context. Some residential providers have become more selective about admissions – particularly patients with complex behavioural or cognitive needs (such as advanced dementia or responsive behaviours) who may require higher staffing ratios or specialised environments.

Most providers employ the "two-week respite view to permanent strategy" for their RACF admissions. This refers to the approach where a resident is funded under the Commonwealth Home Support Program or Home Care packages. This is a trial period for the facility, the resident, and their family. There is a cohort of residents who "fail" in their respite placement and are admitted to the hospital, often with a prolonged hospital admission awaiting a second or third attempt at placement success. This becomes a self-reinforcing "difficult long stay" patient, with the utilisation of large amounts of health resources due to a "revolving door" style of placement choice.

Dementia Australia reports that some aged care services are even "declining to accept people with complex needs" under current conditions. This reflects the reality that today's RACF population is, on average, older and frailer than in the past, with more complex health profiles. The Australian Institute of Health and Welfare, as well as the Department of Health and Ageing reports, indicate that residents entering care are "becoming increasingly older, with more complex needs," underscoring the growing care acuity in residential aged care facilities (RACFs)[3,4]. A key driver of this trend is the success of initiatives that promote "ageing in place" or "ageing at home." Government programs, such as Home Care Packages, are explicitly designed to help older people stay at home longer and delay entry into residential care. As a result, when individuals do transition from home or hospital into an aged care facility, they tend to be older with greater medical complexity. In practical terms, this means hospitals are discharging patients who require more intensive support, while aged care providers, facing staffing and regulatory constraints, may be cautious about taking on such high-needs residents quickly. This mismatch can lead to discharge delays and extended hospital stays for those caught between the acute and aged care systems.

Rationale for a Hospital–Aged Care Engagement

Within Metro South Health, these challenges are well recognised. **CAREPACT** (Comprehensive Aged Residents Emergency Partners in Assessment, Care, and Treatment) is a hospital–aged care partnership program[5]. Established in 2014, CAREPACT's model operates across hospitals and residential aged-care facilities to streamline care for frail older adults and prevent unnecessary hospital admissions. The program provides in-reach support, clinical coordination, and alternative care pathways for aged care residents, resulting in improved outcomes, including a decrease in emergency presentations from residential aged-care facilities. Given its role at the acute-aged care interface, CAREPACT has firsthand insight into the barriers that slow down transfers from hospitals to nursing homes. In recent times, following the Royal Commission changes and the increasing complexity of aged care residents, CAREPACT has observed growing tension at this interface – hospitals report difficulty in placing certain long-stay patients.

In contrast, aged care providers voice concerns about resource limitations and risk management for incoming residents. This prompted CAREPACT to initiate targeted stakeholder engagement, bringing the aged care industry's perspective to the forefront. Rather than assuming the reasons for discharge bottlenecks, MSHHS (through CAREPACT) sought to directly consult with aged care providers and peak bodies to hear "**what the industry is saying**" about accepting patients from hospitals. By acting as a broker of industry insights, CAREPACT aims to ensure that the real-world experiences and needs inform any hospital-led solutions of the residential aged care sector.

A core activity in this engagement was a regional aged care stakeholder forum held at the Glen Hotel in May 2025. This forum brought together representatives from local RACFs, aged care executives, and other

stakeholders to discuss the processes for discharge and admission. It provided a platform for aged care providers to candidly identify barriers that prevent or delay their admission of hospital patients (for example, gaps in discharge planning, communication issues, funding or staffing challenges) and to suggest enablers that could facilitate quicker safer and more transfers that result in permanent residential status. The discussion and feedback from this meeting, along with follow-up consultations, form the basis of this report.

Purpose and Objectives

This investigation, led by CAREPACT on behalf of MSHHS, is focused on solutions. The ultimate purpose of the report is to present the aged care industry's feedback on how hospitals and health services can better support timely transitions to residential care. The central question is: *What changes in the hospital sector could enable RACFs to accept patients sooner?* In exploring this, the report documents the **key barriers** currently perceived by aged care providers that hinder earlier or more frequent hospital patient admissions into RACFs. By articulating these barriers and potential enablers, MSHHS aims to identify actionable improvements – whether in hospital discharge processes, cross-sector communication, patient preparation, funding arrangements, or support services – that could reduce the duration of hospital stays for patients transitioning to aged care. The findings and insights gathered through this stakeholder engagement are intended to inform both MSHHS's internal strategies and broader cross-sector initiatives aimed at improving the flow of patients from hospital to residential aged care. With acute beds under pressure and aged care undergoing reform-driven change, collaboration between hospitals and aged care providers is crucial to ensure that older patients can transition to the proper care setting as soon as it is safe and feasible.

General Practitioner Perspective

Dr Peter Adkins – a Senior Clinical Advisor at Brisbane South Primary Health Network (BSPHN) and an experienced general practitioner in aged care – provides a frontline perspective on the challenges of discharging long-stay patients to residential aged care. He observes that residential aged care facilities (RACFs) are often reluctant to accept patients with complex behavioural issues, such as those with advanced dementia who may wander or become aggressive. Several systemic factors contribute to this hesitancy. Workforce limitations in RACFs result in a shortage of skilled staff to manage challenging behaviours, leading to staff burnout, higher turnover, and safety concerns for both residents and caregivers. Dr. Adkins notes that recent aged care reforms and heightened regulatory oversight, while well-intentioned, have inadvertently made care more challenging. Strict rules on the use of restraints and mandatory incident reporting require facilities to meet rigorous standards, which can deter them from taking on high-risk individuals. He points out that the Australian National Aged Care Classification (AN-ACC) funding model does not sufficiently resource the extra supervision required by cognitively complex but physically low-dependency residents, resulting in a funding gap for these high-risk patients.

Additionally, continuity of care in RACFs is compromised by high staff turnover and lower skill mixes; experienced nurses are often replaced by junior or casual staff, making it difficult to maintain consistent care for residents with complex needs. This environment often leaves external providers to fill the gaps. For example, over-stretched GPs and hospital outreach teams are frequently called upon when facility staff lack the necessary capacity or expertise. Dr Adkins highlights that the traditional GP-RACF interface has weakened over time, as fewer GPs regularly visit nursing homes, and care has become increasingly fragmented, with a growing reliance on telehealth contractors and after-hours locum services. The breakdown in these relationships means that critical information and ongoing management plans can be lost, further hindering the smooth transition of complex patients from the hospital to an RACF.

Despite these challenges, Dr. Adkins proposes a constructive path forward through a structured transition model. He advocates for a trial admission period in which the hospital, RACF, and primary care providers share responsibility for the patient's care. For example, a patient ready for discharge could be placed in a RACF on a

time-limited trial (around four to six weeks) with an *"automatic back-transfer"* agreement. If the placement proves unsustainable, the patient has the right to return to the hospital within that trial period. Clear roles and responsibilities would be defined for each party, including hospital specialists, the RACF care team, and the patient's GP, who would remain in close communication and collaborate on the care plan during the transition. To support the RACF staff and GP, Dr. Adkins recommends providing additional resources, such as a dedicated phone consultation line and on-site outreach support, for the duration of the trial. Family members or substitute decision-makers would be engaged through case conferences to set realistic expectations and agree on care strategies before and during the placement. Throughout the trial, non-pharmacological behaviour management would be emphasised (with chemical restraints used only as a last resort in line with legislation), and any use of psychotropic medication would involve proper consent and review. By setting up a shared-care model with safety nets (including the option of returning to the hospital and the input of geriatric or dementia specialists as needed), Dr Adkins believes RACFs would be more willing to accept patients with complex needs. This approach aims to create a "win-win" for hospitals and aged care: hospitals can discharge long-stay patients sooner, and RACFs receive the necessary support to care for these individuals without shouldering the risk alone. In summary, the GP perspective emphasises that improving the hospital-to-RACF interface will necessitate addressing funding and workforce constraints, revitalising GP involvement in aged care, and piloting innovative transition models to ensure continuity of care for vulnerable older patients.

Geriatrician Perspective

Dr Lisa Kelly, Senior Staff Specialist in Geriatric Medicine at the Princess Alexandra Hospital and leader of its Acute Cognitive Unit offers a complementary perspective focused on the hospital side of discharge challenges. Drawing on extensive experience with long-stay elderly patients, Dr Kelly identifies several key drivers of discharge delays, especially following recent changes in aged-care regulations. She notes that patients with advanced dementia and complex behaviours have become particularly hard to place in RACFs under the new framework. In many cases, these patients are **high-need cognitively** (e.g. prone to aggression or wandering due to dementia) but **low-need physically** (requiring minimal help with mobility or personal care). Unfortunately, the current funding and policy settings do not adequately account for this profile. The AN-ACC funding model, introduced as part of the aged care reforms, tends to allocate lower subsidies for residents with low physical care needs, even if their cognitive and supervision needs are very high. This means facilities receive insufficient funding to cover the extra staffing and time required to manage challenging dementia behaviours. At the same time, post-Royal Commission reforms have instituted tighter controls on how aged care providers manage such behaviours.

There is now intense pressure to minimise any use of psychotropic medication or sedatives, classified legally as "chemical restraints" when used to control behaviour. Providers must adhere to strict consent and documentation requirements for any restrictive practice – for instance; a doctor must obtain informed consent from a designated substitute decision-maker before administering medication as a restraint. Moreover, the **Serious Incident Response Scheme (SIRS)** requires aged care homes to report incidents such as resident aggression or self-harm, increasing the administrative burden and potential scrutiny when caring for high-risk individuals. Dr Kelly observes that these necessary quality safeguards, while improving oversight, can also make RACFs more risk-averse. Facilities may hesitate to accept a resident who is likely to trigger reportable incidents or who may require interventions that are difficult to implement under current rules. Additional barriers further complicate placements: for example, patients who lack the means to pay a refundable accommodation deposit (RAD) or those with significant mental health comorbidities often face limited options for aged care placement. In effect, a cohort of hospital patients who are medically stable for discharge remain stuck because the aged care system, as currently configured, struggles to accommodate their complex profiles and needs.

To overcome these barriers, Dr. Kelly advocates for a co-designed transitional care model bridging hospital and RACF services. She emphasises that any solution must be a collaborative effort involving hospitals, aged care

providers, primary care practitioners (including PHNs and GPs), and specialist dementia services. In her vision, the transition process would be staged and proactive. Before discharge, hospital teams would identify potential placement candidates early and begin planning. This includes confirming the patient's legal decision-maker (e.g. family or guardian) and involving them in discussions, ensuring the patient's medications are optimised (with clear clinical justifications for psychotropic use to comply with restraint regulations), and assessing that the patient's behaviours are stabilised to a level that a RACF can safely manage. Suppose a patient is flagged for possible transfer to an RACF. In that case, geriatric and dementia specialists can be consulted to develop a tailored behaviour support plan or cognitive care plan to accompany the usual Aged Care Assessment Team (ACAT) assessment. Once a suitable aged care facility engages with the placement team, Dr Kelly suggests a thorough exchange of information and support between the hospital and RACF before actual discharge. Up-to-date clinical summaries and care plans should be provided to the facility, and opportunities should be arranged for RACF assessors or staff to meet the patient (for example, through a pre-admission visit or case conference). This builds confidence that the facility understands the patient's needs and has a strategy in place.

At the point of transfer to the RACF, Dr. Kelly proposes a formal trial placement, often initiated as a respite admission of approximately six weeks, with intensive support in place. During this initial period, the RACF would not be left to cope alone. Hospital outreach services, in conjunction with the patient's general practitioner (GP), would provide scheduled follow-up and on-call advice. For instance, a nurse or physician from the hospital's aged care team might visit or telehealth regularly to help manage any issues that arise. Specialist input from Dementia Support Australia (DSA) or a similar organisation could be mobilised to train staff in managing specific behaviours. If the patient's care needs temporarily exceed the facility's standard staffing (for example, requiring one-on-one supervision at times), short-term additional support or funding could be arranged to bridge the gap.

The goal of this intensive phase is to ensure the patient adjusts to the new environment and to address any problems that could otherwise lead to transfer back to the hospital as quickly as possible. This safety valve encourages facilities to give the patient a chance. **If the trial is successful and the resident becomes permanent**, Dr. Kelly recommends tapering the external support rather than ending it abruptly. For instance, specialist nursing or geriatrician follow-up may continue for up to 12 months on a consultative basis, gradually stepping back as the RACF gains confidence in caring for the resident. Ongoing communication channels would remain open, allowing the facility to quickly liaise with hospital specialists or the GP if new issues arise. Throughout this process, feedback from the RACF is crucial. Dr. Kelly stresses that the model should be co-designed, asking facilities what support would make them more willing to accept complex patients and adjusting the approach accordingly. She also notes the importance of joint funding and governance – such a transition program might be funded collaboratively by the hospital (or health service) and the aged care system, ensuring both sectors have a stake in its success.

In summary, the geriatrician perspective highlights that many long-stay hospital patients could be discharged if systemic gaps are addressed. Dr Kelly's insights suggest bridging those gaps through a partnership model: one that aligns funding with patient complexity, eases regulatory burdens through shared responsibility, and actively supports RACFs and families during the critical transition period. The outcome would be not only timely hospital discharges but also better continuity of care and quality of life for some of the most vulnerable older adults in the health system.

MSH Long Stay Report November 2024

The report tabled by Tania Quaglio provides a comprehensive scoping review of long-stay patient trends, enablers, and barriers across Metro South Health. Developed through engagement with 131 stakeholders across medical, nursing, and allied health disciplines, the report offers a detailed mapping of initiatives, workforce models, discharge pathways, and the governance mechanisms in place to manage patients who are medically and functionally ready for discharge but are unable to transition due to systemic delays. It includes

an analysis of over 40 programs and services, highlighting the creation of the MSH Long Stay Dashboard—a tool designed to provide real-time visibility of patients awaiting discharge and their respective barriers.

Key findings relevant to the current report include the identification of residential aged care access as a significant barrier, particularly for patients exhibiting complex behaviours or requiring specialised environments such as memory support units. Behavioural concerns alone accounted for 36.4% of all long-stay census patients at the time of reporting, with a further 17.5% of long-stay patients classified as social admissions without active medical needs. The report also notes a significant rise in National Disability Insurance Scheme (NDIS) related long-stay patients, now comprising 27.7% of the cohort, reflecting broader systemic gaps in disability discharge planning and community-based step-down care. Strategic recommendations include strengthening cross-sector partnerships with aged care and disability services, establishing escalation pathways and clearer referral systems, and exploring interim transitional care models for patients who are difficult to place.

The stakeholder feedback outlined in this report builds upon and complements the MSH Long Stay Report by introducing the direct voice of the aged care sector. While the 2024 report offers a system-level perspective from within Metro South Health, the CAREPACT–led engagement activities described here provide the missing external lens, capturing the perspectives of aged care providers on risks, funding constraints, placement challenges, and the types of patients they find increasingly difficult to support. Together, these reports form a comprehensive picture of the structural and operational barriers to timely discharge, laying the groundwork for co-designed solutions aimed at reducing long-stay admissions across the health and aged care continuum.

Preliminary Stakeholder Engagement

In the lead-up to the planned stakeholder forum on 28 May 2025, Dr Terry Nash, Clinical Director of CAREPACT, and Erin Cranitch, Assistant Director of Nursing, undertook preliminary engagement activities to ensure that the voices of both hospital-based clinicians and aged care sector representatives were reflected early in the consultation process. Drawing on the expertise and data provided by members of the Metro South Health Long Stay Committee – including Kellie Stockton, Brett Davies, Fiona Tradd, Leesa Knott, Tania Quaglio, and Michelle White – this initial phase focused on understanding the structural and operational barriers that both the hospital and residential aged care sectors face in facilitating timely transfers of care.

Feedback from internal stakeholders across Metro South Hospital and Health Service (MSHHS) consistently aligned with the themes articulated by Dr Peter Adkins and Dr Lisa Kelly. Across all directorates, there was clear recognition that aged care providers have become increasingly risk-averse in their decision-making, particularly in response to a combination of workforce limitations, tightened regulatory oversight, and heightened public expectations following the Royal Commission into Aged Care Quality and Safety. Staff across MSHHS report encountering significant delays in placing medically stable patients into residential aged care despite their discharge readiness and note that these challenges are now embedded in routine practice across multiple hospital sites.

Further detailed discussions were held with Aged Care Clinical Managers and Admissions Coordinators, facilitated by Erin Cranitch and Dr Nash. These conversations revealed several key insights into the practical constraints and cautious deliberations that guide admission decisions in the aged care sector. Firstly, it was highlighted that all aged care providers maintain active waiting lists for their beds, and the decision to admit a new resident involves a complex process of matching an individual’s care needs, behaviours, and interpersonal characteristics to the available bed and the broader profile of the residential community. Most providers indicated that bed turnover is typically rapid. Vacancies are filled rapidly within 48 hours, primarily due to two circumstances: the death of residents and those classified as "respite with a view to permanent" who are no longer able to be cared for on respite. In such cases, these individuals are sent back to the hospital, as there are no safer alternatives available.

It was universally noted that these vacancies are almost always offered initially as *respite placements*. This approach allows the provider to comply with the legal requirements of the Aged Care Act, which mandates a formal process of acceptance and permanent admission. Respite admission provides a critical legal buffer, allowing providers to assess suitability over time and retain the option to refuse permanent entry if the placement proves unsafe or inappropriate for either the incoming resident or others in the facility. Providers were clear in expressing that their preference for respite-first placements is not driven by avoidance but by due diligence – ensuring a proper match between resident and facility before committing to long-term care.

Aged care stakeholders also expressed a strong desire to accept new residents. Many cited compelling financial imperatives to maintain bed occupancy, as well as an ethical commitment to supporting hospital discharge and continuity of care. However, these intentions are heavily tempered by operational realities. The cost of accepting a resident whose care needs cannot be met by existing staff or infrastructure is viewed as prohibitive – not only in terms of financial strain but also in terms of resident safety, staff wellbeing, and legal exposure. Of particular concern is the rising prevalence of residents with behavioural and cognitive disturbances, whose needs may exceed the facility's capacity to manage the residents safely. Providers repeatedly emphasised the need to weigh the risk of harm to the incoming resident against their duty of care to existing residents and their staff.

Many facilities reported recent incidents of staff injury or work cover claims related to resident aggression. Such events place additional strain on the already limited workforce, thereby reducing the facility's ability to accept other high-risk residents safely. Some providers described the cumulative impact of these events as creating a "hard floor" in their risk tolerance – particularly **when the new resident poses *any* potential threat to others**. Additionally, providers highlighted the reputational risk of complaints from existing residents and their families. Any perceived compromise to the safety, comfort, or amenity of current residents, particularly in shared accommodation settings, is treated with the utmost seriousness. For this reason, behavioural unpredictability, poor insight, and interpersonal incompatibility were all described as critical factors in admission decisions, particularly for new residents transitioning from the hospital.

Further compounding these issues is the **Serious Incident Reporting Scheme (SIRS)**, which requires facilities to formally document and act upon any episode of aggression, neglect, or harm. Providers were not critical of the reporting obligations themselves – in fact, many emphasised their commitment to transparency and resident safety. However, they did identify the **administrative burden** and reputational scrutiny that comes with repeated, unresolved incidents or prolonged investigations. One provider noted that the regulatory expectation is not merely to report such incidents but to demonstrate that the service has taken meaningful action to prevent recurrence. This has created a strong incentive to avoid admitting any resident whose behaviour, history, or needs might pose a risk to others – **particularly if the care plan relies on assumptions, generalities, or poorly documented behavioural history.**

Another recurrent theme was **mistrust or uncertainty about the quality of communication from hospitals**. Several providers shared experiences in which critical information about a resident's behaviour or needs was omitted or underplayed in the handover process. This has led to increased scrutiny by aged care providers of all incoming documentation, often involving multiple layers of managerial review before a placement is approved. While this added caution helps providers ensure safety and compliance, it also introduces delays and increases the administrative load on both hospital discharge teams and RACF admissions staff. Providers emphasised that their cautiousness is not rooted in unwillingness to support discharges but in a deep awareness of their legal, clinical, and ethical responsibilities to existing residents and staff.

In summary, this early phase of stakeholder engagement has confirmed that the RACF sector remains committed to supporting transitions from hospital to residential care but is doing so under significantly constrained and risk-averse conditions. Providers are eager to collaborate with hospitals on innovative solutions, particularly where shared responsibility, transition planning, and staged admissions can help mitigate

uncertainty and risk. The forthcoming engagement forum presents a vital opportunity to co-design models that better align hospital discharge processes with RACF operational realities – ensuring safe, timely, and sustainable transitions for older people across the Metro South region.

Stakeholder Engagement Summary

On 28 May 2025, CAREPACT and the Brisbane South Primary Health Network (PHN) hosted a Leadership Breakfast at The Glen Hotel, bringing together approximately 100 representatives from across the residential aged care sector. Attendees included clinical managers, nurses, executives, advocates, and service providers from aged care organisations across the Metro South region. The primary objective of this engagement was to understand, from the perspective of the aged care industry, the barriers to timely hospital discharge and to explore practical, co-designed solutions that support safer and more feasible new admissions.

Facilitated by Dr Terry Nash, Clinical Director of CAREPACT, the session provided a psychologically safe space for stakeholders to share views openly. Participants were assured that their feedback would remain anonymous unless they opted to be identified in a follow-up survey. This approach was explicitly designed to foster honesty and depth of response and to position aged care providers not as recipients of hospital-driven processes but as co-leaders in reforming transitional care.

The session was structured into two thematic halves using live polling via the Slido platform:

- **Part 1: Empathy Mapping**
  - Focused on exploring the emotional, operational, and systemic pressures facing aged care providers during the discharge and admission process.
- **Part 2: Solution-Oriented Discussion**
  - Shifted toward identifying what changes could be made—by hospitals, funders, and systems—to support successful transitions of care.

Questions Asked During the Session

Participants were invited to contribute to the following questions, designed to capture both the emotional experience and operational constraints of the industry, as well as to surface practical enablers of better care transitions:

Empathy Mapping Section

- *What is your professional role or background? (Word Cloud)*
- *Name one thing that currently works well when transitioning a new resident from a hospital to an RACF. (Open Text)*
- *In one or two words, what frustrates you most about the current hospital-to-RACF discharge process? (Word Cloud)*
- *What types of patients or scenarios are most challenging for your facility to accept from the hospital? (Open Text)*
- *What is your biggest fear or worry when admitting a new resident from the hospital into your care? (Open Text)*
- *When deciding whether to accept a new resident, which of the following factors has the most impact on your decision? (Ranking Poll – complex behaviour, funding type, family dynamics, restraint use, etc.)*
- *Which patient characteristics are most likely to lead your service to delay or decline admission? (Multiple Choice – e.g. bariatric care, antipsychotic use, family conflict, etc.)*
- *Is there a resident profile that often results in declined or delayed admission at your facility? (Open Text)*

Solution-Oriented Section

- *What support or change would most help RACFs accept hospital discharges more quickly and safely? (Open Text)*
- *If the hospital sector could change one thing immediately—like a magic wand—what should it be? (Open Text)*
- *Which potential enablers would most improve hospital-to-RACF transitions? (Ranking Poll – shared care plans, back-transfer rights, extra staffing, funding boosts, etc.)*
- *What is the most important thing that should happen in the first 72 hours after a complex resident's transfer from the hospital to RACF? (Open Text)*

These questions were designed to elicit both practical insight and values-based reflection. Responses provided a detailed view of why facilities may hesitate to accept certain hospital discharges, the types of risks they are required to manage, and how system design (including AN-ACC funding limitations, regulatory reporting burdens, and workforce shortages) influences decision-making.

Results of Discussion

Participants

The event had 105 registered participants and a total of 80 attendees. Participants primarily hold senior clinical and management roles within Residential Aged Care Facilities (RACFs):

- Clinical and Nursing Leadership:
  - Clinical Managers
  - Facility Managers
  - Clinical Care Coordinators
  - Clinical Nurse Consultants (CNCs)
  - Registered Nurses (RNs)
  - Clinical Nurses
- Executive and Operational Leadership:
  - General Managers
  - Directors
  - Admissions Managers
  - Care Managers
- Specialist Practitioners and Allied Health Professionals:
  - Nurse Practitioners specialising in Behavioural and Psychological Symptoms of Dementia (BPSD)
  - Social Workers
  - Parkinson's Disease Australia Representative
  - Professionals with dual Social Work/Psychology roles

Participants were predominantly experienced aged care professionals in management or senior clinical roles, reflecting significant decision-making capacity and direct responsibility for resident care transitions from hospitals to aged care homes.

These profiles suggest respondents had a clear understanding of clinical complexities, operational challenges, and systemic barriers affecting aged care transitions. They also held insights into organisational policies, family engagement issues, behavioural management, and staff support needs within the aged care sector. There were also representatives of the Commonwealth Department of Health and Dementia Australia.

Key Themes

Theme 1: Clinical Handover and Documentation

Key Difficulties:

- Incomplete, inaccurate, or contradictory discharge summaries.
- Poor behavioural and medication management plans.

Magic Wand Solutions:

- Ensure **real-time digital discharge summaries are accessible by RACFs** immediately upon discharge.
- Provide detailed and personalised clinical handovers, explicitly including behaviour management plans and psychotropic medication rationales.

Valuable Quotes:

- *"A complete and honest handover including nursing care plan and functional information. Sometimes hospitals hide things such as challenging behaviour."*
- *"Digital discharge summary system that ensures real-time communication."*

Theme 2: Advance Care Planning and Goals of Care

Key Difficulties:

- Lack of clear or realistic goals of care upon discharge.
- Absence of meaningful Advance Health Directives (AHD) and Enduring Power of Attorney (EPOA).

Magic Wand Solutions:

- Mandatory completion of clear and realistic goals of care discussions before discharge (especially new admission to the aged care home).
- Facilitate hospital-RACF-family meetings to clarify expectations explicitly around end-of-life care and clinical trajectories.

Valuable Quotes:

- *"Discuss Statement of Choices with families and residents. Explain that aged care is not a falls-proof facility."*
- *"The patient understands where they are going and the goals of care."*

Theme 3: Behaviour Management (BPSD)

Key Difficulties:

- Complex behavioural issues are inadequately documented or managed.
- High risk of aggressive or intrusive behaviours impacting safety in RACFs.

Magic Wand Solutions:

- Comprehensive, personalised behaviour support plans to accompany residents upon discharge.
- Post-discharge follow-up from behavioural specialists or hospital outreach teams.

Valuable Quotes:

- *"Behaviour management plans, proper diagnosis."*
- *"Aggressive behaviours without suggested strategies to minimise changed response."*

Theme 4: Family Expectations and Dynamics

Key Difficulties:

- Unrealistic family expectations lead to significant stress and resource utilisation in RACFs.
- Family conflict causes disruptions and increased demands on RACF staff.

Magic Wand Solutions:

- Facilitate transparent and realistic discussions among families, hospitals, and RACFs prior to discharge.
- Enhanced communication strategies ensure families understand the limitations and scope of care in RACFs.

Valuable Quotes:

- *"Help the family to understand the reality about care/services that can be provided at RACH."*
- *"Family input and support, in-depth history and good documentation."*

Theme 5: Timing of Hospital Discharges

Key Difficulties:

- Late-day or weekend discharges cause significant operational difficulties.
- Reduced availability of clinical support at RACFs during out-of-hours discharges.

Magic Wand Solutions:

- Mandate weekday, preferably morning, discharges to ensure full RACF staffing and clinical support availability.
- Implement robust escalation pathways for after-hours queries to ensure timely responses.

Valuable Quotes:

- *"Don't discharge late in the afternoon on a Friday."*
- *"Residents come in late to the facility. Would be good to come in by 10 am."*

Theme 6: Medication Management

Key Difficulties:

- Frequent lack of proper medication charts and supplies upon resident arrival.
- Inaccurate or missing medication information in discharge summaries.

Magic Wand Solutions:

- Provision of at least one-week medication charts and immediate medication supplies upon discharge.
- Dedicated pharmacist-to-pharmacist medication reconciliation during the handover.

Valuable Quotes:

- *"Give medication charts for a week until we can get a GP review. More accurate information."*
- *"PRNs charted and stocked during the discharge."*

Theme 7: Clinical Support and Follow-Up

Key Difficulties:

- Lack of hospital follow-up support or clinical reassessment post-discharge.

- Difficulty contacting hospital clinicians after discharge to address arising concerns.

Magic Wand Solutions:
- Immediate post-discharge follow-up by hospital clinicians or specialist outreach teams is recommended.
- Ensure continuous hospital-RACF clinical communication channels remain active after discharge.

Valuable Quotes:
- *"Follow-up with a clinician from pre to post-discharge."*
- *"Communication between medical officers and nurses. It's usually impossible to speak to a treating clinician."*

Theme 8: Facility Resource Limitations and AN-ACC Funding

Key Difficulties:
- Inadequate funding and resources to safely accommodate complex residents.
- Restrictive AN-ACC funding mechanisms limiting acceptance of high-need residents.

Magic Wand Solutions:
- Additional targeted funding or incentives to support RACFs accepting complex or difficult-to-place residents.
- Recognise and fund specific care needs (behavioural, bariatric, dementia-related) adequately through AN-ACC.

Valuable Quotes:
- *"Understand the problems facing RAC—the constant struggle between filling beds (occupancy) and budget, getting the 'right fit', often not the high needs RAC resident."*

Theme 9: Staff Training and Safety

Key Difficulties:
- Increased risk of staff injury or burnout from aggressive or highly intrusive behaviours.
- Insufficient specialised training for staff handling complex behavioural or clinical care needs.

Magic Wand Solutions:
- Fund specialised training and staffing solutions specifically for high-needs residents.
- Immediate escalation pathways and external support services for critical behavioural incidents.

Valuable Quotes:
- *"Violent patients that staff have called a code black as we do not have any security staff."*
- *"Knowing there would be immediate help when we have a problem."*

Theme 10: Comprehensive Initial Transition Management

Key Difficulties:
- Chaotic initial 72-hour period post-discharge without comprehensive support plans.
- Difficulty stabilising residents quickly, leading to rapid deterioration or hospital readmissions.

Magic Wand Solutions:

- Structured, comprehensive initial transition management involving multidisciplinary teams (GPs, allied health, nursing, families).
- Immediate clinical assessments and detailed care planning are executed within the first 72 hours.

Valuable Quotes:

- *"Meeting with family, GP, and RACH clinical manager to set expectations and goals of care."*
- *"Comprehensive clinical handover: medication reconciliation, behaviour plan, risk assessment and family meeting."*

Highest Value Messages and Ideas:

- Implement mandatory face-to-face clinician-to-clinician handovers with comprehensive, detailed plans that cover medication, behavioural, and advance care plans.
- Immediate hospital follow-up and ongoing communication post-discharge.
- Realistic and transparent family discussions facilitated by hospital teams before RACF transitions.
- Prioritise weekday discharges early in the day, supported by robust escalation pathways for urgent concerns.
- Enhanced AN-ACC or additional targeted funding to resource complex care needs in RACFs adequately.

Concessional Beds and Funding Model Concerns

Under the new Aged Care Act 2024, concessional residents in Residential Aged Care Homes (RACHs) are defined as individuals with limited financial means whose accommodation costs are predominantly funded through government subsidies. Despite the positive intent of reforms aimed at enhancing equity and quality of care, significant concerns remain regarding the availability of concessional beds and the adequacy of funding mechanisms. Notably, there is no mandated requirement within the current regulatory framework that obligates RACHs to accept concessional residents. This policy gap could inadvertently limit access to essential residential care services for financially disadvantaged individuals.

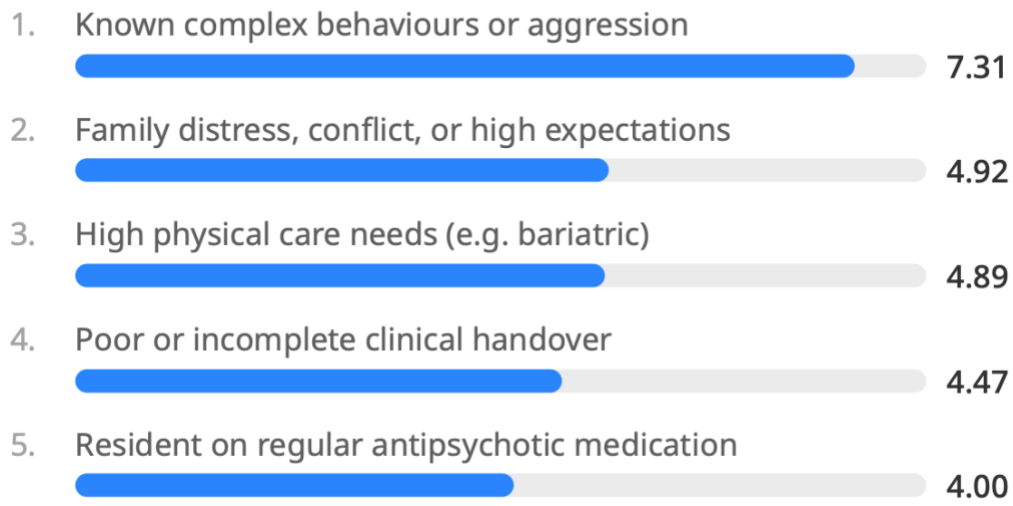
The feedback from stakeholders highlights the pressures facilities face under the Australian National Aged Care Classification (AN-ACC) funding model, particularly regarding resource allocation and resident selection processes. One representative notably stated, "***Understand the problems facing RAC—the constant struggle between filling beds (occupancy) and budget, getting the 'right fit', often not the high-needs RAC resident.***" This quote underscores the inherent tension within the current funding model, where facilities might be financially incentivised to prioritise admissions of residents who offer more favourable funding outcomes, potentially disadvantaging concessional residents.

Therefore, there is a clear need to review and refine funding strategies to ensure equitable access and sufficient incentives for facilities to accommodate concessional residents. Enhanced targeted funding support, transparent incentives, and regulatory mandates could collectively improve the acceptance rates of concessional residents, aligning operational practices more closely with the social equity objectives of the new Aged Care Act. The working group proposed in this report should prioritise addressing these funding disparities, ensuring that concessional residents receive equitable opportunities for timely and appropriate residential aged care placements.

Graphs

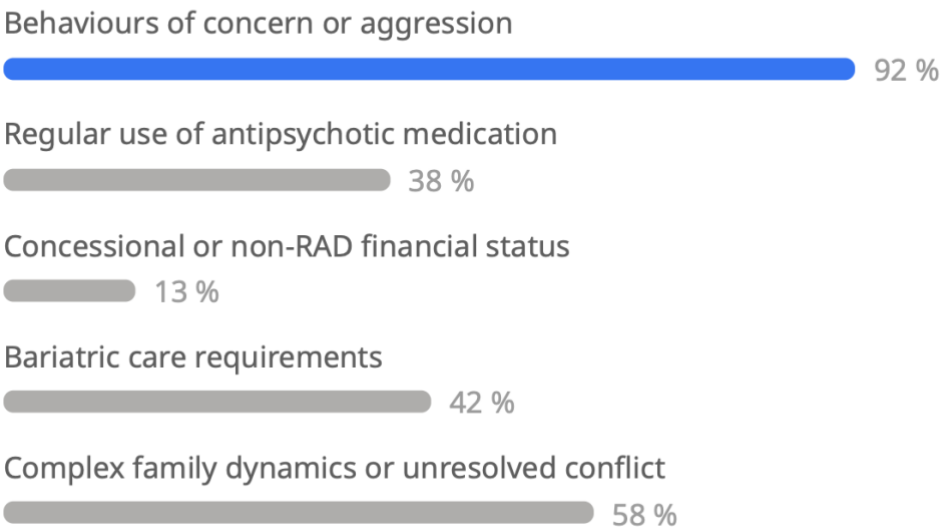
When deciding whether to accept a new resident from the hospital, which of the following factors has the most impact on your decision? (Please rank in order of influence)
(1/2)

0 3 6



Which of these patient characteristics would most likely prompt your service to delay or decline admission, even if a bed is technically available?
(1/2)

0 2 4



Direct Quotes

Handover

1. *"A clinical handover that is meaningful, completed in person, was mentioned at the Royal Commission over and over again by the industry."*
2. *"Complete documentation and giving an actual handover. We often receive residents without even a discharge summary."*
3. *"Clinician-to-clinician handover with patient AND family involved, with some agreement on goals of care and dying trajectory."*

4. *"Face-to-face clinical handover and a follow-up of the resident after a week to see how they are settling in."*

Behaviours

1. *"Along with aggressive and abusive [behaviours], one that we also forget is their actual intrusive behaviours—wandering into other people's rooms, taking stuff. [This] can cause almost as much of an issue with staff and other residents as aggressive behaviours."*
2. *"Violent patients that staff have called a code black as we do not have any security staff."*
3. *"Residents with challenging and unmanageable behaviours with no comprehensive behaviour management plan."*
4. *"Aggressive behaviours without suggested strategies to minimise this changed response."*
5. *"Behaviours related to dementia and residents who may have been heavily medicated prior to admission."*

RACF Clinicians

1. *"Our staff have got great clinical skills, and they know these residents really, really well. It would be really appreciated if hospital staff listened to the clinicians. They're calling CAREPACT or any hospital to get some assistance because they've exhausted their skills, and they've got great skills. But if they were actually listened to a little bit more, it would be helpful."*
2. *"There was a resident on palliative care, the wife was EPOA. The wife passed away, and when the resident showed signs of actively being palliative, the daughter started coming. There were three [family members] with three different opinions, and all of them had authority. We had to send him back to the hospital… He became really sick, went to hospital, and then parked in the hospital rather than [following] what his wishes were and what his wife had decided."*
3. *"Doctors and nurses are very scared to say that someone's dying. Very scared—not scared because the patient will be upset, the patient is the one who knows what's going on. But doctors and nurses are scared they might miss something reversible, scared they haven't done everything, scared they're going to be criticised."*

Discussion

The ongoing issue of prolonged hospital stays, particularly for older adults awaiting placement in residential aged care facilities (RACFs), places a substantial strain on acute care resources and negatively impacts patient outcomes. Current data highlight significant increases in long-stay admissions, which are exacerbated by the complexity of patient needs and difficulties in identifying suitable discharge destinations. These systemic challenges underscore the urgent requirement for innovative, responsive transition-of-care models tailored to the evolving aged care landscape.

Central to addressing these challenges is recognising the recent policy shifts driven by the new Aged Care Act 2024 and the updated Aged Care Quality Standards, both of which elevate resident rights and mandate heightened care quality. These reforms impose rigorous standards that necessitate more robust and clinically informed approaches to managing residents, particularly those with complex behavioural and cognitive presentations. Consequently, the transition-of-care model must align with these standards, ensuring regulatory compliance while maintaining a high standard of resident safety and care.

Feedback from key stakeholders, including general practitioners (GPs), geriatricians, and aged care providers, strongly emphasises the inadequacies of current discharge processes, notably in documentation accuracy and completeness. The necessity of mandatory, face-to-face clinical handovers between hospital clinicians, RACF teams, and families has been overwhelmingly supported. Such handovers would facilitate clear communication of essential details, including behavioural management plans, medication prescriptions, and advance care directives, significantly improving safety and care quality upon resident admission.

The consistent messages from all stakeholders revealed a mismatch between existing funding models, particularly AN-ACC, and the high supervision and care needs of residents with cognitive complexity. This **mismatch results in RACFs hesitating to accept patients due to inadequate resourcing**, underscoring the critical need for targeted financial support and specialised staffing solutions. Addressing these funding gaps through strategic investments can enable facilities to manage high-risk admissions better, ultimately improving the transition experience for residents.

The first 72 hours of a new admission to Aged Care were highlighted in discussions. Comprehensive, multidisciplinary support is recommended during this initial period, involving medication reconciliation, specialist behavioural management, advanced care planning, and ongoing clinical oversight. This wrap-around care approach would significantly mitigate early readmissions and resident distress, creating a safer and more seamless integration into the RACF environment.

Given these complex, intersecting challenges, establishing an executive-endorsed working group comprising RACF clinical leaders, hospital clinicians, primary care providers, and aged care executives is imperative. This collaborative approach ensures that proposed solutions are pragmatic, evidence-based, and reflective of real-world operational realities. Through co-design, the model can robustly address the current gaps, fostering improved patient transitions, reducing hospital bed pressures, and elevating overall care standards within the evolving aged care framework.

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