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HCCA Submission and Feedback on the Model of Care and Model of Service Delivery for the University of Canberra Public Hospital

Background

The Health Care Consumers' Association (HCCA) of the ACT is a health promotion organisation that was incorporated in 1978 to provide a voice for consumers on local

Health issues and now provides opportunities for health care consumers in the ACT to participate in all levels of health service planning, policy development and decision making.

Our work includes:

- Policy development, advice and responses
- Advocacy and representation
- Information dissemination
- Sector consultation and coordination
- Sector capacity building.
- consumer representation
- training in health rights and navigating the health system
- community forums
- working for the improvement of quality and safety of health services

HCCA currently supports fifty one consumer representatives on one hundred and nineteen committees in the ACT and we have trained forty six new consumer representatives in 2015.

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Key Issues

- The need for clear communication with the community about the role of the University of Canberra Public Hospital.
- It is crucial that strong links are made with public transport providers as well as community transport to ensure the new facility is accessible to all.
- The use of volunteers and what their role will be at UCPH
- The inclusion of extended hours for both the facility and services
- The need for a clear articulation of how the University of Canberra Public Hospital will manage future demands of the ACT and surrounding regions
- The implications of the contracting out of Soft Facility Management at the University of Canberra Public Hospital

1. General Comments

The HCCA has been an instrumental partner with ACT Health in the decision to build a sub-acute hospital. We have long supported the concept of integrated and networked health services and facilities that meet the needs of our community and are pleased that the development of the UCPH is progressing.

We are also pleased to note the Government's focus on patient centred care, accessibility of serviceman the quality and safety of services, rather than the financial construction costs. Furthermore, we are heartened by the former Health Minister's comments that "*the global cost should not be the most significant factor*" in making decisions regarding the design of the facility.

Sub-acute care is increasingly gaining recognition as an important level of care, offering cost savings and more focused patient care. It provides patients with the opportunity to heal and recover without the high cost of an extended acute hospital stay. The National Hospital and Health Reform Commission identified that there is also an urgent need for substantial investment in, and expansion of, sub-acute services – the 'missing link' in care – including a major capital boost to build the facilities required[1]. There is a general lack of community understanding about what this is and we want to work with the Government to ensure that this is successfully communicated

1.1. Overall

The document lacks specific case studies/ patient journeys to illustrate how the model will work within the network of other services. The inclusion of personalised examples would help people to understand how this hospital differs from and at the same time integrates with Calvary and Canberra Public Hospital. There needs to be greater depth and breadth of the patient journeys, providing both step up and step down case studies/ journeys. The current patient journeys provided within the Model of Care document are flow diagrams and don't give an adequate picture of how this new model will work for consumers.

We would like clarification of the process for incorporating feedback from the Time to talk website and public consultation to the Model of Care and Model of Service Delivery as currently this is not clear. The consultation process needs to clearly articulate the method in which feedback and comments will be acknowledged and how they will be responded to and /or incorporated into the document.

In June 2015 HCCA provided extensive written feedback on an earlier draft of the Model of Care. This feedback was acknowledged by the project officer but was not addressed and no advice provided on how this feedback could be used to shape the Model of Care. As there was no clear process in place on how to address feedback the information was not integrated or formal acknowledged, never closing the loop.

[1] National Health & Hospitals Reform Commission, p.6. (See also p.171.)

This is one example of the need to clearly articulate the feedback processes and the method in which it is assessed.

The Model of Care does not state the number of beds and day spaces that will be open on day one. This needs to be communicated now as it is about service delivery and care models. We understand that it will be a phased opening but this needs to be clarified.

1.2. Key Issues

HCCA has identified six key issues that need to be addressed in both the Model of Care and the Model of Service Delivery:

1.2.1. Communication with the community about the role of UCPH

Communication with the community about the role of the University of Canberra Public Hospital needs to be consistent, frequent, and early messaging to ensure safety around what is provided at the facility. This includes clearly outlining the services that will not be at UCPH, practically emergency services and walk in facilities.

1.2.2. Links with public and community

It is crucial that strong links are made with public transport providers as well as community transport to ensure the new facility is accessible to all. There is currently very little information on how the facility will be accesses by other means other than private vehicles.

We strongly encourage ACT Health to establish working relationships with transport providers, to understand the needs and demand for these services. This will be invaluable in preparing clear information to consumers, carers, the community and other health service on how these services are accessible to all using UCPH.

1.2.3. Use of volunteers

Throughout the Model of care there is limited information on how volunteers will be used at UCPH. Volunteers are a valuable resource within the health system that can improve the experience of being in a hospital. They are used throughout Canberra and Calvary Public Hospitals. Currently the Model of Care provides very little information on how volunteers will be involved at UCPH.

It is noted that under section 2.1.62 “Volunteers” in the Model of Service Delivery document, that this service “is to be developed”, however when it is developed will this be detailed in the Model of Service document?

1.2.4. Extended hours

There needs to be the inclusion of extended hours for both access to the facility and the services delivered. Currently the Model of Care states that rehabilitation services are restricted to business hours. Services need to be provided at UCPH across all days of the week if it is to a patient centred model.

The current thinking is that hospitals need to operate a 24/7 model to reduce length of stay and maximise this scarce resource. Services at UCPH need to be provided outside the standard business hours to best meet the needs of consumers needing timely and responsive rehabilitation services consistent with a patient centred model.

1.2.5. Future demand

There is no information as to how the University of Canberra Public Hospital will manage future demands of the ACT and surrounding regions. Bothe the Model of Care and the Model of Service Delivery need to clearly articulate the way in which the facility will meet future demand, such as moving to different models of care to deal with a change in demographic and demand.

1.2.6. Soft Facility Management

As this is a new contracting model for ACT Health it needs to be very clear the role in which the Soft Facility Management provider plays. It is vital to clearly define the role of Soft Facility Management and what interaction they will have with consumers, as currently this is not clear. This includes if and how they will be interacting with consumers and ACT Health to provide experienced contract managers to manage the Soft Facility Management. The importance of robust contract management is vital in insuring these services are provided at a safe and high quality standard.

2. Overarching RACC Model of Care Issues

2.1. Model of Care

2.1.1. Coordinated Care

The inclusion of a care coordinator in the RACC Model of Care is a positive outcome for consumers. This service will proved assistance for patients, cares and families to assist them through the treatment and reduce repeat tests and visits.

> "*A patient coordinator where you have one person to contact for a whole myriad of things, particularly in the case of my elderly mother who is battling with a serious condition. The number of repeat visits and telling the story over and over, the confusion of finding what you need and repeating test because one clinician wants it can be overwhelming. A coordinator that can be you contact person, understands what you need and can direct you through the maze of the hospital system is incredibly helpful*" **- Consumer feedback provided to HCCA**

However the UCPH RACC Model of Care document provides very little detail as to how and when a care coordinator or key link person will be allocated and what is classified as a multi-disciplinary care program. An example of a patent journey that utilises a care coordinator would explain the how, when, and who of the care coordinator role. For example will the care coordinator have any specialty training or will they just a member of the care team?

It is important to make it clear that families can be involved, in the care of patients including setting goals and to rehabilitation plans.

> "If it is be a truly patient cantered care model then patients and their families/ carers where appropriate should be involved in multidisciplinary team meetings" **- Consumer feedback provided to HCCA**

Under section 4.1.2.4 Care Delivery, care coordinator and key link person is used interchangeably, this section would be clearer if one or the other is used.

2.1.2. Extended Hours Service Provision

Hospitals need to be patient centred and service centred, one way to achieve this is to provide rehabilitation and support services across all days of the week and not restricted to business hours on week days. The current thinking is that hospitals need to operate a 24/7 model to reduce length of stays and maximize this scarce resource.

> *"My father was admitted to Calvary rehabilitation following an acute stay and received absolutely no rehab or exercise for 36 hours. He got so frustrated he took himself off with his wheelie walker and did laps around the carpark as he was used to daily exercise and it concerned him how little rehab was actually offered. Even after waiting the 36 hours, he received less than one hour a day of rehab in a group setting and spent the rest of the day twiddling his thumbs. He asked to be discharged as was deconditioning rather than reconditioning"*
> **– Written Consumer feedback provided to HCCA**

It is stated in Section 4.1.2.3 RACC Assessment that "for patients admitted on weekends, the multi-disciplinary assessment and individual rehabilitation plan will be developed for the patient as soon as possible after admission, generally within 48 hours if admitted on a Saturday and within 24 hours if admitted on a Sunday"[2]. This means that patients will have to wait up to 48 house before they are provided with a rehabilitation plan or begin treatment. These delays to rehabilitation increase lengths of stays at a cost to both the system and the patient and are not consistent with a patient centred model.

2.1.3. Carers, Family and Visitors

Carers, Family and Visitors can offer a valuable source of help as well as information about the patient's history, routines, symptoms and more. For these family members, participating in this way is essentially an extension of the ongoing care role they play at home, both before and after hospitalisation.

Carer's, families and visitors should be encouraged to be involved in care and made to feel welcome at all times. This includes the placement of comfortable seating within the carer/ family zone of each inpatient room. The inclusion of a 'carer zone' in each inpatient space is encouraged constant with evidenced based design principles. In some cases provision for overnight stay needs to be made, i.e. palliative patient at the end of life who has suddenly deteriorated and does not want to be transferred elsewhere. There is currently no information in the Model of Care explaining how Carers and family members will be involved in care. The ACT Health Visiting Hours — Visitor Guidelines states that visiting hours 6am to 9pm with "*approved visitors arriving after 9 pm and before 6 am will need to enter the hospital via the Emergency Department and present to the security office*[3]". How will visitors access UCPH after hours? A study by Donald Berwick, of the Institute for Healthcare Improvement stated in his article Restricted Visiting Hours in ICUs: Time to Change[4], a study that examined the benefits of unrestricted patient visitation, 88% of families stated it had a positive benefit to their overall experience and decreased their anxiety by 65%. Has increasing visitor hours been considered for UCPH?

> *"I think being a family member with older parents that there is a lot of stuff that is going on while they are in there that isn't communicated to us. He may have*

[2] ACT Health 2015, The Rehabilitation, Aged & Community Care (RACC) University of Canberra Public Hospital (UCPH) Model of Care V4.0 Section 4.1.2.3 RACC Assessment
[3] ACT Health n.d, "*Visiting Hours — Visitor Guidelines*", ACT Government
[4] Berwick, D, Kotagal, M (2004). —Restricted visiting hours in ICUs: time to change.‖ JAMA, 292, pp. 736-737

> *wanted to tell me but didn't have the details, so it would be good to have staff tell you"*. – **Consumer Feedback**

Including carers and family members in care activities can support the clinical care team providing such care activities as:

- Personal care – bathing, backrubs, hair care
- Meal assistance – feeding, menu selection, encouraging, recording
- Ambulation assistance – wheelchair use, encouraging, monitoring
- Monitoring fluids
- Diversional activities – reading, writing, companionship
- Treatments – mouth care, dressings, exercises
- Catheter/drain care
- Safety measures

The Model of Care needs to provide a greater focus on supporting and involving carers, family and visitors, including the positive involvement that the carers and family can provide to patients. This will support the ideals of patient centred care that is currently lacking in the Model of Care.

2.1.4. Discharge Planning

The Model of Care does not provide any information on discharge planning. There have been a number of issues that have been presented to HCCA regarding discharge planning including patients:

- discharged too early, due to a need for the bed
- discharged without appropriate support in the community or from community health
- and discharged without proper consultation with family (particularly in the geriatric setting).

Will there be enough follow up support for people once they have been discharged to reduce possibility of readmission? Does the discharge planning consider not only the physical needs of the patient but also the psychological needs to avoid extended lengths of stay whilst waiting for home modifications or care to be provided?

The planning needs to discourage the early and inappropriate discharge of patients especially those who are frail, elderly and people who live in Residential Age Care Facilities. This practice comes not only at a huge cost to the patient but also to the system when the patient is readmitted into hospital as they failed to get the rehabilitation or reconditioning they needed.

Consumers support a more consumer centred and co-ordinated approach to the provision of information induces contact information and discharge planning. It was felt that this co-ordinated approach would alleviate many of the reported difficulties and in the words of one consumer prevent the increasing *"DIY health system."*

2.1.5. Hydrotherapy Pool

We have been advocating for increased access to the UCPH Hydrotherapy Pool to be built at UCPH. The benefits of hydrotherapy are well documented and we would like to see more detail about how the pool will be made available for the community after hours. Neither the Model of Service Delivery nor the RACC Model of Care provide information about how the community access the pool after hours. The RACC model of Care under Section 4.5 Hydrotherapy state that "*equitable access, based on clinical need, will be available to eligible patients throughout the ACT*". There is also information outlining how external providers will gain access, but there is no detail set as to who and how the community will access the service in the documents.

There is a degree of concern in the community that the existing hydrotherapy pool at the Canberra Hospital will be closed when the pool at UCPH is opened. We believe the need for hydrotherapy is such that a second pool within the ACT Health system is justified. If the TCH pool is closed the consumers living in south Canberra will not be catered for, particularly for those with limited mobility and access to transport. Having limited access to hydrotherapy is damaging to those with arthritis and other chronic conditions and insufficient management of these conditions can cause an increase of symptoms requiring more contact with the health system and potentially hospitalisation. Increasing the access to hydrotherapy for the ACT community allows people to self-manage their conditions and eases burdens on the health system.

At present, hydrotherapy pools throughout Canberra can only be accessed by Arthritis ACT during downtimes of other organisations (e.g. TCH). This restricts the availability of low cost hydrotherapy for ACT residents with arthritis and other musculoskeletal conditions.

> *I just don't know what's going to happen… for example one woman who lives right down in Isabella Plains and although she has a car, I don't know that she'll be too happy with driving all the way over there y'know… Or certainly not more than once a week. And people who have to do it who live on the south side and have to do it by public transport, I don't think they will do it. Simple as that. –* ***HCCA interview with Arthritis ACT Hydrotherapy Pool Supervisor and consumer 2014***

There is strong support for the continued operation and should be an integral part of any future developments at the TCH.

2.1.6. Pain Management

The RACC Model of has scares reference to pain and there is no reference to the potential need to manage pain for a deteriorating patient (page 38). There is a need to manage pain before it becomes chronic as currently one in five people suffer from pain and with those over 65 it rises to one in three people. Chronic pain is projected to increase as Australia's population ages from around 3.2 million in 2007 to 5 million

by 2050[5]. There is a need for UCPH to adopt pain management for those suffering from acute pain as to prevent is from developing into chronic pain.

> *Acute pain needs to be dealt with at UCPH before it becomes chronic. Don't confuse the two issues: Acute is less than 3 months VS chronic more than 3 months. The issues is that people don't get treatment from specialists/ personnel regarding acute pain because "It's nothing" or "You will be right". People get stigmatised and then they end up in chronic pain and have to wait 18 months to try and get a foot in the door at the Pain Unit at TCH.* **– Written Consumer feedback provided to HCCA**

As there will be a high percentage of patients in a step down model, post-surgery there is a need for pre-emptive measure to prevent and manage pain. A pain management program at UCPH can reduce the risk of pain becoming chronic. This could be done in a similar way a fall prevention plan is provided upon admission, providing ongoing preventative pain management and monitoring.

For instance there will be 30 elderly rehabilitation beds for conditions including fractures, cognitive impairment, surgery recovery and Parkinson's disease. People suffering with Parkinson's disease can also have an 'acute' (less than 3 months) flare up of their pain and if their condition is deteriorating then they will need to access a specialist pain service and not their GP or staff at the Aged Care Residential Facility. A person can have their 'chronic' pain 'stabilised' and 'managed' however, something can happen which causes a person to have an 'acute' pain flare up which needs to be managed responsively and appropriately without if possible resorting to transfer back to an acute setting.

The adoption of a pain management program would allow for the ongoing management of pain not only through medication management but also utilising lifestyle options.

2.1.7. Opportunities for Meaningful Activity

As patients will be there for long periods of time including weekends where there will be no rehabilitation sessions held it is important for inpatients to maximize their engagement and activity during the non-therapeutic times. This is especially important with the longer stay patients.

Supervised/ organised wellness activities should be provided like yoga, gardening, walking, stretching, knitting, etc. Keeping patients engaged in this way could support their rehab goals and therefore reduce their length of stay.

[5] MBF Foundation (2007) The high price of pain: the economic impact of persistent pain in Australia – Pain Management Research Institute, University of Sydney.

2.1.8. Functional Relationships with other Services

Along with the need to include connections to palliative care in functional relationships it is important to clearly consider possible functional relationships with the new community health centres throughout Canberra, the GP Superclinic and UC Health Hub run adjacent to the site identified for the construction of UCPH. We are also keen to learn more about the heath precinct at UC and what opportunities that will deliver for innovation and integrated care into the future.

Another important consideration is the relationship of UCPH with the surrounding community spaces and areas like parks and shopping centres. Many rehabilitation centres encourage patients to practise using new equipment (such as mobility aids) or exercise techniques in the surrounding area of the rehabilitation centre. This allows patients to conceptualise and practise using these new found techniques or aids in a home like or community environment. These connections will be crucial in providing continuity of care for consumers of services in the network of ACT health providers in the ACT. Clearly articulating these relationships also helps to visualise how UCPH will work to provide transitional care and step-up and step-down programs to the Canberra community. We are pleased to see the inclusion of a walking track around the UCPH which could be utilised to this end and reiterate the need for this to have a sealed surface in order for it to be safely utilised.

2.1.9. Advance Care Planning

Advance Care Planning (ACP) needs to be integrated and embedded across all the systems providing the option to all who use the services at UCPH. The statement about "All admissions to UCPH will be offered the chance to do an ACP" has been removed but it is a positive that ACP included throughout the Model of Care.

Under Section 3 Overarching Future Model of Care for RACC Services across the ACT, page 30 it states "*Advanced care planning will be encouraged*". Rather than the word "encouraged" it should be changed to "supported".

Section 4.1.1.1 RACC Sub-acute Inpatient Units at UCPH under Deteriorating Patients at UCPH page 39, the words after "admitted to the" could be changed to "geriatric wards". Also why was the Slow Stream ward not included here?

For section 4.1.2.4 Care Delivery page 45, "*forward planning of services including integration with domiciliary services, equipment loan services and advanced life care planning*". This is good to see, however how will this be implemented?

The advance care consent directive for mental health consumers will be in place by the opening of UCPH, how will it be ensured that both RACC and MH services know that this is in place for a person and how it will be managed?

2.1.10. Palliative Care

The inclusion of a palliative care service at UCPH is an opportunity to provide more choices and control in the provision of palliative care support to us in the ACT. We are aware of a model of providing palliative care in the inpatient setting at Sunshine Hospital in Victoria where they have combined GEM/Palliative Care ward. The unit creates a relaxed, home like environment. It also has a private garden which provides an alternative area for consumers to spend time with their families outside or for families to spend time on their own.

The Model of care under section 4.1.1 Service Elements states that "*in addition, services that will also be accessible to RACC inpatients include, but are not limited to: A range of medical consultation services e.g. cardiology, respiratory, orthopaedics, surgical, endocrinology, Consultation Liaison Psychiatry, palliative care*". How will palliative consultation services be provide to patients?

To avoid transfer and respect of patient wishes it is important to offer end of life planning that will go hand in hand with Advance Care Planning and palliative care. It is important to reflect functional relationships with current palliative care services in the ACT and how they can work with UCPH to support patient's wishes.

2.1.11. Culturally and Linguistically Diverse Communities (CALD)

HCCA notes that despite clearly stating the relatively high percentage of people in the ACT and surrounding regions who were born overseas and speak a language other than English at home, the Model of Care fails to include specific actions or goals around ensuring access for them. This must be addressed to ensure that subsequent models of care and changes to services are sensitive to the needs of these members of the community. Consideration of CALD community needs in health service provision is a requirement as stipulated in the ACT Health Multicultural Coordinating Framework[6]. These requirements include the development and understanding of the health needs of its CALD communities, provide services and information which are accessible in culturally safe and appropriate ways to people from CALD communities and develops and maintains the cultural needs of the health service.

> "*All Authors of policy and strategic framework documents consider and are provided with advice on potential CALD impacts"* - **Key Action Areas (Section 6.1.2) ACT Health Multicultural Coordinating Framework 2014 - 2018**

UCPH needs to provide materials to promote the availability of interpreters for patients/consumers, including training to support staff in the promotion and use of interpreter services. This also includes the need for translated documents and way finding integrated into the services at UCPH.

[6] ACT Health (2014), *Health Multicultural Coordinating Framework 2014-2018*

> "*One of the habits of CALD consumes is reverting back to their mother tongue, what have you taken into account for the aging multi-cultural needs such as translation service? The services need to be proactive rather than reactive. There needs to be more translated documents.*" – **Consumer feedback provided to HCCA**

The Model of Care also needs to consider the needs of the CALD community in regards to larger families. How will the services be provided to accommodate larger CALD families visiting loved ones in inpatient wards? It is also vital to provide access to culturally appropriate foods, meeting the food needs of the ACT and surrounding CALD community.

> "*I am Muslim and I don't eat pork, I would like to have the option that the food that is served to me is comforting but also meets my cultural needs*" – **Consumer feedback provided to HCCA**

The Model of Care needs to provide further detail as to how they will be address the needs of the CALD.

2.1.12. Patient Journey and Pathways Through Care

The experience of rehabilitation and geriatric care is often extremely variable between the individuals receiving care. Whilst care should be flexible enough to meet the needs and choices of individuals, unnecessary variation in treatment plans and referral pathways within at UCPH not only makes it hard for consumers, families and carers to navigate the system. We are also concerned that this could expose consumers to higher risk of poor health outcomes.

The introduction of clear treatment pathways like those seen in *HealthPathways* which is currently being introduced in the ACT and surrounding region has been shown to make significant improvement in the way primary health care teams, allied health teams and hospitals provide care and improve patient outcomes. Given the introduction of this new initiative, it is essential this is linked into the current UCPH RACC Model of Care.

Consumers, families and carers also benefit from increased knowledge and understanding of what they can expect in their whole journey. This not only allows them to make informed choices about their care but also allows them to assess if their treatment is meeting their needs and expectations. In response to this need HCCA would like to see the UCPH RACC Model of Care clearly articulate goals and action around increasing community health literacy around services and treatment options as a means for consumer empowerment and better health outcomes.

2.1.13. Health Literacy

Health literacy is a focus of HCCA, and our work in this area is based on the understanding that health outcomes are better when consumers have good health literacy and when health services, activities and support groups have inclusive policies and practises[7]. The Health Literacy program enables disadvantaged and marginalised health consumers to build skills and knowledge to improve their use, understanding, awareness and confidence engaging with their own health, their families health and with support services, community services and with the health system. The link between health literacy and better health outcomes is well established[8]. Developing strategies to reduce the effects of low health literacy on health outcomes warrants the attention of policymakers, clinicians, and the community.

2.2. Infrastructure

2.2.1. Use of Courtyards, Walking Track and Connections to University of Canberra

The provision of a safe walking track and good connectivity to University of Canberra campus and lake provides opportunities for staff, families and careers to use these recreational facilities for themselves and with patients. It is in everyone's best interests to make the most of the surrounds and maximise engagement and exercise opportunities throughout the whole facility, including the accesses to courtyards and the surrounding grounds.

2.3. Workforce

2.3.1. ACT Health Staff

It is essential that it is clear to the ACT community that there will be the workforce in place to staff the new UCPH ensuring that the staff skill mix and roles are appropriate for each functional unit and the rehabilitation centre as a whole. This along with the assurance that this new centre will not diminish much needed staffing at other ACT Health services is crucial for UCPH to fulfil its role as envisioned for the network of health services in the ACT.

There needs to be appropriate numbers of trained Registered Nurses to ensure that the more complicated care can be done in a timely fashion. The Model of Care makes no reference to how or if assistant in nursing will be used in the work force mix. This also raises the question as to how registered nurses and enrolled nurses will be supported in delivering patient care.

[7] Australian Primary Health Care Research Institute (APHCRI) Video Interview *The role of primary health care in the context of the larger health system Dr Dr Hernan Montenegro, Health Systems Advisor at World Health Organization* accessed May 2014-http://www.youtube.com/watch?v=FHAwMo_8Q5E

[8] Berkman ND, Sheridan SL, Donahue KE, Halpern DJ, Crotty K. Low Health Literacy and Health Outcomes: An Updated Systematic Review. Ann Intern Med. 2011;155:97-107.

> "*We need to make sure there is enough highly trained nurses to do the roles that only they can do – we don't want patients waiting around to get their wounds dressed because only the care assistant ants are available*" **– Written Consumer feedback provided to HCCA**

The Model of Care does not outline the necessary workforce mix that will meet the needs of consumers this includes the role of volunteers and students. In this process has ACT Health conducted research into consumer experiences and expectations of allied health and nursing assistance, extended scope roles, peer workers, and the use of volunteers in service delivery? There also needs to be clear information on how ACT Health staff will interact with contracting staff, setting out clear boundaries and responsibilities. This will provide valuable information on the current system and how it can be improved for UCPH.

HCCA is also very keen to learn about the opportunities for shared care between UCPH treating teams and general practitioners. Given the importance of having a model of care that enables step up as well as step down referrals, the integration of the role of general practice is important.

2.3.2. Volunteers

Volunteers are a valuable resource within the health system that can improve the experience of being in a hospital. Volunteer's roles can vary depending on the services and the volunteer's wants and experiences. Broadly it can be defined under three main categories:

- Support to visitors and the public
- Support to patients and their families
- Support behind-the-scenes

Throughout the Model of care there is limited information on how volunteers will be utilised at UCPH. The document outlines under section 2.3.1 Strengths/Benefits of Current Services "*Enhanced service provision through the RACC volunteer team*". We would like to see more detail about this included in the Model of Care

Section 4.1.3 Inpatient Care - Service Delivery Team it states that "Volunteers will continue to provide an invaluable service to RACC patients including but not limited to a strong presence in the main entrance providing assistance with way finding and patient transport and assisting with therapy sessions". Are these the services that are offered at TCH RACC? There needs to be further information on what enhanced services volunteers will be providing.

2.3.3. Aboriginal Liaison Officers

Under section 4.1.1 Service Elements the document states that the Aboriginal and Torres Strait Islander Liaison Service. Currently this service is under heavy demand, will there be additional staffing to cover this new facility? Also will Aboriginal and

Torres Strait Islander Liaison staff be based at UCPH or will it be an outreach model from Canberra or Calvary Public Hospital.

2.4. Technology

2.4.1. Information Communication and Technology (ICT)

ICT needs to play a pivotal role in the provision of safe health services throughout ACT Health. This means that ICT systems need to be integrated throughout all ACT Health facilities, incorporating reliable and safe eHealth systems across the board.

For the patient entertainment system there needs to be more than free to air provision to ensure patients can maintain communication with their loved ones, access their health records, enhance their health literacy and make menu choices. This system could also enable telehealth/Webcam capabilities to enable offsite consultant support to reduce patient transfer which in turn lessens length of stay, transport and supervision costs to the system.

Other ICT systems that are important to consumers are:

- Bed sensors will allow for improved falls management initiative to lessen the impact of falls when they happen. We are pleased to see this provision.
- Patient tracking and ID is important to lessen the need for locked wards and to enable the most efficient and safe method of identifying patients in an integrated electronic system of medication delivery and general treatment.
- The safe and effective use of an electronic medication management systems (EMMS). Medication errors remain the second most common type of medical incident reported in hospitals, and of all medication errors, omission or overdose of medicines occurs most often[9]. The successful use of an EMMS will improve patient safety and he quality use of medicines.
- Bed side write up. Point of care write up is fundamental to modern healthcare delivery. The model reduces errors, advance safety and reliability of care, promote nurses and other health-care members to interacted with the patient, carer and family, increase patient and family satisfaction with care, encourage innovation and to add value to the care provided[10].

  UCPH Model of Care needs to outline how it will be providing point of care write up, this needs to include the ICT components of how it will be achieved i.e. will it be on tablets, bedside computers etc.

We would like to see these components of ICT included within the Model of Care to improve the patient safety, experience of patients and carers and families utilising the services at UCPH.

[9] Australian Commission on Safety and Quality in Health Care n.d, "*Electronic medication management systems in hospitals background*", Australia

[10] Dearmon. V, Roussel. L, Buckner. E, Mulekar. M, Pomrenke. B, Salas. S, Mosley. A, Brown. S & Brown. A 2013, "*Transforming Care at the Bedside (TCAB): Enhancing Direct Care and Value-added Care*" Journal of Nursing Management 21, 668–678

2.5. Specific RACC Model of Care Comments

The Rehabilitation, Aged & Community Care (RACC) University of Canberra Public Hospital (UCPH) Model of Care is outlined in the Introduction as a Model of Care for UCPH. However almost half the document outlines the current profile of the RACC activities including acute services.

If "*an overarching Model of Care has been developed to inform the future delivery of RACC services across the ACT*"[11], as outlined in section 3 of the Model of Care, Section 2 and 3 can be referred to the overarching RACC Model of Care rather than included within the UCPH RACC Model of Care. This will provide a greater focus on how service will be provided at UCPH and refer to the overarching RACC Model of Care when needed.

Section 1 Introduction, Page 5:

- The document states that "*the new UCPH facilities will enable significant enhancement and increased capacity of RACC services in the ACT".* Is the opening of UCPH a relocation of services, not additional service?
- Under "*Centralised care provision for rehabilitation and geriatric services at UCPH will be facilitated by:"* What about the inclusion of reassures and building workforce?

Section 1.2.2 Glossary:

- The glossary needs to include definitions for Public Hospital, Non-Acute and Step Up/Sep Down model

Section 2.1.1 Inpatient Care Settings, Page 13:

- Under point Sub-acute Geriatric Unit it refers to "*8 non-acute beds*". What does this mean? How do they differ to sub-acute?

Section 2.1.2 Inpatient Service Pathways:

- There are only Inpatient Services Pathways for step down treatment. Step up pathway for both Rehabilitation and Geriatric Services need to be included.
- What happens to the pathway for inpatient services if there are no beds available at UCPH? Will the patient stay in an acute setting?

Section 2.1.2.2 Geriatric Services, Page 17:

- *"If no bed is available in the ACE ward, patients may be admitted to other outlying wards*". What proportion would use outlying wards? Is the care comprised due to not being in an ACE ward? Are the outcomes of those using outlying wards measured?
- How does Calvary John James fit into orthogeriatrics?

Section 2.3.2 Areas for Improvement, Page 23:

[11] ACT Health 2015, The Rehabilitation, Aged & Community Care (RACC) University of Canberra Public Hospital (UCPH) Model of Care V4.0

- The issue of "*the transition between different parts of the service (inpatient and ambulatory services) is not seamless and could be enhanced*" is a big problem. How will the Model of Care address this?
- The document states that "the Acute Rehabilitation Ward (Ward 12B) is currently operating at 100% occupancy and additional capacity is required". Does this mean there will be the provision of additional beds upon opening?
- The issue of the Canberra Hospital Patient Transport Vehicle fully booked for non-urgent patent transport has been consistently raised by HCCA.
- The "*provision of end of life and advanced care planning could be strengthened*" also needs to include Palliative Care.

Section 2.4 Known Innovations to be incorporated for future RACC Services:

- What does "*integrated electronic systems that are easily accessible*" mean? This needs to be explained.
- Are there timeframes for the roll out of the Queue Flow system at UCPH?
- The statement of "*centralised integrated intake, booking and scheduling*" what does this mean? CHI has not been reviewed, so how do they know it will generate efficiencies and improvements?
- How will "*it is proposed that in the future greater links with adjacent health services as well as primary care providers be established*" happen? There is no information as to how this will be achieved.

Section 3.1.1 Overarching Principles:

- Under Safe and high quality care under point four "*cohorting of patients*" does not need to be included. Why is "safe care will also be optimised through the placement of staff spaces that enable observation of patient and visitors in key clinical and gathering areas" important? How does this impact on the safe care? Is this referring to personal safety?
- Under Enhanced person centred care
    - how will "*Services will be culturally competent, safe and appropriate for Aboriginal and Torres Strait Islander peoples"* be achieved?
    - include falls risk assessment at presentation / admission, in addition to medication history,
    - include flag for possible elevated risk due to use of medicines known to have that effect,
    - ensure patient story has been accurately recorded for reference, in order to minimise re-telling the same story,
    - plan for timely response to the nurse call system, to avoid patient distress and falls in bathroom,
    - ensure patients at moderate or high risk of falling are prompted to go to bathroom at regular intervals and
    - plan to have supervision of patients with moderate or high risk of falling, while they wait to be admitted.

3. Model of Service Delivery

Section 3.2 Acronyms and Glossary should be moved to the top of the document to provide information of the acronyms and glossary to readers and to maintain continuity to the UCPH RACC Model of Care.

3.1. Transportation Arrangements

HCCA notes that one of the reasons in selecting the site of the UCPH was the need to be accessible to the ACT community. To many this means making sure that UCPH is close to major transport routes.

> *"Accessible transportation to health facilities is critical. The Kambah Village Creek facility and Therapy ACTs Holder facility are excellent examples of how to 'stuff-up' locating a facility. They are also excellent examples of how a problem - accessible transport links to ACT Health services - is continually ignored and not rectified. It is these 'stuff-ups' that show that consultation is only a 'tick box' exercise by ACT Health. As Village Creek and ACT Therapy problems are yet to be solved many, many years after they were identified."* **– Written consumer feedback provided to HCCA**

ACT Health need to work across directorates and agencies to ensure an increased capacity in the provision of community transport that will result with the opening of UCPH. The service is currently unable to meet demand now, especially in the peak hours each day and with some community providers having there "books closed" to new users at present.

The Model of Service Delivery states under section 2.1.45 Patient Transport – External "*non-urgent transport for ambulatory services patients attending the facility – this service will be provided through external providers (e.g. volunteer transport, ACTION buses and Territory and Municipal Services)*". Has planning been put into place as to how this will be managed, such as the use of volunteers? What other services will be put into place to meet increased demand for transport needs? This point is very vague as to how non-urgent transport for ambulatory services patients will attain reliable transportation to the new facility.

For non-urgent inpatient transport the Model of Service Delivery outlines that this model has yet to be completed. Once this new model is completed will the Model of Service Delivery be amended to reflect the completed non-urgent inpatient transport model?

3.2. Soft Facility Management

There is currently very little information in the Model of Service Delivery as to how soft services will be provided under the Soft Facility Management (FM) contract.

It is important to clearly explain the new model of Soft FM service delivery at UCPH and outline what interaction contracted staff will have with consumers, as currently this is not clear. As an example it needs to state under 2.1.34 Manual Handling that all handling of patients' is only provided by ACT Health staff.

Under section 2.1.51 Security it states that security operations will be provided by a contractor, does this mean it will be overseen by ACT Health security or only the contract managed by ACT Health?

Are services such as food going to be provided by the Soft FM? Drawing out the question of how food will be prepared i.e. will it be cooked on site, or cooked off site and reheated?

It is very vital to clearly identify the involvement of Soft FM and if and how they will be interacting with the consumer. There has been issues throughout Australia recently in the health sector in the poor provision and management of Soft FM when it is contracted out to external providers. These issues include under resourcing of staff and other budget allocations, poor record keeping and documentation, and unsafe response times to breakdowns. It is vital that ACT Health is clear on the role Soft FM has at UCPH as well as strong contract management to make sure the Soft FM are providing high quality services.

3.4. Car parking

We are happy to see the inclusion of 250 underground parking spaces for UCPH, this will drastically improve access to consumers. However there are concerns as to how these parking spaces will be managed. It is important to provided priority parking to patients, carers and families. Currently under section 2.1.41 Parking it makes no reference to the underground parking and how it will be managed, the Model of Service Delivery needs to include that these parking spaces will be managed by ACT Health.

This also raise the issues of how University of Canberra will manage the parking spaces. Under section 2.1.41 Parking it states that "*staff, government vehicle, public and accessible parking will be provided by the University of Canberra*", does this mean that ACT Health will not have oversight of the way in which the parking will be provided? This does course concern as it removes control form UCPH and could potentially have adverse effects on consumers.

As there is currently pay parking on the University of Canberra campus ACT Health will need to provide some form of validation for patients, carers and families. This management could be done in a similar way the University of Canberra Health Hub operates. Where validations of parking tickets to consumers is provided of no cost.

The provision of accessible parking at UCPH is a crucial issue and there is insufficient detail on its provision in the Model of Service Delivery. There needs to be additional detail as to the number of accessible parking spaces provided including

what data/ guidelines were used in making the determination. The standard minimum 3% accessible parking spaces will not meet demand for the UCPH demographic. It is important that considerations are takin into account for the current and future RACC consumer demographic, so a more appropriate number of accessible parking spaces can be provided. Additionally, provision needs to be made for sufficient height clearance underground for some users of accessible carparks who have rooftop wheel chair hoists. There have been instances where facilities in the ACT have not considered this need in their planning and have had to retrofit at great expense to accommodate this need.

4. Further comments

HCCA sees great potential in the creation of a sub-acute facility on the grounds of Canberra University. Sub-acute care is increasingly gaining recognition as an important level of care, as it 'is more patient centred and provides cost savings in decreasing demand for acute care, providing the opportunity for people to heal and recover without the high cost of an extended stay in an acute hospital. As part of the community consultation held at HCCA on the members of the community wrote questions about the Model of Care and UCPH to be addressed by ACT Health which are included in Appendix 1 that are questions from the consultation and Appendix 2 that are questions provided to HCCA.

HCCA is excited to see the progress in the development of this new facility and looks forward to a response from the ACT government and ACT Health to our submission as well as continued involvement in the development, planning and implementation of the sub-acute facility.

The Health Care Consumers' Association of the ACT

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Appendix 1 – Consumer Questions from Public Consultation on the Model of Care for UCPH

1. On discharge will appointments be made for patients there and then for other services?
2. Patient Identification – will it be wrist bands?
3. Are the chronic care nurses or program included?
4. Will there be an outpatient CARS linked to specialist in all hospitals?
5. What age group will be accepted into Rehab?
6. Effective discharge – what is actually different?
7. People being willing to participate in rehab – does that mean those with cognitive impairment or who lack capacity would not be attempted to rehabilitate? What efforts/ strategies would be put in place to encourage participation?
8. I have heard that there is a reluctance to include the term dementia or consider these people likely patients. Given when screening occurs for cognitive impairment in hospitals prevalence is high – up to 60% - is it right to not include as eligible or as part of the language?
9. People with cognitive impairment are very likely to take longer to improve/ regain function. Should these people not be highlighted as very likely candidates for slow stream rehab? I.e. Resolving a delirium.
10. Will there be support provided for people with dementia or cognitive impairment to attend the RACC Day program as this may work well for some of these people.
11. Re-enabling environment – these are some good examples in documents. What about living areas, i.e. laundry, family room, kitchen, study (i.e. Homelike)? What about what patients wear i.e. getting dressed for the day, etc.?
12. How will risk/ dignity of risk be incorporated into the person centred patients goal oriented model, when so often risk is given the greater priority? Hospitals/ institutes are generally very risk adverse.
13. There does not need to be a new facility in order to deliver person centred care. What will be different about this new hospital in this area?
14. Minimising patient transfers between services, wards, etc is very welcome particularly with older people with confusion/ cognitive impairment.
15. Bed management issues (pressure of beds) often gets in the way of good care. How will this new hospital maximise its function in this environment?
16. Increased agitation is listed as a non-urgent deterioration. This can often be a sign of a medical emergency ie. Delirium
17. Booking/ notification system electronic. How does this work for people with cognitive impairment/ sensory impairment?
18. Multi-faith service – what about non-faith based spiritual support?
19. Page B Summary Paper: Consultation Paper – Reference to low level residential aged care no longer exists. Assessment is now for residential care.
20. It was mentioned that the dementia care in hospitals program – will this program be rolled out at UCPH?

21. How will outside organisations access relevant information and provide information about patients with an electronic medical record? Has there been consideration for communicative access for non-health agencies?
22. Reference to making the faculty non-institutional and home-like? Lockable bedside lockers – is this home-like? Having someone else in a bed next to you – is that home like?
23. To avoid confusion ie. Emergency misdirection, why call it a hospital? Call it a centre.
24. Pain Management program needed. Not for “well” with chronic pain but those who are at risk of developing chronic pain. Ie. Active spasm management – not TCH
25. What clinical services would be provided through model of service delivery?
26. For consistency move acronyms and terminology to the front
27. I disagree that every personnel/ specialist at UCPH can deal with pain. GPs get 2 hours of pain tr5aining in their 4-6 year degree. Acute pain needs to be dealt with at UCPH before it becomes chronic. Don’t confuse the 2 issues: Acute less than 3 months VS chronic more than 3 months. People don’t get treatment from specialists/ personnel RE acute pain because “It’s nothing” or “You will be right”. People get stigmatised and then they end up in chronic pain and have to wait 18 months to try and get a foot in the door at the Pain Unit at TCH.
28. UCPH as far as I am aware is for acute injury/ illness therefore it should be acute pain looked at. I realise that older people (geriatrics) have pain and some are chronic pain issues. However, to get this issue programmed it needs to focus on acute pain.
29. Model of Care document says no surgery BUT ACT Health presentation says acute admission can be for orthopaedic surgery – very confusing. Later Linda said no acute surgery unit – so confusing again.
30. Model of Care and service delivery documents – all have spelt as collocation

Appendix 2 – Consumer Questions Provided to HCCA

1. How will feedback received during this period of public consultation effect change? What is the process for integrating and responding to this feedback?
2. What data and information sources were used in the development of the model of care?
3. How will this new model be evaluated? Will there be a pre and post model implementation evaluation? How will we know that it has adequately addressed the weaknesses in the current model? Are there measurable outcomes expected? What are the measures of success?
4. HCCA interviewed consumers of current RACC services to inform the strengths and weaknesses section of the RACC model of care, the following weaknesses were identified by consumers. Could you please specifically outline the measures adopted in this model to address these gaps in service delivery?
5. Identified issues by consumers:
6. This new model mentions a patient centred approach to care, could you outline specifically the more patient centred approaches to care that will be new in this model?
7. The workforce profile lists the inclusion of the Aboriginal Liaison Officer but not a Consumer Consultant. Is it possible to include a Consumer Consultant also? It is highly appropriate considering peer workers are also being considered as part of the rehab team.
8. Could you outline the 'best practice' elements of care provision in this new model?
9. How will the move to bedside write up be transitioned? What method will be employed – hand held device, clinical desktop for inpatient room, shared clinical/patient system? Once this decision is made, how will the implications from this decision inform design changes? Will there be clinical supported decision making technologies incorporated into the electronic patient health record?
10. Will there be a patient entertainment system – it seems to be referred to as simply 'a free to air tv" – are there further innovative approaches? Will patients be able to look up health information/ keep in touch with loved ones/ order food on this system?
11. Will bed sensors be used as falls management mechanism?
12. Will patient tracking be used as an alternative to locked wards?
13. Will there be use of webcams at bedside to avoid patient transfer when accessing off site specialist consultations/assessments?
14. There is good evidence on the use of personalised electronic games in rehabilitation – will these be considered?
15. How does this new model improve equality of access to rehabilitation services?
16. Can you outline a patient journey using examples of step up and step down processes?
17. Given there is no endorsed clinical services plan, nor a documented model of care to base this new document on, how do we know that it will be embedded and integrated?

18. In the planning for this model of care, pain management was identified by consumers as an issue, can you detail how this will be addressed in this new model?
19. There are issues now with consumers who don't drive being able to access medical appointments in the ACT, won't these increase with this new model? How will you address this?
20. It seems that older person's mental health sub-acute care has been omitted from the model operating at UCPH, why leave out older person mental health, is this best practice to not have a sub-acute step down , step up model available for persons over 65 years. Wouldn't they too benefit from a rehabilitation model that is separate from the acute facility?
21. Will there be a hearing loop at UCPH to assist in the care of those with hearing impairments
22. There are very inexpensive kits available to support those with vision impairments and hearing loss during an impatient stay, can their use be imbedded in this model of care?
23. Why are the patients in the older persons Rehab unit likely to be discharged home or to a low care residential aged care facility? In most instances low and high care residents are missed in at RACF – does this mean if you are likely to be discharged to a high care facility you won't be at UCPH?
24. How many inpatient beds will be operationalised on day one of opening, similarly how many day service places will operate on day 1? Are these numbers based on demand for service or resources available?
25. What new and innovative measures will be in place to prevent falls in this newly designed facility?
26. How long after admission to an inpatient unit, will a falls assessment be completed?
27. What innovations are three in this model to improve care after discharge from this facility? How will it improve the continuity of care and prevent readmissions?
28. At 4.3 it lists the environmental enrichment activities that could be available at UCPH – these don't seem very innovative e.g. Jigsaw puzzles, board games, eating in a communal dining area. Is there a possibility to include more innovative or stimulating measures than these? Art therapy, yoga, walking group, gardening, and electronic gaming. There is evidence around the benefits of EG in rehabilitation settings
29. Will there be an increase in geriatric rehab services to meet the increased needs of older persons with chronic conditions and dementia?
30. At the last consultation on the RACC model of care, we were told that data was being gathered on the proposed mix of patients expected at UCPH. Can you share that work with us now to indicate the demographics of the patients expected at UCPH e.g. how many in the age brackets under 50, 60, 70,80 , how many with cognitive loss, how many post-surgery, how many awaiting RACF placement,
31. Will rehab be based on negotiated goals with patients and their families and carers where appropriate?
32. Can you outline the Palliative approach to care that will take place at UCPH?
33. Will there be additional accessible carparks to accommodate the specific demographic at a rehab centre?

34. Will patients be able to control their lighting and temperature in the inpatient units?
35. In the case of someone having a major health event will the advanced care directive be easily accessed by an integrated health record across all settings?
36. The advanced consent directive for mental health consumers have been in place for 3 years by the opening of UCPH, will the system know if there is one in place for a person and will each system - RACC and MH have access to both these directives?