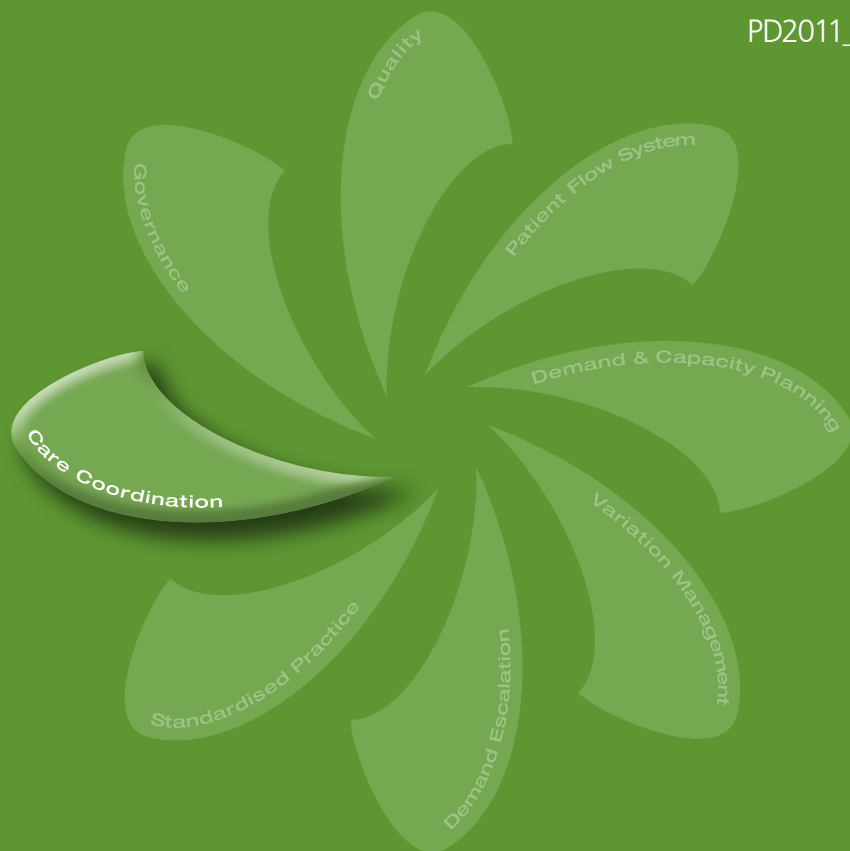


Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals

Staff Booklet: The Principles of Care Co-ordination

PD2011_015



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How to use this Booklet

This booklet should be used by all staff that have a direct responsibility for the delivery of care for patients in NSW public hospitals.

Patient care coordination in hospital is the responsibility of everyone who cares for patients.

Every staff member who is involved in patient care is responsible for providing clear and accurate information to the patient and their family/ carer.

This booklet is based on policy directive *Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals (PD2011_015)* and comprises the care coordination component of the Patient Flow Systems framework.

There are five steps to effective Care Coordination that all appropriate patients must go through before transferring back to the community. These are:

1. Pre-Admission / Admission
2. Multidisciplinary Team Review
3. Estimated Date of Discharge
4. Referrals & Liaison for patient transfer of care
5. Transfer of Care out of the hospital

This booklet outlines the tasks/activities staff are required to be completed to ensure effective care coordination.

Care Coordination

What is Care Coordination?

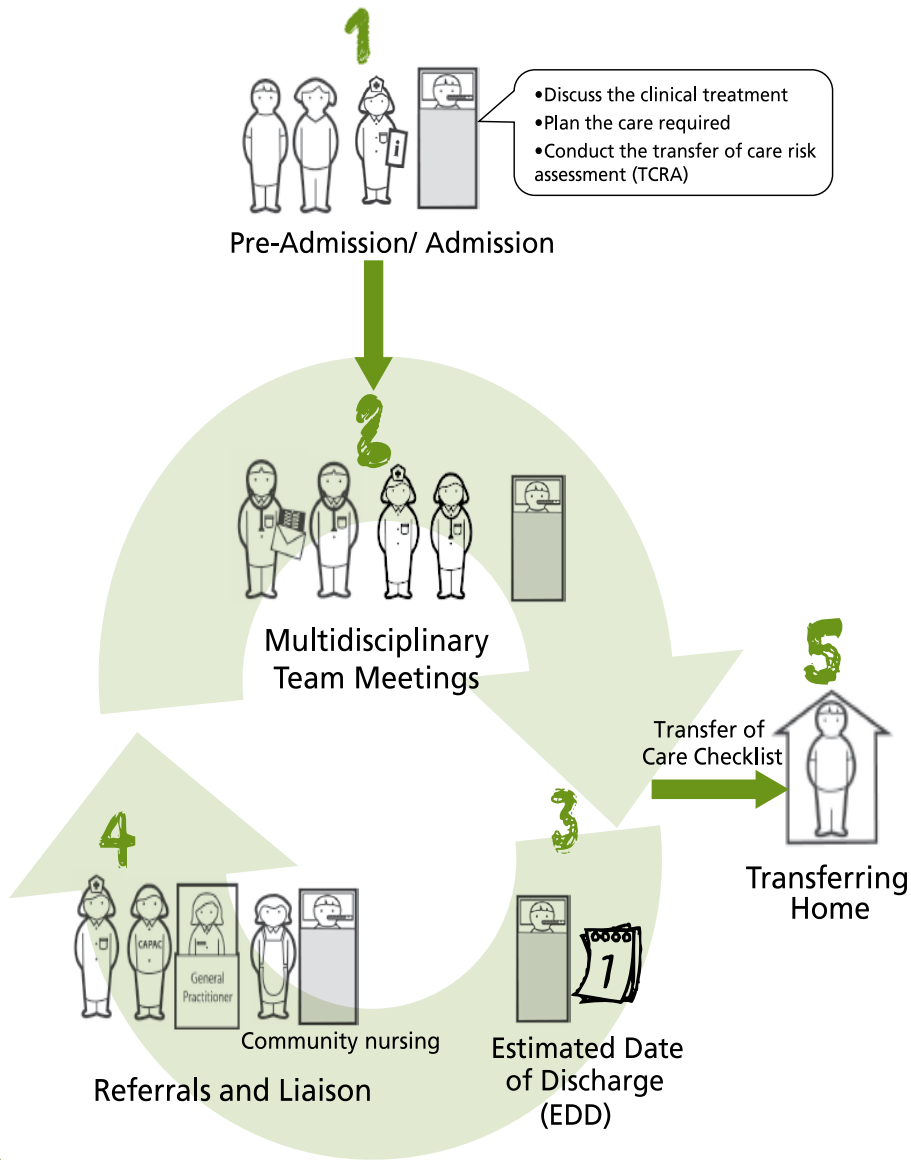
- Identifying issues
- Planning clinical treatment
- Communicating and explaining clinical treatment
- Removing unnecessary waits and communicating any unavoidable waits to patients, carers and other staff
- Patient centred care – understanding the patient’s perspective and keeping them informed comfortable. More specifically, if the reason for their hospitalisation causes greater impact on how they function with their disability.
- Who is providing consent for treatment and ongoing care arrangements (for example, a legally appointed substitute decision maker)?

Why we need to change what we are doing

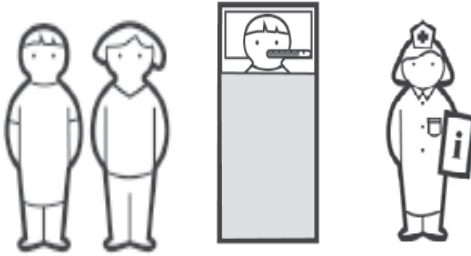
The results of NSW patient surveys and interviews confirm that patients are happy with the care they receive yet they are frustrated with delays and a lack of involvement in their care. Quite often patients are not involved in or informed of care decisions, and are not aware of delays to care or informed of the reason for these delays.

By standardising our approach to care coordination, patients will be able to move safely and in a timely manner through the hospital system and receive the right support at the right time. This booklet outlines the tasks for staff to undertake to achieve optimum care coordination. This approach aims to ensure patients receive the best care at the right time, and that they are able to return safely into the community with the support they need.

Care Coordination Model



1



Patient presents to ED or Unit, and is admitted as unplanned (emergency) or planned (pre-admission). The patient is admitted, then Transfer of Care Risk Assessment completed.

Pre-admission/ Admission

- A patient enters hospital as a non-planned admission to the Emergency Department, inpatient Unit or through planned routes.
- Whichever way a patient is admitted to a hospital, their transfer of care needs on leaving the acute setting must be identified and considered in their overall care plan.
- Depending on the mode of admission, these risks may need to be addressed before admission, or at admission, but always before the patient returns to their usual place of residence.

To coordinate the care of a patient appropriately, it is important to identify any reason that could delay a patient returning home. Completing a Transfer of Care Risk Assessment (TCRA) is only the first stage in the process. The information collected needs to be used by the multidisciplinary team to plan for the patient's transfer.

2

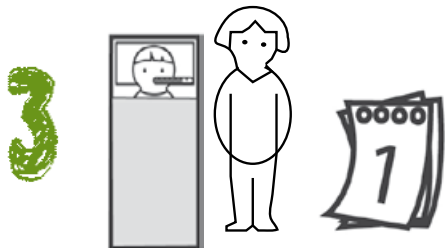


Multidisciplinary team meets twice weekly to discuss patient progress.

Multidisciplinary Team Review

At a minimum, the Multidisciplinary Team (MDT) should meet twice weekly. It is this group that agrees on the treatment plan, addresses the transfer risks and sets the Estimated Date of Discharge (EDD), in consultation with the patient or carer.

- It is important to conduct part of the review at the bedside so the patient and carer can be involved and be aware of the treatment plan.
- For the purpose of planning and coordinating the care of each patient, it is essential that the MDT take into consideration the information collected through the Transfer of Care Risk Assessment Tool.
- The patient's care plan is developed with the MDT and, as each stage is met, it can be checked off in the patient's notes as part of the Transfer of Care Checklist. Once all the milestones are met, the patient is ready for the transfer of care.
- The patient's transfer of care plan can be provided to the patient, General Practitioner, Community Nursing or other external care provider once the patient is ready for transfer. Information provided to patients and carers should be in plain language.



Estimated Date of Discharge

The Estimated Date of Discharge (EDD) is an essential part of care coordination to assist clinical teams to organise their work. This should lead to organising referrals before the day of transfer. EDD principles include:

A patient's EDD should be visible near their bed reminding staff of the date they are working towards, and to inform the patient and their family or carer.

The Multidisciplinary Team should use the Estimated Date of Discharge to synchronise referrals to other teams and/or disciplines that are not involved in regular multidisciplinary team rounds/reviews.

If a patient's condition deteriorates, it is necessary to revise the EDD.

If a patient does not leave when indicated by the Estimated Date of Discharge due to system delays, it is **not appropriate to change the EDD**. This should provide the opportunity to review the issues arising. It is important to establish a system allowing staff and managers to view the impact and frequency of these delays.

4



Community nursing

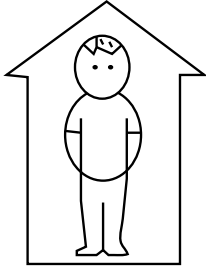
Referrals and Liaison

The Multidisciplinary Team will identify the patient's requirements for service and coordinate the timing of services to best meet the needs of the patient and the planned Estimated Date of Discharge.

It is important to identify what services the patient will require during the acute episode of care. Each facility is required to develop a **referral structure to enable staff to easily contact the relevant service providers**. Referral details should be recorded in one place in the patient's medical record, then on any relevant individual referrals. Some examples of these services are:

- Community Packages (ComPacks)
- Community Post Acute Care (CAPAC) or Hospital in the Home (HITH)
- Transitional Aged Care Programs
- Community Nursing
- General Practitioners

5



Transferring to the community

The Transfer of Care Readiness Checklist must include:

- Reason for hospitalisation
- The Estimated Date of Discharge (EDD)
- Plain language and legible documentation of the transfer of care plan and information specific to the patient condition
- Medication education / medication reconciliation if identified in the Transfer of Care Risk Assessment by the Multidisciplinary Team, or if medications have changed whilst in hospital.
- Documentation for outside services/organisations, if referred
- Transport arrangements: does the patient have someone to collect them from hospital and are they aware of the Estimated Date of Discharge and time? If requiring transport using NSW Ambulance, bookings must be made before the date of transfer.
- A record of patient's valuables present on admission Transfer of Care documentation should include the NSW **healthdirect** contact number: 1800 022 222

