ELDAC
End of Life Directions for Aged Care

Transfers Between Care Settings – Client and Family

This pamphlet answers commonly asked questions about transfers between care settings at the end of life. Related pamphlets cover the topics of *Medication Management* and *Nutrition and Hydration* at the end of life.

Transfers of care

As people's needs change towards the end of life, they may need to be transferred between different health services or care settings. For example, a person might need to be moved to hospital for acute care or they may wish to go to a hospice for specialist end of life care.

As people nearing the end of life are more likely to have complex medical and care needs, it is important that transfers are carefully planned and managed.

Who decides to transfer a person?

It is preferable to minimise unplanned transfers for people nearing end of life. This can help to reduce any discomfort or risks to their safety or wellbeing and minimise distress and anxiety. A person's comfort and dignity takes priority at this time.

When considering a transfer, those responsible for coordinating the person's care will discuss options with the person (and if they wish, their family or support network), to see if they consent to being transferred, and how a transfer might be avoided. The person can refuse to be transferred.

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If the person does not have decision-making capacity:

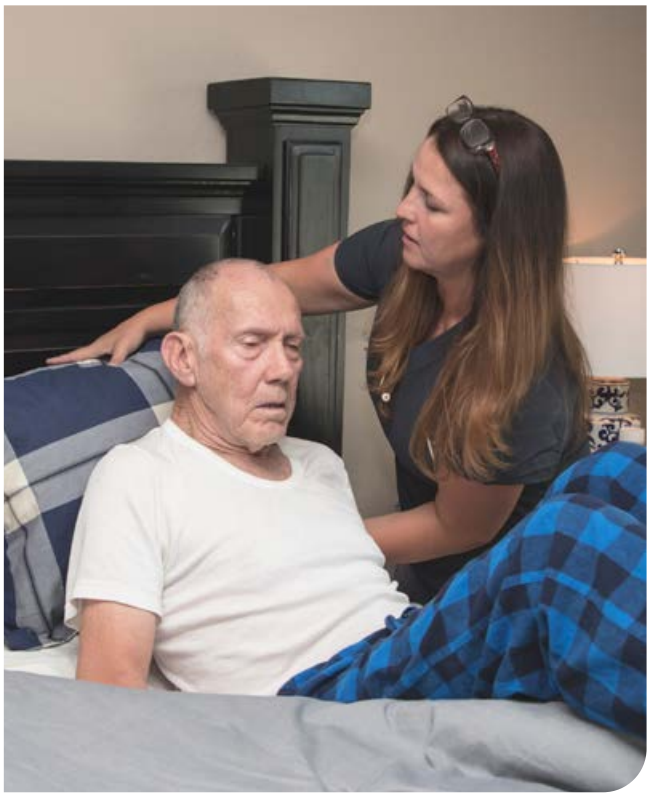
- The person's directions about treatment and transfer in their valid Advance Care Directive must be respected by health professionals and care staff. A Directive that refuses transfer and treatment must be followed, even if it means the person's life may be at risk. Preferences, values and choices expressed in other advance care planning documents will also be taken into account to guide decisions about treatment and transfer.
- If the person does not have an Advance Care Directive, health professionals and care staff will consult a substitute decision-maker (this is sometimes a close family member or trusted friend) to make decisions about transfer, care and treatment. Their advance care planning documents (if they exist) should be taken into account to guide decisions about treatment and transfer.

There may be urgent circumstances (e.g., an emergency) where it may not be possible to gain the consent of the person (or their substitute decision-maker) to a transfer. In such circumstances, it is lawful to transfer a person without their consent or that of their substitute decision-maker.

Can a residential aged care facility support people to die comfortably?

Some people fear that dying in residential aged care will be unpleasant or impersonal. But dying in an aged care facility can be comforting, particularly if it has been a person's home for some time and they are familiar with the staff, and their friends and family can be present.

Residential aged care facilities are well equipped to provide 24-hour palliative care in a less clinical setting than in hospital. Nurses and others working in residential aged care have the skills and experience to provide quality end of life care that maximises a person's comfort and dignity. The aged care facility may also be able to support a person's family or friends to stay overnight during this time.



What does a well-prepared transfer look like?

If a person chooses to transfer (or needs to transfer to another care setting), it is important for this to be planned and coordinated to ensure there are no interruptions to care.

The person (and if they wish, their family, friends or supporters), will be involved in the planning. If the person does not have capacity to be involved, their substitute decision-maker will be included in planning. A transfer date will usually be planned in advance. However, there may be situations where transfer must be delayed, for example if the receiving service does not have arrangements in place or the person's condition changes.

The service transferring the person is responsible for handover information to ensure coordinated care is provided. This will include information about their condition, treatments, medications and their Advance Care Directive and/or other advance care planning documents (where these exist).

Arrangements will also be made to transfer the person's medications and personal items.

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Transferring to a residential aged care facility

When a person is transferred to a residential aged care facility from hospital or another health service, the aged care provider may need to undertake a reassessment of their condition, needs and preferences. This may involve the person, their family or supporter (if they want them involved) or their substitute decision-maker (if they do not have capacity) and other health professionals, such as their regular GP or specialists.

The provider should ask the person about their specific preferences for their end of life care, including any cultural or religious needs. If the person cannot communicate about this (because they do not have capacity) the provider should work with their substitute decision-maker to understand their end of life care preferences, to meet their needs, respect their wishes and make them comfortable.

Transferring to home to die

A person may decide that they want to die at their home or a family/friend's home. In these circumstances, the aged care service can make arrangements to transfer the person so that their family, friends or supporters can care for them during the final days and hours of their life.

There are some support services available to help care for people at home as their death approaches. The aged care provider can help make the necessary connections and arrangements as part of the transfer process and provide information to support family or friends.

Conversations about the end of life

Having conversations about death and dying with family, friends, supporters, health professionals and care workers can be an important way to prepare for a person's death.

While these conversations can be difficult, they help to understand a person's preferences and how they want people to be involved in their end of life care.

Helpful questions about transfers

It may be difficult to find the right words or questions to ask health professionals and care staff when a person is dying.

If you feel like you don't understand what is happening or information is unclear, don't be afraid to ask questions. You have a right to understand why a transfer is happening.

Helpful questions about transfers when a person is dying

1. What will be the difference in care for my Dad if he is transferred to hospital?
2. How will the hospital provide better care for me?
3. If my Mum is transferred, will I be able to stay with her overnight?
4. If I am transferred to home, is there someone my wife can call to help her when she needs it?
5. If Dad is transferred to hospital, will he have to stay there until he dies?
6. How will the hospital know what Mum likes and doesn't like?
7. What could go wrong if we choose to transfer my sister to a hospice?

Key actions the residential aged care facility will take to manage transfers of a resident between care settings towards the end of life

- Discuss with the person where their preferred location to die is, and ensure this is recorded.
- Enable the person to make informed choices about transfers and respect their right to refuse to be transferred and to refuse treatment.
- Work with the person to avoid any unplanned or unnecessary transfers.
- Follow relevant directions in the person's Advance Care Directive including refusals for transfer or treatment.
- Ensure any transfers are underpinned by effective planning, risk management, coordination, and communication with everyone involved.
- Facilitate continuity of care between settings by sharing current and comprehensive information about the person's needs and preferences with those involved in their transfer and subsequent care.
- Ensure adequate supports are in place if the person is transferring to a private residence (e.g., a family home).
- Involve the person's substitute decision-maker if they do not have the capacity to consent or make choices.
- Communicate with and involve family or friends in discussions and care planning, if the person wants.

The Aged Care Quality Standards require that '*The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and dignity preserved.*' (Standard 3(3c))

Helpful resources

ELDAC's End of Life Law Toolkit.

Aged Care Quality Standards consumer resources

Charter of Aged Care Rights

The Conversation End of life conversations can be hard

This resource has been informed by a review of contemporary Australian and international literature including authoritative sources on the Australian policy, legal and practice environment. Additionally, three focus groups of nurses working in a variety of aged care settings were held and content was reviewed by experts in the ELDAC network.

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