CARER CONTROLLED HEALTH RECORD

for a person you support

This Carer Controlled Health Record aims to help communicate information about the person you support to all relevant health professionals in hospital. It will also enable you to obtain information, participate in decision-making and prepare for care after hospital.



Information About Care Needs: 7 Carer Details Plouide this information to the health Pro-



Telephone Relationship to the Pers I din the substitu

Who is admiring the person you support. Carerinformation

NAME **OF CARER:**

Telephone

NAME OF PERSON SUPPORTED:

Nobile

their telationship to the person you support? Fitst name Nobile

KNO, deraits of other contact person (specifibe)

IKNO, details of substitute decision maker (specify be)

IK NES, details of other cater (specify below) CARER CONTROLLS Email Surname

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INTRODUCTION

How is this *Carer Controlled Health Record* helpful to 'YOU' the carer and the person you support?

Going to hospital can be a worrying time, and the person you support may not always be able to communicate their needs to health professionals. When you arrive at hospital, you and the person you support will be asked about previous hospital admissions and whether they have a *My Health Record*. It can be hard to work out what health professionals need to know about the person you support, and you want to feel sure that you have given enough information. Planning for what happens when the person you support is discharged or transferred from the hospital should begin on admission and continue throughout their hospital stay. The more you are involved in health care decisions and planning, the more you will be informed and prepared to provide care after hospital.

This Carer Controlled Health Record will help you record information about the person you support. This information can be shared with health professionals to assist them to tailor medical, health and nursing care to the individual needs of the person you support. This record can be used on its own or in part to complement a My Health Record.

How does this Carer Controlled Health Record complement the Australian Government's My Health Record?

The Australian Government of Australia has made available a free electronic *My Health Record*. To create a *My Health Record* for the person you support you need access to the internet and register online (see Part C Resources section for details). A *My Health Record* allows you to share health information with health professionals. It contains information about medical conditions and treatments, allergies, medicine details and prescriptions, test and scan reports, medical consultations, medical history, referrals and discharge summaries. It also enables you to attach an Advance Care Plan and add personal notes only you can see.

The Carer Controlled Health Record is different to the My Health Record in that it aims to make clear the expectations you and the person you support have about involvement in discussions and decisions about care delivery in hospital, and after discharge or transfer. It also provides specific details about the care needs of the person you support to help health professionals provide individualised care in hospital.

Advance Care Planning

An Advance Care Plan contains directions about medical treatment, who has been appointed the substitute decision-maker, preferences about health and personal care and preferred health outcomes. It can be attached to this *Carer Controlled Health Record* or if you have one, a *My Health Record*. If the person you support does not have an *Advance Care Plan* you should consider working with them to get one so that their wishes can be respected (see Part C Resources section).

How to use this *Carer Controlled Health Record*

This Carer Controlled Health Record is divided into three (3) parts and can be used for any admission to hospital.

PART A enables you to record information about yourself and any other carers, information about the role/s you and others provide, your level of involvement with care and the care requirements. It also provides space to record information about the person you support and their communication and physical care needs. The information in Part A will be helpful to hospital health professionals.

PART B helps you and the person you support understand hospital care and become involved in decisions and planning for hospital discharge or transfer. In this section, you can write information about current medicines, hospital treatments and care needs. It also offers you questions to ask health professionals with space to record answers. Part B will complement a My Health Record, if you have one.

PART C lists resources and contact details of organisations you may find helpful. This section also provides space for you to attach an Advance Care Plan if you have one. If you have a *My Health Record* you would attach the Advance Care Plan to it.

How is this *Carer Controlled Health Record* helpful to a health professional?

Caring for someone who is disabled, frail or a person with dementia can be both challenging and complex for health professionals. The evidence shows health professionals do not always adequately recognise or acknowledge the support role of the carer and the wealth of information they have that can improve health care planning and delivery, particularly if the person they support cannot provide information themselves. The information in this *Carer Controlled Health Record* will assist the health professional provide individualised care and acknowledge your role as a support person.



PART A contains information about Carer Details, My Role as the Carer, General Information About the Person I Support, Communication Care Needs and Physical Care Needs.

> Carer Details

| Provide this information to the health professional in the emergency department or hospital ward who is admitting the person you support. | | | | |
|---|------------------------------|------------------|---|--|
| Carer information | | | | |
| Title | First name | | Surname | |
| Telephone | Mobile Email | | | |
| Relationship to the person | I support is: | | | |
| I am the substitute decision | n maker YES NO If | NO, details of | substitute decision maker (specify below) | |
| Title | First name | | Surname | |
| Telephone | Mobile | Email | | |
| I am the contact person Y | ES NO If NO , details | of other conta | act person (specify below) | |
| Title | First name | | Surname | |
| Telephone | Mobile | Email | | |
| Is there another carer? YE | S NO If YES , details | s of other carer | (specify below) | |
| What is their relationship t | o the person you support? | | | |
| Title | First name | | Surname | |
| Telephone | Mobile | Email | | |

> My Role as the Carer

| Toileting | YES NO | Others: |
|--|--------------------------|--|
| Assisting with eating | YES NO | |
| Dressing & grooming | YES NO | |
| Showering | YES NO | |
| Meal preparation | YES NO | |
| Laundry | YES NO | |
| Medication | YES NO | |
| Transport/driving | YES NO | |
| Cleaning | YES NO | |
| Shopping | YES NO | |
| Outings | YES NO | |
| Moving around | YES NO | |
| Finances | YES NO | |
| Others (specify in next column) | YES NO | |
| CURRORTER | | A NOT CURRORTER |
| SUPPORTED • | | • NOT SUPPORTED |
| | | |
| If you need more support at home | e, what support would l | nelp? |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| Expectation of involvemen | at in health care fo | or the person I support (Tick the box that applies) |
| Expectation of involvemen | it iii iieaitii care it | the person is support (thek the box that applies) |
| I want to be involved in health car | e decisions (e.g. doctor | 's visits and nursing care) Yes No |
| | | for transfer to another hospital, rehabilitation facility, |
| residential care facility, or discharg | ge nome. | |
| YES NO | with the destar and re- | so in sharm of the area |
| IL TES DISCUSS VOUR INVOIVEMENT V | vitil the doctor and hur | se in charge of the area. |

> General Information About the Person I Support

| Name | | | | |
|------------------|---|----------------|----------------|-----------------------------|
| Title | First name | | Surname | |
| What does the pe | erson like to be called? | | | |
| Tell us about | the person you su | pport | | |
| | v articulate and intelliger ir working life as a chef. | | | |
| | | | | |
| Language | | | | |
| Main language sp | ooken at home | Is an interpre | ter needed? YE | NO If YES , explain: |
| Regular doct | or (general practiti | oner) | | |
| Name | | | | Telephone |
| Name of medical | practice | | | |
| | | | | |
| Address | | | | |
| | professionals and | specialists | | |
| | professionals and | specialists | | Telephone |
| Other health | | specialists | | Telephone |
| Other health | ofessional | specialists | | Telephone |

Other health professionals and specialists (continued)

| | Name | | Telephone | • |
|---|--|---|------------------------------|-------------------------|
| | Type of health professional | | | |
| | Name of medical practice | | | |
| | Address | | | |
| | Living situation | | | |
|) | Lives by self Lives with main carer Lives with other carer Lives in an aged care facility Other (specify in next column) | YES NO YES NO YES NO YES NO YES NO YES NO | Other: | |
| | Community services used | (in the last 6 mo | nths) | |
| | I/we currently receive assistance f (eg. Home Care Package (level), D | | o, Meals on Wheels, Respite | Care, overnight relief) |
| | Type of service & how often recei | ived Na | me of service & contact deta | ails |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | Visits to the emergency d | epartment and h | ospital admissions | |
| | Number of visits to the emergency | y department in the las | st 6 months | |
| | Number of admissions to the hosp | oital in the last 6 month | ns | |
| | Date of last hospital admission | | / | то/ |
| | Name of hospital where last admir | tted | | |

| YES, is this new or long standing? That worsens their confusion? That reduces their confusion? The person I support was confused during their last hospital stay YES NO That do you think caused their confusion? The person I support has been diagnosed with dementia YES NO The person I support has been dia | History of confusion/dementia/delirium | |
|--|--|--|
| /hat worsens their confusion? /hat reduces their confusion? /hat reduces their confusion? /hat do you think caused their last hospital stay YES NO /hat do you think caused their confusion? /hat do you think caused their last hospital stay YES NO /hat do you think caused their last hospital stay YES NO /hat do you think caused their last hospital stay YES NO /hat do you think caused their last hospital stay YES NO /hat do you think caused their last hospital stay YES NO /hat do you think caused their last hospital stay YES NO /hat do you think caused their last hospital stay YES NO /hat do you think caused their confusion? /hat do you think caused their last hospital stay YES NO /hat do you think caused their last hospital stay YES NO /hat do you think caused their last hospital stay YES NO /hat do you think caused their last hospital stay YES NO /hat do you think caused their last hospital stay YES NO /hat do you think caused their last hospital stay YES NO /hat do you think do you their last hospital stay YES NO /hat do you think caused their last hospital stay YES NO /hat do you think do you their last hospital stay YES NO /hat do you their last hospital stay YES NO /hat do you their last hospital stay YES NO /hat do you their last hospital stay YES NO /hat do you their last hospital stay YES NO /hat do you their last hospital stay YES NO /hat do you their last hospital stay YES NO /hat do you their last hospital stay YES NO /hat do you their last hospital stay YES NO /hat | Can get confused YES NO | |
| that reduces their confusion? the person I support was confused during their last hospital stay YES NO hat do you think caused their confusion? That do you think caused their confusion? The person I support has been diagnosed with dementia YES NO an you tell us what type? Tho made the diagnosis? Tho made the diagnosis? The person I support has been diagnosed with dementia YES NO Action an you tell us what type? Tho made the diagnosis? The person I support has been diagnosed with dementia YES NO Action and you tell us what type? Tho made the diagnosis? The person I support has been appointed? YES NO Action and you tell us what type? The person I support has been appointed? (specify below) The person I support has been appointed? (specify below): The person I support has been appointed | If YES , is this new or long standing? | |
| the person I support was confused during their last hospital stay YES NO YES, who made the diagnosis Advance Care Planning as an Enduring Power of Attorney been appointed? YES No YES, who has been appointed? (specify below) ame Contact details Contact details Contact details Oes the person you support have an Advance Care Plan or similar directive document? YES No No No YES No YES No The person you support have an Advance Care Plan or similar directive document? YES No | What worsens their confusion? | |
| the person I support has been diagnosed with dementia YES NO any you tell us what type? Tho made the diagnosis? Tho made the diagnosis Tho made the | What reduces their confusion? | |
| the person I support has been diagnosed with dementia YES NO an you tell us what type? If you made the diagnosis? If you made the diagnosis as an Enduring Power of Attorney been appointed? YES NO YES, who has been appointed? (specify below) ame Contact details Test, who has been appointed? (specify below): Test, | The person I support was confused during their last h | nospital stay YES NO |
| an you tell us what type? //ho made the diagnosis? pproximate date of diagnosis | What do you think caused their confusion? | |
| //no made the diagnosis? pproximate date of diagnosis divance Care Planning as an Enduring Power of Attorney been appointed? YES NO YES, who has been appointed? (specify below) ame Contact details as someone been appointed to make medical decisions for the person you support? YES NO YES, who has been appointed? (specify below): ame Contact details oes the person you support have an Advance Care Plan or similar directive document? YES NO ttach the Advance Care Plan to the back of this record or My Health Record if you have one. | The person I support has been diagnosed with deme | ntia YES NO |
| pproximate date of diagnosis dvance Care Planning as an Enduring Power of Attorney been appointed? YES NO YES, who has been appointed? (specify below) ame Contact details as someone been appointed to make medical decisions for the person you support? YES NO YES, who has been appointed? (specify below): ame Contact details oes the person you support have an Advance Care Plan or similar directive document? YES NO tach the Advance Care Plan to the back of this record or My Health Record if you have one. | Can you tell us what type? | |
| as an Enduring Power of Attorney been appointed? YES NO YES, who has been appointed? (specify below) ame Contact details as someone been appointed to make medical decisions for the person you support? YES NO YES, who has been appointed? (specify below): ame Contact details Contact details | Who made the diagnosis? | |
| as an Enduring Power of Attorney been appointed? YES NO YES, who has been appointed? (specify below) ame Contact details as someone been appointed to make medical decisions for the person you support? YES NO YES, who has been appointed? (specify below): ame Contact details oes the person you support have an Advance Care Plan or similar directive document? YES NO tach the Advance Care Plan to the back of this record or My Health Record if you have one. | Approximate date of diagnosis | |
| as someone been appointed? (specify below) as someone been appointed to make medical decisions for the person you support? YES NO YES, who has been appointed? (specify below): ame Contact details Oes the person you support have an Advance Care Plan or similar directive document? YES NO tach the Advance Care Plan to the back of this record or My Health Record if you have one. | Advance Care Planning | |
| as someone been appointed to make medical decisions for the person you support? YES NO YES, who has been appointed? (specify below): ame Contact details oes the person you support have an Advance Care Plan or similar directive document? YES NO tach the Advance Care Plan to the back of this record or My Health Record if you have one. | Has an Enduring Power of Attorney been appointed? f YES , who has been appointed? (specify below) | YES NO |
| YES, who has been appointed? (specify below): ame Contact details oes the person you support have an Advance Care Plan or similar directive document? YES NO ttach the Advance Care Plan to the back of this record or My Health Record if you have one. | Name | Contact details |
| YES, who has been appointed? (specify below): ame Contact details oes the person you support have an Advance Care Plan or similar directive document? YES NO ttach the Advance Care Plan to the back of this record or My Health Record if you have one. | | |
| oes the person you support have an Advance Care Plan or similar directive document? YES NO ttach the Advance Care Plan to the back of this record or <i>My Health Record</i> if you have one. | Has someone been appointed to make medical decision of YES , who has been appointed? (specify below): | ions for the person you support? YES NO NO |
| ttach the Advance Care Plan to the back of this record or <i>My Health Record</i> if you have one. | Name | Contact details |
| ttach the Advance Care Plan to the back of this record or <i>My Health Record</i> if you have one. | | |
| | | |
| they do not have an Advance Care Plan, speak about it with the person you support and see your local of | | |

> Communication Care Needs

| Before this Hospital Admission This information will assist health | | ter communicate with the person you support. |
|--|-----------------------------|--|
| Hearing | | |
| Has some deafness Right ear Left ear Bot Wears a hearing aid Is the hearing aid with them? | h ears YES NO YES NO | Comments: |
| Vision | | |
| Has poor eyesight Wears glasses for reading Wears glasses for long distance vision Are their glasses with them? | YES NO YES NO YES NO YES NO | Comments: |
| Teeth | | |
| Wears denture/s or partial dentures Top Bottom Are their dentures with them? | YES NO | Comments: |
| Speaking | | |
| Has difficulty speaking | YES NO | Comments: |
| Memory | | |
| Has memory problems | YES NO | Comments: |

| Remembering names, conversations and events | YES NO |
|---|--------|
| Remembering the time of the day, where they are and why they are here | YES NO |
| Understanding what is being asked of them | YES NO |
| Making decisions about their day to day care | YES NO |
| Describe what type of assistance is needed for the items ticked. | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| What activities or behaviours may cause them to become upset or agitated? | |
| What activities or behaviours may cause them to become upset or agitated? (eg. showering, using the toilet, taking medications, asking them to do something) | |
| | |
| | |
| | |
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| | |
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| | |
| | |
| | |
| (eg. showering, using the toilet, taking medications, asking them to do something) | |
| | |
| (eg. showering, using the toilet, taking medications, asking them to do something) | |
| (eg. showering, using the toilet, taking medications, asking them to do something) | |
| (eg. showering, using the toilet, taking medications, asking them to do something) | |
| (eg. showering, using the toilet, taking medications, asking them to do something) | |
| (eg. showering, using the toilet, taking medications, asking them to do something) | |
| (eg. showering, using the toilet, taking medications, asking them to do something) | |
| (eg. showering, using the toilet, taking medications, asking them to do something) | |
| (eg. showering, using the toilet, taking medications, asking them to do something) | |
| (eg. showering, using the toilet, taking medications, asking them to do something) | |

> Physical Care Needs

| Mobility | | |
|---|--|---|
| Walking, standing, moving around Independent Manages with assistance Needs full support | Rising from a chair Independent Manages with assistance Needs full support | Stairs Independent Manages with assistance Needs full support |
| Needs specific supervision or assistar | nce with: | |
| | | |
| | | |
| Uses a mobility aid YES NO | | |
| | | |
| Describe (e.g. walking stick, walking) | frame, wheel chair): | |
| Describe (e.g. walking stick, walking | frame, wheel chair): | |
| Describe (e.g. walking stick, walking | frame, wheel chair): | |
| Describe (e.g. walking stick, walking j | frame, wheel chair): | |
| Describe (e.g. walking stick, walking s | frame, wheel chair): | |
| | | |
| Skin | d/or bruised YES NO | |
| Skin Skin can easily be damaged, torn and | d/or bruised YES NO | |
| Skin Skin can easily be damaged, torn and | d/or bruised YES NO | |
| Skin Skin can easily be damaged, torn and | d/or bruised YES NO | |
| Skin Skin can easily be damaged, torn and | d/or bruised YES NO | |
| Skin Skin can easily be damaged, torn and Does the person have any current ski | d/or bruised YES NO | |
| Skin Skin can easily be damaged, torn and Does the person have any current ski | I/or bruised YES NO | |
| Skin Skin can easily be damaged, torn and Does the person have any current ski Toileting Independent Manages with | I/or bruised YES NO | |
| Skin Skin can easily be damaged, torn and Does the person have any current ski Toileting Independent Manages with | I/or bruised YES NO | |

Toileting (continued)

| Wears a co | Catheter NO Catheter |
|---|--|
| Describe: | |
| | |
| | |
| Toileting ai | id needed YES NO |
| | e.g. raised toilet seat): |
| Describe (e | e.g. raisea tollet seat). |
| | |
| | |
| Do they ex | xperience constipation? YES NO |
| What helps | s? |
| | |
| | |
| | |
| Eating a | meal |
| Eating a Indep | meal meal mendent Manages with assistance Needs full support |
| Indep | |
| Indep | pendent Manages with assistance Needs full support |
| Indep | pendent Manages with assistance Needs full support |
| Indep They need | pendent Manages with assistance Needs full support |
| They need Uses an aid | pendent Manages with assistance Needs full support specific help with: |
| They need Uses an aid | pendent Manages with assistance Needs full support specific help with: |
| They need Uses an aid | pendent Manages with assistance Needs full support specific help with: |
| Indep They need Uses an aid Describe (e | pendent Manages with assistance Needs full support specific help with: d to help with eating YES NO e.g. plate guard, cutlery with a moulded handle): |
| Uses an aid Describe (e | pendent Manages with assistance Needs full support specific help with: d to help with eating YES NO e.g. plate guard, cutlery with a moulded handle): needs |
| Uses an aid Describe (e | pendent Manages with assistance Needs full support specific help with: d to help with eating YES NO e.g. plate guard, cutlery with a moulded handle): needs cly been |
| Uses an aid Describe (e | pendent Manages with assistance Needs full support specific help with: d to help with eating YES NO e.g. plate guard, cutlery with a moulded handle): needs |

Dietary needs (continued)

| Describe (e.g. diet for diabetic control, semi-solid diet): | |
|---|----------------------------------|
| | |
| Has a food allergy/allergies/intolerances YES NO | |
| Describe: | |
| | |
| Likes the following foods: | |
| | |
| Likes the following food but they should be minimised of | or avoided: |
| | |
| Describe why: | |
| Distillate the following foods: | |
| Dislikes the following foods: | |
| Drinking | |
| Independent Manages with assistance | Needs full support |
| Needs help with: | |
| Uses an aid to help with drinking YES NO | Describe (e.g. two handle cup): |
| oses an aid to help with drinking 125 NO | Describe (eigrewe namate eap). |
| Requires thickened fluids YES NO | Describe the level of thickness: |
| | |
| Do they ever cough while drinking? YES NO | |
| Likes an alcoholic drink during the day YES NO | |

| Dressing/undre | ssing |
|-----------------------|---|
| Independent | Manages with assistance Needs full support |
| Needs help with: | |
| Bathing/showe | ring/grooming |
| | ing/grooming |
| Independent | Manages with assistance Needs full support |
| Needs help with: | |
| Sleep | |
| | |
| Independent | Manages with assistance Needs full support |
| Needs help with: | |
| | |
| Usual sleep and wak | e times: |
| | What times and have lange? |
| Has daytime naps Y | YES NO What time and how long? |
| Prefers to sleep thro | ugh the night In a bed In a chair On a couch/daybed |
| How many pillows do | oes the person sleep with? |
| Has a routine that pr | repares them for sleep YES NO |
| Describe (e.g. 30 mir | nutes before bedtime they have a warm drink of XXXX): |
| | |
| The person I support | t gets up at night and walks around the house YES NO |
| What helps them sle | ep through the night? |
| | |
| What helps them to | go back to sleep if they wake? |
| At night, the person | experiences |
| Pain Itchi | |
| | |



PART B will help keep you up-to-date about hospital care and what needs to happen after the person you support leaves hospital. Some of the information in this section may be in the *My Health Record* if the person you support has one.

> Summary Medical History - What you know

| nown medical history | | |
|--------------------------|--|--|
| e.g. high blood pressur | e, depression, arthritis, pressure sore, infections, diabetes, cataracts): | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| What apprations have t | hey had? (e.g. hip replacement) | |
| viiat operations nave t | ney had: (e.g. hip replacement) | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| Vhat are they allergic t | o? (e.g. foods, medications, adhesive tapes, scented products) | |
| | | |
| | | |
| Vhat happens if they h | ave an allergic reaction? | |
| | | |

> Current Medicines

Medicines includes all tablets, liquids, creams and inhalers. Much of this information will be in a *My Health Record*, if the person you support has one. If over the counter medicines or doctor prescribed medicines have been commenced and there is no *My Health Record*, obtain information about them from the label and show this record to the health professional on admission. Alternatively, you can take the medicines to hospital.

| Medicine name | 1. How often is it taken? 2. How much is taken & when? | What do you understand as the reason for taking the medicine? |
|--|--|---|
| Example: Prescribed medicines (e.g. Warfarin) | One tablet each morning before food | To thin the blood |
| Example: Over the counter medicines (e.g. Paracetamol) | Two tablets four times a day | For joint pain |
| Example: Herbal medicines (e.g. St Johns Wort) | 5mls twice a day with food | To improve mood |
| | | |
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| | | |

> A guide to help you be informed and involved about what happens in hospital and prepare you and the person you support for discharge

Even with your best efforts there may be things discussed during the hospital stay that you will

Treatments, procedures, tests, and assessments while in hospital Each time you visit the person you support, look for an opportunity to ask a health professional about what treatments, procedures, tests and assessments have been done so you have a general understanding. Notes: Questions to ask about preparing for care at home after hospital Will I be able to continue to care for "x" at home? Is there someone at the hospital who will help me to organise extra help I will need at home? Who will arrange it? When will it commence? What will it cost? For example: ■ District nursing service/community nursing service Help with cleaning and housework Alterations to the home and installation of equipment Meals on wheels

Respite care (e.g. a break for a few hours, days, or weeks)

Who else can help me after I leave the hospital?

Who can I contact at the hospital if I have any questions or problems?

Questions to ask about preparing for care at home after hospital (continued)

| Notes: | | | | | | |
|--|--|------------|--------------------------------|------------------------|-----------|--|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| Living arrangemen | ts after hosp | ital | | | | |
| At some time during t conversation/s with h | | | | | o have a | |
| After hospital the person I | My home | | Other: | | | |
| support will be | heir home | | | | | |
| = | Rehabilitation uni | | | | | |
| = = | Residential aged on the contract of the contra | | | | | |
| | | | 2.1 | | | |
| They will be transported Me | from hospital by | | Other: | | | |
| Ambulance or a pat | ient transport se | rvice | | | | |
| Other (specify in ne | | | Date and time this will occur? | | | |
| | | | Date:/ | /Time: | | |
| After hospital help |) | | | | | |
| Before leaving hospita person you support n | • | • | | after discharge/transf | er if the | |
| Name of person | Title or designation | Name of ho | spital/service | Contact phone number/s | Best tim | |
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Equipment, medical/nursing supplies, or home modifications

Has someone spoken to you about equipment, medical/nursing supplies, or modifications to the home that may be needed?

Do you know:

- Whether your needs as the carer will be assessed and who will assess them?
- Whether an assessment will be completed before discharge from hospital?
- What will be provided free of charge or if not, at what cost?
- Who will provide the equipment and or medical/nursing supplies and how will you get these?
- When supplies will be delivered and when home modifications will be completed?

| now to use any new equipment: | |
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| Notes: | |
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| Appointments after hospital discharge | |
| Before discharge/transfer you should know about any appointments that have been made for the | |

Name of health professional/clinic/department/service provider: What the appointment is for: Where it will take place: Has the booking been confirmed? Date of appointment Time of appointment NO Contact details: What I need to bring:

| | 2. | Name of health professional/clinic/department/service provider: | | | | | | |
|---|----|---|-------------------------|---------------------|--|--|--|--|
| | | What the appointment is for: | | | | | | |
| | | Where it will take place: | | | | | | |
| | | Has the booking been confirmed? YES NO | Date of appointment | Time of appointment | | | | |
| | | Contact details: | | | | | | |
| | - | What I need to bring: | | | | | | |
|) | 3. | Name of health professional/clinic/depar | tment/service provider: | | | | | |
| | | What the appointment is for: | | | | | | |
| | | Where it will take place: | | | | | | |
| | | Has the booking been confirmed? YES NO NO | Date of appointment/ | Time of appointment | | | | |
| | | Contact details: | | | | | | |
| | | What I need to bring: | | | | | | |
| | 4. | Name of health professional/clinic/depar | tment/service provider: | | | | | |
| | | What the appointment is for: | | | | | | |
| | | Where it will take place: | | | | | | |
| | | Has the booking been confirmed? YES NO NO | Date of appointment// | Time of appointment | | | | |
| | | Contact details: | | | | | | |
| | | What I need to bring: | | | | | | |

Changes to medicines

The person you support may have had their medicines changed while in hospital. They may have stopped taking a medicine, the dose may have changed, or they may have started taking a new medicine. Information about medicines the person you support will be taking when they are discharged can be provided below.

| 1. | Name of medicine |
|----|------------------------------------|
| | What does it do? |
| | When is it given? |
| | For how long? |
| | What should I look out for and do? |
| | What if they won't take it? |
| 2. | Name of medicine |
| | What does it do? |
| | When is it given? |
| | For how long? |
| | What should I look out for and do? |
| | What if they won't take it? |
| 3. | Name of medicine |
| | What does it do? |
| | When is it given? |
| | For how long? |
| | What should I look out for and do? |
| | What if they won't take it? |
| 4. | Name of medicine |
| | What does it do? |
| | When is it given? |
| | For how long? |
| | What should I look out for and do? |
| | What if they won't take it? |

Involvement in care after hospital discharge At some time during the hospital stay you should have a talk with one or more health professionals about your involvement in care after hospital. Be honest about what you are able to do and what is too difficult for you. I have had a discussion with a health professional about what I have to do with: YES NO Wound dressings Catheter care YES NO Moving the person I support (e.g in and out of bed) YES NO YES Helping take medicines NO Medical equipment purchase/hire and use YES NO Physiotherapy YES NO YES Other (specify below) NO Other: Notes:

Education needs

Being in hospital can change the support you will need to provide at home. There may be new things you need to know so that you can provide support. Ask to have any care changes explained to you. You may be asked to do a 'trial of care' to see how you are able to cope and to identify if you need more help. The following points are provided to help you start a conversation with health professionals about your education needs.

Before discharge from hospital I have been taught or have received information about:

Pain

- How I know they have pain
- What the best ways to relieve their pain are
- Who can help us manage pain

Toileting

- How to manage toileting
- How to establish and/or continue a toileting routine
- How to apply and dispose of continence aids
- Know when continence aids need to be changed

Bathing, showering, dressing and grooming

- How to bathe/shower
- The types of clothing and/or equipment that can make bathing and dressing easier
- How to put on and take off compression stockings
- How to protect a wound dressing so it does not become soiled or wet
- How to replace a wound dressing that has become soiled or wet
- When to replace a wound dressing

Sleep

- How to help the person I support sleep at night
- What I can do if they can't sleep and they move around the house at night

Meals

- Whether I can get 'meals on wheels', or other help to prepare meals
- How I access help with meals and what it costs
- Helping with eating
- Any special dietary requirements

Behaviours and confusion

- How a particular behaviour/s can be a result of an unmet physical and/or emotional need
- How to work out what the unmet need is
- Different ways that can be used to prevent behaviour/s resulting from an unmet physical and/or emotional need
- Different ways that can be used to respond to behaviour/s resulting from an unmet need
- What I should do if I think the level of their confusion has changed making care more difficult
- Who should I contact if I need help

Transport

■ What options are available for assistance with transport to attend appointments

Treatments and procedures

Any new treatments or things I will have to do

Education needs (continued)

| Notes: | | | |
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Community Services needed

Before the person you support is discharged from hospital community services may need to be organised. Community services used before hospital admission and stopped may need to be recommenced and others started. Someone at the hospital should have a conversation with you about what services are available in your local area.

- Have you been provided with information about what community services are available to assist you and the person you support?
- Have you spoken with a health professional at the hospital about the need to recommence a community service/s you received before hospital admission?
- Have you spoken with a health professional at the hospital about any new community service/s you and the person you support will need at home and how they will be arranged?

Community Services needed (continued)

| Notes: |
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| Hospital discharge/transfer plan or summary |
| All patients discharged from hospital have a discharge or transfer plan or summary completed and you or the person you support should receive a copy, which will complement the information you have gathered in this guide. |
| A written copy of the hospital discharge/transfer plan or summary of care should include: A summary of the treatments, procedures, tests and assessments including information about any test results still to be received Date and time of discharge/transfer and transport arrangements Services after hospital or care that has been organised or is needed Referrals, follow up appointments or planned therapies Information about any equipment, medical supplies or home modifications needed Medication changes and current medications |
| Changes to previous treatments Instructions about any assistance you might need in order to provide care at home Discharge support - hospital contact details for assistance after discharge Details of care arranged after discharge |
| If this is not available at the time of discharge from hospital, ask whether a copy will be sent to you. |
| Notes: |
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PART C

> Resources

Advance Care Planning

Palliative Care Australia contains specific information about Advance Care Planning for the state in which you live. Palliative Care Australia:

- http://palliativecare.org.au and for information on Advance Care Planning:
- http://palliativecare.org.au/support-andservices/advance-care-planning

Alzheimer's Australia

Alzheimer's Australia advocates for the needs of people living with all types of dementia, and for their families and carers. Alzheimer's Australia provides support services, education and information.

- National office telephone: (02) 6278 8900
- Mational office email:
 - nat.admin@alzheimers.org.au
- https://fightdementia.org.au (with links to contact Alzheimer's Australia offices in each state)

Carers Australia

Carers Australia is the national peak body representing Australia's carers. It has offices in each state and advocates on behalf of carers to influence policies and services and to deliver a range of carer services.

Telephone: 1800 242 636

 www.carersaustralia.com.au
 (contains contact details of Carers offices in each state)

Council On The Ageing (COTA)

COTA is a national peak organisation which representing the rights, needs and interests of older Australians. It makes representation to Australian Government representatives on issues of relevance to older people.

hone: (02) 6154 9740

@ Email:

cota@cota.org.au

www.cota.org.au/australia
(with links to COTA in each State & Territory)

Decision Assist

Decision assist provides palliative care and advance care planning advice and advisory services to older people, aged care staff and General Practitioners nationally.

▼ Telephone: 1300 668 908
 ▼ www.decisionassist.org.au

Department of Health in your State or Territory

ACT

www.health.act.gov.au
Telephone: 13 2281

NSW

www.health.nsw.gov.au
Telephone: (02) 9391 9000

Northern Territory

www.health.nt.gov.au
Telephone: (08) 8999 2400

Queensland

www.health.qld.gov.au
Telephone: (07) 3234 0111

South Australia

www.sahealth.sa.gov.au
Telephone: (08) 8226 6000

Tasmania

www.dhhs.tas.gov.au
Telephone: 1300 135 513

Victoria

www.health.vic.gov.au

Telephone: 1300 650 172 or (03) 9096 0000

Western Australia

www.health.wa.gov.auTelephone: (08) 9222 4222

Elder Abuse

Australian Government

Myagedcare

www.myagedcare.gov.au/legal-information/ elder-abuse-concerns

L Telephone: 1800200422

Australian Capital Territory

ACT Government Community Services: Older Persons Abuse Prevention Referral and Information Line

www.communityservices.act.gov.au/wac/ageing/ elder abuse prevention and assistance

Telephone: (02) 6205 3535

NSW

Senior Rights Services Elder Abuse

http://elderabusehelpline.com.au L Helpline Telephone: 1800 628 221

Northern Territory

Northern Territory Police

www.pfes.nt.gov.au/Contact-us.aspx

📞 Assistance Telephone: 13 14 44

Family violence Units: Alice Springs: 8951 1891 Darwin: 8999 0865 Katherine: 8973 9663

Queensland

Queensland Government:

www.qld.gov.au/seniors/safety-protection/elder-

Elder Abuse Prevention Unit

www.eapu.com.au

📞 Helpline Telephone: 1300651192

South Australia

Aged Rights Advocacy Service:

www.sa.agedrights.asn.au

Helpline Telephone: 1800 372 310

Rural 1800 700 600

Tasmania

Advocacy Tasmania

@ Email:

eahelpline@advocacytasmania.org.au

Leipline Telephone: 1800 441 169

Victoria

Domestic Violence Resource Centre Victoria

www.dvrcv.org.au/elder-abuse-hotline Leipline Telephone: 1800 441 169 Mobile and Interstate: (03) 6237 0047

Senior Rights Victoria

https://seniorsrights.org.au Helpline Telephone: 1300 368 821

Western Australia

Advocare Incorporated

www.advocare.org.au

📞 Helpline Telephone: 1300 724 679 Country Callers: 1800 655 566

Elder Rights Advocacy

Level 2, 85 Queen Street Melbourne VIC 3000

www.era.asn.au

Health Service Complaints

First point of call for any complaint is to the patient liaison service or patient complaints or patient advocate office at the hospital. If the complaint is not resolved or you are dissatisfied with the response received, you can contact the Health Service Commissioner for your State or Territory.

Victoria

Health Services Commissioner

Telephone: 1300 582 113 Fax: (61 3) 9032 3111

@ Email:

hsc@dhhs.vic.gov.au

www.health.vic.gov.au/hsc

NSW

Health Care Complaints Commission

📞 Telephone: 1800 043 159

Fax: (02) 9281 4585

@ Email:

hccc@hccc.nsw.gov.au

www.hccc.nsw.gov.au/Home

ACT

Health Services Commissioner

Telephone: (02) 6205 2222

Fax: (02) 6207 1034

@ Email:

human.rights@act.gov.au

http://hrc.act.gov.au/health/health-servicecomplaints

Tasmania

Health Complaints Commissioner

L Telephone: 1800 001 170

@ Email:

health.complaints@ombudsman.tas.gov.au

www.healthcomplaints.tas.gov.au

Queensland

Office of the Health Ombudsman

📞 Telephone: 133 OHO (133 646)

Fax: (07) 3319 6350

@ Email:

complaints@oho.qld.gov.au

www.hqcc.qld.gov.au

South Australia

Health and Community Services Complaints Commissioner

▼ Telephone: 1800 232 007

@ Email:

info@hcscc.sa.gov.au

www.hcscc.sa.gov.au

Western Australia

Health and Disability Services Complaints Office

Telephone: 1800 813 583
Fax: (08) 6551 7630

@ Fmail:

mail@hadsco.wa.gov.au

www.hadsco.wa.gov.au

Northern Territory

Health and Community Services Complaints Commission

Telephone: 1800 004 474
Fax: (08) 8999 6067

@ Email:

hcscc@nt.gov.au

www.hcscc.nt.gov.au

My Aged Care

Phone: 1800 200 422

www.myagedcare.gov.au

My Health Record

https://myhealthrecord.gov.au

Office for Public Advocate/Public Guardian

The Office of the Public Advocate supports the rights and interests of people who are unable to advocate on behalf of themselves

Victoria

▼ Telephone: 1300 309 337

@ Email:

opa_advice@justice.vic.gov.au

NSW

Telephone: (02) 8688 2650 (STD 1800 451 510) www.publicguardian.justice.nsw.gov.au

ACT

La Telephone: (02) 6207 0707

@ Email:

pa@act.gov.au

Tasmania

📞 Telephone: (03) 6165 3444

@ Email:

public.guardian@info.tas.gov.au

www.publicguardian.tas.gov.au

Queensland

Telephone: (07) 7 3224 7424

@ Email:

public.advocate@justice.qld.gov.au

www.justice.qld.gov.au/public-advocate

South Australia

L Telephone: 1800 066 969

www.opa.sa.gov.au

Western Australia

Telephone: 1300 858 455

www.publicadvocate.wa.gov.au

Northern Territory

Telephone: (08) 8922 7343

www.health.nt.gov.au/Aged_and_Disability/ Adult_Guardianship/index.aspx

Additional resources

| Notes: | | | |
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Add resources available to you and the person you support in your local area. For example, continence

> Advance Care Plan

What is an advance care plan? It is a document that records:

- directions about medical treatment
- the person appointed as the substitute decision-maker
- preferences about health and personal care
- preferred health outcomes.

An Advance Care Plan is made by a competent person for a future time when they may not be competent to make decisions for themselves or be unable to communicate these directions.

If the person you support does not have an Advance Care Plan and you would like to organise one, speak to their general practitioner or a health professional at the hospital. If the person you support has an advance care plan it can be attached to their *My Health Record* or to this Carer Controlled Health Record.