

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

Document Number PD2011_015

Publication date 07-Mar-2011

Functional Sub group Clinical/ Patient Services - Nursing and Midwifery
Clinical/ Patient Services - Governance and Service Delivery

Summary Care Coordination is the process where patient needs are identified and managed from the point of admission. This Policy Directive outlines the five steps in coordinating patient care to improve the patient experience and improve patient flow within the hospital.

Replaces Doc. No. Discharge Planning: Responsive Standards (Revised November 2007) [PD2007_092]

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Applies to Local Health Networks, Board Governed Statutory Health Corporations, Chief Executive Governed Statutory Health Corporations, Specialty Network Governed Statutory Health Corporations, Public Health Units, Public Hospitals

Audience All staff

Distributed to Public Health System, Divisions of General Practice, Ministry of Health, Tertiary Education Institutes

Review date 07-Mar-2016

Policy Manual Patient Matters

File No. H10/82984-5

Status Active

Director-General

This Policy Directive may be varied, withdrawn or replaced at any time. Compliance with this directive is **mandatory** for NSW Health and is a condition of subsidy for public health organisations.

CARE COORDINATION: PLANNING FROM ADMISSION TO TRANSFER OF CARE IN NSW PUBLIC HOSPITALS

PURPOSE

The term 'discharge' is referred to as '**transfer of care**' throughout this policy. This is because a patient's health care does not end when they leave hospital. 'Transfer of care' demonstrates that a patient's care continues beyond hospital as they receive care from another service/facility/or in the community. This could be by a patient's General Practitioner (GP), community health providers, other organisation or by the patient and/or their carers.

Care Coordination is the process where patient care needs are identified and managed. The patient/carers must be involved in care planning from admission through to transfer of care. This policy directive applies to clinical staff involved in the care of inpatients. It outlines a five stage process to guide staff and patients through their hospital stay. Implementation of this approach will enhance patient outcomes, safety and experience.

MANDATORY REQUIREMENTS

Each Health Service is required to meet the standards outlined in this policy. Admitted patients will transition through five stages of care coordination:

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

While the five stages will apply to most patients having an inpatient stay, the stages will be adapted for some patient groups. Patients having scheduled admissions for a course of treatment (eg chemotherapy, dialysis or a multi-staged procedure) may not require a review for each admission in the absence of a change in personal/social circumstances or clinical condition. Planned day only or extended day only patients should have an assessment of their transfer of care needs and arrangements put in place prior to their admission.

IMPLEMENTATION

Health Service Chief Executives are responsible for:

Establishing mechanisms to ensure that the essential stages of care coordination are applied in each facility and are sustained as part of the normal care coordination and transfer of care planning.

All new clinical staff must be educated in and supplied with the staff Reference Manual: '*Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals Reference Manual*', and the principles detailed in this document will be a fundamental part of each facility's clinical staff orientation program.

The five stages of care coordination should be implemented through:

- Development and use of an admitted patient 'Transfer of Care Risk Assessment (TCRA) Tool'.
- All departments (including emergency) must have guidelines in place for care transfer of 'at risk' patients especially between the hours of 10pm and 8am. Where guidelines and checklists already exist (including in paediatrics) it should be confirmed that they comply with the requirements of this policy.
- Structured (set time and duration) multidisciplinary team reviews in each ward/unit with an allocated responsible person for the administration/coordination of the meetings.
- That an Estimated Date of Discharge (EDD) is allocated, documented, displayed near the bedside and on electronic patient management tools, and reviewed for each patient. The patient or carer must be informed of the EDD during their stay.
- Ensuring the Transfer of Care Checklist or equivalent is completed for all appropriate admitted patients before they return to the community.
- All referrals, appointments, and follow-up information including medication advice is discussed and provided to the patient, carer or appropriate service prior to transfer of care, in plain language.

REVISION HISTORY

Version	Approved by	Amendment notes
March 2011 (PD2011_015)	Deputy Director-General Health System Quality Performance and Innovation	Updated and replaced PD2007_092.
December 2007 (PD2007_092)	Deputy Director-General	Replaced Discharge Planning: Responsive Standards (Revised May 2007)

ATTACHMENTS

1. Care Coordination; Planning from Admission to Transfer of Care in NSW Public Hospitals Procedures

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



Issue date: March 2011

PD2011_015

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1 Pre- Admission/Admission

1.1 Definition

At the time of first contact with the patient, a 'Transfer of Care Risk Assessment' (TCRA) or equivalent should be completed by the clinician. A TCRA is used to identify those patients who may have needs that require further assessment and follow-up before they are transferred home or to ongoing care from the acute hospital service. Health Services are responsible for ensuring that a TCRA is completed for all appropriate admitted patients. The results from this TCRA tool should be used to inform the overall management of the patient. Each Health Service, Hospital, and clinical units will need to develop a process for flagging those patients who have been identified as having a transfer of care risk with the multidisciplinary team and to implement procedures for contacting the appropriate health professionals.

The TCRA tool (**Appendix 3**) should be used to gather information on all appropriate patients at admission or pre-admission. The key areas to be addressed are:

1. Is the patient likely to have self-care problems?
2. Does the patient live alone?
3. Does the patient have responsibilities to care for others?
4. Has the patient used community services before admission?
5. Does the patient usually take three or more medications and have their medications changed in the last two weeks?

A TCRA should be completed on initial presentation and whenever the patient's clinical or social status changes.

Pre-admission

For planned admissions, transfer of care planning should begin before the patient is admitted. The TCRA should be conducted at this time. Patients with an identified risk should be referred early to the appropriate community teams so planning for transfer can begin.

Planned Day-only admission

Transfer of care planning must occur for patients having day-only procedures. Facilities may nominate their own processes to ensure the TCRA is completed. For example:

- utilising a pre-admission preparation toolkit;
- nominating staff responsible for assessment of day-only patients

Ideally, this should occur prior to the day of their procedure.

Transfer of Care Risk Assessment Tool (TCRA)

The person conducting the TCRA has the responsibility to communicate any risk identified to the relevant members of the multidisciplinary team. When a transfer of care risk is identified, it must be documented and managed.

A YES response in the TCRA to question two (Does the patient live alone?) and question five (Does the patient usually take three or more medications and have their medications changed in the last two weeks?), will not always indicate that the patient is at risk. Staff should use their clinical judgement as to the requirements for follow up if these two questions are the only yes answers. The patient should be referred to the relevant health professionals for further assessment if required.

Planned Patients

All patients with a planned admission must have their TCRA completed at presentation or before admission to hospital, such as at a pre-admission clinic. Completion of this assessment will allow the identification of transfer of care risks. Necessary referrals should be made before admission, where possible, and confirmed during the acute phase of care.

Non-Planned Patients

For non-planned patients who are admitted to hospital through the ED or through direct admission, **the TCRA must be completed within the first 24 hours of admission.**

2 Multidisciplinary Team Review

2.1 Definition of the Multidisciplinary Team

There must be defined roles and responsibilities for the Multidisciplinary Team (MDT) members assisting in the care coordination process. All members of the MDT are expected to work collaboratively across disciplines to ensure improved patient outcomes. Health Services, Hospitals and Departments will need to ensure local procedures are in place to support a designated time for the MDT in inpatient wards/units to meet.

Multidisciplinary Team Review:

Based on the recommendations made in the *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals*; multidisciplinary rounds should take place twice weekly, while ensuring short stay patients needs are also met. MDT members should agree on the treatment plan, incorporate the transfer of care risks into the patient care plan, and set the Estimated Date of Discharge (EDD).

- It is important to conduct these **meetings or a component of these meetings at the bed side** so the patient and carers can be involved and be aware of the treatment plan.
- More frequent MDT reviews may be necessary for some patients to meet their needs.

In some rural settings, local medical practitioners and allied health professionals are not always available. Local processes need to be in place to ensure appropriate input into decision making regarding the transfer of care.

3 Estimated Date of Discharge

3.1 Definition

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 projected date to coordinate the patient's requirements. While for some patients, the EDD may change due to clinical issues; review of best practice confirms that an accurate EDD can be set for most patients. Discussions with the patient and their family/carer/s, GP, community health and service providers should occur early, for effective care planning.

Any changes to the EDD for clinical reasons or delays in transfer beyond the EDD are to be recorded and relevant staff informed. In this situation it is necessary to contact any relevant community service providers to advise them of the altered EDD. **A regular review process** will keep staff as well as the patient and their family/carer/s informed of their patient's progress.

- **A patient's EDD should be visible near their bed**, reminding staff of the date they are working towards and informing the patient and their family or carer.
- **The multidisciplinary team should use the EDD to synchronise referrals** to other teams and/or disciplines that are not involved in regular multidisciplinary team reviews.
- If the **patient's condition deteriorates it is appropriate to revise the EDD**.
- If a patient does not leave when indicated by the EDD due to system delays it is not appropriate to change the EDD. The delay reason must be recorded and a system to review those delays put in place.

Local processes need to be in place to escalate system delays through patient flow and bed management meetings. IT tools for example, should be used to track these delays and identify the main constraints within the hospital. This data should be used to drive necessary system change to reduce delays in future.

Planning transfer of care from speciality areas

Specialised areas such as Intensive Care Units (ICU), High Dependency Units (HDU), Medical Assessment Units (MAU) and Critical Care Units (CCU) should use the EDD to indicate when patients are able to be transferred to inpatient wards. This will assist patient flow managers to plan the transfer into appropriate wards and prevent ICU/HDU delays in returning patients to non-critical care beds and reduce patients receiving care outside their home ward.

4 REFERRALS AND LIAISON

4.1 Referring to Service Providers

Service providers should be involved in planning for the patient's transfer from the acute setting. Liaison will need to occur with all appropriate providers including the patient's GP and any additional health providers the patient currently receives services from. It is desirable that the name of the patient's GP and their contact details are displayed at the bedside with the patient's EDD.

Once a patient's requirements are identified, discussions with the appropriate providers should occur using the Estimated Date of Discharge as the start date.

Discussions with providers should occur early to provide enough time to make the appropriate arrangements.

It is important to identify what services the patient will require during the acute episode of care. **Each facility is required to develop referral structures to enable staff to easily contact the relevant service providers.** Referral details should be recorded in one place in the patient's medical record, and on any relevant individual referrals (eg. GP and Community Health).

It may not be possible to complete a patient assessment in hospital prior to the transfer of care. If a need for services has been identified, a referral to the appropriate community service provider or General Practitioner should be made. Follow-up by the organisation with the patient will then take place on their return to the community. This follow up may include the need for a more complete assessment in the home environment.

5 TRANSFERRING HOME

5.1 Transfer of Care Checklist

Staff must use the Transfer of Care Checklist to meet the needs of patients before leaving the hospital. **The Nurse Unit Manager is responsible for ensuring that these details are checked, completed and agreed to by the patient before leaving the hospital.**

The Transfer of Care Checklist must cover the following information:

- Estimated Date of Transfer
- Destination of Transfer
- Notification/Transport Booked
- Personal Items Returned
- Referral Services Booked
- Care Plan
- Transfer of Care Summary provided to patient that includes medication information, community and GP referral information and follow up appointments. This should be provided in plain language and explained to the patient.

A template Transfer of Care Checklist is included in the Reference Material. Staff are strongly encouraged to use an electronic checklist if available. Each individual Health Service, Hospital and Clinical Unit should build on these fundamentals in the checklist to address specific local circumstances.

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.

Patient transport needs are to be considered in the transfer of care planning processes. This is particularly important in the case of regional or remote patients as some patients may be eligible for subsidies for the cost of long distance travel.

NSW Ambulance Service manages non-emergency patient transport through the Electronic Booking System. Bookings on the day of transfer are only to be made in exceptional circumstances and bookings after 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.

6 LIST OF ATTACHMENTS

1. Implementation Checklist

For further information and detail on the five steps of Care Coordination, please refer to the 'Care Coordination: From Admission to Transfer of Care in NSW Public Hospitals Reference Manual'. This document will provide additional detail in managing a patient's care from admission. The Reference Manual also contains a Transfer of Risk Assessment template and a Transfer of Care Checklist. This document will be available through the NSW Health website.

Attachment 1: Implementation checklist

Assessed by:		Date of Assessment:	
IMPLEMENTATION REQUIREMENTS	Not commenced	Partial compliance	Full compliance
1. Establishment of a Transfer of Care Risk screen that addresses the five risk areas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<u>Notes:</u>		
2. Structured (set time and duration) multidisciplinary team reviews in each ward/unit with an allocated responsible person for the administration/ coordination of the meetings.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<u>Notes:</u>		
3. All patients have Estimated Date of Discharge (EDD) documented and a review process in place	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<u>Notes:</u>		
4. Ensuring the Transfer of Care Checklist or equivalent is completed for all appropriate admitted patients before they return to the community.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<u>Notes:</u>		
5. All referrals, appointments, and follow-up information including medication advice is discussed and provided to the patient, carer or appropriate service prior to transfer of care in plain language.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<u>Notes:</u>		