CONTINUITY OF CARE PLANNING FRAMEWORK FOR QUEENSLAND

The General Practice Advisory Council has developed this Continuity of Care Framework to guide recommended practice for all service providers involved in admission and discharge planning across the hospital/community interface.

The Framework aligns with the strategic directions of the key partner organisations of GPAC and with national healthcare standards. It is consistent with the Queensland Health Strategic Plan 2007-2012 and the service delivery reforms contained in the Queensland Statewide Health Services Plan 2007-2012.

Once implemented, the Framework can be expected to improve the quality and consistency of continuity of care planning across Queensland and to improve consumer health and well being.

The Framework has been developed through a broad consultative process involving general practice organisations, consumer and community groups, and Queensland Health. We invite service providers across Queensland to work together in partnership to implement the Framework.

WHAT IS CONTINUITY OF CARE PLANNING?
Continuity of care planning is the process of managing patient care from the primary care contact through preadmission, admission, in-patient care, discharge and follow up/maintenance. This involves coordination between a range of community-based and hospital/health service providers, and carers, with particular reference to efficient information transfer between all providers across the hospital/community interface. Part of the planning for discharge process includes the development of a coordinated plan for the community services which need to be in place prior to discharge from hospital.

WHY DO CONTINUITY OF CARE PLANNING?
Good continuity of care planning contributes to improved quality and safety of care, increased patient, carer and service provider satisfaction, reduced readmission rates and appropriate length of stay in health facilities. It can also be expected to reduce duplication of effort and maximise use of resources, including access to appropriate service providers and levels of care.

WHAT IS THE PURPOSE OF THIS FRAMEWORK?
Based on key consensus documents and expert opinion, this Framework outlines ‘best practice’ in the continuity of care planning process. The Framework sets standards for practice, including key accountabilities, resources and systems, so that performance indicators, agreed by stakeholders, can be developed to achieve consistent standards and continuous improvement in continuity of care provision throughout Queensland.

KEY PRINCIPLES
- The needs of the patient are the focus of all continuity of care planning processes.
- Patient and carer involvement in the planning process is essential (including an advocate, if required).
- Continuity of care planning is for all patients. The extent of planning relates to complexity of need. More comprehensive care planning and coordination is required for patients with chronic/complex care needs.
- Planning for discharge starts at first contact with the hospital, or before, admission.
- Continuity of care planning is multi-disciplinary.
- Continuity of care planning is respectful and sensitive to the needs of people from diverse linguistic and cultural backgrounds, including Aboriginal and Torres Strait Islander peoples.
- Subject to privacy provisions, continuity of care planning includes timely ongoing communication, information transfer and service coordination between hospitals and community-based services.

WHAT IS GPAC?
GPAC provides the major mechanism for formal consultation between general practitioners and government in Queensland. Its key role is to facilitate cooperation and collaboration between key stakeholders to support the achievement of an integrated health care delivery system.

THE GPAC PARTNERS ARE:
- Australian College of Rural and Remote Medicine
- Australian Medical Association (Queensland)
- Australian Government Department of Health and Ageing
- Consumer Representatives
- General Practice Queensland
- Queensland Health
- Health Workforce Queensland
- The Royal Australian College of General Practitioners (Queensland)
- Primary Health Care Research Education and Development Collaboration (Queensland)
- Queensland Aboriginal and Islander Health Council

NOTE: ‘Patient’ is used to refer to a patient, client or consumer.

Mr Michael Reid, Director General, Queensland Health
Dr Fiona McGrath, Chair, GPAC

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### Key Activities in the Continuity of Care Process

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-admission/Emergency</strong>&lt;br&gt;(planned)</td>
<td></td>
</tr>
<tr>
<td>GP/Community</td>
<td>Send timely, legible, comprehensive, admission referral, current assessment and care plan to hospital in a secure format (eg secure e-mail).</td>
</tr>
<tr>
<td>Hospital/Health Service</td>
<td>Assess and screen for post discharge needs at preadmission clinic, using appropriate tools.</td>
</tr>
<tr>
<td><strong>Emergency Dept.</strong>&lt;br&gt;(unplanned)</td>
<td></td>
</tr>
<tr>
<td>GP/Community</td>
<td>Unless self-referred, send initial referral from GP/community provider(s) in a secure format.</td>
</tr>
<tr>
<td>Hospital/Health Service</td>
<td>Assess and screen, using appropriate tools.</td>
</tr>
<tr>
<td><strong>Day of discharge</strong></td>
<td></td>
</tr>
<tr>
<td>GP/Community</td>
<td>Note the admission/anticipated discharge date in patient record. Suspend services provided to patient in community. Provide additional patient information, including copy of the assessment and any care plan arrangements, to hospital, if relevant.</td>
</tr>
<tr>
<td><strong>Post-discharge</strong></td>
<td></td>
</tr>
<tr>
<td>GP/Community</td>
<td>Contribute to multi-disciplinary planning (eg telephone, face-to-face, videoconferencing). GPs to use Enhanced Primary Care (EPC) case conferencing or care planning items as needed.</td>
</tr>
<tr>
<td><strong>Discharge</strong></td>
<td></td>
</tr>
<tr>
<td>GP/Community</td>
<td>If ongoing treatment/care is needed, send legible, comprehensive discharge summary/referral to GP and community providers, in a secure format, at discharge or within 24-48 hours of discharge.</td>
</tr>
</tbody>
</table>

© The HACC Ongoing Needs Identification (ONI) tool may be adopted as a referral, risk screening and action planning instrument across all settings/phases of the continuum.

**NOTE:** Day patients are admitted, have procedure and are discharged in one day.
### RECOMMENDED ‘DATA SETS’ FOR DOCUMENTATION TO SUPPORT CONTINUITY OF CARE PLANNING

<table>
<thead>
<tr>
<th>PRE-ADMISSION</th>
<th>PRE-ADMISSION/ADMISSION</th>
<th>IN-PATIENT</th>
<th>DISCHARGE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Admission referral</strong></td>
<td><strong>Risk screening tool</strong></td>
<td><strong>Care Pathway/Discharge Plan</strong></td>
<td><strong>Discharge Summary/Referral</strong></td>
</tr>
<tr>
<td>- Services currently provided for the patient (if known)</td>
<td>- Use appropriate screening tool to screen for post-discharge needs e.g. Thomas et al</td>
<td>- Used throughout the period of hospitalisation to assess and plan for care needs post-discharge.</td>
<td>- To communicate referral information between hospital and GP (and other community providers, as needed)</td>
</tr>
<tr>
<td>- Urgency of referral</td>
<td>- Likelihood of problems in managing self-care (e.g. manages own medications, uses medication management aids)</td>
<td>- Date of admission</td>
<td>- Patient name, address, date of birth</td>
</tr>
<tr>
<td>- Patient name, address, date of birth</td>
<td>- Evidence of mental and/or behavioural problems, including suicide attempt</td>
<td>- Anticipated and final discharge dates</td>
<td>- Carer/primary support person details</td>
</tr>
<tr>
<td>- Carer contact details</td>
<td>- Medical condition which is disabling or deteriorating, including major trauma</td>
<td>- Discharge destination (e.g. home, other facility, family)</td>
<td>- Referring/treating doctor details (GP)</td>
</tr>
<tr>
<td>- Family/social supports available</td>
<td>- Patient lives alone</td>
<td>- Details of referrals</td>
<td>- Consultant name and specialty</td>
</tr>
<tr>
<td>- GP details</td>
<td>- For children, child abuse, parenting capacity, school attendance</td>
<td>a) within hospital eg dermatologist</td>
<td>- Intern/Registrar details</td>
</tr>
<tr>
<td>- Referring practitioner details (if not GP)</td>
<td>- Likelihood of having complex medication, dressings or treatments following discharge</td>
<td>b) external eg tertiary specialist, podiatrist</td>
<td>- Hospital unit of discharge and contact number</td>
</tr>
<tr>
<td>- Referee consultant and hospital dept. (if known)</td>
<td>- Risk of readmission (e.g. 2 or more prior admissions over last 12 months, 5 or more medications)</td>
<td>Practitioners undertaking planning</td>
<td>- Admission date, source and reason for admission</td>
</tr>
<tr>
<td>- History of presenting complaint/ examination findings/investigation results</td>
<td>- Patient has caring responsibilities at home</td>
<td>(internal and external) eg Allied Health, GP, Community Nursing, Pharmacy</td>
<td>- Past medical history, including details of co-morbidities</td>
</tr>
<tr>
<td>- Reason for referral</td>
<td>- Carer availability, profile and strain</td>
<td>- Post-discharge needs identified eg wound care, mobility support, specialised support or liaison, child/adolescent and family needs, therapy recommendations</td>
<td>- Discharge date, time and discharge destination</td>
</tr>
<tr>
<td>- Relevant past medical history (including mental health history)</td>
<td>- Unsafe aspects of discharge destination (eg. steps)</td>
<td>Assessment of home environment</td>
<td>- Discharge summary/referral issue date</td>
</tr>
<tr>
<td>- Current and recent medication and ADRs</td>
<td>- Patient holds health care card, pension card or repatriation health card (gold or white)</td>
<td>Post-discharge services identified from following (include urgency of response)</td>
<td>- Principal diagnosis and other current conditions/complications</td>
</tr>
<tr>
<td>- Clinical alerts (e.g. allergies, blood-borne virus)</td>
<td>- Patient used community services prior to admission</td>
<td>a) Clinical eg GP, community nurse, return hospital appointment, etc</td>
<td>- Procedures and date(s)</td>
</tr>
<tr>
<td>- Smoking status</td>
<td>- Patient had problems managing at home prior to admission</td>
<td>b) Other eg transport services, home medical aids, home structure adaptations, volunteers etc</td>
<td>- Progress notes/comments</td>
</tr>
<tr>
<td>- Alcohol consumption</td>
<td>- Patient requires an interpreter</td>
<td>Medication changes</td>
<td>- Specific follow-up advice for treating doctor/community provider(s) e.g. further treatment/tests</td>
</tr>
<tr>
<td>- Special needs/functional information (e.g. Aids to Daily Living, Adult Guardian)</td>
<td>- Signature, name, position and date</td>
<td>Changes to care services in community</td>
<td>- Discharge medication – dose, route and frequency</td>
</tr>
<tr>
<td>- Existence of Advanced Health Care Directive</td>
<td>- Signature, name, address, date of birth</td>
<td>Client/carer issues/concerns</td>
<td>Medications ceased and new medications started, including reasons for changes and plan/follow-up</td>
</tr>
<tr>
<td>- Signature, name and date (Adapted from SIGN, 1998)</td>
<td>- Signature, name, position and date</td>
<td>Signature, name and position</td>
<td>- Allergies and adverse drug reactions</td>
</tr>
</tbody>
</table>

### NOTE:
- Identify practitioner responsible for completion of these documents. Ensure input from other clinicians for more complex care needs. GPs use EPC items as appropriate.
- These are intended as a guide only. If developing templates or forms based on these ‘data sets’, please consider in conjunction with recognised data dictionaries e.g. Queensland Health/National Health Data Dictionaries.
- The items in these ‘data sets’ are not ranked in priority order.
Definitions
Discharge Plan is the document developed in hospital, in collaboration with the patient, carer, GP and community providers, (see definition below) for the continuing treatment/care required by the patient in another facility, or in the community, following transfer or discharge.

Discharge Summary/Referral is the document prepared at the time of hospital discharge/transfer which details the diagnosis and care provided while hospitalised, or during an episode of care, including admission information, procedures undertaken, treatment, and medication prescribed. It includes a summary of the care needs post-discharge as identified through the multi-disciplinary continuity of care planning process. It may include a copy of the full discharge plan, if relevant.

Community Provider, as used within this document, refers to all services and providers within the community for example residential aged care providers, home care providers, education/welfare providers for children, and registered community based health professionals eg therapy service providers, community pharmacists, community or private practice midwives. It does not include General Practitioners.

Resources/Systems

Information Management
- Computer access/fax machine on all wards and for all GPs/community providers
- Database/record of GPs/community providers on wards, Emergency Departments and in pre-admission clinics
- Standardised admission referral (preferably electronic)
- Standardised discharge summary referral (preferably electronic)
- IT platform, integrated between hospital and community (medium term)

Stafﬁng/Training/Access to Information
- Training and education of staff, including formalised continuing medical education involving GPs/hospital doctors
- Adequate administrative support within the hospital to support the continuity of care planning process
- Statewide collation of effective continuity of care planning activities (eg a web-based resource of effective tools)

Documentation
- Policies and protocols available in hospital wards and clinics, including protocols in pre-admission clinics for notification of community providers, discharge policies and procedures, discharge checklists
- System to ensure that discharge plans are documented in clinical record and made available for all providers involved
- Use of clinical and communication pathways, where appropriate
- Use of relevant patient assessments (eg ONI) as patient information and referral records

Quality Management
- Regular evaluation systems in place, which detail timeframes and responsibilities for reporting/follow up
- Regular review systems, including feedback to GPs/community providers

Hospital/GP and community liaison mechanisms
- Designated discharge coordinator/coordination responsibility and/or liaison mechanisms established (including role of General Practice Liaison Officers)

Key Accountabilities

District Chief Executive Officer
The District Chief Executive Officer is accountable for the successful implementation of continuity of care planning within each Health Service District. This includes ensuring that the following accountabilities have been designated:
- Person(s) responsible for coordinating discharge planning
- Person(s) responsible for preparation and transfer of discharge referral summaries from hospital to community providers within agreed time lines
- Person(s) responsible for evaluation and monitoring of continuity of care planning activities and outcomes
- Provision of resources/systems, as above

General Practitioners/Community Service Providers
- Provision of comprehensive, legible referral information to hospital for all planned admissions, and for referrals to Emergency Department (where relevant)
- Appropriate involvement in multi-disciplinary discharge planning
- Coordination of care in the community, as appropriate
- Early referral in the community to other community providers for screening/assessment and/or intervention e.g. meals on wheels, domiciliary nurses (to avoid unnecessary hospitalisation)

Community Service Providers
- Provision of service profiles, indicating services available and criteria for access
- Provision of patient screening, assessment and care planning information (eg ONI) to hospital, where relevant

Patient Responsibilities
- Give staff as much information about their health as possible
- Ask questions and talk to their family if they want to, before making any decisions about their health care
- Make follow-up appointments, when advised and follow any other staff instructions for their treatment and care

Please Note:
This Framework is intended as a general guide only and is not intended to be prescriptive. The framework should not be considered all-inclusive, nor should it be considered exclusive of other methods of service delivery. Health professionals and care providers must exercise independent judgement as to what is appropriate for individual patients or groups of patients under particular circumstances.

GPAC, and the partner members of GPAC, accept no responsibility for any personal injury, loss or claim however sustained or caused as a result of any person using or relying on the information in this Framework. Any duty owing remains the responsibility of those health professionals and care providers who provide relevant services. GPAC does not endorse any health professional or care provider, or the services they provide, merely because they use this Framework.