Department of Health and Human Services

Marde Bevan
Coroners Registrar
Coroners Court of Victoria
65 Kavanagh Street
SOUTHBANK   VIC   3006

Dear Ms Bevan

Court reference: Investigation into the death of Ahmed ALI (child) COR 2014 004717

Thank you for your letter regarding Coroner Olle's findings and recommendation arising from the investigation into the death of Ahmed ALI (child).

The coroner recommended:

That the Department of Health and Human Services require that emergency departments in hospitals be mandated to provide a legible discharge summary if it is reasonably foreseeable and that upon discharge from the treating department, follow-up of a patient is required by another health service or health professional.

Consistent with section 72 of the *Coroners Act 2008*, please see below the department's response to the recommendation.

The department agrees that accurate, timely communication between health care providers is an essential component for ensuring quality and safety in healthcare.

It is well recognised best practice (*Taylor & Cameron, 2000. Discharge instructions for emergency department patients: what should we provide? Journal of Accident and Emergency Medicine*) that written or electronic communication with the provider of follow-up care should be provided at the time of discharge from an emergency department.

The mode of this communication varies between Emergency Departments, from providing the patient with a printed discharge letter/clinical summary to take to their provider to fax/email transfer of a discharge letter/clinical summary to a nominated follow-up clinician/practice. The varying modes in part reflect availability of technologies.
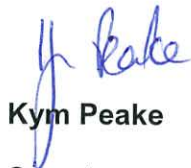
Victorian Public Health Services Boards are responsible for ensuring their staff comply with the expected standard of communication.

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The department, as system stewards, sets policy and compliance expectations for health services. These are outlined in policy documents such as *Transfer of care from acute inpatient services: guidelines for managing the transfer of care of acute patients from Victoria's public health services* and *Guidelines for the Victorian Emergency Care Coordination Program.*

Ahmed's death has caused sadness and pain for his family and friends, and the department thanks the coroner for his recommendation regarding opportunities to improve communication between health care providers, particularly after an emergency department attendance.

For further information, please contact Assistant Director Acute Programs Leonie Scott on 9096 6902 or via email at Leonie.scott@dhhs.vic.gov.au.

Yours sincerely

Kym Peake
Secretary
7/ 9/ 2017

Transfer of care from acute inpatient services

Guidelines for managing the transfer of care of acute

inpatients from Victoria's public health services

health

Transfer of care from acute inpatient services

Guidelines for managing the transfer of care of acute inpatients from Victoria's public health services

Contents

1. Purpose

The purpose of these guidelines are to:

- promote consistent transfer of care practices across the Victorian public health system
- support health services to review their existing discharge and transfer of care practices and to implement more effective transfer of care processes
- improve communication between health services and the patient, the patient's family and/or carer, the patient's general practitioner (GP) and community service providers.

Health services are encouraged to develop or update their own local policies, procedures and staff education programs to align with the principles and guidelines specified in this document.

2. Introduction

The 2008 Victorian Auditor General's Office report *Managing acute patient flows* examined the effectiveness and efficiency of patient flow in Victorian public hospitals. The report recommended that public hospitals develop comprehensive policies and procedures that clearly outline staff roles and responsibilities relating to discharge and transfer of care.

Transfer of care involves transferring professional responsibility and accountability for the care of a patient to another person or professional or a combination of professionals.[1] When a patient is discharged from an acute setting their ongoing care should be transferred to another person or team. The purpose of transfer of care is to achieve a safe, seamless journey that ensures continuity of care for the patient.

Transfer of care is part of the discharge process. Transfer of care in the context of these guidelines can occur when a patient is discharged home following their inpatient admission at which point their care is transferred to their GP, their carer, their family, a community service or an aged care facility. Transfer of care also occurs when a patient is transferred from an acute inpatient setting to subacute or non-acute care if the patient cannot return to their usual residence following their acute inpatient admission.

The transfer of care process plays an important role in enhancing patient outcomes, reducing readmissions, improving hospital efficiency and improving patient flow through health services. Developing and consistently implementing effective transfer of care and discharge processes can reduce unplanned readmissions and the length of time patients stay in hospital.

These guidelines aim to improve patient health outcomes and experiences of discharge and transfer of care from the acute inpatient hospital environment. These guidelines provide a framework for managing the transfer of care of acute inpatients from Victoria's public health services to subacute services, community-based services (such as aged care facilities) and home. A further resource is the Australian Medical Association's position statement *General practice/hospitals transfer of care arrangements.*[2]

These guidelines are presented in three sections to reflect the key phases of transfer of care:

- planning for transfer of care
- implementing the transfer of care plan
- post transfer of care.

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[1] NSW Health 2012, *Transfer of care from mental health inpatient services,* NSW Government, Sydney.
[2] See <https://ama.com.au/position-statement/general-practicehospitals-transfer-care-arrangements-2013>.

3. Principles

The following principles underpin these guidelines across the three phases of transfer of care.

- **The *National safety and quality health service standards* are adhered to.**

  In 2011 the Australian health ministers endorsed the *National safety and quality health service standards*. The standards were developed by the Australian Commission on Safety and Quality in Healthcare and are designed to assist health services to deliver safe and high-quality care. The guidelines in this document are in line with the standards and this document should be read in conjunction with the standards.

- **Patients (and their families and/or carers) are involved in decision making about their care.**

  An effective transfer of care strategy is collaborative and focuses on communication with the patient and their family and/or carer. Transfer of care policies, protocols and practices should be sensitive to the needs of different patient groups and individuals.

- **Victorian public health services have a consistent approach to transfer of care.**

  Standardised transfer of care protocols and criteria should be developed to promote consistency of practice across hospital wards and medical/surgical units, where possible. Where appropriate, there should be clearly defined care pathways that highlight critical points for timely and clinically appropriate transfer of care out of the acute inpatient environment.

- **Roles and responsibilities for transfer of care are clearly understood and communicated within a health service.**

  There should be a health-service-wide transfer of care policy accompanied by local protocols that define staff roles and responsibilities for transfer of care. There should also be clear, documented lines of accountability for decision making about a patient's transfer of care. All staff should assume an appropriate level of responsibility for effective transfer of care from the acute inpatient environment.

- **Transfer of care is coordinated and communicated across all relevant healthcare providers and community support services.**

  Transfer of care should be coordinated and communicated across relevant teams within the health service and between the acute hospital, primary care providers and community support services. These entities and a GP should work in partnership to share the care of patients with complex and chronic conditions. There should be effective information and communication technology (ICT) infrastructure and protocols in place to support timely transfer of information between the acute hospital, primary care providers and community support services.

- **Health services review and monitor their transfer of care performance and related aspects of service demand and capacity.**

  Meaningful data should routinely be collected, analysed, interpreted and reported to improve health services' understanding of their transfer of care performance, service demand and capacity. The performance measures outlined in section 7 of this document can assist health services to measure their transfer of care performance. Tailored information on transfer of care performance should be disseminated and discussed with relevant staff. Where transfer of care performance deviates from an acceptable level, an appropriate response should be enacted.

4. Planning for transfer of care

Key requirements

- Preparation for transfer of care is to begin prior to a planned admission and as soon as possible for emergency or unplanned patients.

- All patients are to undergo a thorough discharge risk assessment within 24 hours of admission.

- An estimated date of transfer of care should be established prior to, or as soon as possible after, an acute patient's admission and reviewed and updated to ensure accuracy and predictability.

- All patients are to have an individualised discharge plan or transfer of care plan.

- Responsibility for coordinating and implementing a patient's discharge or transfer of care plan is to be allocated to a specific individual or team.

- The individual or team responsible for coordinating the patient's discharge or transfer of care should engage with the patient and their carer to prepare them for discharge/transfer of care.

Implementation guidelines

Conducting a discharge risk assessment

As part of the admission process, a discharge risk assessment should be completed. The risk assessment can begin prior to admission for planned patients or at the time of admission for unplanned patients. To ensure comprehensive planning can occur and appropriate services can be arranged to support discharge, discharge risk assessments must be effective in identifying patients with more complex needs or at risk of an unplanned readmission. The discharge risk assessment should be reviewed and updated during the course of the admission.

A discharge risk assessment should be comprehensive and consider the patient's physiological, psychological, social and cultural circumstances. It may address the following areas:

- Is the patient likely to have self-care problems?

- Does the patient live alone?

- Does the patient have caring responsibilities for others?

- Has the patient used community services before admission?

- Has the patient had unplanned admissions to hospital in the previous six months?

- Is the patient at risk of falls?

- Is the patient at risk of developing a pressure injury?

- Is the patient at risk of continuing functional decline?

- Does the patient usually take three or more medications, and have their medications changed in the last two weeks? Does the patient understand how to administer the medications and do they have the ability and willingness to do so?

- Is the patient taking large quantities of Schedule 8 medicines?

Risk assessments should include assessment of the specific needs of Aboriginal and/or Torres Strait Islander Victorians and culturally and linguistically diverse (CALD) patients.

The risk assessment should be updated if the patient's clinical or social status changes.

Estimating a date of transfer of care

The estimated date of transfer of care (or discharge) is a prediction of the date and time that a patient will be transferred to another level of care. This could be the transfer of a patient from acute to subacute services, from one hospital to another hospital, or from hospital to care in the community or home.

Planning for transfer of care needs to be in progress early in the admission and may be supported by clinical or patient pathways. Transfer of care is confirmed and informed by the patient's clinical status and goals of admission.

Unnecessary transfers of care should be avoided and everyone should work together to ensure patients access their definitive care early and avoid being moved around the system.

In determining the estimated date of transfer of care, the patient's ongoing need for care and services should be matched with the availability of these services at the next level of care. For example, if the patient is to be discharged home, the availability of their GP and relevant community service providers should be considered. It is important that relevant support services are organised and in place before the patient is discharged.

If services are not in place at the next level of care or if the patient's condition deteriorates, it is appropriate to revise the estimated date of transfer of care. Changes to the estimated date of transfer of care should be recorded, along with the reason for this revision. Capturing and analysing data on delays to transfer of care or discharge can identify constraints in the system.

The estimated date of transfer of care should be included on patient journey boards and displayed at the bedside. This will ensure that all staff involved in the patient's care are working towards the estimated date of transfer of care. The estimated date of transfer of care should also be clearly communicated to the patient and their carer.

Developing an individualised transfer of care plan

All patients are to have an individualised discharge plan or transfer of care plan. This plan should:

- be informed by, and include, relevant information from the patient's risk assessment, family and/or carer, GP and relevant community providers

- include the estimated date of transfer of care (or discharge) and strategies to ensure the estimated date of transfer of care is met (such as communication plans with community providers, families and/or carers)

- include information about referrals to hospital-based services and/or community services

- include information about the patient's transport arrangements from hospital to their transfer of care location

- include information about the patient's medications and how these will be transferred

- form an integral part of the patient's clinical notes while they are admitted

- be updated as required

- be provided to the patient and/or carer.

Allocating transfer of care responsibility to an individual or team

The person or team responsible for coordinating and implementing a patient's transfer of care plan will differ depending on the patient and the health service. It may be appropriate to employ a multidisciplinary team approach where medical, allied health, nursing and other relevant staff work together through coordinated ward rounds or meetings. An agreed process of communication should be established between the patient and/or carer and the transfer of care team. A key contact for the transfer of care team should also be nominated. Alternatively, it may be appropriate to appoint a single patient treatment coordinator[3] to be responsible for coordinating the patient's transfer of care.

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[3] Patient treatment coordinators can be called many different titles and have different roles, but essentially their role is to implement coordinated and integrated care.

5. Implementing the transfer of care plan

Key requirements

- The transfer of care plan is to be developed and implemented in consultation with patients, their families and/or carers.

- All aspects of the transfer of care plan should be understood by the patient, their families and/or carers.

- A transfer of care summary should be commenced as soon as possible and developed throughout the patient's admission.

- A transfer of care checklist (or equivalent) should be completed for all patients prior to discharge or transfer of care.

- The transfer of patient information must comply with the privacy principles as defined in the *Information Privacy Act 2000* and the *Health Records Act 2001*.

- Patients at higher risk of readmission should be identified and strategies to minimise the risk of readmission implemented.

- The Victorian Quality Council's *Inter-hospital transfer patient transfer form*[4] should be used when transferring a patient from one hospital to another.

- Referrals to appropriate healthcare providers and/or community support services are to be made on completion of the risk assessment.

- Necessary community support services are to be engaged upon a patient's discharge home.

- Continuity of medication management should be maintained.

- An appropriate discharge or transfer of care destination should be confirmed.

Implementation guidelines

Communicating with the patient, their family and/or carer

When planning for discharge or transfer of care, information should be communicated regularly to the patient, their family and/or carer. An effective communication strategy between the health service, the patient, their family and/or carer can avoid unnecessary readmissions to a health service and improve health outcomes and the patient's experience.

The staff responsible for the patient's transfer of care should implement the transfer of care plan in consultation with the patient, their family and/or carer. The communication strategy may include coordinating family meetings at key points in the patient's journey. Hospital staff should ensure the patient, family and/or carer understand the information given to them.

Completing a transfer of care checklist

A transfer of care checklist (or equivalent) should be completed to ensure all appropriate activities have been carried out before the patient is discharged or transferred. This checklist may vary between health services depending on local circumstances.

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[4] See <www.health.vic.gov.au/qualitycouncil>.

Identifying patients at higher risk of readmission

Health services are encouraged to select a model for assessing readmission risk that is most appropriate for their patient population, and is informed by available data. Systems and processes should be in place to monitor the rates of preventable hospital re-presentation and readmission. Focused improvement work may reduce the rate of preventable readmission in high-risk patient populations.

Transferring the patient to another hospital

Inter-hospital patient transfer involves moving a patient from one hospital to another. It also involves transferring information and professional responsibility and accountability for patient care between individuals and teams within the overall system of care.

The Victorian Quality Council's *Inter-hospital transfer patient transfer form* is designed to ensure pertinent and accurate patient information is exchanged between the referring and receiving facility and the transport provider. It is intended for use in transfers between acute health services and may be used in transfers between hospitals and other facilities such as rehabilitation centres and aged care facilities.

A clinical handover tool such as ISBAR (identify, situation, background, assessment and recommendation) should be used to facilitate the handover process.

The receiving health service should advise the referring health service that the referral has been received.

Referring the patient to healthcare providers and community support services

Implementing the transfer of care plan may involve referring the patient to:

- hospital-based services such as individual allied health services, subacute assessment and treatment services, an aged care assessment service (ACAS) (to identify ongoing care needs) or a health independence program (HIP)
- home-based services provided by the hospital such as Hospital in the Home (HITH)
- community health services such as the Royal District Nursing Service (RDNS), Home and Community Care (HACC) or maternal and child health services.

Patients at risk of falls should be referred to appropriate services, where available, as part of the transfer of care process.

Patients with a high risk of developing pressure injuries must have a comprehensive skin inspection conducted prior to transfer.

There must be a process in place for communicating a patient's infectious status whenever responsibility for care is transferred between service providers or facilities.

It is important that referrals are generated in a timely manner so that services can be engaged upon the patient's discharge home. The referral content should be comprehensive and relevant to its recipient. It should be updated during the patient's admission to reflect changes to their condition and care needs on transfer of care.

It is expected that there is a patient identification system in place that requires at least three approved patient identifiers whenever a clinical handover or patient transfer occurs, or whenever transfer of care documentation is generated.

Note that privacy legislation stipulates that referrals cannot be directly transferred from one health service to another without the consent of the patient.

Maintaining continuity of medication management

A current and comprehensive list of medicines must be provided to the patient and/or carer and the receiving clinician during clinical handover, and when concluding an episode of care. The system used to generate the list of medicines must also allow the prescriber to document medication changes or cessations during the episode of care, and the reason for these changes.

An adequate supply of medication should be dispensed with consideration given to the availability of pharmaceutical resources in the patient's local area. The patient may also need other supplies (for example, wound dressings or catheter bags) for the post-acute period. Advice should be given to the patient about how they can access the required medications and consumables after discharge or transfer of care.

Approving a patient's transfer of care

It must be clear to staff and the patient and/or carer who is responsible for approving the patient's discharge or transfer of care.

Staffing models for approving discharges and transfers of care should ensure that available clinical skills are used in the best possible way to support timely and high-quality decision making. The most appropriate person to authorise a discharge or transfer of care will depend on the nature of the inpatient speciality unit and the complexity of the individual patient.

Criteria-led discharge/transfer of care by junior medical staff, nursing/midwifery and allied health staff may reduce the demand for a consultant review of less complex patients and improve transfer of care rates. This approach should be supported by formal transfer of care protocols for appropriate patient groups.

Where approval for discharge or transfer of care is delegated to less senior staff, there should be clear processes in place for escalation to a more senior clinician in the case of difficult decisions and/or where new information becomes available that challenges the intended transfer of care plan.

Confirming an appropriate transfer of care destination

Assessment of the patient by subacute services, the ACAS or another health service may be required to determine the most appropriate transfer of care destination.

It may be necessary to conduct a home visit to assess the safety and suitability of the planned transfer of care environment and to ensure the patient can access their house, has food in the fridge and has essential services connected. Providing and/or installing equipment can support a safe transfer of care home (for example, gait aids, raised seating and rails). It is also important to check that the patient's carers are available for their return.

A patient's mode of transport from the acute hospital to their transfer of care destination should be arranged and confirmed with the patient and/or carer as well as the transport provider. This transport should be safe and appropriate.

6. Post transfer of care

Key requirements

- A patient's discharge or transfer of care summary should be prepared ahead of the estimated date of transfer of care.

- A copy of the transfer of care summary should be sent to the patient's GP within 48 hours after the transfer of care (except for patients undergoing chemotherapy or dialysis where multiple treatments are required. In these circumstances, the summary should be sent to the GP after the patient's final treatment).

- The transfer of care summary should be given to the patient (or a family member and/or carer where appropriate) and sent to other relevant community providers.

- Patients who are deemed to be at higher risk of readmission should be contacted by telephone within 48 hours of discharge or transfer of care as a process for reviewing and identifying and resolving potential issues early.

Implementation guidelines

Working with general practitioners and other primary care providers

Health services are encouraged to utilise the skills and knowledge of their general practice liaison officer, where available, and engage their local division(s) of general practice or Medicare Local(s) to optimise the continuity of patient care after transfer of care from an acute health service.

The Department of Health has published a resource guide, *Working with general practice*,[5] that provides useful tools and examples of how to work effectively with general practice.

Preparing and sending a transfer of care summary

Suggested content for a transfer of care summary can be found in the appendix.

It is best practice to send a typed transfer of care summary to a patient's GP within 48 hours after the transfer of care (except for patients undergoing chemotherapy or dialysis where multiple treatments are required. In these circumstances, the summary should be sent to the GP after the patient's final treatment).

The transfer of care summary should be given to the patient (or a family member and/or carer where appropriate) and sent to other relevant community providers.

The method of disseminating the transfer of care notification may vary depending on the urgency of the patient's needs and the ICT systems in place at the health service and the general practice.

Electronic transfer of care summaries will enable accessible and comprehensive information to be exchanged quickly between hospitals and primary healthcare providers. The potential benefits of a consistent e-transfer of care summary system include improved continuity, safety and quality of patient care (enabling better patient outcomes) and alignment of technologies and processes within an agreed standard. The National e-Health Transition Authority (NeHTA)[6] has developed a standard for the content and specifications of an e-transfer of care summary.

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[5] See <www.health.vic.gov.au/pch/gpp/working>.
[6] See <www.nehta.gov.au>.

There must be a patient identification system in place that requires at least three approved patient identifiers whenever clinical handover, patient transfer or transfer of care documentation is generated.

Contacting the patient after discharge

Ideally, a health service should assess a patient's risk of readmission as part of the initial discharge risk assessment, and again on discharge. Patients who are assessed as being at higher risk of readmission should receive follow-up by telephone (and/or through contact with their GP, family, carer or community provider) within 48 hours to ensure the best health outcomes for the patient and to avoid unnecessary re-presentation to a health service.

Speaking to the patient, their family and/or carer provides the opportunity to:

- evaluate the effectiveness of the transfer of care process within the health service
- evaluate the overall effectiveness of the hospital intervention
- find out if the patient's needs (identified in the transfer of care plan) have been addressed
- reinforce the information given to the patient during their admission
- provide reassurance to the patient, the patient's family and/or carer
- ensure continuity of care for the patient
- address any issues or areas of concern.

7. Performance measures for transfer of care

Health services are encouraged to monitor their discharge and transfer of care performance through collecting and analysing data against a range of internal performance indicators.

Data can be used to identify opportunities for service improvement, and to set a baseline against which change can be measured. The impact of redesign and other improvement work can be measured incrementally and on completion of a project to demonstrate its results.

There are a number of viewpoints from which to assess healthcare services. It is important to obtain information from patients and staff to ensure multiple goals are met.

Key requirement

- Health services actively measure transfer of care performance across the health service and at the ward/speciality level.

Implementation guidelines

Health services are encouraged to monitor services, especially at critical points of the patient journey such as transfer of care. To assist health services a range of different measures are proposed below for consideration. These measures are not required to be reported to the department at this stage.

The measures can be grouped into four main categories: key performance indicators; demand, backlog measures; process measures; and check measures. 'Check measures' examine patient and staff experiences and the effects of change elsewhere in the patient journey or in other parts of the hospital/health system. These categories are not mutually exclusive; in some cases the same measure could be used for more than one category.

It is not expected that all measures be implemented by individual health services. The choice of measures will depend on the focus of the redesign or improvement work, and on the overall aims and priorities of the service.

The feasibility of the measures may depend on the availability of reliable data and/or the capacity of the health service or ward to collect the data. Variations between health services in resource allocation, operational policies and procedures will result in significant differences in the appropriateness of some of the suggested measures, and in the results should these measures be chosen.

1. **Key performance indicators**

   a. **Efficiency and patient flow**

   - Percentage of patients with a completed discharge risk assessment within 24 hours of admission

   - Number of transfers of care within an episode

   - Timeframe between admission (or the intention to admit) and preparing the transfer of care plan (prediction of a transfer of care date and destination)

   - Proportion of patients assessed for transfer of care to subacute services within a clinically appropriate timeframe

   - Proportion of patients assessed by ACAS within a clinically appropriate timeframe

   - Timeliness of notification of community providers (appropriate number of days may vary depending on the service requested)

- Percentage of patients given specialist clinic review appointment details prior to transfer of care
- Percentage of transfer of care summaries dispatched within 24–48 hours
- Proportion of patients receiving follow up within 48 hours of transfer of care, where appropriate

b. Clinical outcomes and effectiveness

- Rates of preventable re-presentation or hospital readmission
- Reasons for preventable re-presentation or hospital readmission
- Proportion of patients for whom a transfer of care summary is completed and dispatched
- Proportion of patients at higher risk of readmission who are followed up within 48 hours of transfer of care
- Quality of transfer of care communication
- Evaluation of whether all elements of the transfer of care plan were implemented as intended
- Evaluation of the effectiveness of the transfer of care plan (*Were post-acute services aligned with the patient's needs on transfer of care?*)
- Percentage of patients offered a specialist clinic review appointment within clinically recommended times

2. Demand and backlog measures

a. Demand

- Rate of referral to relevant services (allied health, HIP, ACAS and so on)
- Proportion of patients transferred to subacute services, home or to another destination

b. Backlog

- Number of patients awaiting transfer
- Outstanding actions for completion within, for example, 24 hours prior to planned transfer of care

3. Process measures

a. Key process times

- Admission to completion of discharge risk assessment
- Completion of risk assessment to referral to care coordinator / allied health staff / other services
- Referral to care coordinator / allied health staff / other services to complete assessment and commencement of care/services
- Number of days between the identification and implementation of actions to address positive risk screening questions
- Referral to review by specialist team / ACAS / subacute services
- Referral accepted to available bed

- Bed available to prepared for transfer of care
- Prepared for transfer of care to transferred to subacute services / residential care / home
- Difference in days/hours between the planned and actual transfer of care date/time
- Staff time to complete other key processes

b. Process quality

- Reason(s) for delayed transfer of care (availability of staff/vehicles to conduct a home visit, access to subacute services, access to a GP or other primary care, access to community services and so on) and duration of delay
- Reason(s) for delayed transfer of care on the day of transfer of care (availability of senior staff to authorise transfer of care, preparation of medications, access to transport, availability of family/carer) and duration of delay
- Percentage of referrals that are complete and accurate

4. Check measures

Patient, staff and referral recipient experiences

- Patient experience (targeted surveys of patient views on care coordination, communication and involvement in decision making about the transfer of care and the appropriateness, timeliness and quality of post-acute support services)
- Staff experience (targeted surveys plus proxy measures such as turnover, sick leave and agency use)
- Satisfaction of referral recipients (targeted surveys of GPs / the RDNS / the local council and/or other programs or community agencies)
- Number and nature of complaints and compliments received from patients, their families and/or carers, GPs and recipients of community referrals

Appendix: Suggested content for a transfer of care summary

Patient demographic information
- Full name
- Name of a parent, guardian or carer (where applicable)
- Address
- Telephone numbers
- Date of birth
- Gender
- Medicare number
- National healthcare identifier (when established)
- Indigenous status (where applicable)
- Interpreter needs, including preferred language (where applicable)

Health service information
- Hospital name and campus
- Medical/surgical unit
- Name of head of unit and their contact details
- Name, designation and contact details of person(s) preparing transfer of care summary

Clinical information
- Dates of admission and transfer of care
- Reason for admission
- Physical examination results
- Management to date and response to treatment
- Investigation results
- Transfer of care diagnosis
- Surgery/interventions performed
- Complications/deviations from the expected care pathway
- Associated comorbidities
- Relevant social or special needs
- Infectious status
- Allergies or warnings
- Complete medication list
- Details of person(s) appointed to make decisions on the patient's behalf (where relevant)
- Details of advance care planning (where relevant)

Post-acute follow-up
- Transfer of care destination
- Medical management plan post transfer of care
- Services arranged to support the patient in the post-acute period
  - Nature of the service
  - Anticipated commencement date
  - Anticipated duration of service
- Details of post-surgical advice / management plan as agreed with the patient
- Follow-up specialist clinics (outpatient) appointments
- Follow-up investigations

Guidelines for the Victorian Emergency Department Care Coordination Program
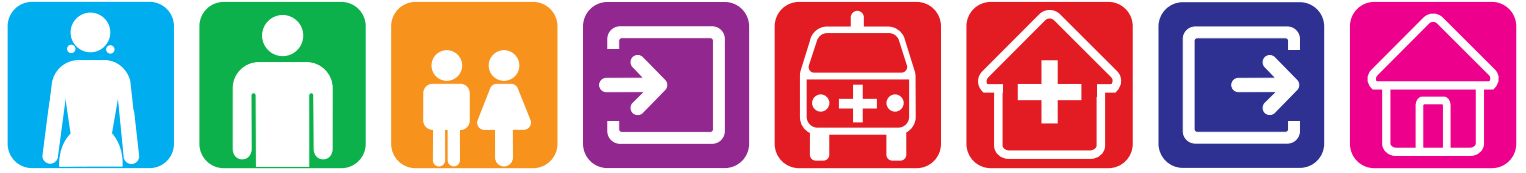
2009

Guidelines for the Victorian Emergency Department Care Coordination Program

2009

Accessibility

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please phone 9096 0490 using the National Relay Service 13 36 77 if required.
This document is also available in PDF and word version format on the Internet
at www.health.vic.gov.au/emergency

Contents

Executive summary

In Victoria, emergency department (ED) care coordination services are provided either by an established multidisciplinary team within the hospital ED or by the hospital's allied health or ambulatory care services on an episodic basis in response to a referral from the ED. Care coordination practitioners work as part of the ED team providing skills and information that contribute to the patient's overall treatment and care.

The *Guidelines for the Victorian Emergency Department Care Coordination Program* has been developed by the Department of Human Services as a resource for health services delivering emergency care. The guidelines are designed to promote consistency of practice and to support continued service improvements by providing:

- a shared understanding of ED care coordination services across Victoria
- a basis for continuous service improvement through comparing existing and best practice guidelines
- a means of ongoing service monitoring and development.

The guidelines set the context for the ED care coordination program by charting the development of the services, outlining relevant policies and describing the service system in which ED care coordination operates. The guidelines delineate the role of the program and its core functions and outline the structure and governance features of the program.

The guidelines are not prescriptive and allow for individual health services to structure their services to meet their differing organisational arrangements and the needs of their local communities and patient populations. The guidelines are to be used in conjunction with organisational quality standards of care, professional codes of conduct, legislative requirements and other regulatory and accreditation health care bodies.

The role of ED care coordination services is to minimise hospital use by facilitating timely access to an integrated system of community-based services. Hospital use can be minimised by diverting hospital ED presentations, providing alternatives to inpatient admissions and by reducing a patient's length of stay in hospital. In particular, ED care coordination services have a role in:

- providing person-centred care that encourages and supports consumer and carer participation
- enhancing the safety and minimising the risk of harm to consumers, carers and the community
- providing a primary access point within the hospital ED for community-based services
- facilitating safe and timely discharge to the community
- promoting continuity of care within and across hospital and community sectors
- contributing to the functional integration of health services
- facilitating clear and continuous communication and information sharing
- building and promoting sustainable collaboration and partnerships between services
- improving the quality of health care
- optimising resource use and the efficiency of care across multiple providers
- promoting interdisciplinary collaboration and team decision making.

The 12 core functions associated with providing a care coordination service in a hospital ED are as follows:

- initial contact
- initial needs identification

- assessment
- care planning
- referral
- intervention
- service brokerage
- early discharge planning
- follow-up services
- outreach services
- stakeholder engagement
- consumer and care engagement.

The guidelines present a description of each of these core functions, the objectives and intended outcomes of each function and the associated staff responsibilities, supporting system resources and tools and good practice indicators.

The service structures established for the ED Care Coordination Program incorporate the following features:

- a multidisciplinary team based in the ED
- extended hours of operation with an after-hours referral system and on-call support
- brokerage funds or access to brokered services provided by programs with a brokerage budget
- formal relationships with relevant programs and services
- established links with the hospital's regional Primary Care Partnership (PCP) and other relevant community-based services and networks
- systems that promote multidisciplinary collaboration and team decision making both within the ED care coordination service and the ED team
- appropriate staff support
- multidisciplinary clinical review, an audit program, quality improvement plans and processes for identifying and managing risk
- client record management, data collection, performance monitoring and reporting systems.

The governance structures established for the ED Care Coordination Program include the following features:

- clear management delegations and line management within the ED
- formal relationships with relevant programs and services
- established links with the hospital's regional PCP and other relevant community-based services and networks
- discipline-specific professional linkages for individual practitioners
- participation in ED risk management systems and plans and quality assurance, and monitoring and reporting processes.

1. Introduction

The Guidelines for the Victorian Emergency Department Care Coordination Program have been developed by the Department of Human Services in conjunction with the Emergency Access Reference Committee – Primary Care Subcommittee, the Emergency Department Care Coordination Managers' Collaborative and other key stakeholders (refer to appendix 1 for details).

The guidelines are a resource for health services providing care coordination services in their hospital ED. They are intended to promote consistency of practice and to support continued service improvements by providing:

• a shared understanding of ED care coordination services across Victoria

• a basis for continuous service improvement through comparing existing and best practice guidelines

• a means of ongoing service monitoring and development.

Victoria's funded ED care coordination services are provided by a multidisciplinary team of practitioners based in a hospital ED. The practitioners work as part of the ED team providing skills and information that contribute to the patient's overall treatment and care. The service has a key role in minimising hospital use by facilitating timely access to community-based services and ensuring continuity of patient care.

Service integration is a key focus of the guidelines, one which reflects the range of community-based services that interface with hospital EDs. The guidelines also emphasise consistency of practice in an environment in which individual hospitals tailor their services to the needs of their patient populations and the demographic and service profiles of the communities they serve.

The guidelines provide an overall structure for the operation and future improvement of Victoria's ED care coordination services. Specifically, the guidelines:

• delineate the role of the service and its 12 core functions

• outlines the structure and governance features of the services

• provide a basis for continuous service improvement

• a means of ongoing service monitoring.

The guidelines are not prescriptive and allow for individual health services to structure their services to meet their differing organisational arrangements and the needs of their local communities and patient populations. The guidelines are to be used in conjunction with organisational quality standards of care, professional codes of conduct, legislative requirements and other regulatory and accreditation health care bodies.

1.1 Background to care coordination in emergency departments

In 2001 the Victorian Government committed to the four-year Hospital demand management (HDM) strategy[1] designed to address the sustained and consistent growth in demand for hospital services, particularly emergency care. The HDM strategy had a system-wide focus and promoted the development of new models of care that would prevent ED presentations, inpatient admissions and unplanned patient readmissions.

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1 http://www.health.vic.gov.au/archive/archive2006/hdms/index.htm

The Hospital Admission Risk Program[2] (HARP) was the prevention component of the HDM strategy that focused on people with chronic and complex conditions by providing new approaches to care at the time of an ED presentation and targeted support on discharge home.

Under the impetus of the HDM strategy, 13 ED care coordination services were established across metropolitan Melbourne between mid-2000 and late 2001. An additional two services were established at regional hospitals in 2003.

HARP funded a number of new and pre-existing ED care coordination projects during this period. As HARP evolved and the projects developed into more comprehensive services designed to meet locally identified needs, the congruence between ED care coordination and HARP lessened. Based on the overall positive impact of HARP, the Victorian Government decided in 2004–05 to mainstream HARP projects into HARP Chronic Disease Management (HARP–CDM) services.[3] The department's Statewide Emergency Program (SEP) assumed program responsibility for Victoria's ED care coordination services.

In 2005–06 the Victorian Government provided additional funding over four years to support the wider implementation of the new emergency models of care trialled under the HDM strategy. Five new ED care coordination services were established under this initiative. A total of 19 metropolitan and regional health services currently receive funding to support care coordination services within EDs.

The mainstreaming of new models of care and the development of ED care coordination guidelines were key priorities identified in the *Better faster emergency care*[4] policy released in 2007.

The guidelines for Victoria's ED care coordination services outline a best practice model of care that will promote consistency of practice and support continued service improvements.

1.2 Policy context

The *Guidelines for the Victorian Emergency Department Care Coordination Program* have been developed in the context of state policies and directions relating to care coordination. The relevant overarching and service-specific policies are detailed in appendix 2 along with a summary of the relevant literature.

Better faster emergency care is the key policy informing the care coordination service guidelines. This policy outlines 10 key priorities for the equitable and timely access to quality emergency care within public hospitals. The approaches advocated in this document are of particular relevance:

- a system-wide approach encompassing the continuum of care coordinated across health care providers and settings
- support for innovation and mainstreaming of new models of care
- continuous quality improvement
- people-centred approaches that are responsive to the needs of individuals and their families and encourage participation.[5]

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2 *Department of Human Services 2006, Improving care Hospital Admission Risk Program, Final report, Melbourne*
3 *ibid. p. 41*
4 *Department of Human Services 2006, Better faster emergency care: Improving emergency care and access in Victoria's public hospitals, Melbourne*
5 *Better faster emergency care, op. cit. pp. 39–42*

These approaches are supported by a range of other relevant departmental policies, notably the *Primary care partnership (PCP) strategy*,[6] *Better access to services (BATS): A policy and operational framework*[7], *Doing it with us not for us*[8] and *Recognising and supporting care relationships*[9] which are detailed in appendix 2.

1.3 Service context

ED care coordination services operate within a responsive, high-throughput hospital environment and are focused the transition of patients to the primary care, acute inpatient, sub-acute and residential care sectors. They operate at the interface between hospital and community-based services and perform a key liaison role. The service context in which care coordination operates is both unique and complex. The main features of the service context are outlined below.

1.3.1 Emergency department environment

In Victoria, EDs are designed to deliver short episodes of time-critical care and treat people who are experiencing a medical emergency. They provide a 24-hour, seven-day-a-week service and treat patients on a walk-in basis. The ED is one of the multiple points of entry to the hospital and broader health system. Establishing linkages between EDs and other parts of the hospital and health system is essential to facilitate the flow of patients through the ED and ensure continuity of patient care.[10]

The ED workforce operates as a multidisciplinary team in which each discipline contributes complementary skills and information that add to the patient's overall treatment and care.

Patients presenting to an ED require many different interventions to complete their processes of care. As the first priority in an ED is to treat patients with the most urgent medical needs, triage is the first point of contact and patients are screened for urgency.

Patients are transferred either directly or from the waiting room to a cubicle in the ED where they are assessed by nursing and medical staff; investigation, treatment and management regimens are commenced as appropriate. Patients are then either discharged to their place of residence, referred to another service or admitted to an inpatient bed for further treatment. Care coordination in hospital EDs involve a number of inter-related processes that complement and contribute to this generic ED process.

People with a wide variety of needs are managed through ED care coordination services. Individual hospitals tailor their services to the needs of their patient populations and the demographic and service profiles of the communities they serve.

6 Department of Human Services 2003, Primary care partnerships strategic directions 2004–06, Melbourne

7 Department of Human Services 2001, Better access to services: A policy and operational framework, Melbourne

8 Department of Human Services 2006, Doing it with us not for us, Melbourne

9 Department of Human Services 2006, Recognising and supporting care relationships for older Victorians, Melbourne

10 Better faster emergency care, op. cit. pp. 15–17

1.3.2 Community-based sector

People presenting to hospital EDs may require the services of a wide range of community-based health and social services. For the purposes of this document community-based health services includes general practice, supported residential services and health care that does not involve an overnight or multi-day stay in hospital.[11] (Refer to appendix 3 for details.)

Victoria's primary care sector is functionally integrated through its PCPs and a vision of service coordination which aligns practices, protocols and systems. Individual agencies retain their independence but can work in a cohesive and coordinated way so consumers can experience a seamless and integrated response.

Not all health and social services from the community-based care sector are fully engaged in the service coordination arrangements. Work is proceeding through the Service Coordination Tool Templates (SCTT) 2009 Revision Project[12] and various area- and project-based initiatives to include more sectors in service coordination. These sectors include: general practice; alcohol and other drugs; mental health; disability; homelessness and public housing; child and family; and child protection.

The key elements of service coordination in the primary care sector have been articulated in the *Victorian service coordination practice manual*.[13] PCPs enhance service coordination by establishing and maintaining partnerships, providing agency leadership and monitoring improved service coordination practice. The resources and tools that support service coordination include the *Human services directory* (HSD) and other local services directories, privacy resources, the SCTT and guidelines and the *Victorian service coordination practice manual*.

11   *Care in your community, op. cit. pp. 2–3*
12   *www.health.vic.gov.au/pcps/coordination/sctt2009/index.htm*
13   *Primary Care Partnerships Victoria 2007, Victorian service coordination practice manual, Melbourne*

2. Role statement for emergency department care coordination services

The role of the ED care coordination services is to minimise hospital use by facilitating timely access to an integrated system of community-based services that enhances the health outcomes and functional independence of Victorians living in the community.

In particular, ED care coordination services have a role in:

- providing person-centred care that encourages and supports consumer and carer participation
- enhancing the safety and minimising the risk of harm to consumers, carers and the community
- providing a primary access point within the hospital ED for community-based services
- facilitating safe and timely discharge to the community
- promoting continuity of care within and across hospital and community sectors
- contributing to the functional integration of health services
- facilitating clear and continuous communication and information sharing
- building and promoting sustainable collaboration and partnerships between services
- improving the quality of health care
- optimising resource use and the efficiency of care across multiple providers
- promoting interdisciplinary collaboration and team decision making.

Hospital utilisation can be minimised in a variety of ways including:

- diverting hospital ED presentations
- providing alternatives to inpatient admission
- reducing the length of stay in hospital.

To improve patient flow through the ED, consumers designated as unlikely to be admitted to an inpatient bed are a primary focus of the care coordination service. Identifying patients deemed likely to be admitted to an inpatient or sub-acute bed ensures discharge planning commences as early as possible in the patient journey and promotes continuity of care.

The role performed by ED care coordination services determines the core functions performed by the service. Section 3 of this paper addresses the core functions of the service in detail.

2.1 Population managed through ED care coordination services

People with a wide variety of needs are targeted for management through ED care coordination services.[14] This is in keeping with the diverse patient population that attend hospital EDs for urgent, short-term episodic care. The consumers targeted by individual ED care coordination services will reflect the hospital's patient population and the demographic and service profile of the communities they serve.

The people managed through the ED care coordination services include those outlined opposite.

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14 Department of Human Services 2006, Results of emergency department care coordination survey August 2007 (unpublished)

People managed through the ED care coordination services include:

- people over 65 years of age, frail elderly
- residential care services clients
- people with complex or chronic medical conditions including HARP clients
- people with complex or non-specific psychosocial issues
- people with:
  - functional decline or mobility difficulties
  - history of falls
  - disability
  - cognitive issues
- people requiring:
  - assistance with activities of daily living and self-care
  - aids or equipment
  - allied health intervention for safe discharge home
- carers responsible for others, including carers who are parents
- children, adolescents and their families
- people with issues relating to:
  - drugs, alcohol and dual diagnosis
  - mental health including anxiety, depression and self-harm
  - homelessness and accommodation
  - physical abuse, domestic violence, child protection or sexual assault
- people frequently representing or at risk of representing to ED
- people who live alone, are socially isolated or have no one to assist them on discharge
- people receiving or who have previously received community services
- patients in the short stay unit and those requiring admission or complex discharge planning.

Appendix 4 outlines the factors to be considered in services providing a paediatric component. It also provides a range of information to assist ED care coordination services to address the needs of children, adolescents and their families who present to hospital EDs.

3. Core functions of emergency department care coordination services

The core functions performed by ED care coordination services are detailed in this section of the guidelines. They reflect and align with the particular roles of the service. The 12 core functions encompassing the activities and processes undertaken by care coordination services in hospital EDs are:

- initial contact
- initial needs identification
- assessment
- care planning
- referral
- intervention
- service brokerage
- early discharge planning
- follow-up services
- outreach services
- stakeholder engagement
- consumer and carer engagement.

In the following sections each of the core functions is described and expanded with information that includes:

- process objectives
- ED responsibilities
- supporting system resources and tools
- intended outcomes
- good practice indicators.

A number of the core functions and associated systems have been illustrated using examples of best practice from various health services across Victoria.

Together this information establishes guidelines and standards for ED care coordination services and it provides a framework for continuous service improvement. The guidelines should be used in conjunction with organisational quality standards of care, professional codes of conduct, legislative requirements and other regulatory and accreditation health care bodies.

3.1 Initial contact

3.1.1 Description

Initial contact is the point a consumer, carer or practitioner first makes contact with the hospital ED. Consumers initiate first contact by presenting in person to ED triage, either on their own initiative, on referral from a primary health practitioner or following transportation by ambulance or police. Practitioners make initial contact with the ED care coordination service, either directly or through ED triage, to secure assistance to prevent a consumer or their carer presenting to an ED or to facilitate an ED presentation.

Initial contact in an ED may include:

- a triage process where the needs of consumers are assessed for urgency
- recording of basic patient information
- direct access to ED care coordination for practitioners making a referral
- reference to alerts and care plans developed for consumers who frequently present to the ED.

Initial contact ends when the consumer or practitioner receives the required advice or information or the consumer is admitted to a treatment cubicle and the process of investigation and enquiry begins.

3.1.2 Process objectives

- To promote timely access to care coordination services.
- To ensure relevant alerts and care plans for consumers frequently presenting to the ED are accessible during the initial contact.

3.1.3 ED responsibilities

The range of ED responsibilities in relation to initial contact include:

- enabling community-based practitioners to access ED care coordination services
- identifying and flagging patients requiring follow-up by care coordination service
- preparing alerts and care plans for consumers who frequently present to ED
- enabling ED staff to access alerts and care plans during initial contact
- informing the consumer's general practitioner (GP), key worker or case manager about an ED presentation.

3.1.4 System resources and tools

Supports for initial contact include:

- policies and procedures covering initial contact
- patient administration systems (PAS) for flagging patients requiring follow-up by care coordination
- PAS systems that allow patients that frequently attend an ED to be flagged and associated alerts and care plans to be accessed
- an e-referral system

- a system facilitating direct contact between community-based practitioners and the ED care coordination service
- staff orientation and information sessions about the care coordination service for ED staff.

3.1.5 Intended outcomes of initial contact

The intended outcomes are:

- timely access to care coordination services for consumers, carers and practitioners
- streamlined care for consumers that frequently present to EDs.

3.1.6 Good practice indicators

Good practice indicators are that:

- triage staff are informed about ED care coordination services and facilitate access to the service
- community-based practitioners have direct access to the ED care coordination service
- the safety of consumers, carers, ED staff and the community is maximised
- for consumers frequently presenting to EDs:
  - key workers or case managers are notified about each ED presentation
  - ED staff has access to alerts and care plans.

Central Intake Contact – St Vincent's Health

ED care coordination services provide a Central Intake Contact (CIC) telephone service. Clinicians from inpatient and community-based services may make direct contact with the ED care coordination service to facilitate a presentation to or diversion from the ED, initiate early referrals or to ensure care planning needs are completed whilst the client is in ED.

A clinician assigned to screening activities in the ED carries a telephone pager throughout the shift and responds to all the calls made to the CIC service. This initial contact system provides a central contact for community services and carers to hand over relevant information on clients presenting to the ED. The CIC ensures:

- clients are seen in a timely manner and do not leave prior to being seen, particularly where cognitive or behavioural issues influence the client's capacity to wait
- clients are appropriately triaged and can be fast-tracked through the ED
- timely medical and allied health interventions during the ED presentation, particularly where the client is not amenable to health care treatment
- there is effective information exchange and the full complexity of the client issues are identified
- alternative community-based services are arranged to prevent unnecessary admissions and facilitate diversions from the ED.

3.2 Initial needs identification

3.2.1 Description

Initial needs identification (INI) is an initial screening process where the presenting and underlying issues are uncovered as much as possible. It is not a diagnostic process but a determination of the consumer's risk and their eligibility and priority for service.

The practitioner undertaking the INI looks beyond the presenting medical and biological issues to the social and environmental issues associated with the ED presentation. INI allows the consumer's health and wellbeing needs to be broadly identified as early as possible in the care processes of the ED with a view to accessing the services available through care coordination or other specialist services.

3.2.2 Process objectives

• To ensure early identification of consumers that may require ED care coordination or other specialist services.
• To ensure relevant alerts and care plans for consumers frequently presenting to the ED are referred to during the clinical work-up and treatment processes.
• To facilitate interdisciplinary collaboration and team decision making.

3.2.3 ED responsibilities

The range of ED responsibilities in relation to INI include:

• completing a Discharge Risk Screen (DRS) as part of work-up and treatment processes
• referring alerts and care plans developed for consumers frequently presenting to ED
• internal referral to the care coordination service
• case-finding activities including monitoring PAS, observing the waiting room and attending clinical handovers and ward rounds
• reviewing referrals from ED staff and external service providers.

3.2.4 System resources and tools

Supports for INI include:

• a DRS based on the Thompson and Associates model (see Appendix 5); as a minimum requirement the DRS is to include the following four potential risk identifiers:
  - patient likely to have self-care problems
  - patient lives alone
  - caring responsibilities for others
  - patient used services before admission

- risk screens utilised by specialist services[15]
- systems and tools supporting documentation of the DRS in the patient history
- a documented referral system for care coordination services that covers referrals made by ED staff, external practitioners, GPs, carers and consumers and referrals made outside business hours
- an electronic e-referral system
- PAS systems for flagging patients requiring follow-up by care coordination
- PAS systems that allow patients who frequently attend ED to be flagged and associated alerts and care plans to be accessed
- advanced care plans, refusal of treatment certificates and supporting electronic alerts system recording consumers ACP status[16]
- Department of Human Services SCTT in Health*SMART* applications
- the *Victorian service coordination practice manual*
- policies and procedures covering INI
- staff orientation and information sessions for ED staff on the DRS, INI and referral processes as well as promoting consumer and carer participation.

3.2.5 Intended outcomes of initial needs identification

The intended outcomes are:

- timely and appropriate identification of consumers requiring care coordination services
- streamlined care for consumers who frequently present to EDs
- improved safety of consumers, carers and ED staff.

3.2.6 Good practice indicators

Good practice indicators are that:

- ED staff utilise risk assessment tools to determine consumer's needs, level of risk and priority for access to ED care coordination services
- ED staff make appropriate referrals to care coordination service and specialist services
- there is no unnecessary duplication of investigations and enquiries for consumers frequently presenting to EDs
- there are no incident reports relating to ED staff safety involving consumers with an alert.

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15 Department of Human Services 2007, *Mental health care framework for emergency department services*, Melbourne; Department of Human Services, 2006, *Vulnerable babies, children and young people at risk of harm: best practice framework for acute health services*, Melbourne. Refer to < http://www.health.vic.gov. au/childrenatrisk/index.htm> and Appendix 4.
16 *Office of the Public Advocate 2006, Enduring power of attorney (Medical treatment)*, Melbourne; Office of the Public Advocate 2004, *Refusal of medical treatment*, Melbourne

Discharge Risk Screen – Southern Health

The ED nursing assessment form used at three Southern Health EDs includes a DRS featuring a series of questions with prompts advising practitioners to make appropriate referrals to the ED care coordination service or relevant allied health professional.

The DRS includes the four recommended potential risk identifiers and two questions that identify the need for a comprehensive falls risk assessment.

Monash Medical Centre has a nursing care review system in place whereby a clinical practice leader and a clinical nurse educator review patient care plans and documentation with ED nursing staff on a daily basis. One of the priorities of the review process is to promote the use of the DRS and highlight the benefits of effective discharge planning for consumers. The system has resulted in improved compliance in DRS completion and an increase in referrals to the ED care coordination service.

3.3 Assessment

3.3.1 Description

Assessment is a decision-making methodology that collects, weighs and interprets relevant information about the consumer. Assessment is not an end in itself but part of a process of delivering care and treatment. It is an investigative process using professional and interpersonal skills to uncover relevant issues and to develop a care plan.

Assessment is a process by which a skilled practitioner investigates in detail the specific needs of a consumer. In the first instance, practitioners undertake a comprehensive generic assessment that addresses the consumer's personal, social and cultural situation and takes account of the availability of community services. Where appropriate, the needs of carers and dependents, including children and adolescents, are to be assessed in relation to the consumer. Assessment is a consultative process involving the consumer and their GP, carers, family and relevant community services.

Specialist, comprehensive, service- and discipline-specific assessments ensure the assessment is commensurate with the service or intervention provided and informs the development of an appropriate treatment or care plan for the consumer. Services providing specialist, service- or discipline-specific assessments in the ED include:

- area mental health services
- child protection or Child FIRST
- the Hospital Admission Risk Program (HARP)[17]
- alcohol and other drug services
- sexual assault crisis care units
- homelessness services
- geriatrician assessment.

Consumers may be referred for comprehensive assessment following discharge from the ED.

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17 *All health independence programs may be accessed through a single point of entry, including HARP, PAC, Hospital in the Home and SACS.*

Assessment is undertaken in order to:

- set care goals
- determine the services and interventions required
- develop a care plan
- make appropriate referrals with the consumer's consent.

The assessment process is facilitated by assessment tools that meet consumer, service and ED reporting and program requirements.

3.3.2 Process objective

- To ensure consumers have access to appropriate assessments to identify their needs and service requirements.

3.3.3 ED responsibilities

The range of ED responsibilities in relation to assessment include:

- referral to the ED care coordination service for assessment
- referral to specialist service for assessment
- referral to another hospital department for assessment and care planning
- undertaking comprehensive generic or discipline-specific assessments
- consulting with consumers and their carers, GP and relevant community-based services
- documentation of assessments in the patient record.

3.3.4 System resources and tools

Assessment will be supported by:

- policies and procedures that articulate the assessment process
- a multidisciplinary assessment tool that incorporates carer assessment
- risk assessment and risk management frameworks developed by specialist services[18]
- the *Victorian service coordination practice manual*
- A documented system for obtaining assessments from the ED care coordination service, specialist services and other hospital departments
- recognised professional development programs covering assessment processes
- staff orientation and information sessions provided by the care coordination service for ED staff on obtaining specialist and service-specific assessments
- training programs for staff in communication skills and how to involve consumers and carers in decision making
- accessible information about health care and treatment and the rights and responsibilities of patients.

18 Department for Victorian Communities 2007, *Family violence risk assessment and risk management framework, Melbourne*. Also at <www.women.vic.gov.au> Office of Housing 2006, *Statewide homelessness assessment and referral framework, Department of Human Services, Melbourne*. See <http://www.health.vic.gov.au/childrenatrisk/index.htm> and Appendix 4.

3.3.5 Intended outcomes of assessment

The intended outcomes are:

- systematic identification of consumers' and carers' needs and the services they require
- consumers and carers are able to actively participate in the assessment process
- effective interdisciplinary collaboration and team decision making.

3.3.6 Good practice indicators

Good practice indicators are that:

- practitioners use appropriate multidisciplinary assessment tools to determine consumers' needs, level of risk and priority for access to services
- assessment processes meet accepted service- and discipline-specific practice requirements
- the ED has processes in place to access specialist and service-specific assessments as required
- the GP and community-based services already providing services to the consumer are consulted during the assessment process
- assessment processes and procedures facilitate multidisciplinary collaboration and team decision making in the care coordination service and the ED team
- assessment outcomes are documented in the patient's medical record.

Generic functional assessment skills – Western Health

The interdisciplinary ED care coordination team at Western Health has developed and introduced training and tools to increase staff clinical skills and standardise generic assessment across all disciplines. The team developed core competency packages for completing four basic occupational therapy (OT) and physiotherapy tasks:

- assessing gait/mobility
- providing basic adaptive equipment
- assessing activities of daily living (ADL)
- assessing the need for OT home assessment or follow-up physiotherapy.

Following an audit of discipline-specific sections of the ED care coordination assessment tool and a literature review the service developed a package consisting of:

- one-on-one education and training
- clinical observation over three patient-related episodes
- a series of flowcharts and decision trees
- pre- and post-evaluation case studies that measured the practitioner's knowledge and confidence.

The training has improved consistency in OT-specific documentation and the awareness of OT issues.

3.4 Care planning

3.4.1 Description

Care planning is a process of deliberation that encompasses:

- liaising and communicating with key stakeholders including GPs
- setting care goals and targets
- determining the type, level and frequency of interventions required
- developing and implementing a care plan
- making appropriate referrals
- exchanging information between service providers (with the consumer's consent)
- case management
- coordinating service delivery
- organising nomination of key worker
- providing feedback to referrers and other stakeholders
- conducting or arranging reviews and reassessment
- monitoring care plans
- arranging for consumers to exit from a service.

Care planning involves the judgement or determination of relative need as well as competing needs and assists consumers to come to decisions that are appropriate to their needs, wishes, values and circumstances. Care planning provides a means of synthesising assessment information and agreed strategies and is important in facilitating appropriate community-based care for consumers presenting to a hospital ED, particularly those with multiple and complex needs.

Care planning also includes:

- crisis intervention strategies
- prevention or protective strategies
- provision of information promoting wellbeing.

In some instances, crisis intervention, prevention and protective strategies may be covered by existing codes and standards of practice.

Care planning is dynamic and occurs at a number of levels.

Service-specific care plans

Service-specific care plans[19] are prepared for consumers accessing one service within a hospital, a community-based agency or from a GP. A service-specific care plan includes elements such as agreed goals, details of service provision, referral information and self-care strategies.

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19 May also be known as a consumer care plan, individual treatment plan, clinical plan, service plan or self-management plan or a personal action plan.

Emergency department care plans

ED care plans are prepared for consumers who frequently present to hospital EDs. Where appropriate, frequently presenting consumers are referred to HARP or another suitable community-based program for assessment and case management.

An ED care plan is prepared if the consumer:

• frequently attends the ED

• has an outpatient appointment

• has established contacts with community-based services

• is at risk of or likely to represent to the ED.

ED care plans outline agreed strategies and interventions for subsequent ED presentations. The plans are prepared in consultation with relevant ED and community-based practitioners, the consumer and their carers and include appropriate monitoring, review and exiting arrangements. The care plans are accessible to ED practitioners so they can be referred to when the consumer presents to the ED.

ED care plans are also prepared for consumers frequently attending a number of different hospital EDs. In this instance, practitioners from the various ED care coordination services liaise with one another and other relevant service providers to develop a commonly agreed ED care plan applicable to all the EDs concerned.

Intra-agency care plans

Intra-agency care plans are prepared for consumers accessing more than one service from the hospital or a number of practitioners within the hospital. An intra-agency care plan is developed to:

• coordinate internal hospital service provision

• facilitate communication of agreed strategies and service interventions between hospital practitioners

• articulate shared goals and outcomes

• outline roles and responsibilities of each practitioner

• nominate the practitioner responsible for care coordination and or case management.

Intra-agency care plans are also used for the services provided by the ED care coordination service, for discharge planning or for coordinating treatment provided to patients in the ED.

Inter-agency care plans

Inter-agency care plans are prepared for consumers with complex or multiple needs who require the services of more than one agency. In this instance, care planning ensures the needs of the consumer are discussed with them, their carer, GP and the various practitioners and agencies involved in their care. Discussions will focus on possible options and will be worked through to an agreed strategy.

As the care provided in hospital EDs is of a short term, episodic nature, the ED care coordination service will either refer the consumers with complex or multiple needs to their GP, an appropriate community-based service for care planning or organise a key worker to coordinate the care planning

process. In many cases the consumer will be admitted to an inpatient or sub-acute hospital bed and the care planning will be undertaken by staff on the unit. The ED care coordination service should ensure continuity of care during the transition period. (Refer also to Section 3.8 Early discharge planning.)

Involvement of general practitioners

Consumers are eligible for a Medical Benefits Schedule (MBS) rebate for a discharge care plan involving a GP or a GP-initiated care plan where the GP helps prepare a written plan in collaboration with all members of a multidisciplinary team documenting an assessment of the patient's health care needs, identified goals, action plan and a time for review. Consumers with chronic medical conditions, terminal conditions, complex care needs, mental health issues and those living in residential aged care facilities can access MBS rebates for care planning.

Care planning activities undertaken by the ED care coordination service are to include the consumer's GP where appropriate. A summary of the outcomes of the ED care coordination assessment, care plans and any interventions are to be forwarded to the consumer's GP. This information is to be incorporated in the notification of patient attendance issued to GPs by the ED.

3.4.2 Process objective

- To ensure consumers have access to care planning services based on appropriate assessments and communication between key stakeholders.

3.4.3 ED responsibilities

The range of ED responsibilities in relation to care planning include:

- contributing information and advice as part of the care planning process
- referring to care plans and monitoring and facilitating progress with implementation
- liaising with the consumer's GP and other key stakeholders
- preparation and implementation of care plans based on assessment information and communication with key stakeholders
- notifying the patient's GP about ED attendance and providing a summary of outcomes of care coordination assessment and intervention
- informing consumers about the care planning process, the role of practitioners and privacy and confidentiality procedures
- obtaining patient consent to share information
- documenting the care plan in the patient record
- making care plans for consumers attending ED frequently accessible to ED staff
- referring to community-based services or another hospital department for service
- monitoring and reviewing ED care plans for consumers frequently attending ED
- organising nomination of a key worker
- providing feedback to referrers and stakeholders.

3.4.4 System resources and tools

Care planning is supported by:

- policies and procedures that articulate the care planning process
- systems for identifying consumers that frequently present to hospital EDs
- codes and standards of practice covering crisis intervention and prevention or protective strategies[20]
- Department of Human Services SCTT – care coordination plan in Health*SMART* applications
- the *Victorian service coordination practice manual*
- an e-referral system
- the HSD and other relevant service directories
- MBS funding for GP involvement in care planning
- accessible information about health care and treatment and the rights and responsibilities of patients
- training programs for staff in communication skills and how to involve consumers and carers in decision making
- resources on advanced care planning processes.[21]

3.4.5 Intended outcomes of care planning

The intended outcomes are:

- documented care plan that details the agreed goals and actions for meeting the assessed needs of consumers and their carers
- consumers and carers are able to actively participate in the assessment process
- effective interdisciplinary collaboration and team decision making.

3.4.6 Good practice indicators

Good practice indicators are that:

- practitioners explain to consumers and carers the value of care planning, the options and processes involved and the role and responsibilities of various practitioners including the key worker role
- the practitioner checks whether a care plan is in place for a consumer with a chronic disease, complex or multiple needs or those that frequently attend the ED
- care coordination services adopt and adhere to established codes of conduct covering crisis intervention, prevention and protective strategies

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20 *Police code of practice for the investigation of sexual assault; Code of practice for the investigation of family violence; Victorian Centres Against Sexual Assault standards of practice; Domestic violence Victorian code of practice; Homelessness assistance service standards (HASS). Available at <http://www.cyf.vic.gov. au/integrated-family-violence/guidelines#F> and <http://www.police.vic.gov.au/retrievemedia.asp?Media_ ID=1717>.*
21 *www.publicadvocate.vic.gov.au*

- there are systems in place to identify consumers who frequently present to the hospital ED and procedures to ensure the consumer is referred to a suitable community-based program or an ED care plan is developed and made accessible to ED staff and processes are in place for monitoring and reviewing care plans
- practitioners liaise with key stakeholders in developing, implementing, monitoring and reviewing care plans
- care planning processes and procedures facilitate multidisciplinary collaboration and team decision making in the care coordination service, the ED team and between other relevant hospital services
- the care plan is documented in the patient's medical record
- the care coordination service uses agreed process to nominate a key worker for consumers requiring an intra-agency or inter-agency care plan
- notifications of attendance from the ED to a consumer's GP include a summary of the assessments, care plans and interventions arranged or undertaken by the ED care coordination service
- care coordination services can provide or access services providing advanced care planning.

3.5 Referral

3.5.1 Description

Referral describes the transmission of a consumer's personal or health information between one agency and another with a request for further assessment, care or treatment.

Referrals may be made at any point along the consumer's care pathway in the ED to facilitate access to INI, assessment, care planning, service provision or care coordination and to ensure allocation of a key worker. Referrals are a major outcome of care planning in the ED.

Referrals to and from the ED frequently involve personal contact between practitioners with referral documentation following the initial contact. This practice is consistent with the urgent, short-term, episodic model of care provided in an ED.

Patient advocacy is a key component of the referral process. Where appropriate, practitioners are to speak on behalf of consumers and carers when dealing with services. Legislative mandatory reporting requirements are to be met as part of the referral process.

There are two main types of referral, as outlined below.

Self-referral

This is where the consumer takes responsibility for contacting another agency to make a referral for themselves. Where a consumer chooses to make a self-referral, practitioners support their choice by providing information, advice and decision support and a copy of supporting documentation as appropriate.

Assisted referral

This is where practitioners within the service system make a referral on behalf of a consumer. An assisted referral includes referrals made between ED practitioners to facilitate patient care and referrals to other acute and community-based services. Referrals to another service require consumer consent and are usually made at the request of the consumer. In some circumstances a referral can be made without consumer consent such as referral to statutory or specialist services or where immediate referral is in the best interests of the consumer, particularly where children, adolescents and their families are involved.[22]

Referrals can generally be prioritised[23] as follows:

- low – meaning 'hold over during peak demand' or respond within seven working days of obtaining consumer consent
- routine – meaning 'attend to in date order' and may include a consumer being placed on a waiting list or respond within seven working days of obtaining consumer consent
- urgent – meaning referral 'cannot wait' or within no more than two working days of obtaining consumer consent (the agency should be contacted prior to making a referral to ensure the agency can accommodate an urgent request).

Feedback is a critical component of the referral process and includes acknowledging that a referral has been received and providing information about referral outcomes such as assessment findings, care planning goals and services or interventions that will be provided.

3.5.2 Process objectives

- To facilitate consumer access to appropriate services in a seamless and timely manner.
- To improve the safety of, and minimise the risk to, consumers, carers and the community.
- To enable ED staff to meet their statutory and duty of care requirements.
- To promote health independence.

3.5.3 ED responsibilities

The range of ED responsibilities in relation to referral include:

- making referrals to community-based services
- making referrals to the ED care coordination service, specialist services or other hospital departments for assessment, care planning or direct service provision
- lodging mandatory reports according to legislative requirements
- reviewing referrals from ED staff and external services providers
- providing a patient advocacy service
- informing consumers about the referral process and privacy and confidentiality procedures

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22 Referral processes for vulnerable children and young people and their families and those requiring child protection, Child FIRST and family services are outlined in Appendix 4. Referrals in the case of family violence and sexual assault may be covered by established codes of practice.
23 This system of prioritisation is not standard across all services. Mental health and other services utilise different systems to prioritise referrals. Differences in practice, particularly in relation to urgent referrals need to be accommodated.

- providing consumers with information to facilitate a self-referral
- obtaining patient consent for information sharing and assisted referral
- documentation of referrals in the patient record
- providing feedback to referrers and stakeholders.

3.5.4 System resources and tools

Referral is supported by:

- policies and procedures that articulate the referral process
- a documented referral system for the care coordination services that covers referrals made by ED staff, external practitioners, GPs, carers and consumers and referrals made outside business hours
- codes and standards of practice covering referrals for crisis intervention and prevention or protective services[24]
- Department of Human Services SCTT including confidential referral cover sheet and templates for obtaining consumer consent in Health*SMART* applications
- the *Victorian service coordination practice manual*
- an e-referral system and community care record
- the HSD and other relevant service directories
- legislation, policies and procedures covering mandatory reporting requirements[25]
- accessible information about health care and treatment and the rights and responsibilities of patients
- staff orientation and information sessions provided by the care coordination service for ED staff on the referral process and associated documentation.

3.5.5 Intended outcomes of referral

The intended outcomes are:

- timely, documented referrals to services that meet the assessed needs of consumers and their carers
- consumers and carers able to actively participate in the referral process
- improved safety of consumers, carers and the community
- consumers are assisted to return home with support and to self-manage their diseases.

3.5.6 Good practice indicators

Good practice indicators are that:

- practitioners explain the benefits and disadvantages of self-referral or assisted referral options, offer to assist consumers with referrals or system navigation and make assisted referrals as required

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24 Refer to Appendix 4.
25 To make a mandatory report or referral to child protection services, visit <www.office-for-children.vic.gov.au/cp/how_to_make_a_referral_or_report>. For referrals to Child FIRST contact <http://www.cyf.vic.gov.au/child-protection-family-services/how-to-make-a-referal-or-report>. Refer also to Appendix 5.

- practitioners explain to the consumer the use of information for the purposes of referral, their options and possible waiting times and limitations associated with various services
- practitioners provide patient advocacy services and speak on behalf of consumers and carers when dealing with services
- practitioners prioritise referrals as low, routine or urgent and make personal contact with and discuss referral with agency concerned
- written referrals follow urgent or immediate referrals made through personal contact
- the ED retains responsibility for the consumer until the referral acknowledgement is received or otherwise obtained
- practitioners provide feedback to agencies and GPs making a referral to the ED care coordination service
- practitioners utilise relevant SCTT templates when making referrals to community-based services
- practitioners have access to the *Human services directory* or other relevant service directories
- care coordination services adopt and adhere to established codes of conduct for referrals for crisis intervention, prevention and protective services
- referrals are documented in the patient's medical record.

External referral systems

E-referral to community-based services from ED – Eastern Health

Early in the decade, Eastern Heath's ED care coordination services were invited by the outer and inner east PCPs to participate in a pilot project to introduce a web-based e-referral system provided by Infoxchange. The ED care coordination services participated in the PCP-led projects that involved:

- participating in user groups to develop system specifications
- identifying and engaging participants for the referral network
- participating in training and support programs.

The web-based system precluded the need to alter the various IT systems utilised in the ED and other parts of their hospitals.

The ED care coordination services provided the primary link between the PCP and the health service. As the e-referral network has expanded, the use of the e-referral system has extended to other acute service areas including allied health services, HARP, aged care assessment services (ACAS) and post-acute care (PAC).

Currently 80 per cent of the ED care coordination's internal and external referrals are made using the SCTT-based e-referral system. The benefits include less time spent on referrals, garanteed confidentiality and privacy of information, timely exchange of information between services, and less duplication particularly where consumers require multiple referrals. The system is also building a history of previous referrals and current service providers as more referrals are made using the system.

Single point of entry for health independence programs

Eastern HARP has developed a single point of entry (SPE) whereby intake coordinates the dissemination of referrals according to priority, provider workload and accessibility. As HARP is a major participant in the e-referral system, the SPE has further streamlined the referral processes for the ED care coordination services. Eastern HARP is working with Eastern PAC and Eastern Health SACS to consolidate their entry points and create a single point of entry for HARP, SACS and PAC.

Internal referral systems

Electronic referrals to hospital allied health services – Western Health

The ED care coordination service at Western Health arranged access to *Health power*, an electronic referral system for service requests to the hospital's allied health services.

Practitioners are able to make direct referrals for a discharge planning assessment for patients admitted from the ED to an inpatient bed. This system ensures timely assessment on the wards and a reduction in the patient's overall length of stay.

3.6 Intervention

3.6.1 Description

A health intervention is a service performed for, or on behalf of, a client with the purpose of improving or maintaining their health, altering the course or outcome of a health condition or promoting wellness.[26]

Interventions encompass generic and discipline-specific activities including, but not limited to:

- crisis intervention
- counselling
- gait, mobility and falls assessments
- providing aids and equipment
- arranging respite and accommodation services
- speech, swallowing and cognitive assessments
- medication arrangements
- dietary education
- education in self-care strategies.

Access to brokerage funds, ED physiotherapy and pharmacy services can facilitate interventions by the ED care coordination service. (Refer to Section 3.7 for details.)

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26 *Millar D 2001, Applying topic maps to the classification of health interventions.*
Available at <www.gca.org/knowledgetechnologies/2001/proceedings/Millar%20Paper.pdf>.

3.6.2 Process objective

- To ensure consumers receive the services, aids and equipment required to meet their needs and facilitate their transition back to the community.

3.6.3 ED responsibilities

The range of ED responsibilities in relation to intervention include:

- arranging provision of aids and equipment and informing consumers about the terms and conditions
- providing crisis intervention and counselling services
- providing and arranging discipline-specific treatment and therapies
- arranging respite or accommodation services
- medication management
- documenting the intervention in the patient record
- informing consumers about intervention, intended outcomes and ongoing self-care strategies
- notifying the patient's GP about ED attendance and providing a summary of interventions provided.

3.6.4 System resources and tools

Health interventions are supported by:

- policies and procedures covering service interventions, hospital aids and equipment program
- consumer information for about health care, aids and equipment, medication and self-care strategies
- accessible brokerage funds
- staff orientation and information sessions provided by the ED care coordination service for ED staff on the interventions provided by the service.

3.6.5 Intended outcome of intervention

The intended outcome is timely, health interventions that meet the needs of consumers and facilitate their transition back to the community.

3.6.6 Good practice indicators

Good practice indicators are that:

- interventions and follow-up arrangements are documented in the patient's medical record
- referral processes and procedures facilitate timely ED access to allied health interventions provided by other hospital departments
- processes and procedures facilitate timely access to the hospital's aids and equipment program
- notifications from the ED to a consumer's GP include a summary of the interventions arranged or undertaken by the ED care coordination service.

3.7 Service brokerage

3.7.1 Description

Brokerage is a process of identifying a service that matches the needs of a consumer and their carer and purchasing it from an external provider.

Service brokerage is used or arranged to:

- facilitate provision of immediate, crisis or urgent care
- enable service provision outside business hours
- prevent an ED presentation
- cover gaps in service availability and capacity
- subsidise the cost of services
- prevent readmission following an unsuccessful discharge from an inpatient unit
- reduce a consumer's length of stay in acute setting.

Brokerage funds are funds specifically allocated to purchase services or packages of care for consumers returning to a community-based setting following an ED presentation. They may also be used to purchase services that would prevent a consumer presenting to an ED.

A brokerage budget can be maintained as part of an ED care coordination service or funds can be accessed through other programs with a brokerage budget, including post-acute care, HARP–CDM and selected community-based services.

Service agreements with a community-based service covering the provision of care planning, referral and intervention functions for consumers returning to a community-based setting following an ED presentation represent an extension of the service brokerage model for a subset of consumers presenting in particular circumstances.

3.7.2 Process objective

- To provide access to the services and care packages required to minimise hospital utilisation

3.7.3 ED responsibilities

The range of ED responsibilities in relation to service brokerage include:

- managing brokerage funds
- purchasing services and care packages that match a consumer's or carer's needs
- arranging services and care packages through programs with a brokerage budget
- monitoring and reviewing the provision and adequacy of brokered services
- documenting brokered services in the patient's history.

3.7.4 System resources and tools

Service brokerage is supported by:

• brokerage funds

• policies and procedures that articulate the process for accessing and initiating brokered services

• the HSD and other relevant service directories

• the Department of Human Services SCTT

• electronic referral systems.

3.7.5 Intended outcomes of service brokerage

The intended outcomes are:

• consumers and cares have access the services and care packages that meet their needs

• unnecessary hospital utilisation is prevented.

3.7.6 Good practice indicators

Good practice indicators are that:

• referral processes and procedures facilitate timely access to brokered services

• processes are in place to monitor brokered services for quality and cost effectiveness

• processes are in place to manage brokerage funds effectively

• information relating to brokered services is documented in patient's medical record.

3.8 Early discharge planning

3.8.1 Description

Early discharge planning is a process of INI, bed finding, assessment, care planning and referral that facilitates the transition of a consumer from one care setting to another. As a hospital admission and transition to the community are part of the continuum of care, early discharge planning is part of the ongoing care provided to consumers presenting to an ED.

Where consumers are to be admitted to an inpatient or sub-acute bed, early discharge planning activities can occur in the ED and the remainder in the inpatient or sub-acute services. Early discharge planning activities include the following components of care:

• notifying current community-based services utilised by the consumer and arranging for services to be suspended where appropriate

• assist in finding a subsitute setting for consumer including inpatient, sub-acute or private hospital bed, respite care or special accommodation and assisting with admission or transfer of consumer

• notifying the consumer's GP

• conducting INI and assessment

• making referrals to other hospital departments, inpatient discharge or care coordination teams and specialist services to facilitate assessments in the inpatient or sub-acute setting

• arranging support for dependents and carers

- liaising and communicating with key stakeholders
- exchanging information between service providers (with the consumer's consent)
- arranging reviews and reassessments.

A key component of early discharge planning is the clinical handover to medical, nursing and allied health practitioners in the relevant inpatient or sub-acute areas on transfer of the patient. Early discharge planning is supported by formal links with key inpatient and sub-acute care units and other programs or services associated with discharge planning including post-acute care services, HARP, aged care assessment services, transition care, the Transport Accident Commission and Royal District Nursing Service and other home-nursing services.

3.8.2 Process objectives

- To facilitate a timely admission to an inpatient or sub-acute bed or transfer to substitute care setting.
- To ensure discharge planning for consumers requiring admission to an inpatient or sub-acute bed commences as early in the patient journey as possible.
- To promote continuity of care for consumers moving from the ED to an inpatient or sub-acute facility.

3.8.3 ED responsibilities

The range of ED responsibilities in relation to early discharge planning include:

- undertaking INI, assessment, care planning and referrals for admitted patients
- documentation of INI, assessments, care plans and referrals in patient record
- locating an inpatient or sub-acute or private hospital bed and facilitating patient admission or transfer
- referring to specialist services, inpatient discharge or care coordination teams or other hospital departments for discharge planning
- clinical handover to inpatient or sub-acute service on patient transfer
- notifying the consumer's GP and other relevant community-based services about their admission and arranging cessation of services
- arranging support for the consumer's carers and dependents.

3.8.4 System resources and tools

Early discharge planning is supported by:

- policies and procedures that cover the early discharge planning process, clinical handover, referrals to allied health departments within the hospital and programs providing discharge planning to hospital patients
- electronic referral systems
- the HSD and other relevant service directories
- The Department of Human Services SCTT
- staff orientation and information sessions provided by the ED care coordination service for ED staff on the early discharge planning provided by the service.

3.8.5 Intended outcomes of early discharge planning

The intended outcomes are:

• timely admission to an inpatient, sub-acute or private hospital bed

• initiation of discharge planning in the ED for consumers requiring admission to an inpatient or sub-acute bed

• continuity of patient care maintained across the acute, sub-acute and community-based care sectors.

3.8.6 Good practice indicators

Good practice indicators are that:

• patients are admitted to an inpatient or sub-acute bed or alternative care setting in a timely manner

• information relating to the discharge planning process is documented in the patient's medical record and is forwarded to practitioners in sub-acute and inpatient units

• referral processes and procedures facilitate timely access to allied health services in sub-acute and inpatient units

• discharge planning processes facilitate multidisciplinary collaboration and team decision making across hospital services

• notifications from the ED to a consumer's GP include a summary of the discharge planning arrangements undertaken by the ED care coordination service

• practitioners notify community-based agencies providing services to a consumer about their admission to hospital

• the needs of the consumer's dependents and carers are addressed as part of discharge planning.

Discharge planning services – Northern Health

The care coordination service at the Northern Hospital interacts with the community, ED, inpatient services and sub-acute facilities to ensure effective referral, handover and discharge of patients and to facilitate the most appropriate use of hospital and community resources.

The care coordination service is comprised of an ED care coordination team and an inpatient care coordination team. Both teams undertake risk screens and comprehensive assessments, develop care plans and make referrals to the most appropriate internal and external programs and services.

The focus of the ED team is to prevent avoidable ED presentations and acute admissions by responding to community referrals, facilitating discharge from the ED and short stay unit to the most appropriate destination, either home or to a sub-acute or community-based facility. The ED team also commences discharge planning for patients moving to an inpatient unit.

The inpatient care coordination team is responsible for discharge planning for complex patients on the inpatient units and assisting patient flow. By ensuring a timely discharge from an inpatient ward to the most appropriate discharge destination, either home or to a sub-acute or residential care facility.

The teams are managed as a single service and utilise common communication systems, processes and resources. Both teams participate in joint staff meetings once a month to discuss service improvements and common issues around handover and communication. Education sessions are also shared.

Each team focuses on a different group of patients and develops relationships with a disparate group of stakeholders. The expertise developed by each team is readily available to across the care coordination service as required. Patient handovers between the teams where there are established relationships and common process promotes continuity of patient care.

The Northern Hospital care coordination service integrates ED and inpatient services and streamlines discharge planning across all areas of the health service.

Direct admission to sub-acute beds – Frankston Hospital

ED care coordination at Peninsula health is provided by the response assessment and discharge (RAD) team. RAD coordinate direct admissions from the ED to sub-acute facilities with the aim of providing the most appropriate care for older patients with rehabilitation needs in a timely fashion.

The RAD team, in conjunction with nursing and medical staff, identifies medically stable ED patients with defined rehabilitation goals. RAD practitioners provide a holistic assessment covering pre-morbid function, the home environment, formal and informal support networks and cognitive capacity. A direct admission to a sub-acute inpatient bed is arranged for patients assessed as being unsafe to return home with support from home-based rehabilitation services. The consumer and their carers are placed at the centre of the assessment and admission processes so they are fully informed and provide the necessary consent at each stage of the process.

The admission process is governed by protocols that allow RAD team clinicians to contact a rehabilitation consultant or geriatrician to discuss their assessment and the goals set for the patient. The consultant or geriatrician decides whether the patient is suitable and ready for transfer to a sub-acute bed and whether the rehabilitation or evaluation and management stream would best meet the patient's needs.

Once an admission is approved, the RAD team contacts the sub-acute assessment service to ascertain if a bed is available and provides the relevant documentation. Provided a bed is available, the patient can be transferred directly to a sub-acute facility from the ED on the same day.

Direct admissions can also be secured for patients seen by the RAD team in the community following this same process. In this instance, a recent medical review is required to ensure that there are no acute medical issues for the patient.

Direct admissions improve the quality of care provided to older people by ensuring the most appropriate care is provided in a timely manner. The process reduces the amount of unnecessary time spent in the ED and acute areas which prevents further patient de-conditioning.

3.9 Follow-up services

3.9.1 Description

Follow-up services represent a systematic process of monitoring and reviewing care plans, referrals and interventions provided through the ED care coordination service.

Follow-up services promote the quality and safety of ED care coordination services and are provided for:

• monitoring the effectiveness of care plans, services and interventions

• visual clarification of assessment issues related to the residential environment

• patient transportation

• patient monitoring, review and short-term case management.

Follow-up is provided where the consumer is identified as at risk, is vulnerable or has complex care needs. Where a consumer is found to require further comprehensive assessment and assertive follow-up services a referral may be made to an appropriate community-based service.

Follow-up contact includes telephone contact, a visit by a practitioner to the consumer's place of residence and liaison with relevant hospital or community-based service providers to monitor the consumer's status.

3.9.2 Process objectives

• To provide a systematic process of monitoring and reviewing care plans, referrals and interventions provided through the ED care coordination service.

• To enhance the safety and quality of services provided to consumers, carers and the community.

• To facilitate the delivery of services at people's homes or in the community.

3.9.3 ED responsibilities

The range of ED responsibilities in relation to follow-up services include:

• determining consumer eligibility for follow-up services

• monitoring and reviewing care plans, services and interventions provided through the ED care coordination service

• addressing assessment issues related to the residential environment and providing interventions as required

• monitoring and undertaking reviews of patients and providing case management services

• documenting the details of follow-up services in the patient record

• liaising with key stakeholders

• referring consumers requiring further comprehensive assessment or assertive follow-up services to community-based services.

3.9.4 System resources and tools

Follow-up are supported by:

- policies and procedures that articulate the follow-up process
- consumer eligibility criteria
- electronic referral systems
- the HSD and other relevant service directories
- the Department of Human Services SCCT.

3.9.5 Intended outcomes of follow-up services

The intended outcomes are:

- care plans, referrals and interventions provided through the ED care coordination service are systematically monitored and reviewed
- improved safety of consumers, carers and the community.

3.9.6 Good practice indicators

Good practice indicators are that:

- care plans, services and interventions provided through the ED care coordination service are systematically monitored and reviewed
- eligible consumers receive a follow-up contact from the ED care coordination service
- information relating to follow-up services is documented in the patient's medical record
- practitioners liaise with key stakeholders.

3.10 Outreach services

3.10.1 Description

Outreach services allow health care to be provided in a community setting away from where the clinician normally practices. Outreach services are designed to prevent ED attendances and provide services that are easily accessible to consumers and service providers.

Out reach services involve a visit by an ED practitioner to the consumer's place of residence or a referral to an appropriate hospital or community-based service that provides outreach services including, post-acute care, aged care assessment service, Hospital in the Home, Aged Care Clinical Inreach Support Program, home assessment rehabilitation team, ConnectED and aged care liaison team supporting residential aged care facilities. Outreach can also include networking and capacity building within the residential care sector. Outreach services are designed to build on existing service platforms and avoid duplication of services.

3.10.2 Process objective

- To facilitate the delivery of services at people's homes or in the community to prevent ED presentations.

3.10.3 ED responsibilities

The range of ED responsibilities in relation to outreach services include:

- providing assessment and intervention services required to prevent an ED presentation
- referring to outreach services
- documenting outreach services in the patient record
- liaising with key stakeholders.

3.10.4 System resources and tools

Outreach services are supported by:

- policies and procedures governing provision of outreach services
- electronic referral systems
- the HSD and other relevant service directories
- the Department of Human Services SCTT.

3.10.5 Intended outcomes of outreach services

The intended outcomes are:

- prevention of hospital presentations
- services are provided in the community.

3.10.6 Good practice indicators

Good practice indicators are that:

- referral processes and procedures facilitate timely access to outreach services
- presentations to ED are reduced
- residential care facilities have greater capacity to manage medical and nursing requirements of residents within their facilities
- information relating to outreach services is documented in the patient's medical record
- practitioners liaise with key stakeholders.

Home-based intervention service – Frankston hospital

ED care coordination at Peninsula health is provided by the response assessment and discharge (RAD) team. In 2001 the RAD team and the Metropolitan Ambulance Service (MAS) worked in partnership to develop a pilot project that would reduce unnecessary demand on ED and ambulance services by providing early intervention to suitable consumers in their home.

MAS paramedics identify consumers that would not require emergency care provided they were supported at home by their GP and RAD team intervention. The RAD team conducts home visits where necessary and provides appropriate equipment and community referrals to meet the consumer's particular needs.

During the six-month pilot project the RAD team received 29 referrals from MAS. The RAD team accepted 21 referrals (72.4 per cent). Four patients required MAS intervention following RAD involvement. The home-based intervention service is now an ongoing program.

3.11 Stakeholder engagement

3.11.1 Description

Stakeholder engagement is an ongoing, structured process that allows practitioners and services to come together regularly to:

• gather, convey and receive information, knowledge and ideas

• develop trust, confidence, rapport and consensus

• determine and develop agreed methods of communication and service coordination

• establish and work together towards common goals and benchmarks

• build and maintain networks and effective working relationships

• collaborate on policy and program development

• identify, manage and resolve difficulties and conflicts and achieve positive outcomes.

This process is designed to promote continuity of care and ensure consumers experience seamless care within and across the acute, sub-acute and community-based sectors.

Stakeholder engagement is supported by linkages with PCPs and other relevant service networks. PCPs are regional alliances of health and human services that address a range of system and practice changes around partnership development, integrated health promotion, service coordination and integrated chronic disease management. Linkages can be established with PCPs either directly or via the area providing hospital representation on the regional PCP. A range of community-based health and social services are not currently engaged in PCPs and the statewide service coordination arrangements. Linkages can be established with these services at an individual agency level or through their existing networks.

The relationships developed through stakeholder engagement may be formal or informal. The range of relationships would include:

Formal relationships	Informal relationships
Working relationship	Information exchange
Referral	Regular meetings
Formal reporting	Provision of clinical support and advice
Program development	Case reviews and care planning
Information exchange and feedback	Benchmarking and research
Clinical handover	Program, protocol and process developments
Case conferencing	Educational
Joint service	Interagency collaboration
Budgetary	

Formal relationships may be established with a variety of internal and external services or programs. Key services would include:

Services within the health service	External services
• Post-acute care	• Community health centres
• HARP	• Municipal councils
• Hospital in the Home	• Housing and crisis accommodation services
• Acute and sub-acute inpatient services	• Royal District Nursing Service
• Area mental health service	• General practitioners
• Allied health departments	• Community rehabilitation services
• Aged care assessment services	• Community aged care services
• Alcohol and other drug services	• Child FIRST
• Community-based rehabilitation services	• Child protection services
• Victorian Forensic Paediatric Medical Services	• Victoria Police

Informal relationships may be established with a range of services and networks including:

• an ED care coordination manager's collaborative

• divisions of general practice

• discipline-specific allied health departments and professional alliances

• supported residential accommodation and residential care facilities.

These informal relationships support staff development and facilitate effective service delivery and promote program development within the ED care coordination service.

3.11.2 Process objectives

• To promote functional integration of health and social services utilised by consumers presenting to a hospital ED.

• To enhance the continuity of care for consumers and carers.

• To promote staff and program development within the ED care coordination service.

3.11.3 ED responsibilities

The range of ED responsibilities in relation to stakeholder engagement include:

- exchanging service information with key stakeholders
- establishing direct or indirect links with regional PCPs
- utilising Victorian service coordination practices and tools
- establishing working relationships with key internal and external services and programs utilised by consumers presenting to the ED
- establishing and utilising resource directories
- building and participating in appropriate networks
- undertaking research and participating in joint benchmarking activities
- participating in joint case reviews, professional development and training opportunities with other hospital and community-based services and programs
- collaborating on joint policy and program developments.

3.11.4 System resources and tools

Stakeholder engagement is supported by:

- policies and procedures that articulate stakeholder engagement processes
- joint staff training and professional development activities
- memoranda of understanding, protocols and service agreements
- the HSD and other relevant service directories.

3.11.5 Intended outcomes of stakeholder engagement

The intended outcomes are:

- improved access to services and continuity of care for consumers and carers
- improvement in staff knowledge and competence
- continuous improvement of ED care coordination services.

3.11.6 Good practice indicators

Good practice indicators are that:

- the ED care coordination service collaborates with other organisations and positions itself strategically within the wider service system
- the ED care coordination service has developed ways of sharing information between organisations that enhances working relationships and consumer outcomes
- practitioners utilise Department of Human Services care coordination processes and tools to promote functional integration of services within and across the acute, sub-acute and community-based sectors
- practitioners have access to the *Human services directory* and other relevant service directories
- the ED care coordination service has links to its regional PCPs either directly or via the area providing hospital representation on their regional PCP

- practitioners utilise established processes to identify, manage and resolve difficulties and conflicts between services
- practitioners participate in joint training and staff development activities with other hospital and community-based services and programs.

Interagency protocol on family violence – Werribee Mercy Hospital

The ED care coordination services at Werribee Mercy Hospital established an interagency protocol with the Werribee Police Family Violence Unit to provide guidelines for both ED staff and the Family Violence Unit regarding consumers presenting with family violence issues.

The protocol covers:

- criteria for referral to the Family Violence Unit
- referral procedures including notifications, completion of family violence risk assessment, obtaining consumer consent to police involvement, conducting a multidisciplinary assessment (including police as team members) and determination of appropriate interventions
- referral information and emergency contact details and notifications to the Department of Human Services where the consumer declines assistance and children are involved.

The protocol was designed to reduce the psychological trauma for victims of family violence by ensuring that ED staff and police provided a more timely response and work as a team rather than individual organisations. Training was provided for both ED and Police Family Violence Unit staff before the protocol was implemented.

The protocol has had a number of benefits, including:

- prompt police attendance at the ED for consumers presenting with family violence issues
- prompt responses by ED staff for police who attend with victims of family violence
- improved use of police resources
- fewer representations to the ED and improved access to hospital services
- provision of appropriate medical, psychosocial and legal assessments
- consumers receive a consistent and coordinated response and are actively involved in the decision-making processes
- a reduced level of risk by ensuring consumers are discharged with safety plans including community referrals and legal interventions.

3.12 Consumer and carer engagement

3.12.1 Description

Consumer and carer engagement is a systematic process that allows practitioners to actively engage consumers in their own care and treatment and, where appropriate, encourage the participation their carers. Engagement ensures consumers and their carers are:

- aware of their rights and responsibilities as patients
- informed about their treatment and health care
- actively involved in decision-making processes

- certain their information is treated in accordance with the legislative requirements covering consent, privacy and confidentiality.

The engagement process is applicable across all of the 12 core functions outlined in the sections above.

3.12.2 Process objectives

- To promote consumer participation in their own care and treatment.
- To support care relationships between consumers and their carers.

3.12.3 ED responsibilities

The range of ED responsibilities in relation to consumer and carer engagement include:

- informing consumers and carers about care processes, treatment and health care
- informing consumers and carers about privacy and confidentiality procedures and obtaining patient consent to information sharing
- providing access to interpreter services, translated materials and promoting culturally sensitive practice.

3.12.4 System resources and tools

Consumer and carer engagement is supported by:

- information on health care and treatment and the rights and responsibilities of patients
- policies and procedures covering consumer consent and privacy
- interpreter services and translated material
- staff training programs in communication skills and involving consumers in decision making
- a system for obtaining and monitoring consumer and carer feedback and satisfaction
- resources on advanced care planning processes for obtaining consent for treatment[27].

3.12.5 Intended outcome of consumer and carer engagement

The intended outcome is consumers and carers are informed about care processes and actively supported to participate.

3.12.6 Good practice indicators

Good practice indicators are that:

- practitioners work with consumers to identify the need for supports such as interpreters, translated material and culturally sensitive practice
- practitioners explain to the consumer the rationale for collecting information and how that information will be used to assess their needs (practitioners only collect relevant information)

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27 Office of the Public Advocate 2006, Medical/dental treatment for patients who cannot consent, Melbourne

- practitioners explain to consumers their rights and responsibilities including access to their health records, the implications of providing and not providing information and consent requirements[28]
- there are clear procedures and processes for obtaining and documenting consumer consent and complying with privacy requirements
- practitioners utilise established systems for obtaining consumer consent to share information between services as required[29]
- there are clear procedures and processes relating to advanced care planning and associated legal obligations and matters of consent
- practitioners make referrals without consumer consent in accordance with the *Health Records Act* and other requirements such as duty of care and mandatory reporting.

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28 *Your information: it's private*
29 *www.health.vic.gov.au/pcps/publications/index; www.betterhealth.vic.gov.au; www.dhs.vic.gov.au*

4. Structure and governance of emergency department care coordination services

The following sections outline a broad structure for the ED care coordination services operating in Victoria and the key governance features. The structure and governance of the services are designed to support a multidisciplinary emergency service operating at the acute and community care interface.

4.1 Service structure

In Victoria, ED care coordination services are primarily delivered by a multidisciplinary team within the hospital ED. In some locations care coordination is delivered on an episodic basis by the hospital's allied health services or an ambulatory care program in response to a referral from the ED.

The key elements of the service structure for a multidisciplinary team operating within a hospital ED are described below.

Staffing structure

- A multidisciplinary team based in the ED
- A mix of practitioners from disciplines including:
  - nursing
  - occupational therapy
  - physiotherapy
  - social work

Service components

- Extended hours of operation with an after-hours referral system and on-call support
- Brokerage funds or access to brokered services provided by programs with a brokerage budget
- Multidisciplinary team-based services structured to include management and provision for:
  - outreach services to the community
  - in-reach services to sub-acute and inpatient services

Service linkages

- Formal relationships with relevant programs and services including health independence programs, (HARP, PAC and SACS), HITH, ACAS, AMHS and alcohol and other drug services
- Established links with the hospital's regional PCP and other relevant community-based services and networks

Support components

- Assessment process that meet discipline-specific practice and program requirements
- Established referral systems between the ED and hospital allied health services and specialist services
- Clinical handover systems that promote multidisciplinary collaboration and team decision making both within the ED care coordination service and the ED team

Staff support

- Appropriate model of clinical supervision for practitioners, team leaders and service managers
- Discipline-specific professional linkages for individual practitioners for professional development, training, peer review and supervision
- Staff credentialing process
- Education of student practitioners

Quality assurance

- Multidisciplinary clinical review and audit program
- A quality improvement plan and processes, including:
  - ongoing and periodic outcome analysis
  - review of adverse events
  - consumer and staff experience surveys
  - staff competency evaluation and performance appraisal
  - staff development and training opportunities
  - budget reviews
  - development and review of policies and strategic plans
- Processes for identifying and managing risk that link to the health service's risk management plan
- Staff safety procedures covering:
  - clinical emergencies
  - working in isolation
  - home visits
  - critical incident management
  - infection control procedures
  - other relevant matters

Records management

- Client record management, including processes for:
  - obtaining informed consumer consent in accordance with relevant privacy legislation[30]
  - documenting information
  - secure information exchange
  - transfer of information between agencies and practitioners

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30 *www.health.vic.gov.au/pcps/publications/index; www.betterhealth.vic.gov.au; Office of the Public Advocate 2006, Medical/dental treatment for patients who cannot consent, Melbourne*

Performance monitoring

- Data collection, performance monitoring and reporting systems
- Research activities and promotion of evidence-based practice

The key structural elements required for ED care coordination services delivered through the hospital's allied health services or an ambulatory care program in response to a referral from the ED are:

- a system for initial needs identification in the ED
- an established referral system between the ED and hospital's allied health services or other relevant program that:
  - determines the target population to be serviced
  - allows prioritisation of referrals
  - identifies the purpose for the referral and the type of services to be provided (assessment, care planning, service intervention)
  - articulates the process of referral
- clinical handover systems that promote multidisciplinary collaboration and team decision making between the ED team and relevant hospital allied health services and programs
- a multidisciplinary clinical review and audit program that involves relevant hospital programs and allied health services
- client record management, including processes for:
  - obtaining informed consumer consent in accordance with relevant privacy legislation[31]
  - documenting information
  - secure information exchange
  - transfer of information between agencies and practitioners
- data collection and reporting systems.

4.2 Governance structure

The key features of a governance structure supporting ED care coordination services are:

- clear management delegations and line management within the ED
- formal relationships with relevant programs and services including sub-acute and inpatient services and relevant ambulatory care programs including health independence programs (HARP, PAC and SACS), HITH, ACAS, AMHS and alcohol and other drug services
- established links with the hospital's regional PCP and other relevant community-based services and networks
- discipline-specific professional linkages for individual practitioners
- participation in ED risk management systems and plans
- participation in the ED quality assurance processes
- participation in the ED monitoring and reporting processes.

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31 www.health.vic.gov.au/pcps/publications/index; www.betterhealth.vic.gov.au

Referral Information Management System – Ballarat Health Services

Ballarat Health Services has implemented the Referral Information Management System (RIMS) to facilitate e-referrals from the ED to community-based services.

RIMS generates referrals by auto-populating information from the hospital's patient administration system (PAS) into an electronic referral form, usually the SCTT forms. The referrals are distributed to community-based services via the e-referral system provided by connecting care or via an auto faxing mechanism where secure email is not in place.

The three PCP groups in the Grampians region have been instrumental in introducing and building the capacity for an e-referral system among the community-based services.

RIMS allows the ED care coordination service to access electronic information already entered into the hospital PAS, which reduces the time spent preparing referrals. Clinicians also get immediate acknowledgement that their referral has been received by the relevant service. The availability of computers and staff able to train and support clinicians in using RIMS were key enablers in adopting e-referral across Ballarat Health Services.

5. Conclusion

The *Guidelines for the Victorian Emergency Department Care Coordination Program* has been developed by the Department of Human Services as a resource for health services delivering emergency care. The guidelines are designed to promote consistency of practice and to support continued service improvements.

The guidelines are not prescriptive and allow for individual health services to structure their services to meet their differing organisational arrangements and the needs of their local communities and patient populations. The guidelines are to be used in conjunction with organisational quality standards of care, professional codes of conduct, legislative requirements and other regulatory and accreditation health care bodies.

Appendix 1: Emergency Access Reference Committee – Primary Care Subcommittee

Chairperson	
Mr Bill Newton	Chief Executive Officer, General Practice Victoria
Members	
Dr Margaret Grigg	Assistant Director, Access and Metropolitan Performance, Department of Human Services
Ms Sylvia Barry	Manager, Primary Health Integration, Primary Health Branch, Department of Human Services
Dr Simon Young	Director, Emergency Department, Royal Children's Hospital
Dr David Isaac	General Practice Liaison Service, St Vincent's Health
Dr Sharon Monagle	Senior Medical Adviser, Primary Health Branch, Department of Human Services
Ms Lorraine Xavier-Ambrosius	Manager, Care Coordination, Western Health
Ms Susan Pike	Manager, Care Coordination, Northern Health
Ms Ann Maree Keenan	Executive Director, Ambulatory & Nursing Services, Austin Health
Ms Sue O'Sullivan	Manager Emergency Program, Department of Human Services
Secretariat	
Ms Wendy Davis	Senior Project Officer, Emergency Program, Department of Human Services

Appendix 2: Policy statements relevant to emergency department care coordination services

1.1 A better state of health

The government's 2005 policy *Victoria: A better state of health*[32] outlines five overarching principles that provide a vision for health care in this state. They are:

- best place to treat
- together we do better
- technology to benefit patients
- a better patient experience
- a better place to work.

1.2 Directions for rural health

Rural directions for a better state of health[33] provides a framework for rural health services to continue developing and enhancing their roles in the system of care across Victoria. It is intended to help health services orient themselves towards the changing needs of communities and make the best use of available resources to deliver improvements in the health of rural Victorians. The three broad directions that have been identified are:

- promote the health and wellbeing of rural Victorians
- foster a contemporary health system and models of care for rural Victoria
- strengthen and sustain rural health services.

1.3 Care in your community

Care in your community: A planning framework for integrated ambulatory care[34] provides a 10-year vision for an integrated and person- and family-centred health system. It is about refocusing and investing in the best mix of hospital and community-based care services to better meet the needs of Victorians. It focuses on integrating the component parts of the system and reforming existing systems, structures and processes to support flexible service delivery and person-focused continuity of care. The planning principles for the policy are:

- consolidate and improve the range, level and quality of community-based services
- services delivered in hospital settings to complement community-based services
- services delivered at people's homes or in the community are the preferred option
- maximise equitable distribution of services with a focus on addressing disadvantage
- maximise ease of access to services
- promote collaborative outcomes based on partnerships focused on a health-populations approach.

The key enablers of this integrated planning approach are suitable funding models and information management systems, a workforce structured to person-centred care and autonomous organisations working together in partnership.

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32 Department of Human Services 2005, *Victoria: A better state of health, Melbourne*

33 Department of Human Services 2005, *Rural directions for a better state of health, Melbourne*

34 Department of Human Services 2006, *Care in your community: A planning framework for integrated ambulatory care, Melbourne*

1.4 Better quality, better health care

The Victorian Quality Council (VQC) was established in 2001 to foster quality and safety in Victorian health services. The council's framework *Better quality, better health care*[35] outlines the principles and practices necessary for effective monitoring, management and improvement of health services. The six interdependent dimensions of quality identified in the framework are:

- safety of health care: harm arising from care is avoided and risk minimised
- effectiveness of health care: health care interventions deliver measurable benefit and achieve the desired outcome
- access: there is timely, equitable access to services on the basis of need irrespective of cultural or linguistic background, gender, age or socio-demographic status
- acceptability: health services meet the expectations of patients and feedback is encouraged
- appropriateness: selection of health care interventions is based on the likelihood that the intervention will produce the desired outcome for a patient and on using evidence and established professional standards
- efficiency: resources are utilised to achieve value for money within health settings.

1.5 Better faster emergency care

Better faster emergency care sets the policy direction for Victorian emergency services with the aim of ensuring equitable and timely access to quality emergency care within public hospitals.
It identifies 10 priorities:

1. develop new service options
2. improve coordination between EDs and ambulance services
3. improve the patient experience
4. mainstream new models of care
5. explore new ways of working
6. enhance safety and quality of care
7. promote better systems of care
8. promote better management of care for people with mental health problems
9. promote better management of care for older people
10. promote better management and care of children.

The enablers to support the implementation of the 10 priorities are systems improvements, service planning, funding policy reform, workforce development, information technology and data management solutions and partnership development.

The expansion and development of patient-centered emergency care service models that support flexibility and patient choice is a key action articulated in the document.

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35 *Department of Human Services and Victorian Quality Council 2003, Better quality better health care:
A safety and quality improvement framework for Victorian health services, Melbourne*

1.6 Primary Care Partnerships

The state government initiated the *Primary Care Partnership (PCP) strategy*[36] in 2000 to improve the health of people using primary health care services and to reduce avoidable use of hospital services. The introduction of service coordination process and tools and an integrated health promotion framework have produced significant system improvements and strengthened the primary care sector. The current vision for PCPs includes:

- an integrated health care system, based on partnerships, where providers see planning and working together to better meet the needs of their communities as core business
- widespread consumer, carer and community participation in service design, implementation and evaluation
- consumers' needs identified early and appropriate services delivered promptly
- improved service coordination practice enhanced and embedded in agency practice, streamlining assessment and access to services
- widespread, efficient and effective referral and care coordination between health care providers
- reliable information and communications technology infrastructure and agreed standards in place enabling electronic communication, including e-referral
- a health system geared to health promotion, prevention and early intervention for at-risk individuals and groups, minimising the onset of disease and preventing hospital admissions.

1.7 Service coordination

Better access to services (BATS): A policy and operational framework[37] details the vision for Victoria's service coordination whereby practices, protocols and systems are aligned through functional integration. The principles underpinning service coordination are as follows:

- a central focus on consumers
- partnerships and collaboration
- social model of health
- competent staff
- duty of care
- protection of consumer information
- engagement of other sectors.

36 Department of Human Services 2003, *Primary care partnerships strategic directions 2004–06, Melbourne*

37 Department of Human Services 2001, *Better access to services: A policy and operational framework, Melbourne*

PCPs have progressed from locally defined service coordination practice to a statewide approach. This work is based on the BATS policy and operational framework. *The Victorian service coordination practice manual*[38] and *Good practice guide for practitioners*[39] were released in 2007 to:

• define practices, processes, protocols and systems that support service coordination across Victoria

• provide a basis for monitoring and continuous improvement of service coordination.

The Victorian service coordination practice standards set out agreed process objectives, consumer outcomes, good practice indicators and systems tools for practitioners involved in service coordination.

In 2007 the department commenced a care planning project[40] aimed at progressing inter-agency care planning practice across Victoria through Primary Care Partnerships. It will include mapping of current inter-agency care planning work, sharing of good practice models, identifying barriers and enablers, and developing a framework to further the implementation of effective interagency care planning that includes revising the service coordination plan component of the SCTT.

1.8 Doing it with us not for us participation policy

The *Doing it with us not for us: Participation in your health service system 2006–09*[41] policy highlights consumer participation as an essential principle of health development, community capacity building and the development of social capital. The aim of the policy is for consumers, carers and community members to participate with health services and the Department of Human Services in improving health policy and planning, care and treatment and the wellbeing of all Victorians.

Prioirity actions at the individual care level where consumers and, if appropriate, their carers are actively involved in their own care and treatment, include:

• promoting the rights and responsibilities of patients

• communicating clearly and respectfully

• providing accessible information about health care and treatment

• communicating and providing information about treatments and care that is developed with consumers and where appropriate carers

• listening and acting on the decisions the consumer and, where appropriate, carers make about their care and treatment.

These actions should involve consumers and where appropriate carers and community members.

38 *Primary Care Partnerships Victoria 2007, Victorian service coordination practice manual, Melbourne*
39 *Primary Care Partnerships Victoria 2007, Good practice guide for practitioners, Melbourne*
40 *http://www.health.vic.gov.au/pcps/coordination/care_planning.htm*
41 *Department of Human Services 2006, Doing it with us not for us: Participation in your health service system 2006–09, Melbourne*

1.9 Carers recognising and supporting care relationships

The Department of Human Services policy framework *Recognising and supporting care relationships*[42] identifies three overarching principles in focusing on care relationships.

These are: participation; recognition and respect; and supporting care relationships.

To support the department's policy framework, program areas have developed action plans that acknowledge and address the important elements of care relationships. *Recognising and supporting care relationships for older Victorians action plan 2006– 2009*[43] identifies actions to support care relationships for older people and their unpaid carers.

The plan identifies a number of approaches to program and service delivery that will help maintain and improve the quality of services and include:

• health-promoting approaches to maximise potential health and wellbeing of people in a care relationship

• service coordination and partnerships for better access to services as and when needed and smooth transition between services

• continuous quality improvement to identify and implement evidence-based best practice

• monitoring outputs to record and demonstrate quantity of services delivered, spread of services and access and service gaps

• accountability by service providers so that intended services are delivered.

1.10 Health independence programs guidelines

The *Health independence program (HIP) guidelines*[44] have been developed to provide direction for, and facilitate alignment of, PAC, SACS and HARP. HIP services support the transition from hospital to the home and prevent the need for hospitalisation. The HIP guidelines outline aligned program processes including:

• defined point of access units to link a client to the range of programs needed

• common assessment practices and protocols and information sharing across programs

• common referral practices and protocols to facilitate transition between programs

• coordination of services between programs

• processes that support continuity of care.

The guidelines outline the key components of service provision for the development of a person-centred service model that promotes efficiency and effectiveness across the continuum of care. Standards are set for service delivery, program management and corporate services.

42 Department of Human Services 2006, *Recognising and supporting care relationships for older Victorians, Melbourne*

43 Department of Human Services 2006, *Recognising and supporting care relationships for older Victorians action plan 2006– 2009, Melbourne*

44 Department of Human Services 2008, *Health independence program guidelines (draft), Melbourne*

1.11 Mental health care framework for emergency department services

The *Mental health care framework for emergency department services*[45] provides direction for the delivery of emergency medical health care in Victoria's hospital emergency departments. The framework is intended to assist health services to:

• plan appropriate ED care for people who present with mental health needs

• promote service coordination and collaboration between specialist mental health services and EDs

• promote best practice management and care coordination.

The framework provides a set of overarching guidelines that encompass the areas of service delivery and clinical care. The framework is underpinned by the following principles:

• recognition of the human rights of people with mental disorders

• timely access to mental health assessment and care for people who present to EDs with a mental illness or disorder

• a collaborative team approach between the ED, mental health service and other services where appropriate

• continuity of care through the development of links between EDs, internal departments and other organisations

• integration with the broader health system, with clear role and linkages to other services to ensure appropriate access and continuity of service

• best care within available resources.

1.12 Towards a new blueprint for alcohol and other drugs treatment services

A blueprint discussion paper[46] has been developed, outlining plans for responding more effectively to the needs of Victorians who have alcohol and other drug problems over a five-year period. The blueprint that emerges from the discussion paper will provides a framework for:

• developing a stronger client-centred focus in the delivery of services to deliver better outcomes for individuals with alcohol and other drug problems

• articulating a shared vision, principles, aims and goals to continually improve the Victorian drug service system

• establishing strategic priorities and future directions to guide service planning, delivery and evaluation

• defining and clarifying roles, responsibilities and accountabilities of all stakeholders

• ensuring stronger collaboration, partnerships and linkages to respond more effectively to alcohol and other drug issues for individuals, families and communities.

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45 *Department of Human Services 2007, Mental health care framework for emergency department services, Melbourne*

46 *Department of Human Services 2007, Towards a new blueprint for alcohol and other drugs treatment services, A discussion paper, Melbourne*

1.13 Statewide homelessness assessment and referral framework

Victoria's *Statewide homelessness assessment and referral framework*[47] is a practice and systems approach to providing people seeking assistance with timely and effective access to homelessness services. This framework operates at the local, regional and statewide level to provide consistent, high-quality initial assessment and referral. It reflects the Homelessness assistance service standards (HASS).

The framework is based on the following overarching principles:

- a consumer-focused and strength-based approach
- equity of access to the resources of the homelessness service system
- support for skilled workers with training, supervision and efficient tools
- collaboration and partnerships between agencies and the Department of Human Services
- reasonable care to address the risks faced by each homeless person
- maximising the use of the available homelessness resources.

This framework is for use in government-funded homelessness assistance services wherever initial contact occurs and applies to initial assessment for all people seeking homelessness assistance.

1.14 Crisis protection framework

An integrated strategy for child protection and placement services is the result of detailed research and analysis undertaken by the Department of Human Services over the past 12 months. This work was undertaken to identify better responses to complex and chronic problems within some families, and to allow intervention earlier to prevent child abuse and neglect from occurring. The strategies identified provide a clear direction and focus, immediately and for the longer term. This work has resulted in the development of a more integrated approach to service delivery for children, young people and their families.

The integrated strategy is based on five key themes, which emerged from the analysis:

- strengthening prevention and diversion
- improving flexibility and responsiveness to the complex and changing needs of families and children
- community-based solutions to recognise local issues
- more effective support for Indigenous children and families
- capacity building to improve services and processes.

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47 Office of Housing Department of Human Services Victoria 2006, Statewide homelessness assessment and referral framework, Melbourne

1.15 Vulnerable children and young people

Vulnerable babies, children and young people at risk of harm: best practice framework for acute health services[48] has been developed to document the vital role performed by public hospitals in identifying and protecting babies, children, and young people at risk of harm from abuse and neglect.

The framework comprises a suite of information and resources to enable hospitals and individual health professionals who deliver acute health care to:

• identify babies, children and young people at risk of harm from abuse or neglect

• respond rapidly and effectively to ensure the child's immediate safety

• set in train a multi-agency response that ensures that safety in the long term and supports the wellbeing of the child and family.

The framework is part of a broad, multi-pronged approach by the Department of Human Services to improve responses to these vulnerable children and the coordination and consistency of responses across the service system, with the aim of providing the best and most appropriate range of services for each child at risk and their family.

This approach includes tools to assist in identifying vulnerable babies, children and young people, the development of enhanced Victorian Forensic Paediatric Medical Services, education and training for acute health staff and increased liaison with regional child protection services both within the department and between health services and other agencies providing services for vulnerable children.

1.16 Women's safety strategy

Men's use of violence against women is a significant public health issue with serious social, economic and health consequences for women, their families and communities.[49] In Victoria significant advances have been made to improve assistance to women and children directly affected by this violence. In 2002 the Victorian Government developed its *Women's safety strategy*,[50] a five-year plan to guide coordinated action across government to reduce the level and fear of violence against women. The strategy, as it currently stands, has a set of principles to guide the government's future activities to reduce the level, and fear, of violence against women. There are four key areas:

• protection and justice

• options for women

• violence prevention and education

• community action and coordination.

The Office of Women's Policy is currently planning for the *Women's safety strategy 2008–2012*.

48 Department of Human Services 2006, *Vulnerable babies, children and young people at risk of harm: best practice framework for acute health services, Melbourne*

49 *Violence is the biggest cause of death, disability and illness for women aged 15–45 years. Victorian Health Promotion Foundation 2004, Health costs of violence measuring the burden of disease caused by intimate partner violence, North Carlton*

50 *Office of Women's Policy 2002, Women's safety strategy, Melbourne*

1.17 Victorian sexual assault reform

The Victorian Government's sexual assault reform model is a new approach to policy development. It is a systems approach based on collaboration and partnership, aimed at changing attitudes and behaviours across the criminal justice system. Its key objectives are to create a system that:

- encourages people to report sexual assault
- minimises the trauma and distress for complainants throughout the criminal justice process
- leads to a reduction in the incidence of sexual assault in the community.[51]

The Victorian Law Reform Commission has recommended many non-legislative reforms aimed at improving the criminal justice system's response to sexual offences. Some of the initiatives are:

- enhanced counselling for victims of sexual assault and expanded crisis care responses
- new forensic nurses to improve complainants' access to appropriate and timely forensic medical services and to improve police investigations
- 'One-stop shops' such as multidisciplinary centres in Frankston and Mildura to deliver integrated justice and human service responses to victims including police, medical and counselling responses
- a range of court and other systems reforms.

1.18 Integrated family violence service system

In Victoria, family and domestic violence legislative and systems reforms introduced in 2006 identify elements central to providing an effective and consistent response across the state:

- enhancement of the multiple entry pathways to ensure that a person entering the system receives a consistent response regardless of the entry point
- expanded and improved support services that embrace diversity
- provision for individual advocacy for women and children who experience violence at all points in the system
- common risk assessment and referral processes
- consistent case coordination
- intensive case management for high-risk and complex needs families
- a more streamlined justice response through legislative and practice change
- longitudinal tracking of cases
- effective data collection and recording that includes data on Indigenous, CALD and women with disabilities
- capacity for advocacy at a systems level, informed by individual advocacy
- effective and efficient monitoring and evaluation processes/mechanisms.[52]

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51 Department of Justice 2006, *Sexual assault reform strategy*, Melbourne
52 Office of Women's Policy 2005, *Reforming the family violence system in Victoria: Report of the Statewide Steering Committee to Reduce Family Violence*, Melbourne

The implementation of these elements will not only provide a consistent approach but will ensure that the system delivers high-quality responses at the first point of entry. This will help to reduce the number of times women and children who experience violence and/or men who use violence re-enter the system, leading to more effective early intervention strategies and preventing the escalation of violence.

Partners for the reformed family violence system include:

- Victoria Police, magistrate's courts, Family Violence Division of the Magistrate's Court and the Family Violence Intervention Project
- family violence support and crisis accommodation services
- men's behaviour change programs including the Men's Referral Service
- community legal services.[53]

1.19 Improving care for older people

Improving care for older people[54] sets the policy direction for sub-acute services for older people. It identifies the need for health services to:

- adopt a strong person-centred approach to delivering care and services
- better understand the complex health care needs of older people
- improve integration within their community-based programs and with ongoing support services available in the broader community.

The key principles underpinning the policy include:

- all people across Victoria have access to Centres Promoting Health Independence
- robust protocols and agreements developed between health services and ongoing community support providers ensure older people continue to receive the care they require in a coordinated and integrated manner
- treatment and care provided:
  - places the person at the centre of their own care and considers the needs of the older person's carers
  - includes a comprehensive assessment where there is a positive risk screen
  - includes interdisciplinary care planning and includes the older person as a participant in the team
  - is coordinated to achieve integrated care across all settings
  - in a setting that best meets their needs.

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53 *Department for Victorian Communities 2005, Changing lives: a new approach to family violence in Victoria, Melbourne*
54 *Department of Human Services 2003, Improving care for older people, Melbourne*

1.20 Strategic directions in assessment: Victorian Home and Community Care Program

The aims of the *Strategic directions in assessment: Victorian Home and Community Care (HACC) Program*[55] were to investigate the range of current practice, to identify operational issues affecting delivery of assessment services and to make recommendations for the development of an assessment framework for the HACC program in Victoria.

The program's report concludes that assessment in the client's home is the most appropriate setting for a HACC broad needs-based assessment. It also identifies the practices required to support this type of assessment including:

- separating care management from home-based needs assessment
- care coordination includes the provision of assistance to a client leading up to and following on from the assessment process
- use of a standardised kit of assessment tools and use of SCTT
- designation of HACC assessment agencies
- a health promoting approach to service delivery
- processes to determine priority of access and demand management
- carer assessment and recognising client diversity in assessment
- comprehensive assessment to frail older people
- professional development.

1.21 Improving discharge outcomes for younger people with a disability in health services

Improving discharge outcomes for younger people with a disability in health services[56] outlines principles to guide and improve communication, planning and discharge processes between health services and the department's Disability Services, for younger people (aged less than 65 years) with disabilities. The high level principles are as follows:

- a shared understanding between health services and Disability Services regarding their service systems, roles and responsibilities and access to other community supports and services
- regional or sub-regional avenues for communication
- defined points of access in both health services and regional Disability Service Intake and Referral teams to coordinate the response for a younger person with a disability whose discharge is being planned.
- hospital or rehabilitation service make early initial contact with regional Disability Service Intake and Response teams to facilitate timely planning and assessment for discharge

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55 *Department of Human Services 2005, Strategic directions in assessmen:t Victorian Home and Community Care Program, Melbourne*
56 *Department of Human Services, 2009, Improving discharge outcomes for younger people with a disability in health service, Melbourne.*

- a joint framework for responding to the needs of younger people with a disability which includes: early joint planning, clear timelines for referrals Disability Services, common tools or templates to share information and clarity around progressing out-of-region discharges
- timely planning for discharge including registration on the Disability Support Register, allocation of supports, access to hospital discharge support programs such as PAC, Transitional Care Program and Rehabilitation in the Home and health independence support programs.

1.22 Hospital guide for people with a disability: Providing support during hospital admissions

The draft *Hospital guide for people with a disability: Providing support during hospital admissions*[57] aims to improve health care delivery and the outcomes for people with a disability by providing practical information on the care of people with a disability within acute health settings. The Guide describes the key tasks and activities to be undertaken prior to admission, during hospitalisation and in preparation for discharge. It delineates the roles and responsibilities of both hospital and disability staff caring for a person with a disability, particularly those people who are residents of a Disability residential service.

1.23 Relevant literature

A number of recent reviews have addressed the role of care coordination in improving health system performance. These studies indicate:

- multidisciplinary case management effectively reduces hospital admission rates from the ED[58]
- multidisciplinary case management has a positive effect on some psychosocial factors for frequent ED attenders but increases their rate of ED attendance[59]
- high levels of staff, patient and carer satisfaction with ED care coordination[60]
- care coordination interventions represent a wide range of approaches at the service delivery and systems level [61]
- the effectiveness of care coordination is most likely dependent upon appropriate matching between intervention and the care coordination problem [62]
- targeted care coordination programs have positive effects on the quality of care but the evidence on financial savings is inconsistent.[63]

57 *Department of Human Services, 2009, Hospital guide for people with a disability: Providing support during hospital admissions, Melbourne.*
58 *Corbett HM, Lim WK, Davis SJ, Elkins AM 2005, 'Care coordination in the emergency department: improving outcomes for older patients', Australian Health Review, Vol 29 No. 1, pp. 43–50*
59 *Phillips GA 2006, 'The effects of multidisciplinary case management on selected outcomes for frequent attenders at an emergency department', Medical Journal of Australia, Vol 184 No.12, pp. 602–606*
60 *Moss JE et al. 2002, 'A multidisciplinary care coordination team improves emergency department discharge planning practice', Medical Journal of Australia, Vol 177, pp. 427–431*
61 *Stanford University-UCSF Evidence-based Practice Centre 2007, 'Closing the quality gap: A critical analysis of quality improvement strategies', Vol. 7 Care Coordination, Stanford, p. vi*
62 *Stanford University, p. vi*
63 *Hofmarcher MM, Oxley H, Rusticelli E 2007, Improved health system performance through better care coordination OECD health working paper, pp. 6–8*

Appendix 3: Community-based health care

For the purposes of these guidelines, community-based health care refers to any health care that does not involve an overnight or multi-day stay in hospital. It includes general practice, medical specialists, residential care services (including residential aged care services, supported residential services and residential mental health services such as community care units), sub-acute mental health prevention and recovery care (PARC) services and those services provided on an outreach basis where care providers visit people living in a residential facility.

A broad range of government-funded health care services are covered, including:

- same day medical and surgical services
- outpatient services
- Hospital in the Home
- sub-acute home and community-based services
- specialist community mental health services (including psychiatric disability rehabilitation and support services – PDRSSs)
- community-based palliative care services
- community-based elements of integrated cancer services
- maternity services (antenatal and postnatal care)
- Hospital Admission Risk Program
- post-acute care
- community health services
- dental services
- Home and Community Care services
- alcohol and drug services.

The term 'community-based health care' does not suggest that all of these services will be, or should be, delivered outside hospitals. Some services will continue to be delivered in hospitals for reasons of safety, quality and efficiency (critical mass and access to infrastructure and other services).

Appendix 4: Services for children and adolescents and their families

ED care coordination services address the needs of children, adolescents and their families. A number of factors need to be considered in programs with a paediatric component, including:

- the developmental stage of the child such as cognitive, emotional, social and physical abilities, activities of daily living, speech and language skills
- the family unit in which the child functions and grows including parents, siblings, extended family members, carers and foster carers
- consent and the need to involve older children in decisions regarding their own health
- the service with which a child may be linked including the education system, child care, disability, health and maternal and child health services
- the specialised nature of paediatric care.[64]

The following information is designed to assist ED care coordination services to address the needs of children, adolescents and their families presenting to hospital EDs.

Vulnerable children and adolescents and their families

The *Children, Youth and Families Act 2005* came into effect in April 2007 and a range of enhanced service delivery arrangements were implemented to provide for children in need

of protection from serious abuse and neglect and to support the assessment and engagement of vulnerable children and families in community-based services.

A central feature of the legislation is the establishment of two distinct, yet interrelated, pathways into family services where there are significant concerns about the wellbeing of children. By 2009 Child FIRST (Child and Family, Information, Referral and Support Teams) will provide a community-based referral point into family services. Community Based Child Protection will support every Child FIRST by facilitating the collaboration between family services and child protection.

When should I refer to Child FIRST?

A referral to Child FIRST may be the best way of connecting vulnerable children, young people and their families to the services they need to protect and promote their healthy development.

Families requiring the support of family services generally have complex needs, which can adversely impact on child's development if appropriate supports and interventions are not provided in a timely manner. Significant concerns about the child's wellbeing and development are highlighted by how often issues are occurring, how serious the issues are and, most importantly, how the issues are affecting the child's development.

Family services practitioners, with experience in assessing the needs of vulnerable children, young people and families, staff Child FIRST. In addition, Community Based Child Protection facilitate collaboration between these community-based intake services and child protection, providing advice to Child FIRST and family services about the engagement of families with complex needs and the identification of significant risk factors, and ensuring timely child protection involvement if a child is at risk of significant harm.

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64 *Department of Human Services 2008, Health independence program guidelines, pp. 55–56*

What happens when I make a referral to Child FIRST?

Child FIRST will discuss with you the initial needs of the child, young person and family that you have concerns for to determine the most appropriate response. Services will be prioritised to families on the basis of need, to prevent difficulties escalating to a level that will significantly impact on the child's development and consequently lead to the entry into child protection.

Some families may be assisted by the provision of information and advice only; however, for most families referred to Child FIRST, a cycle of assessment, planning and action will commence.

How is a referral to Child FIRST made?

The following web link provides information and contact details including Child FIRST site location maps.

www.cyf.vic.gov.au/child-protection-family-services/how-to-make-a-referal-or-report

To make a mandatory report or referral:

www.office-for-children.vic.gov.au/cp/how_to_make_a_referral_or_report

Where practitioners are unsure what action to take or whether to report to child protection or make a referral to Child FIRST, call 1300 369 536 and ask for a secondary consult.

Children Youth and Families Division

For additional information refer to the Children Youth and Families Division website.

www.cyf.vic.gov.au

Vulnerable babies, children and young people at risk of harm: best practice framework for acute health services

This framework comprises a suite of information and resources to enable hospitals and individual health professionals who deliver acute health care to:

- identify babies, children and young people at risk of harm from abuse or neglect
- respond rapidly and effectively to ensure the child's immediate safety
- set in train a multi-agency response that ensures that safety in the long term and supports the wellbeing of the child and family.

Refer to: www.health.vic.gov.au/childrenatrisk/index.htm

Codes of practice for family violence and sexual assault

Referrals in the case of family violence and sexual assault may be covered by established codes of practice, including:

- *Police code of practice for the investigation of sexual assault*
- *Police code of practice for the investigation of family violence*
- *Victorian Centres Against Sexual Assault standards of practice*

- *Code of practice for specialist family violence services for women and children*
- *Homelessness assistance service standards (HASS)*

Refer to:　www.cyf.vic.gov.au/integrated-family-violence/guidelines#F

　　　　　www.police.vic.gov.au/retrievemedia.asp?Media_ID=1717

Formal protocol between Department of Human Services and Victoria Police Family Violence referral pathways 2006–2008

Refer to:　www.cyf.vic.gov.au/family-violence-sexual-assault/library/publications/referral_pathways

Services network contact sites

Victorian CASA Forum

The Victorian CASA Forum Inc is the peak body of the 15 Centres Against Sexual Assault, and the Victorian after-hours Sexual Assault Crisis Line.

Refer to:　www.casa.org.au/index.php?page_id=86

Domestic Violence Resource Centre Victoria

Domestic Violence Resource Centre Victoria (DVRCV)

DVRCV is a statewide service that provides information and referral to specialist support services.

Refer to:　www.dvirc.org.au/ServicesHub/ServicesIndex.htm

Appendix 5: Discharge Risk Screen

In 1998 the Department of Human Services commissioned Thomas and Associates[65] as part of the *Effective discharge strategy* to develop a valid, reliable and practical screening tool designed to predict whether patients required services following discharge from acute care.

The 12-item version of the Risk Screening Tool was found to result in a 90 per cent correct classification of service need. When the tool was shortened to four items, 86 per cent correct classification was still achieved, indicating that the four factors are strong predictors of service need. The four factors found to be most predictive of service need were:

• patient likely to have self-care problems

• patient lives alone

• caring responsibilities for others

• patient used services before admission.

The Risk Screening Tool is designed to enhance clinical judgment and facilitate higher levels of service and safety for patients following discharge from acute care environments.

The 12-item version of the risk screening tool is outlined below.

Risk Screening 0Tool for post-discharge services

Please answer each of the following 12 questions. If any question receives a yes answer then the patient should be further assessed for suitability for more complex discharge planning. If two or more questions are answered as yes, it is likely that some post-discharge services will be required.

Risk factors	Yes	No	Action
1. Is the patient likely to have problems in managing self-care (such as washing, meal preparation, shopping)?			
2. Is there any evidence of a mental and/or behavioural problem?			
3. Is the medical condition of the patient disabling or deteriorating?			
4. Does the patient live alone?			
5. Is the patient likely to have complex medication, dressings or treatments following discharge?			
6. Does the patient have a history of multiple recent admissions (two or more prior admissions over the past 12 months)?			
7. Does the patient have caring responsibilities for others at home?			
8. Are there any unsafe aspects of the discharge destination for the patient (such as steps)?			
9. Does the patient hold a health care card or pension (for example, is the patient from a low-income background)?			
10. Did the patient use community services prior to their admission (such as home help, meals on wheels)?			
11. Did the patient have any problems in managing at home prior to admission?			
12. Does the patient require an interpreter?			

65 Thomas and Associates 1998, *Final report of the development of a risk screening tool for service needs following discharge from acute care project*, Department of Human Services, Melbourne

Explanatory notes to accompany the Risk Screening Tool for post-acute discharge

It is important to note that the need for additional support following discharge from an acute care setting is determined not only by the physical and mental state of the patient but also the supports available in the setting to which the patient is being discharged. This means that information about the available supports needs to be collected in addition to the clinical information about the patient. The questions asked in the Risk Screening Tool have been derived from a detailed literature analysis of the available research as well as through expert consultation.

Risk screening question	Explanatory notes
1. Is the patient likely to have problems in managing self-care (such as washing, meal preparation, shopping)?	If the patient's functional status is poor then post-discharge service needs may be required. If the functional status of the patient is poor and ADL seems to be a problem then answer this question as yes.
2. Is there any evidence of a mental and/or behavioural problem?	Mental or behavioural problems provide a warning sign for patients in terms of possible needs for post discharge services. The answer should be yes to this question if the patient is confused, disruptive or exhibiting disturbed behaviour.
3. Is the medical condition of the patient disabling or deteriorating?	Research has shown that if the patient's condition is deteriorating or disabling then post-discharge services may be required. If the patient is seriously disabled by their condition or it is deteriorating then answer yes to this question.
4. Does the patient live alone?	If the patient lives alone their post-discharge care requirements should be carefully assessed. Answer yes to this question if they live alone.
5. Is the patient likely to have complex medication, dressings or treatments following discharge?	If the patient has complicated and technical post-discharge requirements then the ways in which these requirements are to be handled needs further assessment. Answer yes if any of the conditions apply.
6. Does the patient have a history of multiple recent admissions (two or more prior admissions over the past 12 months)?	Patients who have frequent recent admissions are likely to continue the trend. This may require more complex discharge planning. In this instance if the patient has two or more previous admissions in the past year answer as yes for more detailed assessment.
7. Does the patient have caring responsibilities for others at home?	If the patient has significant care responsibilities that cannot be assumed by someone else this may compromise their recuperation. If the answer is yes to this question a more detailed assessment of needs will be required.
8. Are there any unsafe aspects of the discharge destination for the patient (such as steps)?	Some patients cannot manage the steps at their homes, for example, or have other safety issues. If the answer to this question is yes, then more detailed assessment is indicated.
9. Does the patient hold a health care card or pension (for example, is the patient from a low-income background)?	Low income has been found to be a key predictor of need for post-acute services. If the person has a low income, answer yes to this question as it may indicate the need for more complex discharge planning.

10. Did the patient use community services prior to their admission (such as home help, meals on wheels)?	If the patient has recently used community services prior to their admission, it is likely this requirement will continue. In this instance answer yes for further assessment.
11. Did the patient have any problems in managing at home prior to admission?	If the patient had pre-admission problems it is likely that these will continue during their recuperation following discharge. Answer yes as further assessment is indicated.
12. Does the patient require an interpreter?	Access to support may be impeded by low English fluency. This factor needs to be considered in the discharge plan. Answer yes if the person requires an interpreter in everyday communication.

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Useful websites

Hospital demand management

www.health.vic.gov.au/archive/archive2006/hdms/index.htm

Department of Health and Ageing

www.health.gov.au/internet/wcms/publishing.nsf/Content/ageing-acfi-aboutacfi.htm

Better Health Channel

www.betterhealth.vic.gov.au

Department of Human Services

www.dhs.vic.gov.au

Primary Care Partnerships

www.health.vic.gov.au/pcps/publications/index

Office of the Public Advocate

www.publicadvocate.vic.gov.au

Children, Youth and Families – *Family violence common risk assessment framework*

www.cyf.vic.gov.au/integrated-family-violence/guidelines#F

Victoria Police – *Code of practice for the investigation of sexual assault*

www.police.vic.gov.au/retrievemedia.asp?Media_ID=1717

Your information: it's private

www.health.vic.gov.au/archive/archive2006/hdms/index.htm