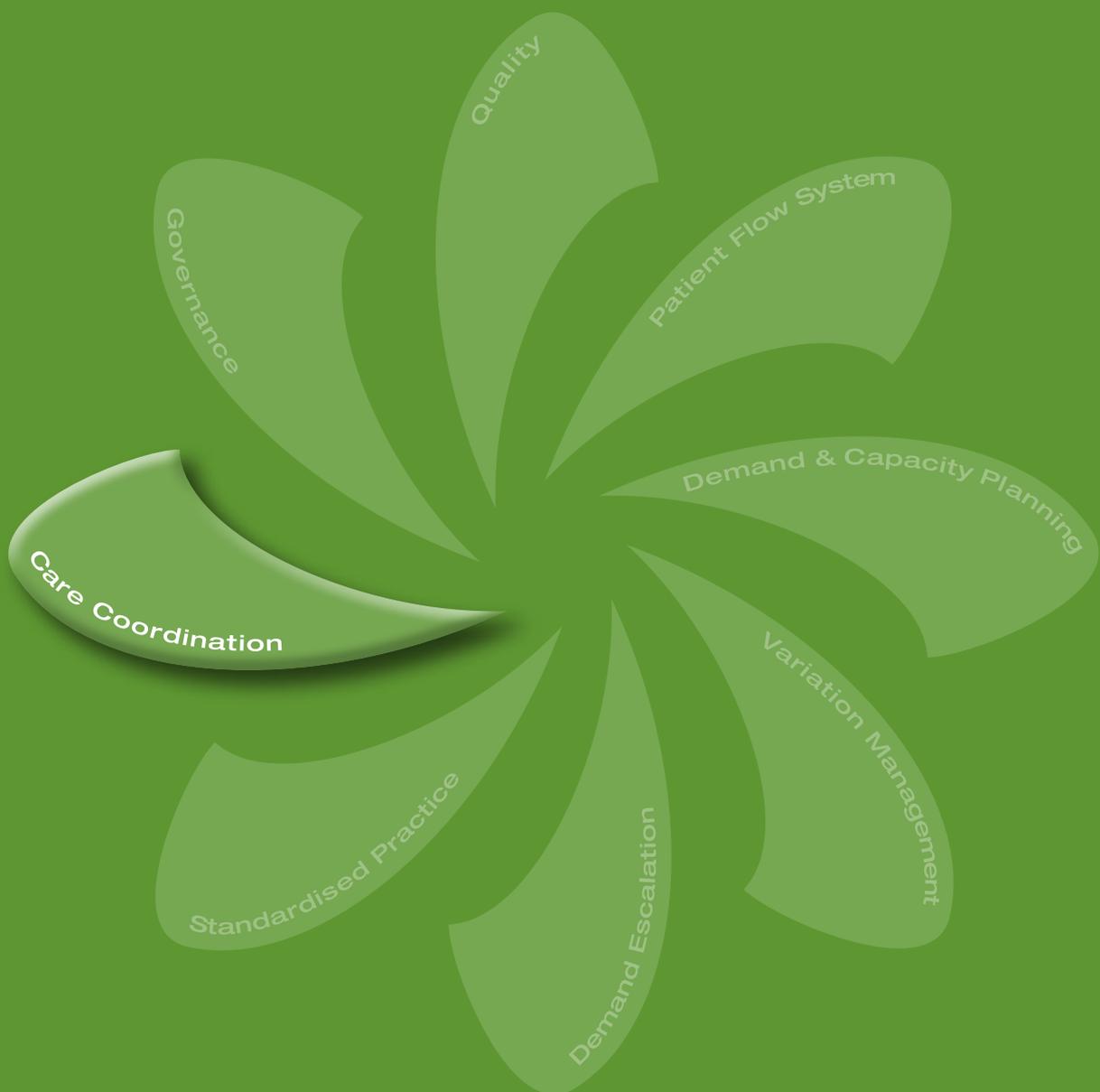


Care Coordination: From Admission to Transfer of Care in NSW Public Hospitals

Reference Manual



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Introduction: How to use this manual

This manual should be read in conjunction with the *Care Coordination; Transfer from Admission to Transfer of Care in NSW Public Hospitals Policy Directive*. This manual contains considerations clinical staff may need to take into account to manage patients. This manual should be used as reference material and referred to only in exceptional situations. The manual addresses the five steps of care coordination:

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

It is recognised that the patient journey is different for each individual. The majority of patients will follow the pathway described in the *Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals Policy Directive*. However, this Reference Manual also outlines specific circumstances that may arise and provides information and actions to address variations in the patient journey. The reference manual is intentionally detailed to provide information to assist staff to make informed decisions when managing patient care.

In addition to this manual, NSW Health has also provided a Staff Booklet. This booklet provides a guide for clinical staff to assist in the coordination of patient care. The Reference Manual should complement the booklet.

Patient Flow Systems

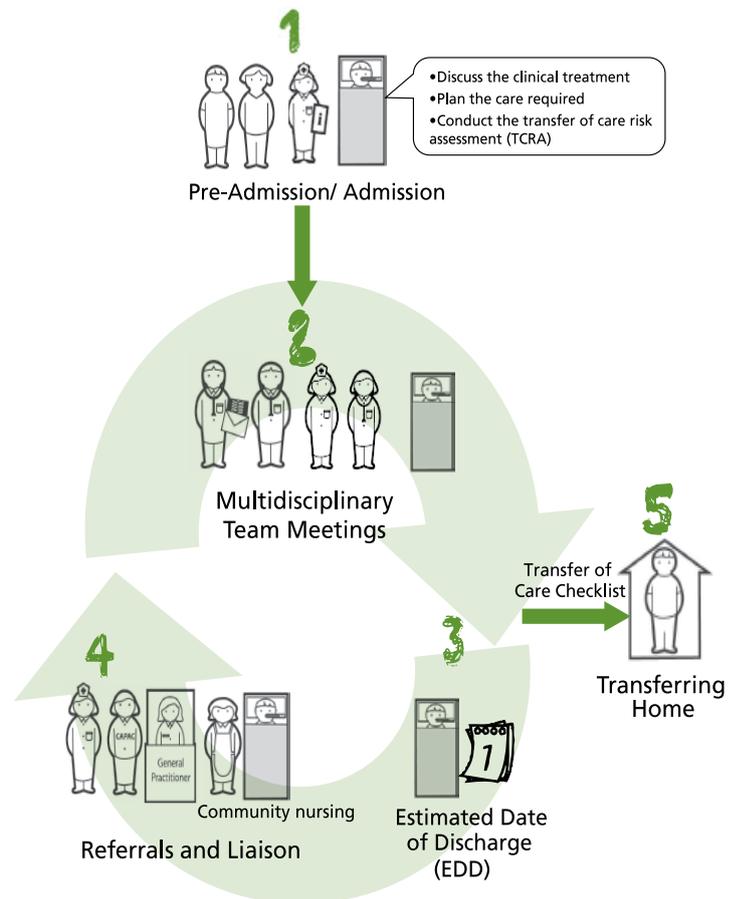
This booklet is based on policy directive *PD2011_15 Care Coordination: Planning from Admission to Transfer of Care in Acute NSW Public Hospitals* and comprises the care coordination component of the Patient Flow Systems framework comprising of seven essential elements:

1. Care Coordination,
2. Demand and Capacity Planning,
3. Demand Escalation,
4. Governance,
5. Quality,
6. Standardised Practice, and
7. Variation Management

Patients are the main focus and we must ensure they have access to the right care, at the right time, and in the right place, with minimum waiting times.

Summary of the Five Steps of Care Coordination

1. Transfer of care planning should begin **prior to admission** for planned patients and as soon as possible after **admission** (<24hrs) for emergency (non-planned) patients. For planned admissions, if this has not occurred, then a transfer of care risk assessment should be done at admission. For emergency admissions, a transfer of care risk assessment (TCRA) must be completed within 24 hours of the patient being admitted as part of the admission/ treatment process. This information needs to be available for the Multidisciplinary Team or responsible person for planning care coordination and patient transfer needs.
2. Health professionals from all disciplines need to work closely together. The **Multidisciplinary Team (MDT)** can help fulfil this function and should include the patient and their family/carer in any communication and planning process.
3. For the MDT to coordinate the delivery of care an **Estimated Date of Discharge (EDD)** is required. An EDD must be established as soon as possible after admission and within 24 hours of admission. The EDD communicates to the patient, carer and staff the timeframes for care delivery, and can highlight potential or actual delays. The MDT's designated lead is responsible for addressing and resolving delays. Any delays need to be communicated to the MDT, the patient and the responsible manager.
4. **Referrals** to care/service providers outside of the core MDT need to be made in a timely manner, when clinically appropriate and within the agreed EDD timeframe. Navigating the referral process is the responsibility of the MDT and the lead clinician.
5. As care is delivered to the patient a **Transfer of Care Checklist (TCC)** (or its equivalent) is required. This document for the Multidisciplinary Team, patient and carer, the progress against standardised and patient specific needs on leaving the acute facility.



Pre Admission / Admission

1.1 Flagging the Transfer of Care Risk Assessment in the medical record

The Transfer of Care Risk Assessment (TCRA) is to form part of the patient medical record and should be located in a prominent position within that record. The TCRA is based on the model developed for the Victorian Department of Health.¹ This model has an 86% sensitivity rating for patients at risk and requiring services after transfer from hospital.

Reviewing medications on admission

Poor medication compliance can result in many hospital admissions. If medications have not been reviewed prior to presentation or admission, take the following steps at the time a patient is admitted to hospital:

- To establish current medication prescription and usage, take an accurate medication history in consultation with carers and if required, the patient's GP or other relevant services.
- If inappropriate or unnecessary medications are identified, the medical team and the pharmacist should develop a medication management plan before transfer of care.
- Patients who are drug and/or alcohol dependant including nicotine dependent, should be managed appropriately and referred to the necessary services. Take drug dependency into consideration when reviewing medication and transferring from hospital.

1.2 Considerations for Transfer of Care Risk Assessment

The following list of considerations encompasses patients of all ages. A patient may fit into more than one of the categories below.

1. Physical impairment and or disability

- Poor mobility
- Immobility
- History of falls
- Visual and or hearing impairment

2. Health issues

- Pre existing wound
- Multiple chronic health problems
- Poly-pharmacy
- Incontinence
- Chronic pain
- Malnutrition / weight considerations
- Pressure sores
- Unable to perform activities of daily living (eg bathing, dressing, grooming, eating and toileting).
- Cognitive impairment
- Behavioural disturbance
- History of alcohol and/or substance misuse
- Multiple hospital admissions over a 6 month period
- Mental illness
- Life limiting illness (Palliative Care)

3. Social care and support issues

- Accessing community-based services for care and support
- Bereavement and loss
- Loss of a carer
- Carer unable to continue in caring role
- Social isolation
- Cultural and/or language issues
- Single parent
- Young carer (ie looking after siblings or older sick parent)
- Elder abuse/ child abuse/ sexual abuse
- Domestic violence – women who are vulnerable at home

¹ Victorian Department of Human Service and Health: Thomas and Associates. *Final Report of the Development of a Risk Screening Tool for Service Needs Following Discharge From Acute Care Project.* August 1998.

- Guardianship, other legal issues, out of home care placements
- Lives in supported accommodation eg Residential Care/ Licensed boarding houses
- Homelessness
- Poor home/community environment – needs to be physically accessible with minimal risk

4. Carers

Carer stress can be underestimated and this role may lead to neglect of the carer's own health needs and social isolation, which may increase the physical and emotional impacts of caring. Carers include the following groups:

- parents who are carers for children and adults with disability,
- children who have a caring role for a parent or sibling and
- those from culturally and linguistically diverse groups who identify as carers.

When a carer is hospitalised, their caring responsibilities should be recorded in their medical record. Health staff need to be alerted that emergency respite may be required for the person for whom they usually care.

Local level planning that includes liaison with community services maybe necessary to develop additional strategies to meet the needs of carers and their family members. Further information on carers is available in the Policy Directive Carers Action Plan 2007–2012 (PD2007_018).

5. Patients with disability

Many patients with disability already have a range of support needs provided for them at home by:

- General community services
- Disability services – which can include residential care workers, assistants and therapy staff as well as health professionals (eg nurses, occupational therapists, physiotherapists, social workers, psychologists)
- Family, friends, legal guardian and neighbours.
- General Practitioners

The MDT or treating team need to ascertain the following information:

- Clarification of the role of people already involved in providing care, including contact details
- Mobility, transport requirements, other specific needs (eg to address hearing or vision impairment etc) including clarifying what can be done to make them

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)?

For further information see: *Disability – People with a Disability: Responding to Needs During Hospitalisation (revised Jan 08)* PD2008_010 and the Allocation of Places in Supported Accommodation Policy and Procedures 2009; Department Ageing, Disability and Home Care document.

6. People with dementia and/or delirium

For patients with dementia and/or delirium, early identification and action is critical. Delirium in older people is a serious condition associated with higher mortality and morbidity, complications and increased length of stay.² People with dementia are at increased risk of developing delirium during an acute illness and delirium can alter the course of an underlying dementia.³ The length of stay is currently four times greater than for patients without dementia and the case-mix complexity is almost double.⁴

It is important to be aware that a patient with dementia has an increased risk of falling because of reduced muscle strength, flexibility and physical capacity. Lack of confidence, reduced activity and a general change in life circumstances can also lead to depression. The hospital also presents the patient with unfamiliar surroundings, people, food, and routine along with a lack of staff knowledge about the patient's habits and lifestyle cues.

Dementia also affects the person's relationships with their spouse, family, carer and friends. A patient with dementia should always be transferred from the acute setting to an appropriate care environment with adequate community supports.

In instances where a diagnosis of dementia has not been made, issues such as cognitive impairment and/or delirium need to be identified and consideration of this given in the transfer of care plan.

2 AHMAC Health Care of Older Australians Standing Committee (2006). *Clinical Practice Guidelines for the Management of Older People*.

3 Inouye, S.K. (2006). Delirium in older persons. *N Engl J Med*, 2006. 354(11): p. 1157-65.

4 Australian Government Department of Health and Aged Care 2000, Hospital Use by Older People: A Case Mix Study, *Occasional Papers NEW series 11*.

7. People from rural and remote areas

People living in rural and remote areas do not always have the same access to services as those in metropolitan areas. As a result, community supports and alternatives to hospitalisation may not be available. People in these communities still experience inequities in accessing specialist services, despite innovative models of care being established such as telehealth.

The development of local protocols will assist in meeting the transfer of care needs of patients returning home to rural and remote areas.

An adequate supply of medication should be dispensed to match the availability of pharmaceutical resources in their local area. Local protocols should be established to ensure patients have an adequate supply of medication on transfer back to the community.

Rural patients should be transferred back to the originating hospital, or a hospital with an equivalent level of care capability close to the patient's geographical home location once specialised care has been delivered and if clinically appropriate.

A range of options should be available to facilitate safe transport to the patients' home. Consideration should be given to the time, distance and dislocation involved if requiring carers to attend acute health services and transport patients to and from these services.

Further information on transport is available in the Inter-Hospital Transfer Guidelines (revised 2010) (PD2010_In draft) and the *Isolated Patient Transport and Accommodation Assistance Scheme (IPTAAS) Guidelines* (GL2009_012).

8. Patients from culturally and linguistically diverse (CALD) backgrounds

Patients (and their families/carers) from culturally and linguistically diverse backgrounds should have access to interpreter services as required.

Further information on health interpreters is available in the Policy Directive: *Standard procedures for working with health care interpreters* (PD2006_053). This includes a list of interpreter contact details.

9. Aboriginal and Torres Strait Islander Patients

Each Health Service has a Manager/Director of Aboriginal Health (AM/DAH) and that person should be involved in all aspects of planning and coordination of health care and service delivery to Aboriginal patients.

Health staff should engage with AM/DAHs, their representatives or other Aboriginal health staff (eg Aboriginal Health Education Officers and Aboriginal Hospital Liaison Officers) to ensure that protocols and practices are culturally appropriate and consistent with the needs of their local communities. Aboriginal Impact Statements should be undertaken to ensure protocols are culturally appropriate. Further information on Aboriginal Health Impact Statements is available in: *Aboriginal Health Impact Statement and Guidelines* (PD2007_082).

Health staff, especially those in front line services, should undertake cultural education to ensure culturally appropriate health care for Aboriginal patients. This education is available online at: <http://lms.cucrh.uwa.edu.au/moodle>. Staff should also be aware of the importance of correctly identifying Aboriginal patients at admission.

10. Children

Staff caring for paediatric patients should ensure that an assessment of the child, parent/guardian, and where applicable siblings; is completed during the admission to identify any issues that may impact on them prior to leaving hospital. Staff must adhere to the principles of mandatory reporting as outlined in *Protecting Children and Young People* (PD2005_299) and if necessary, staff should seek further clarification from the Department of Community Services.

The hospital admission and transfer of care processes should be discussed with the parent/principal carer and, as appropriate, the child. Referral for appropriate health professional assessment must be made when issues are identified.

11. Vulnerable Patients

Various policies are in place to support the needs of vulnerable patients, for example, where there are issues relating to child abuse and/or domestic violence. Relevant health professionals are to be contacted and suitable arrangements made. Further information on dealing with domestic violence and child protection is available in the *Policy Directives: Domestic Violence – Identifying and Responding (PD2006_084) and Child Protection Roles and Responsibilities – Interagency (IB 2010_2005)*. Other agencies such as NSW Police and relevant support services may be required to make alternative arrangements such as the transfer of care to a women's refuge. 48-hour follow-up calls should occur for higher risk patients when appropriate.

Where there are particular issues relating to abuse of older people, relevant health professionals are to be contacted. Please refer to the NSW Government, Interagency Protocol for responding to Abuse of Older People 2007[3].⁵

12. Homelessness

Homelessness affects adults and children from all cultural backgrounds and from all parts of the state. Homeless people do not have access to safe, secure, and affordable housing.

The three currently accepted definitions of homelessness are:

Primary Homelessness – This description applies to a person who lives on the street, sleeps in parks, squats in derelict buildings, or uses cars or railway carriages as temporary shelter.

Secondary Homelessness – This term is used to describe people who move frequently from one form of temporary shelter to another. Some examples include emergency accommodation, youth or women's refuges or boarding houses, living with friends or family.

Tertiary Homelessness – This term is used to describe people who live in premises where they don't have the security of a lease guaranteeing them accommodation, nor access to basic private facilities. Some examples include boarding houses, caravan parks, and hotels.

The NSW Homelessness Action Plan 2009-2014 outlines NSW's response to reducing homelessness. *"A way home: Reducing Homelessness in NSW" NSW homelessness Action Plan 2009 – 2014* outlines a range of key objectives for patients being transferred from medical and mental health facilities. This includes the goal of 'no exits into homelessness' for patients being transferred from health facilities.

The development of local protocols will assist in addressing objectives outlined in the NSW Action Plan, to meet the transfer needs of patients who are homeless.

⁵ NSW Government (2007). Interagency Protocol for Responding to Abuse of Older People.

Multidisciplinary Team Review

The definition of a Multidisciplinary Ward Review is:

‘a structured round where key clinicians involved in the patients care meet together to discuss the patients care and the coordination of that care. The round is a place where dialogue and feedback occurs in relation to the needs of the patient and provides the multidisciplinary team an opportunity to plan and evaluate the patient’s treatment and transfer of care together.’⁶

The role of the MDT is to:

- Define patient goals,
- Manage the patients Transfer of Care Plan,
- Communicate patient progress with the patient and/or their family or carer
- Coordinate referrals and the transfer of the patient back to the community.

The goal of the Multidisciplinary Team (MDT) is to improve patient care through the collaboration of a range of disciplines.

The minimum core membership includes:

Team Leader

A member of the team needs to take responsibility for the efficient scheduling, conduct and documentation of the meeting. The team leader is focused on care coordination, is responsible for allocating tasks to members, and ensuring tasks are completed within the agreed EDD for specific patients. This role can be carried out by any of the professions represented, depending on the patient’s needs and ensuring it is clinically approved by the authorising medical officer.

Nursing/ Midwifery representative

A Clinical Coordinator such as the Nurse Unit Manager (NUM) or individual nurses or midwives within the ward/ unit, should be involved in providing relevant clinical, social and psychological input to the MDT.

Medical representative

A senior medical officer within clinical teams dedicated for the time and duration of the meeting, to provide expert clinical guidance on the treatment plan, input to the EDD and transfer of care planning.

Allied Health representative

A member of each allied health team, or an allied health team leader to offer advice on referrals; assist in coordinating referrals with non-core disciplines, advising on EDD and transfer of care planning. Community Health Service personnel, Aboriginal Health Education Officers, Aboriginal Health Workers and/or Aboriginal Hospital Liaison Officers should be included on the MDT where appropriate or at the patient’s request.

2.1 Multidisciplinary Team Review Process

The patient’s care plan is developed by the MDT. As each milestone/ stage is met, it can be documented in the Transfer of Care Checklist (TCC) within the patient’s notes. Once all the milestones are met the patient is ready for transfer of care. This procedure prevents delays for patients at the end of their stay. **Any member of the MDT may transfer the care of the patient, once all milestones are met as agreed in the plan, and clinically appropriate as decided by the Attending Medical Officer (AMO).**

Individual variances to the Transfer of Care Checklist should be clearly documented. The planned care can then be transferred to the patient/carer, GP, community nursing or external care provider.

⁶ *Multidisciplinary Ward Rounds: A Discussion Paper*, Improving Safety and Creating Better Experiences for Patients Advisory Group, April 2010, NSW Health.

SECTION 3

Estimated Date of Discharge (EDD)

The Estimated Date of Discharge (EDD) predicts the likely date that a patient will be transferred from hospital back into the community. It provides everyone involved in the patient's care, including the patient and their family/carer(s), with a tentative date to coordinate the patient's requirements.

Changes to the EDD should be recorded and the history of changes kept. If a patient is clinically ready to be transferred but is delayed due to a delay to a service/diagnostic/etc, then their EDD should not be changed. This is so the delay to transfer can be captured. By identifying delays, transfer processes can be improved. Staff should track the most common delays for patients. This data can be then aggregated to understand the main constraints in the system.

Referrals and liaison for patient transfer

4.1 Coordinating referrals

To ensure that appropriate referral and follow-up is made, the process should be delegated to someone who has responsibility for making the arrangements and ensuring that all referrals have been received and will be actioned by the receiving service.

Where a number of issues have been identified, it may be most appropriate for contact to be made with a hospital social worker or allied health representative. This should include consultation about the level and the type of service required for the patient's ongoing transfer of care needs. In more chronic and complex cases it will be appropriate for service providers or a community case manager to assess the patient in hospital and to coordinate the services that will be required on transfer of care. This should occur before the patient meets their EDD. If the EDD changes due to a change in the patient's medical condition, the change should be communicated to the community case manager.

General Practitioner

After the patient is transferred from hospital their GP plays an integral role in ensuring the quality of ongoing care. Once it is established that the patient has a GP, the GP should be advised of both the patient's admission and their EDD. This should occur at the beginning of the patient's hospital stay, where possible. Early notification maximises the GP's opportunity for involvement in the patient's transfer of care planning.

Out of Hospital programs – Supporting Transfer of Care

These programs support a patient leaving hospital with clinical and community support for a set period of time. These packages aim to both reduce the time a patient spends in hospital and also prevent readmission. These programs include:

- Community Packages (ComPacks)
- Community Post Acute Care (CAPAC)
- Transitional Aged Care Program
- Hospital in the Home (HiTH)

Allied Health Services

Allied health services may also be involved in assessing patients prior to transfer of care from the hospital to home as well as following up patients who need complex care once returned home.

This may include:

- Physiotherapy
- Occupational Therapy
- Speech Pathology
- Nutrition and Dietetics
- Social Work/ Counselling

Community Health Services

Staff should know which local community health services and speciality services are available for patients on transfer from hospital.

This may include:

- Community nurses,
- Specialised services such as
 - mental health teams
 - community psycho-geriatric services
 - drug and alcohol services
 - palliative care services
 - maternity, child and family support services

Improved communication with community health staff before and during the patient's admission will also improve care coordination. Community health staff should be encouraged to visit identified patients in hospital to assess their ongoing needs at home and discuss the patient's needs with the multidisciplinary team. Timely communication between the MDT and community health staff will assist this process. Hospital staff should be aware that most community health services are unavailable on the weekend and after hours and communication needs to occur during business hours.

Where a patient requires ongoing complex management at home, community health staff will need to be provided

with information before the patient leaves the hospital. At this time hospital and community health staff can also discuss management protocols and review and organise any consumables required to support at-home care. Discussion between the hospital and community health service staff should include identification of:

- Any potential manual handling issues, that is, for bariatric or less mobile patients.
- Any potential violence issues (involving either the patient or associates of the patient, who may be present during a community health visit) where these have been identified by the hospital during care.

This information will assist community health service staff when undertaking an occupational health and safety or security risk assessment prior to visiting the person in the community. Refer to PD2005_2005_315 *Zero Tolerance to Violence in NSW Health*, PD2005_409 *Workplace Health and Safety Better Practice Guide* and the *NSW Health Security Manual Protecting People and Property: NSW Health Security Risk Management Policy and Guidelines*.

Consideration should be given to the particular community provider's capacity to respond to the patient's needs after leaving hospital including:

- The expected level of service required (how many hours per week)
- Potential gap between referral and service commencement
- Equipment required (eg electric beds, hoists)
- Consumables required (eg incontinence products).

Clear referral guidelines and protocols with community service providers are essential and must be written, implemented, monitored and reviewed. HACC services have set eligibility criteria for referrals. The Allied Health representative on the MDT team should be able to provide advice on service eligibilities.

Community Support Programs

Residential care-equivalent programs in the community have now replaced residential care options in some instances. Some of these programs include:

- Community Aged Care Packages (CACP)
- Extended Aged Care in the Home packages (EACH)
- Extended Aged Care in the Home – Dementia packages (EACH-D)

- Attendant Care Program (ACP)
- Ventilator-Dependent Quadriplegic Program (VDQ)
- Accommodation and support programs
- Residential Care Respite
- Family Support Services

There is an assessment process that is completed before a person is accepted into these programs, for example, older people require an Aged Care and Assessment Team (ACAT) assessment for the CACP and EACH package and for a residential care respite program. Once a person is linked with a program there will be a coordinator or case manager appointed who is responsible for the ongoing negotiation and management of the package of care. Liaison with that person on admission or prior to the transfer of care is important to clarify individual patient needs and ensure appropriate communication about care details. The case manager or coordinator will often make contact with hospital staff to discuss any areas of concern. The contact details for the case manager/ coordinator should be included with the patient record.

Residential aged care/supported accommodation

It may not be feasible for the patient to return to their previous accommodation on leaving hospital. For example, if a clinical event has changed their ongoing care needs. In such instances the patient's residential status may need to be revised (from low care to high care) by ACAT or allied health if appropriate. Their family/carer/s should be involved in these discussions and supported while arrangements are made for alternative residential accommodation. The former residential care manager/supervisor should also be involved in finding alternative placement. Discussions should be initiated as soon as the need is recognised since arranging alternate residential accommodation can take some time.

Before a transfer occurs, the residential manager/supervisor of the facility/accommodation where the patient will be transferred should be consulted about any ongoing management or treatments that are required (for example, complex wound care, administration of certain medications, advance care planning discussions). As residential care facilities have limited access to GPs, medications including medication review, prescriptions and ongoing arrangements need to be clarified with the relevant pharmacy prior to transfer.

Most low-level care facilities are unable to accommodate the needs of a transferred patient after office hours as they do not have the staff to manage the care involved.

This means it is often not appropriate to transfer a patient back to a residential care facility after 4.00pm or during the night, unless prior arrangements have been made with the relevant Residential Care Manager or Director of Nursing.

4.2 Community Resource Information

A clear understanding by health care staff of services and networks within the local community is an important component of improved transfer of care practices. Some health services have adopted a Single Point of Access model (SPA); for these health services the following information is already included in the SPA business rules. Staff should have ready access to an updated package of community resource information. It will be necessary to nominate a person responsible for ensuring that this information is kept current and made available to staff.

The community resource information package should include the following:

- Public and private community service providers in the local area (with contact names and details of service times and costs to the patient for occasions of service at home)
- Details of relevant local community networks and forums (including meeting times)
- Copies of services directories published by local Government authorities
- Details of Commonwealth Carelink Centres which provide free information about community and aged care services, disability and other services in local areas (phone 1800 052 222 or visit <http://www.commcarelink.health.gov.au>)
- Details of Seniors Information Services (SIS) which provide information about services funded by HACC – eg Food Services, Home Nursing, Community Options, Neighbour Aid, Dementia Support and Allied Health.
- More information on Residential care is available at: <http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-rescare-index.htm>

Equipment

Patients may need equipment aids to support their recovery at home. Allied health staff may assist with identifying appropriate equipment for the patient's needs. In some cases equipment will need to be ordered from Enable NSW. Further information is in *Program of Appliances for Disabled People (PD2005_563)* or at <http://www.enable.health.nsw.gov.au>.

The Australian Government Department of Veterans' Affairs (DVA) currently has an agreement with Program of Appliances for Disabled People (PADP) Lodgement Centres to supply limited equipment and supplies (eg dressings) to eligible veterans and war widows/widowers under the Rehabilitation Appliance Program. Each hospital must have a process for assessment, referral and ordering equipment/supplies required by eligible DVA benefits and services recipients.

In 2000, the supply of oxygen was removed from PADP as detailed in the *Policy Directive Oxygen and Related items – Arrangements for the Provision (PD2005_589)*. Health Services are responsible for the supply of oxygen or oxygen supplement equipment according to local policies.

Equipment can also be purchased or hired through local pharmacies and a number of private medical equipment companies. While health professionals should discuss alternatives with the patient, they must inform them of the potential costs involved. Hospitals will need to develop protocols for such arrangements and relevant information should be included in any hospital resource folder/s.

Transfer of care out of the hospital

5.1 Medication reconciliation

Patients with an identified medication risk as per the TCRA or advice from the MDT should be prioritised for the pharmacist's review over non-urgent cases. Each Pharmacy department will need to establish a system to effectively prioritise patients to facilitate safe transfer of care and meeting the EDD.

The pharmacist should review the patient's medications and complete a revised medication list (clearly detailing the medication, dosage and the times they are to be taken). Patients should be advised to present this medication list to their community pharmacist and GP at their next visit.

Patients (and their guardians where appropriate) must be educated about their medications (eg how to take them) and informed of any changes to their medication regime.

A clearly written medication list (in an appropriate format for the patient) is to be sent home with the patients and their families/carers, particularly for those who will experience visual problems or who have medication compliance problems (for example, patients with cognitive impairment).

A compliance aid (for example a 'Webster' pack) should be recommended for patients who have been identified as having problems in managing their medication at home. A high contrast version should be used for people who are vision impaired.

The patient's GP should be informed of any adverse drug reactions while in hospital and/or the assessment of the need for a compliance aid.

Where clinically warranted, to avoid patients inadvertently having repeat prescriptions filled for medications that are no longer appropriate, the hospital pharmacist may communicate with the community pharmacist and provide information about the patient's transfer of care medications and ongoing arrangements for medications:

Where there are any issues with the patient's medication compliance their family/carer/legal guardian should be included in discussions about strategies to assist with compliance.

The patient's GP can arrange for a Home Medicines Review (HMR) after transfer of care home which involves the patient, carer and other relevant members of the health care team together with their GP and community pharmacist. If an HMR is indicated, the hospital pharmacist should make arrangements as part of the transfer of care process.

5.2 Medical Transfer of Care Referral

Every GP or Aboriginal Community Controlled Health Services (ACCHS) and community nurse (where appropriate) should receive a written transfer of care referral (known also as the transfer of care summary or discharge summary) when the patient is transferred out of hospital or within 48 hours of the transfer. In short stay services such as EDs, day only or planned day only services, a short stay referral summary may be utilised instead of a full transfer of care referral summary, where clinically appropriate. There are varied systems in place across health services that provide GPs with a copy of the transfer of care referral. The optimal method is for an electronic transfer of information at the time the patient is transferred.

The transfer of care referral represents the formal transfer of responsibility for patient treatment and care from the hospital to the GP. It provides:

- A summary of the person's clinical episode of care
- A list of medications with information about changes to medications
- Follow-up advice for the GP or ACCHS
- Details of community services involved or residential care arrangements

The transfer of care referral must be:

- Legible (preferably typed) and
- Relevant to the needs of the GP.

If referrals have also been made to community nursing services or other community health staff, a copy of the relevant reports should be attached. Transfer of care referrals may be sent by fax where security requirements can be met. Further information is available in the *Medical Discharge Referral Reporting Standard (MDRRS) (GL2006_015)*.

5.3 Transport

Patient transport needs are to be considered in the transfer of care planning processes. Some patients may be eligible for subsidies for the cost of long distance travel for example, rural patients needing to access specialist medical or oral surgical treatment through IPTAAS and babies needing audiology assessments through the State-wide Infant Screening Hearing Program.

Day-only patients may have special transport requirements. Although community transport services are sometimes used to deliver a person home after a day procedure, the level of care and responsibility requested often exceeds what is reasonable for these services to provide, especially for those patients who have had a general anaesthetic, chemotherapy or require portable oxygen. Community transport services should not be placed at risk by being asked to provide transport for patients who need a higher level of care than they can provide.

Currently, Patient Transport Services (PTS) can be booked by hospitals to transfer patients back to their homes through the Electronic Booking System (EBS). This system allows the NSW Ambulance Service time to prepare non-emergency vehicles ahead of time. This system is now being managed online and all bookings must be made at least one day before the transport is required. Bookings on the day of transfer are only to be made in exceptional circumstances and bookings after 12 midday will not be taken. Early booking for the next available ambulance will prevent patients waiting long periods for PTS transport to arrive by improving resource management, and ensure appropriate transport is available for patients when required. Further information is available in the *Transport for Health Policy Directive (PD2006_068)*.

NSW Health Policy Directives and Guidelines

Transfer of care planning

Policy Directive PD2005_082 Discharge Policy for Emergency Department at risk people

Policy Directive PD2009_060 Clinical Handover – Standard Key Principles

Medications

Policy Directive PD2007_077 Medication Handling in NSW Public Hospitals:

Section 4.4.1.2 Provision of Medication under the 2003-08 Australian Health Care Agreement (AHCA)

Section 4.4.1.3 Supply of Discharge Medication

Child protection/sexual assault

Mandatory Reporting Guidelines for children under the age of 16 who are homeless or at risk of homelessness
<http://sdm.community.nsw.gov.au/mrg/app/summary.page>

Policy Directive PD2005_299 Protecting Children and Young People

Policy Directive PD2005_494 Neonatal Abstinence Syndrome Guidelines

Disability

Policy Directive PD2008_010 Disability – People with a disability: Responding to their needs during hospitalisation (revised Jan 08).

Department Ageing, Disability and Home Care: Allocation of places in supported accommodation policy and procedures. 2009. (Please note, this is not a NSW Health Policy): Section 7.5 Declaring a vacancy after exit to the criminal justice system or health facility

Policy Directive PD2005_563 Program of Appliances for Disabled People

Suicide Prevention

Policy Directive PD2005_121 Management of patients with possible suicidal behaviour

Transport

Transport for Health Policy – PD2006_068

Policy Directive PD2005_537 Ambulance coverage following the introduction of Medicare

Policy Directive PD2006_061 Ambulance Services to

Pensioners and Other

Policy Directive PD2005_096 Transfer of patients from public hospital to private facilities

Guidelines GL2005_038 Transfer of patients between public hospitals

Policy Directive PD2005_139 Transport of People who are Mentally Ill

Consumables

Policy Directive PD2005_253 Bleeding Disorders – charging for consumables used in home based treatment of bleeding disorders

Health Interpreter Services

Policy Directive PD2006_053 Standard procedures for working with health care interpreters.

Aboriginal Health Services

Policy Directive PD2005_547 Aboriginal and Torres Strait Islander origin – recording of information of patients and clients

Publication – Ensuring Progress in Aboriginal Health on New South Wales: a reader-friendly information kit. NSW Department of Health 2002.

Advance Care Planning

Guideline GL2005_056 Using Advance Care Directives (NSW)

Guideline GL2005_057 End of Life Care and Decision Making

Guideline GL2008_018 CPR – Decisions Relating to No Cardiopulmonary Resuscitation Orders

My Health Record

Copies can be obtained from the Better Health Centre (BHC) Publications Warehouse:

Business Hours: 8 am–4 pm Monday to Friday

Address: PO BOX 672,
NORTH RYDE BC NSW 2113

Telephone: (02) 9887 5450

Fax: (02) 9887 5452

E-mail: bhc@nscchahs.health.nsw.gov.au

Example Transfer of Care Risk Assessment (TCRA)

Transfer of Care Risk Assessment (TCRA)

Estimated Date Of Discharge (EDD) _____

Date _____ Completed by _____

ADDRESSOGRAPH LABEL

Please answer all five questions. A 'YES' RESPONSE means CONTACT the appropriate health professional for assessment and transfer planning.

Transfer of care risk factors	Yes	No	Health professional contact for assessment	Date & time of referral	Plan completed (Sign and date)
1. Is the patient likely to have self-care problems? (eg walking, falls, bathing, dressing, cognitive issues, preparing meals, shopping – or requiring nursing assistance for wound dressings, catheter care, injections, etc)	<input type="checkbox"/>	<input type="checkbox"/>	Continuing Care Coordinator (Discharge Planner)		
2. Does the patient live alone? * (ie Is the patient likely to require help at home?; emergency follow-up; safe and accessible environment?) *Staff to use their discretion re the need for follow-up, review admission history.	<input type="checkbox"/>	<input type="checkbox"/>	Care Co-ordinator		
3. Does the patient have caring responsibilities for others? (ie Is there a partner/child/family member/friend/pet who depends on the patient for care?)	<input type="checkbox"/>	<input type="checkbox"/>	Occupational Therapist		
4. Has the patient used community-based services before admission? (eg community nursing, Meals on Wheels, CACP, residential care or supported accommodation)	<input type="checkbox"/>	<input type="checkbox"/>	Physiotherapist		
5. Does the patient usually have three or more medications; have they changed medications in the last two weeks? (Also consider if on large quantities of S8 drugs.)	<input type="checkbox"/>	<input type="checkbox"/>	Social Worker		
			Community Case Manager		
			Community Health		
			Specialist CNC (diabetes, aged care, other)		
			ACAT Drug and Alcohol Service Mental Health Team Ethnic Health Worker Aboriginal Health Worker GP, Other (specify)		

Example Paediatric Transfer of Care Risk Assessment

Acknowledgement to The Children’s Hospital Westmead.

AMO	MRN			
Ward	NAME			
Date of Admission	DOB SEX			
(Please affix label in this box)				
<p>Discharge Planning Risk Assessment (Adapted from the Royal Children’s Hospital in Melbourne)</p> <p>Completed by _____ Date _____</p> <p>Signature _____ Time _____</p> <p>Identify risk factors for discharging the patient by selecting (✓) the appropriate box in the 5 categories listed below. Refer to the reverse page for recommendations as to the resources that may be utilised by the patient upon discharge, so that risks to the patient are reduced. The Discharge Planning Risk Assessment is to be completed prior to the patient’s discharge from hospital. This document may be completed more than once during the patient’s stay in hospital, which reflects changes to the patient status.</p>				
<p>1. Medical surgical care requirements</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none; vertical-align: top;"> <input type="checkbox"/> Head injury or other permanent high level care needs <input type="checkbox"/> Multiple medical conditions or disability present <input type="checkbox"/> Child will experience reduction in physical and/or mental functioning on a short or long term basis (Please specify) _____ </td> <td style="width: 50%; border: none; vertical-align: top;"> <input type="checkbox"/> Multiple admissions have occurred prior to this one <input type="checkbox"/> Child in terminal phase of illness <input type="checkbox"/> Admitted with multiple injuries <input type="checkbox"/> Other (Please specify) _____ </td> </tr> </table>		<input type="checkbox"/> Head injury or other permanent high level care needs <input type="checkbox"/> Multiple medical conditions or disability present <input type="checkbox"/> Child will experience reduction in physical and/or mental functioning on a short or long term basis (Please specify) _____	<input type="checkbox"/> Multiple admissions have occurred prior to this one <input type="checkbox"/> Child in terminal phase of illness <input type="checkbox"/> Admitted with multiple injuries <input type="checkbox"/> Other (Please specify) _____	
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<p>2. Anticipated post-hospital care needs</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none; vertical-align: top;"> <input type="checkbox"/> Home nursing and/or attendnat care required <input type="checkbox"/> Vent assist/tracheostomy/oxygen dependent: (Specify) _____ <input type="checkbox"/> Management of multiple medication/side effects </td> <td style="width: 50%; border: none; vertical-align: top;"> <input type="checkbox"/> Parenteral nutrition <input type="checkbox"/> NG tube <input type="checkbox"/> Gastrostomy tube <input type="checkbox"/> Other (Please specify) _____ </td> </tr> </table>		<input type="checkbox"/> Home nursing and/or attendnat care required <input type="checkbox"/> Vent assist/tracheostomy/oxygen dependent: (Specify) _____ <input type="checkbox"/> Management of multiple medication/side effects	<input type="checkbox"/> Parenteral nutrition <input type="checkbox"/> NG tube <input type="checkbox"/> Gastrostomy tube <input type="checkbox"/> Other (Please specify) _____	
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<p>3. Family and child issues</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none; vertical-align: top;"> <input type="checkbox"/> Parent/carer(s) appear extremely overwhelmed/distressed <input type="checkbox"/> Parent/carer(s) indicate they do not want child home <input type="checkbox"/> Parent/carer(s) unable to manage level of care <input type="checkbox"/> Parent/carer(s) potentially unable to afford the necessary supplies/equipment <input type="checkbox"/> Child’s custody arrangement is unclear <input type="checkbox"/> Behaviour/mental health problems in parent <input type="checkbox"/> Behaviour/mental health problems in child </td> <td style="width: 50%; border: none; vertical-align: top;"> <input type="checkbox"/> Previous or current abuse and neglect issues <input type="checkbox"/> Protective services involved <input type="checkbox"/> Parent–child interaction problems are observed <input type="checkbox"/> Other disabled children in the home <input type="checkbox"/> Parental conflict or family violence present <input type="checkbox"/> Homeless/transient living situation <input type="checkbox"/> Language/cultural issues <input type="checkbox"/> Other (Please specify) _____ </td> </tr> </table>		<input type="checkbox"/> Parent/carer(s) appear extremely overwhelmed/distressed <input type="checkbox"/> Parent/carer(s) indicate they do not want child home <input type="checkbox"/> Parent/carer(s) unable to manage level of care <input type="checkbox"/> Parent/carer(s) potentially unable to afford the necessary supplies/equipment <input type="checkbox"/> Child’s custody arrangement is unclear <input type="checkbox"/> Behaviour/mental health problems in parent <input type="checkbox"/> Behaviour/mental health problems in child	<input type="checkbox"/> Previous or current abuse and neglect issues <input type="checkbox"/> Protective services involved <input type="checkbox"/> Parent–child interaction problems are observed <input type="checkbox"/> Other disabled children in the home <input type="checkbox"/> Parental conflict or family violence present <input type="checkbox"/> Homeless/transient living situation <input type="checkbox"/> Language/cultural issues <input type="checkbox"/> Other (Please specify) _____	
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<p>4. Community resources</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none; vertical-align: top;"> <input type="checkbox"/> Family lives in rural/isolated area <input type="checkbox"/> Extensive community agency support/care required <input type="checkbox"/> More than one community agency involved in post-hospital care <input type="checkbox"/> Lack of respite/social supports for caregivers </td> <td style="width: 50%; border: none; vertical-align: top;"> <input type="checkbox"/> Communication delays among agencies <input type="checkbox"/> Extended waiting list for services <input type="checkbox"/> Transportation difficulties for continuing care <input type="checkbox"/> Other (Please specify) _____ </td> </tr> </table>		<input type="checkbox"/> Family lives in rural/isolated area <input type="checkbox"/> Extensive community agency support/care required <input type="checkbox"/> More than one community agency involved in post-hospital care <input type="checkbox"/> Lack of respite/social supports for caregivers	<input type="checkbox"/> Communication delays among agencies <input type="checkbox"/> Extended waiting list for services <input type="checkbox"/> Transportation difficulties for continuing care <input type="checkbox"/> Other (Please specify) _____	
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<p>5. Organisational coordination</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none; vertical-align: top;"> <input type="checkbox"/> More than one medical/surgical specialty involved <input type="checkbox"/> Post-hospital care requires coordination/case management </td> <td style="width: 50%; border: none; vertical-align: top;"> <input type="checkbox"/> Lack of clarity over legal issues such as guardianship or DOCS <input type="checkbox"/> Other (Please specify) _____ </td> </tr> </table>		<input type="checkbox"/> More than one medical/surgical specialty involved <input type="checkbox"/> Post-hospital care requires coordination/case management	<input type="checkbox"/> Lack of clarity over legal issues such as guardianship or DOCS <input type="checkbox"/> Other (Please specify) _____	
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<p>Please list the community agencies and/or service providers that were involved in this child’s care prior to the current admission</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; border: none; vertical-align: top;"> <input type="checkbox"/> General Practitioner Contact: _____ </td> <td style="width: 33%; border: none; vertical-align: top;"> <input type="checkbox"/> Paediatric Outreach Blacktown <input type="checkbox"/> Paediatric Outreach Fairfield <input type="checkbox"/> Paediatric Outreach Liverpool <input type="checkbox"/> Paediatric Outreach Mt Druitt <input type="checkbox"/> Paediatric Outreach Campbelltown </td> <td style="width: 33%; border: none; vertical-align: top;"> <input type="checkbox"/> Community Health <input type="checkbox"/> Child and Family Health <input type="checkbox"/> Other (Please specify) _____ </td> </tr> </table>		<input type="checkbox"/> General Practitioner Contact: _____	<input type="checkbox"/> Paediatric Outreach Blacktown <input type="checkbox"/> Paediatric Outreach Fairfield <input type="checkbox"/> Paediatric Outreach Liverpool <input type="checkbox"/> Paediatric Outreach Mt Druitt <input type="checkbox"/> Paediatric Outreach Campbelltown	<input type="checkbox"/> Community Health <input type="checkbox"/> Child and Family Health <input type="checkbox"/> Other (Please specify) _____
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<p>Note other issues relevant to discharge planning:</p>				

DISCHARGE PLANNING RISK ASSESSMENT

M2C

Example Transfer of Care Checklist

EDD		ADDRESSOGRAPH LABEL
Destination		
Notification (relatives)		
Transport	<input type="checkbox"/> Booked	<input type="checkbox"/> Confirmed
Personal items returned	Date	
Medications	<input type="checkbox"/>	_____
Valuables	<input type="checkbox"/>	_____
X-rays	<input type="checkbox"/>	_____
Equipment	<input type="checkbox"/>	_____
Dentures	<input type="checkbox"/>	_____
Hearing aids	<input type="checkbox"/>	_____
Spectacles	<input type="checkbox"/>	_____
Referral Services	Referral	Appointment
Community Case Manager	<input type="checkbox"/>	<input type="checkbox"/>
Community Nurse	<input type="checkbox"/>	<input type="checkbox"/>
Domiciliary	<input type="checkbox"/>	<input type="checkbox"/>
Meals on Wheels	<input type="checkbox"/>	<input type="checkbox"/>
ACAT	<input type="checkbox"/>	<input type="checkbox"/>
Occupational Therapist	<input type="checkbox"/>	<input type="checkbox"/>
Physiotherapist	<input type="checkbox"/>	<input type="checkbox"/>
Pharmacist (Community)	<input type="checkbox"/>	<input type="checkbox"/>
Home Care	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify)	_____	_____
Transfer of care plan	Complete	Patient/Carer Copy
Revised medication	<input type="checkbox"/>	<input type="checkbox"/>
Revised equipment	<input type="checkbox"/>	<input type="checkbox"/>
Medical transfer of care referral	<input type="checkbox"/>	<input type="checkbox"/>
Community nursing referral	<input type="checkbox"/>	<input type="checkbox"/>
Allied Health referral	<input type="checkbox"/>	<input type="checkbox"/>
Community services referral	<input type="checkbox"/>	<input type="checkbox"/>
Plain English post-care instructions	<input type="checkbox"/>	<input type="checkbox"/>
Comment	_____	
Transfer of Care Plan explained to Person / Carer (Clinician) _____		
(Pt / Carer) _____ (Name) _____		
Transfer Checklist Completed by _____ Date _____		

