

Section three

Good practice examples and resources

Appendix A	1
Good practice in Victorian public hospitals: A selection of successful examples	
Good practice example 1.3A	3
The Discharge Planning Unit provides single point of contact for hospital staff	3
Western District Health Service	3
Good practice example 1.3B	4
A generic approach to patient assessment and discharge reduces unplanned hospital admissions	4
Peninsula Health	4
Good practice example 1.3C	5
Case management model a success with heart patients	5
Eastern Health	5
Good practice example 1.3D	7
Primary midwifery care partnerships provide better results for both women and their midwives	7
Northeast Health Wangaratta	7
Good practice example 1.3E	9
Case conferences improve transition planning and communication with patients	9
Western Health	9
Good practice example 1.3F	11
Medically led discharge meetings result in better transition planning	11
Northern Health	11
Good practice example 1.4A	12
Training staff in transition practices increases patient satisfaction	12
Wodonga Regional Health Service	12
Good practice example 1.4B	13
Video helps improve interdisciplinary team meetings	13
St Vincent's Health	13
Good practice example 1.4C	14
Educating staff in transition practices leads to higher patient satisfaction	14
Colac Community Health Service	14

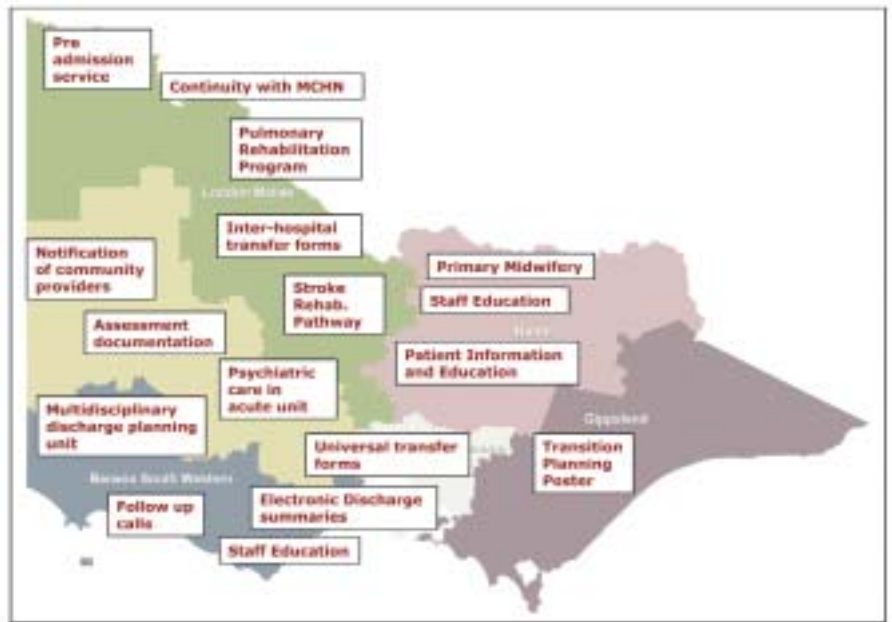
Good practice example 1.4D	15
Successful integration of psychiatric care into an acute hospital unit	15
Mt Alexander Hospital	15
Good practice example 2.1A	16
Guide assists staff to produce better patient information	16
Austin Health	16
Good practice example 2.1B	17
Poster leads to improved transition planning and higher patient satisfaction	17
Gippsland Regional Consortia	17
Good practice example 2.1C	19
Pulmonary patient rehabilitation program records 96 per cent patient satisfaction	19
Kerang and District Hospital	19
Good practice example 2.2	20
Patients benefit from regionally aligned assessment documentation	20
Stawell Regional Health	20
Good practice example 2.3A	21
A coordinated approach to stroke rehabilitation	21
Goulburn Valley Health	21
Good practice example 2.3B	22
Increasing patient empowerment and clinical leadership through pathways	22
Bayside Health	22
Good practice example 2.4	23
Home visit from pharmacist results in safer use of medication	23
Bayside Health and Austin Health	23
Good practice example 2.5A	24
Good communication with GPs improves continuity of care	24
Bayside Health	24
Good practice example 2.5B	25
Acute health medical officers and GPs unite to enhance patient management	25
St Vincent's Health, Inner Eastern Melbourne, Melbourne and Otway Divisions of General Practice	25

Good practice example 2.5C	26
Electronic recording enables discharge summaries to be dispatched within an hour	26
Barwon Health	26
Good practice example 2.5D	27
Improving communication between hospital staff and primary care providers	27
Austin Health	27
Good practice example 2.6A	28
Generic inter-hospital transfer process improves patient care	28
Goulburn Valley Health	28
Good practice example 2.6B	29
Universal transfer policy a success all round	29
Barwon sub-region consortia	29
Good practice example 2.6C	30
Linking hospitals and maternal child health nurses ensures continuity of care for young children	30
Swan Hill District Hospital	30
Good practice example 2.6D	31
Poster aids referral to medical, allied health and community providers	31
Wodonga Regional Health Service	31
Good practice example 2.6E	32
Uniform notification process leads to improvements in post-hospital referral services	32
Wimmera Health Care Group and East Grampians Health Service	32
Good practice example 2.8A	33
Calls to 'at-risk' patients after discharge enhance patient care	33
Bayside Health	33
Good practice example 2.8B	34
Post-discharge telephone calls improve patient satisfaction	34
East Grampians Health Service	34
Good practice example 2.8C	36
Post-discharge follow-up calls improve patient care and referral relationships	36
Otway Health And Community Services	36

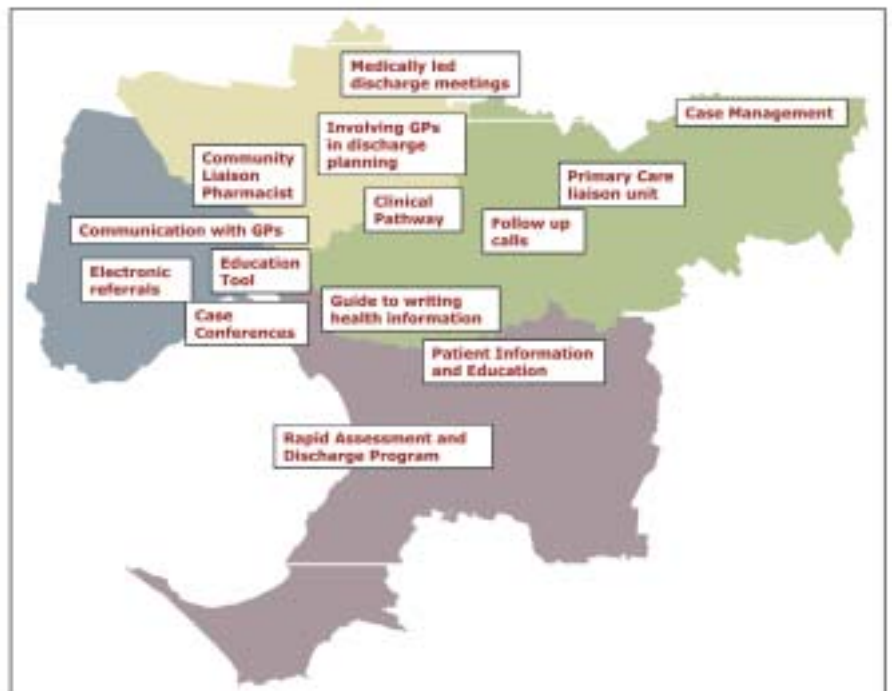
Attachments	37
Attachment 1 – The Alfred ‘Patient call back data sheet’	37
Attachment 2 – Wodonga Regional Health Service ‘How to refer to services’	38
Appendix B – Good practice Guide Contributors	41
Case study contributors	41
General contributors	42
Appendix C – Service directories	43
Victorian service directories	43
Infoxchange	43
Specific-need service directories	44
National aged care service directory	44
Disability online	44
Health insite	45
Appendix D – The Good Reading Guide	47
Useful Reading	47
Glossary	67

Appendix A

Good practice in Victorian public hospitals: A selection of successful examples



Rural good practice examples



Metropolitan good practice examples

Good practice example 1.3A

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The Discharge Planning Unit provides single point of contact for hospital staff

Western District Health Service

Aim

To improve the patient transition planning process

How

Western District Health Service established a multidisciplinary Discharge Planning Unit to provide hospital staff with a single point of access, for assistance with patient transition planning.

The unit, located at Hamilton Hospital, developed transition documentation and a resource folder. It educates ward staff on transition principles and processes as part of orientation and provides ongoing training.

Who

Internal stakeholders involved in the process included the Director of Nursing, the Quality Manager, the Director of Medical Services and the Discharge Planning Manager.

The management of Post Acute Care and Hospital in the Home services are included within the unit to further facilitate access to home services.

Benefits and outcomes

The unit has gained a high profile within the hospital and is integral to patient care. Patients are more involved in their transition planning.

Coordination of post-hospital services for patients has improved, as have links with community service providers.

These benefits have extended to improve services for the rural and isolated community.

Good practice example 1.3B

A generic approach to patient assessment and discharge reduces unplanned hospital admissions

Peninsula Health

Aim

To provide an efficient system for assessing and coordinating the transition of patients who present to the Emergency Department.

How

A multidisciplinary team at Frankston Hospital, Peninsula Health assesses and arranges services for emergency department patients who are able to return directly to the community.

For patients who require admission to the hospital, the team begins the transition planning process in the emergency department.

The service operates from 8am to 9pm seven days a week.

Who

All team members have been educated in the necessary assessment skills and operate as a trans-disciplinary team. This means patients can see health professionals of any discipline – and receive the same assessment.

This generic approach has been achieved by training each health professional in the assessment skills of the other disciplines. For example, social workers are trained in assessment skills of occupational therapy and nursing.

Benefits and outcomes

The number of patients admitted or re-presented has decreased.

Better transition planning means that patients are linked to the community services they require faster and more effectively.

Emergency department staff are more confident that patients receive community support once they return home.

The service has improved links between the hospital and community service providers.

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Good practice example 1.3C

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Case management model a success with heart patients

Eastern Health

Aim

Improved management of all patients admitted with chronic heart failure to decrease hospital length of stay, Emergency Department presentations and readmissions in this target population.

How

Box Hill Hospital, Eastern Health introduced the chronic heart failure (CHF) case manager position in December 2001 to improve the management of this patient group.

A case manager assesses each patient admitted with this condition in regards to their suitability for this program. During the patient's hospital stay, the case manager facilitates the patient's care, ensuring that the appropriate investigations are made. The patient and their family are educated about their medication and self-management of their heart failure with the formation of an Action Plan. The case manager also participates in discharge planning with the multidisciplinary team in regards to post-hospital services.

The patient's GP is sent a letter informing them of the CHF case management service and a copy of the Action Plan.

After discharge, the case manager visits the patient at home within one week and conducts a physical and psychosocial assessment, noting in particular their ability to perform Activities of Daily Living. Following the home visit, the case manager arranges further services as required and discusses problems that may have arisen with the GP. The case manager continues to be available to the patient as a contact to answer any queries. Patients not under the care of a cardiologist are referred to the Heart Failure Clinic (Box Hill Hospital) for ongoing management and assessment of their suitability to attend the Phase 2 Heart Failure Rehabilitation Program located at Whitehorse Community Health Service (WCHS).

The hospital has developed a multidisciplinary clinical pathway for the targeted patient group. Hospital staff can also contact the case manager to obtain information or assistance regarding a patient's management plan.

Benefits and outcomes

Patient satisfaction levels have increased, with patients finding that their action plans are useful. Management of the target patient group has also improved, as indicated by the improved adherence to best-practice medication management for this patient group.

Emergency department presentations, inpatient admissions and re-admission rates of the target patient group have fallen significantly, as has the average length of stay for heart failure admissions with complications.

The hospital conducts ongoing evaluation of the improvements resulting from the model. Links with GPs have improved because GPs have greater involvement in the development of patient management plans.

The hospital attributes the success of the case management model to the patient-centered approach and consultation with patients and their carers throughout the model's development.

The hospital has appointed a second case manager to meet the growing demand for this service. This service has also been established in other hospitals within Eastern Health and for other patient groups as a result of its success.

Good practice example 1.3D

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Primary midwifery care partnerships provide better results for both women and their midwives

Northeast Health Wangaratta

Aim

To develop a model of care for maternity patients that includes named midwife and client partnerships.

How

Northeast Health Wangaratta has developed a Midwife led model of care for maternity patients. The Community Midwife Program is a group practice of five midwives who case-manage women throughout their pregnancy, maintaining contact from first presentation to post-delivery, providing 24-hour access until six weeks post partum.

The named midwife case-manages the patient throughout her pregnancy, maintaining contact from first presentation to post-delivery and providing 24-hour access to the patient.

Women are offered this model of care when booking at the hospital or when they attend their GP for confirmation of pregnancy. Their level of care is determined by their risk assessment.

Three different streams of care cater for the mothers' needs. These include midwife care only for low-risk pregnancy, shared care between a midwife and antenatal clinic or midwife and GP for medium risk, and obstetrician care with midwife support for high-risk pregnancies.

Who

The model was developed and implemented by a steering committee including consumers, GPs, maternal child health nurses, obstetricians, paediatricians, midwives, Australian Nursing Federation and the Australian College of Midwifery at Northeast Health Wangaratta.

Outcomes and benefits

This service model offers women the assurance of having a known midwife throughout her pregnancy with increased choices of how, when and where care is delivered. High levels of client satisfaction have been demonstrated with maternal & neonatal safety measures equal or better than the state average.

The number of normal deliveries has increased – in fact; the hospital notes a 10-12 per cent decrease in caesarean deliveries.

Women in rural and remote areas receive more equitable access to midwifery services as the midwives offer flexible appointment times, home based care for the antenatal & postnatal period and outreach clinics in neighbouring towns.

The model has also resulted in a number of benefits for midwives who are reportedly more satisfied with their role.

The skill level of the midwifery workforce has increased and students from all over Victoria have been attracted to this highly-regarded primary midwifery model which has now been published in “Guidelines to Midwifery Care.”

Communication between the midwives, GPs and obstetric consultants has improved with associated improvement in networking and referral to community services.

Good practice example 1.3E

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Case conferences improve transition planning and communication with patients

Western Health

Aim

To design a case conference format that provides a stronger focus on patient outcomes.

How

At the Aged Care Unit at Williamstown Hospital, members of the multidisciplinary team meet weekly to discuss newly admitted patients and those who are due for review. The hospital has designed the meetings to ensure that they are focused on patient outcomes and each team member has a clear role.

The case conference meeting is divided into two parts: the first part is chaired by the geriatrician, and the second part by the case coordinators*.

Case coordinators are assigned to patients with complex needs. They are members of the patient care team and may be a nurse, occupational therapist, physiotherapist or social worker. They are responsible for the patient's transition and are a central communication point for the patient and their family/carer.

The case coordinator discusses the patient's care with the patient before the case conference, assisting the patient to establish his/her goals. These are then presented at the meeting by the coordinator who facilitates the team's development of a patient-oriented plan. The case coordinator discusses the outcomes with the patient and their family/carer.

The outcomes of the meeting are recorded on the case conference sheet, so that after-hours staff can provide consistent feedback to the patient and family/carer. Staff document any problems voiced by the family/carer and these are resolved together with the patient and case coordinator.

Who

The case conferences are attended by members of the multidisciplinary team, including the physiotherapist, occupational therapist, nurses, medical officers, pharmacist, consultants, resident medical officers, RDNS liaison, social worker, dietician and speech pathologist. However, the meetings are not person-dependent, so that they can proceed even if a member of the team is missing.

Benefits and outcomes

Patients and their families/carers are more involved in transition planning. Patients are more aware of their discharge date and more involved in deciding that date.

Team communication has improved, providing patients with more consistent care. The hospital has developed education processes and guidelines to support the case conference model.

**Williamstown Hospital uses the term 'Case Coordinators'. The model of care aligns to the case management model described within section 3 of this guide.*

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Good practice example 1.3F**Medically led discharge meetings result in better transition planning****Northern Health****Aim**

To provide a focus on discharge rather than medical treatment at medical meetings and to ensure a more efficient transition process.

How

At The Northern Hospital, Northern Health, each unit runs a weekly medically led discharge meeting. The focus of these meetings is to determine transition plans for patients within the unit. Factors that may affect the patient flow are identified and, if necessary, a working group is formed to resolve issues.

Prior to the meeting, medical officers undertake an assessment of each patient's post-hospital needs. At the meetings the medical officers give a brief overview of the patient's medical condition and current management and discuss their progress. The patient's post hospital needs are discussed and a likely discharge date flagged and a transition plan is developed. The medical officer then discusses the outcome with the patient. Meetings are regular and kept to 30 minutes.

New staff, particularly medical officers, receive training on the meeting process and transition planning practices as part of their orientation.

Who

Meeting attendance includes the Operations Director-Medicine, consultants, hospital medical officers, nurses, the care coordinator, allied health representatives, representatives of the Hospital-in-the-Home and Post Acute Care services and external providers, for example Royal District Nursing Service.

Outcomes and benefits

Patient care needs, patient flow and transition issues are identified and resolved early.

The meetings have successfully overcome issues with large-volume patient groups, reduced length of hospital stays, minimised weekend transfer blocks and increased cooperation with community care service providers.

Presentations by external providers have given hospital staff an increased understanding about the services available to patients after hospitalisation.

Good practice example 1.4A

Training staff in transition practices increases patient satisfaction

Wodonga Regional Health Service

Aim

To increase staff understanding of transition planning policies and processes.

How

Wodonga Regional Health Service developed an education package for its staff about transition planning policies and processes.

Areas covered included discharge risk screening, assessment, referrals, expected date of discharge, community resources and hospital follow-up.

Benefits and outcomes

Staff have changed their work practices and introduced innovative practices such as daily discharge planning meetings.

Patients are more involved in their transition planning and more aware of their expected date of discharge. Since the program began, this awareness has increased from 25 to 66 per cent. Patient satisfaction increased from 88 per cent in 2000 to 100 per cent in 2002.

The hospital continues to measure and review the effectiveness of the package in improving transition practices.

In May 2003, Wodonga Regional Health Service received a Transitioning Care Award, for Outstanding Performance in Transition Planning from the Department of Human Services. The hospital achieved an excellent discharge audit score for both its acute and sub-acute services and achieved high levels of patient satisfaction with the discharge, follow-up index and overall care index of both Years One and Two of the Victorian Patient Satisfaction Monitor.

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Good practice example 1.4B

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Video helps improve interdisciplinary team meetings

St Vincent's Health

Aim

To improve the effectiveness of interdisciplinary team meetings.

How

An audit of interdisciplinary team meetings revealed considerable variation in the frequency of meetings, the quality of information collected and subsequent documentation.

To improve the quality of future meetings, the hospital developed a 'train the trainer' education program that included a video for hospital staff.

Focusing on patient outcomes and transition planning, the video shows how to conduct effective interdisciplinary team meetings. It features different members of the team explaining their role and perceptions of the key aspects of a team meeting.

Other issues covered in the video include good interdisciplinary communication, patient transition, leadership, agendas, respect and trust.

Benefits and outcomes

Those that have participated in the program to date have commented that the quality of team meetings has improved and members of the team have a greater understanding of each other's roles.

Treatment and care for patients are improved as there is a team approach to the assessment of patient needs and the development of care plans.

Good practice example 1.4C

Educating staff in transition practices leads to higher patient satisfaction

Colac Community Health Service

Aim

To increase staff understanding of transition planning and available resources within the hospital and the community.

How

An audit identified gaps in the hospital's documentation and knowledge of services that facilitate transition planning.

In response, the hospital developed a staff education program about transition practices. A two-day 'train the trainer' workshop educated a multidisciplinary group representative from each unit or department. The workshop not only educated the trainees, but provided them with the skills to teach others.

Benefits and outcomes

The trainers have become clinical champions, promoting improvements and providing education in transition planning to all hospital staff.

Staff are more aware of the importance of early referral and the hospital has recorded improved performance in all processes of transition planning, including documentation.

Information is shared more effectively among ward staff. Each ward undertakes a regular patient record audit, allowing them to measure their performance and target their education. Education on transition planning is part of the quality plan of each ward.

The hospital notes a marked improvement in patient satisfaction with transition planning and a reduction in hospital readmission rates.

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Good practice example 1.4D

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Successful integration of psychiatric care into an acute hospital unit

Mt Alexander Hospital

Aim

To integrate psychiatric care into an acute care hospital.

How

The Community Mental Health Team (CMHT) supported the hospital to provide psychiatric inpatient care for low-to medium-risk patients.

The CMHT support included education and training as well as on-call advice for hospital staff.

Mt Alexander Hospital educated all unit staff in psychiatric care.

The process of care is evolving and a culture of positive change has been developed.

Benefits and outcomes

Of the total numbers of patients with psychiatric needs that previously travelled to the regional hospital for care 80 per cent are now treated locally at Mt Alexander Hospital.

Patients who do require transfer to the regional hospital are now able to use Mt Alexander Hospital as a step-down unit.

Local treatment has reduced travel time for both patients and carers requiring services. Patients maintain close contact with their carer/family and can remain in the care of their GP during hospitalisation.

Patients have better access to local community resources, including support systems such as employment services.

Hospital staff have embraced the culture change positively and demonstrated enthusiasm and commitment to the project.

The hospital and the CMHT have developed a closer relationship. This has provided the added benefit of access to early intervention which has minimised the need for specialist hospitalisation.

Closer links have been formed between staff, GPs, psychiatric services, patients and their carers and community representatives. These groups are now participating in a steering group for the effective follow-up of suicidal patients from the ED.

The hospital has become a referral point for other hospitals developing this model.

Good practice example 2.1A

Guide assists staff to produce better patient information

Austin Health

Aim

To help hospital staff create quality patient information material.

How

Austin Health has developed a best practice guide that helps staff create high-quality patient education material.

The guide, available in a training manual and via the hospital's intranet, provides information on how to produce material that is patient focused, written in plain English, based on best available evidence and professionally presented. Patients are consulted for their input when information is being developed.

Workshops and coaching provide further training in this area and a central, electronic catalogue of brochures has been developed to ensure easy access to all materials and mechanisms for quality control.

Benefits and outcomes

Patients receive well-presented, legible and accurate information that they can read and understand.

The Project Officer, Effective Discharge Strategy was quoted as saying, "Patients have an improved understanding about their procedure, condition and their hospital stay, including discharge planning."

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Good practice example 2.1B

Poster leads to improved transition planning and higher patient satisfaction

Gippsland Regional Consortia

Aim

To encourage incoming patients to plan and discuss their transition from the hospital to the community.

How

A consortia of 4 hospitals in the Gippsland region including Bass Coast Regional Health, Gippsland Southern Health Service, West Gippsland Healthcare Group and South Gippsland Hospital, produced a transition planning poster and brochure to encourage incoming patients to discuss and plan their transition from hospital to the community.

The poster is displayed in all client areas, including community service offices and GP rooms throughout the Gippsland region.

The brochure is issued to patients when they are making their hospital booking. It details the hospital stay from pre-admission to going home and provides an explanation of the operation, medication management and a discharge checklist.

Pre-admission staff discuss potential post-hospitalisation needs with the patient and may, with the patient's consent, make referrals to the required community services. Meetings between patients and community service providers can be arranged before admission to ensure that potential services can be discussed.

The brochure and poster are available to community providers and GPs who are involved in distributing the information.

Who

Patients were involved in the testing and evaluation of the poster and brochure, which was also reviewed by Vision Australia.

Outcomes and benefits

The hospital measured the success of the brochure and poster and their effect on re-admissions and patient satisfaction.

It has found that patients are more prepared for their hospital stay and transition. Patient satisfaction levels have increased and complaints have decreased.

Links between the hospital and the community service providers are stronger and community services respond more effectively to referrals.

Other hospitals and community services in the Gippsland region have also implemented this process.

The process for developing these communication tools is now being used to communicate other types of information.

Overnight patients are followed up 2-10 days from discharge by telephone to evaluate their discharge, whether they were provided with enough information, if their needs have been met with appropriate community services and providing opportunity to provide feed back about their hospital experience.

Good practice example 2.1C

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Pulmonary patient rehabilitation program records 96 per cent patient satisfaction

Kerang and District Hospital

Aim

To help pulmonary patients better manage their condition and to improve their general health, energy, physical fitness, nutritional status and ease of breathing and decrease the functional limitations that lung disorders cause, thus reducing frequent hospital admissions.

How

Patients who were experiencing frequent admissions due to their pulmonary problems were invited to attend a ten-week course on respiratory management. The course teaches self-management skills, which prevent exacerbations of their condition as patients are, better able to manage their lung disorder. The program consists of three components: education, exercise and group therapy. The program was developed with patient involvement through focus groups, a satisfaction survey and needs analysis.

Benefits and outcomes

Patients benefit from improved quality of life and surveys have demonstrated 96 per cent satisfaction with the information received. The participants report that participation in the course has enabled them to lead a more active lifestyle. Patient health outcomes have improved substantially, including increased awareness of how to manage their condition, increased support in the community and reduced length of hospital stay. Readmissions have been substantially reduced. For example, some patients who averaged eight hospitalisations a year now records only two admissions per year. Clinical pathways for in-patients have also been developed. Relationships with community service providers and other health services have improved.

Good practice example 2.2

Patients benefit from regionally aligned assessment documentation

Stawell Regional Health

Aim

To ensure all hospitals in the Grampians region use standardised assessment and admission processes.

How

Grampians region discharge champions established a working party to review the existing assessment documentation and developed an assessment tool that was concise and easy to use.

This single tool was then adopted by all the public hospitals in the Grampians region providing regionally aligned assessment documentation.

Stawell Regional Health then reviewed their documentation and adopted this tool with adaptations relevant to local issues.

Who

Stawell Regional Health established a multi-disciplinary committee comprising; a GP liaison officer, a quality improvement manager, clinical director, health information manager, a consumer representative, District Nurse, Division 1 and Division 2 nursing representatives, Allied Health representative and the discharge champion.

Benefits and outcomes

Patients who are transferred do not need to be reassessed or asked the same admission questions.

Standard documentation is used by all hospitals in the region.

Documentation within each hospital has improved and staff have a better understanding of the importance of thorough assessment and documentation.

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Good practice example 2.3A

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A coordinated approach to stroke rehabilitation

Goulburn Valley Health

Aim

To improve the outcomes for stroke patients by using a consistent and coordinated approach to their rehabilitation.

How

Goulburn Valley Health has developed a clinical pathway for patients undergoing rehabilitation following a stroke. The pathway follows the patient from admission to the rehabilitation unit and transition to home or residential care, and involves patients and their carers in their care and transition planning.

The pathway is multidisciplinary and ensures that all targeted patients receive the best evidence-based care.

The stroke rehabilitation pathway includes ongoing monitoring by the hospital, at six and twelve months post-hospitalisation.

To evaluate the pathway's effectiveness, the hospital is auditing patient records before and after its implementation and measuring factors including the length of hospital stay, patient outcomes, variance analysis, transition plans and community service involvement.

Who

The pathway was developed by a multidisciplinary team and championed by the rehabilitation specialist.

Community service providers were consulted during the development of the pathway.

Benefits and outcomes

Patient outcomes have improved, and patients are more satisfied with their care and post-hospital arrangements.

Patients and their carers are more involved and staff have been prompted to implement the Enhanced Primary Care Items (Medical Benefits Scheme) for patients transitioning from the stroke rehabilitation unit. This risk assessment tool ensures that key data is collected and communicated when the patient is released or transferred.

Variance analysis has highlighted other issues, such as incontinence, that the hospital has now addressed.

Good practice example 2.3B

Increasing patient empowerment and clinical leadership through pathways

Bayside Health

Aim

To develop clinical pathways to manage multidisciplinary care.

How

The Alfred, Bayside Health produced medical and surgical clinical pathways for use by multidisciplinary teams caring for patients.

The pathway is a documentation tool used to manage the care of the patient, from the point of admission to either the next level of care or a return to the community.

Sequentially timed outcomes prompt the multidisciplinary team members to prepare and plan for a patient's safe transition, each day of the clinical pathway. This includes patient education.

A policy and procedure manual supports and guides the development of the clinical pathways and ensures a consistent process is followed.

Information booklets for patients outline the expected plan of care and the patient's responsibilities in achieving the desired outcomes.

Variance reporting is reviewed regularly and communicated to the clinical teams. Teams aim to identify trends, as a means of improving clinical outcomes and maximising resources. A database has been developed to capture this data and supply timely reporting.

If needed, the document can be changed in line with current evidence and practice to ensure that the pathway is maintained as a flexible and dynamic tool.

Who

A dedicated clinical pathway coordinator takes responsibility for all pathway construction and supports the clinical teams.

The multidisciplinary team involved in the care of the patient play a key role in developing the pathway.

Benefits and outcomes

Patients feel more empowered as they know more about their care on a daily basis.

Clinical staff are on-side and enthusiastic. Strong leadership and executive support ensure that the program is sustainable.

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Good practice example 2.4

Contact for further information

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Home visit from pharmacist results in safer use of medication

Bayside Health and Austin Health

Aim

To improve medication use, safety and storage in the home.

How

As part of a large-scale project, two metropolitan hospitals – The Alfred, Bayside Health and the Austin Hospital, Austin Health – employed a community pharmacy liaison pharmacist to visit patients at home who were assessed as being at risk of having difficulties with their medication.

The pharmacist assessed patients during their hospital stay, obtaining the patient's consent, and reviewing their health record and medication history. The pharmacist then contacted the patient within 48 hours of going home to arrange a home visit within five days after hospitalisation.

During the home visit, the pharmacist reviewed all the patient's medication, including medication sent home with the patient and previously prescribed medication stored in the house.

Patients were educated and reassured about their medication storage and regimes. Medication-related problems or potential problems were identified and communicated to the patients' healthcare practitioners.

With the patient's consent, the pharmacist removed any out-of-date medication and sent a report of the home visit and the medication list to the patient's GP and community pharmacist.

Benefits and outcomes

Patients feel reassured about their medications and receive answers to their questions.

Medication-related problems were identified, prevented and resolved.

Communications with healthcare practitioners was improved.

Continuity of care has improved.

Good practice example 2.5A

Good communication with GPs improves continuity of care

Bayside Health

Aim

Improving continuity of care from the community to the hospital.

How

Aged Care Services at Caulfield General Medical Centre, Bayside Health, contacts GPs at patient admission to improve the continuity of care from the community to hospital.

When a patient is admitted, a fax is sent to the patient's GP to notify them of the hospital admission and, within 24 hours, a medical officer telephones the GP to discuss details of the patient's premorbid health status and function (including medication regimes).

To prompt the medical officers, ward clerks place a GP notification stamp on the record requesting the following information: the GP's phone number, the time and date of contact, the person who contacted the GP and general information about the patient.

An audit in late 2002 indicated medical staff contact GPs on admission, for 68 per cent of patients. A discharge summary was dispatched to the GP within 24 hours of patient separation for 82 per cent of patients.

Each quarter, the hospital audits compliance with the GP notification process. Medical staff are informed of results at their weekly meetings.

Who

Learning to communicate with GPs at admission and discharge is part of the induction of new medical officers at the hospital.

Benefits and outcomes

Patients feel more confident that they will receive optimum treatment because the health providers are fully informed of their medical needs.

Realistic recuperation goals can be set when the hospital team is aware of the patient's premorbid status.

Clarification of medication regimes assists in patient assessment and treatment.

Contact for further information

Jackie Goodman
Caulfield General Medical Centre
Telephone: 03 9276 6000
Fax: 03 9276 6431
Email:
jackie.goodman@cgmc.org.au

Good practice example 2.5B

Contact for further information

Renae O'Toole
Nurse Unit Manager
GEM Unit
St Vincents Health
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Fax: 03 9288 2091
Email: renae.otoole@svhm.org.au

Acute health medical officers and GPs unite to enhance patient management

St Vincent's Health, Inner Eastern Melbourne, Melbourne and Otway Divisions of General Practice

Aim

To improve patient management through increased communication between hospitals and GPs.

How

St Vincents Health and three divisions of general practice established a communication process between the acute health medical officers and GPs. Contact between the two parties is made at admission to and discharge from hospital.

Initially, after the patient has given consent, the ward clerk books a call and the hospital medical officer calls the GP. With the GP's input, the hospital develops and records a care plan.

The hospital has developed a database for multidisciplinary discharge summaries. Throughout the patient's hospitalisation, members of the multidisciplinary team contribute information on the patient's health status to the database. This creates a discharge summary that is completed within the unit and quickly faxed to the patient's GP.

Benefits and outcomes

Hospital staff have an increased understanding of the GP's role and information from the GP has been found to enrich care delivery.

Information is provided more quickly to the GP, which has increased the continuity and consistency of care.

Currently, only 40% of GPs have been contacted, but the hospital hopes to encourage the involvement of more GPs in the hospital phase of care. Other modes of contact to increase GP input at admission are being considered.

Good practice example 2.5C

Electronic recording enables discharge summaries to be dispatched within an hour

Barwon Health

Aim

To improve continuity of care by providing GPs and community providers with information quickly after discharge.

How

Geelong Hospital and the Grace Mackellar Rehabilitation and Aged Care Service, Barwon Health, have sped up the process of dispatching discharge summaries to GPs, providing a summary of the patient's hospital episode within an hour of the patient leaving hospital.

Hospital medical officers enter data (including electronic PBS prescriptions) into an electronic clinical system (CORDis) during the patient's hospital admission. Pharmacists review the admission medication within 24 hours and enter information into the system. Hospital medical officers and audio typists enter operation and outpatient notes into CORDis.

The discharge summary is dispatched to the relevant GPs immediately after discharge, either by fax or email – and can also be transmitted to other facilities, when patients are being transferred.

The system is used throughout the health service with high compliance ratios. The hospitals evaluate the system monthly, providing feedback to users.

Benefits and outcomes

Continuity of care has improved as GPs and community service providers now receive information before the first post-hospital review of the patient.

The discharge summary is legible, and contains all relevant clinical data and a complete list of medications.

The GP is better able to provide continued patient management and to monitor medication compliance. Community providers are able to respond quickly and appropriately to the patient's post-discharge needs.

GP satisfaction surveys taken over three consecutive years demonstrate sustained improvement in the system.

Contact for further information

Jannie Selvidge
Geelong Hospital
Telephone: 03 5246 5153
Fax: 03 5226 7019
Email:
Jannies@barwonhealth.org.au

Good practice example 2.5D

Contact for further information

Taya Shevchenko
Director
Hospital Primary Care Liaison Unit
Telephone: 03 9496 2961
Email: Taya Shevchenko@
austin.org.au

Improving communication between hospital staff and primary care providers

Austin Health

Aim

To improve communication between the hospital and the primary care sector and to coordinate collaborative primary care initiatives.

How

A Primary Care Liaison Unit was established to improve communication between the hospital and the primary care sector, including GPs. The unit also coordinates the hospital's involvement in primary care initiatives.

The unit provides a single point of contact for primary care providers with the hospital. It also liaises with local divisions of general practice and GPs.

Who

The hospital's GP liaison officers, GPs and hospital executives (including the Chief Executive Officer) developed the unit.

Benefits and outcomes

Communication between primary care providers, GPs and hospital medical staff has greatly improved.

Regular GP satisfaction surveys, hospital medical officer questionnaires and GP workshop responses are some of the measures of the success of activities undertaken by the unit.

Good practice example 2.6A

Generic inter-hospital transfer process improves patient care

Goulburn Valley Health

Aim

To create a generic, patient-oriented inter-hospital transfer process to assist patient transfer between hospitals.

How

Goulburn Valley Health developed a generic, inter-hospital transfer documentation process, with specialty service modules. The process has been implemented in health services both within and outside the region.

Nurses and allied health staff complete the transfer document and send it with or ahead of the patient who is moving from one acute health care facility to another. The transfer document provides the receiving hospital with all the information it will need about the transfer.

All forms used for transfer documentation were replaced to ensure uptake of the new process.

Patient focus groups on information privacy were held to ensure that the new transfer process met their needs and concerns.

Benefits and outcomes

The receiving hospital now receives better quality information about the patient's health needs and status.

Patients are asked fewer repetitive questions when they are moved between hospitals and there is less opportunity for adverse events arising from poor information sharing.

Staff find the system easy to use and there are fewer phone calls from the receiving hospitals about patient care.

The Loddon Mallee and South West regions, Western District Health Service and Kyabram and District Health Service have also adopted the same or similar processes.

Contact for further information:

Leigh Gibson
Director of Community
and Integrated Care
Shepparton Hospital
Telephone: 03 5832 2700
Fax: 03 5821 1648
Email:
Leigh.Gibson@gvh.humehealth.org.au

Good practice example 2.6B

Contact for further information

Jannie Selvidge

Telephone: 03 5246 5153

Facsimile: 03 5226 7019

Email:

Jannies@barwonhealth.org.au

Universal transfer policy a success all round

Barwon sub-region consortia

Aim

To develop a universal transfer policy and transfer form to manage the information needs of hospital and aged care services (public and private) in the region.

How

The Barwon sub-region consortia (54 aged care providers and four public hospitals) developed a universal transfer policy and transfer form that is now used by each organisation.

The form is completed at the time of transfer and faxed to the receiving service, containing all the information necessary to continue care from one setting to the next.

The form includes prompts to ensure that all relevant information is provided and identifies contacts for further information.

Who

All aged care community providers and representatives from departments within the acute and sub-acute services were involved in the development of the transfer policy and form. This has ensured that the transfer process suits each organisation's environment and meets the needs of the patient.

The working group, which included representatives from the hospitals and aged care services, continues to meet bi-monthly to resolve transition issues. The forum provides an opportunity for acute care staff, including emergency department representatives, pharmacists, unit managers and care coordinators, to meet with the aged care managers on a regular basis to share information and resolve issues.

Benefits and outcomes

Continuity of care has improved and patient assessments have been streamlined as hospital and aged care providers now receive better quality information when the patient moves between care settings.

The flow of communication and issue resolution between members of the consortia has improved.

There is increased flexibility around transfer times and medications being dispensed in appropriate modes to meet the needs of the aged care facilities.

Good practice example 2.6C

Linking hospitals and maternal child health nurses ensures continuity of care for young children

Swan Hill District Hospital

Aim

To provide ongoing community support for young children admitted to hospital and their parents.

How

Swan Hill District Hospital has developed a system of notifying the Maternal and Child Health Nurse (MCHN) when children under six are admitted to hospital.

When a child is admitted, the staff request verbal consent from the parents to contact the MCHN. The nurse is contacted by telephone and informed of the child's changed needs. When transition plans are confirmed, the multipurpose referral form is faxed to the nurse and the staff update the History of Illness section of the patient's Child Health Record Book.

Who

Hospital staff are educated about the role of the MCHN and the process for working effectively with them.

Benefits and outcomes

Families are supported in the community as the MCHN provides ongoing education and advice about issues such as chronic asthma, growth deficits and family dynamics.

The process has formalised the relationship between the hospital and the MCHN.

The process has been built into the paediatric pathway to ensure its ongoing sustainability.

Contact for further information:

Yvonne Penny

Charge Nurse, Midwifery Unit

Swan Hill District Hospital

Telephone: 03 5033 9269

Email:

midwifery.dept@swanhillhosp.vic.gov.au

Good practice example 2.6D

Contact for further information:

Janis Doyle
 Discharge Planner
 Wodonga Regional Health Service
 Telephone: 02 6051 7448
 Email: janis.doyle@wrhs.org.au

Poster aids referral to medical, allied health and community providers

Wodonga Regional Health Service

Aim

To simplify a process that was perceived as complex by hospital staff and to develop a clear, easy to follow tool that would assist ward staff when referring to medical, allied health, GPs and community service providers.

How

The discharge planning unit at Wodonga Regional Health Service developed a services poster that shows the referral process and criteria for referring to internal medical and allied health staff and external providers including community services and GPs (see attachment 2).

The poster builds on a tool originally developed by St Vincents Health and has been adapted to suit local needs. It has been further enhanced through the application of eye-catching colours to help ensure that staff can easily follow the poster.

The poster is displayed in the Emergency Department and wards for easy reference. It has also been distributed to GPs and community providers.

Benefits and outcomes

Hospital staff find it easier to refer to other internal and external service providers as the poster clearly describes the referral process, including information such as business hours, assessment requirements and out of hours contacts.

The poster simplifies a procedure that staff often found complex and confusing.

Referrals to internal and external services are more targeted and streamlined.

Staff have greater confidence in their ability to make appropriate referrals.

Good practice example 2.6E

Uniform notification process leads to improvements in post-hospital referral services

Wimmera Health Care Group and East Grampians Health Service

Aim

To improve referral processes to community service providers.

How

Hospitals within the Wimmera and Grampians region use a uniform notification and referral process.

When patients enter hospital, the admission process identifies any community services that the patient received before admission. The hospital faxes these services to notify them of the patient's admission using a generic form.

The multidisciplinary care team develops a discharge plan and expected date of discharge with the patient. Referral information is then faxed to all relevant community health providers.

The notification and referral process is included in the hospitals' policy and procedure manuals. New staff are educated about this process as part of their orientation.

Annual audits within each health service review the process to ensure ongoing improvement.

Who

The process of developing the notification and referral process included a consumer representative, patients, carers, community service providers and visiting medical officers to ensure that the process was able to address their needs.

Benefits and outcomes

All hospitals communicate with community service providers using an agreed format and process.

Community services quickly receive information they require and services commence promptly when patients return home from hospital.

Community service providers have reported improvements in the information content of referrals that "relieved pressure of planning through more timely notification, saved resources by cancelling visits when a patient was admitted and decreased the distress of home carers that occurred when they made home visits and found that the patient was not at home." (EDS Project Officer)

Hospitals within the region benchmark their compliance to encourage continued improvement.

Contact for further information

Pat Dodson

Wimmera Health Care Group

Telephone: 03 5381 9184

Fax: 03 5381 9154

(marked ATTENTION Admission/
Discharge Coordinator)

Email:

Pat.Dodson@whcg.grampianshealth.org.au

Good practice example 2.8A

Contact for further information

Ruth Crawford
Quality Manager
The Alfred
Telephone: 03 9276 2881
(pager 4030)
Email: r.crawford@alfred.org.au

Calls to 'at-risk' patients after discharge enhance patient care

Bayside Health

Aim

To improve follow-up care for patients who are considered 'at risk' after discharge.

How

At The Alfred, Bayside Health, a 'named nurse' telephones all patients assessed as being 'at risk of discharge needs' after returning to the community. All patients (except those being transferred to another hospital) are assessed for the need for a follow-up call. The hospital's guidelines document the inclusion and exclusion criteria for patients requiring calls.

The nurse discusses the telephone call (including a mutually convenient date and time for the call and the telephone number) with the patient during the hospitalisation.

The nurse and patient go through the Discharge Plan together before the patient goes home. This includes details of whether the patient requires and agrees to a call, and if so, the date and time are agreed.

The sheet also contains details of outpatient appointments, community services arranged, the contact person and other instructions. A copy of this plan is given to the patient.

The nurse who cared for the patient makes the call, usually within 10 days of discharge. The nurse makes a second call if there is no response to the first call. The nurse records the time and date of the call on the call back data sheet as well as documenting any actions taken.

The hospital takes all care to maintain confidentiality when contacting patients. Where the patient is concerned about privacy, they have the option of contacting the hospital rather than being called. Prior to the call, the nurse obtains a copy of the patient's medical record and transition plan, and a patient call back data sheet.

The ward staff audit the data sheets each month for feedback. The quality manager, nursing and ward staff receive the audit results. Ongoing staff education, form review and staff feedback ensure the process remains relevant and sustainable.

Benefits and outcomes

Feedback from the nurses making the calls indicates that transitional planning has improved and that patients appreciate the follow-up.

Good practice example 2.8B

Post-discharge telephone calls improve patient satisfaction

East Grampians Health Service

Aim

To develop a post-discharge follow-up call system to assess whether patients' post-hospital needs are being met.

How

All patients going home from East Grampians Health Service receive a telephone call to assess whether their post-hospital needs are being met. (However, patients being transferred to another hospital, discharged at their own risk or regularly re-admitted for ongoing treatment, such as dialysis or chemotherapy are not called.)

In the pre-admission patient information brochure and during admission to the ward, patients are informed that they will receive a follow-up call. Patients consent to the follow-up as part of their consent to health information distribution and other services provided during the episode of care. The hospital routinely includes the post-hospital follow-up form in the patient's medical record.

The nurse who assists with the transition process files the follow-up form to initiate the patient being called within 10 days. An experienced registered nurse calls the patient. To ensure privacy and discretion, the nurse does not leave messages with other household members or identify themselves as a representative of the hospital unless speaking with the patient or carer.

The nurse records the patient's responses to the form questions and follows up any issues. The nurse reinforces instructions, reassures patients/carers or provides emergency contacts, as required. Occasionally, the nurse refers the patient to allied health or community services or advises them to seek medical attention. The nurse reminds the patient of any appointments and the contact numbers to call for assistance.

The follow-up process was developed and trialled on one ward in 1998 then expanded across the health service network in 2000. The process is sustainable because the process is supported by policy and procedures.

To ensure formal reporting on the process, a patient/resident representative receives a monthly report on compliments and concerns expressed during the calls which are then included in the hospital wide report circulated monthly to all departments and management committees.

Contact for further information

Mary Bruce

PAC Case Manager

Telephone: 03 5352 5511

Fax: 03 5382 3711

Email: mbruce@eghs.net.au

Benefits and outcomes

The calls address patient issues and satisfaction with discharge processes has risen from 95 to 98 per cent.

Feedback from the calls has enabled the hospital to improve the information that it provides to patients before and during admission.

The Project Officer at East Grampians Health Service commented “The involvement of this process has been very effective, both in receiving positive feedback from consumers and for the follow up of planning and care”

Good practice example 2.8C

Post-discharge follow-up calls improve patient care and referral relationships

Otway Health And Community Services

Aim

To improve patient care post-discharge and during the referral process to community service providers.

How

All patients going home from Otway Health and Community Services receive a follow-up call within five days of leaving hospital. The hospital explains the telephone follow-up process and content of the call to the patient at admission. The patient's consent is obtained, along with their telephone details and an agreed time to call.

When calling, the hospital uses a survey to monitor patient satisfaction that forms part of the patient's Client Discharge Information Record. The hospital contacts the patient, as arranged, asks questions from the survey and documents the patient's responses on the Client Discharge Information Record. The hospital immediately follows up all issues and this follow-up is also documented on the Client Discharge Information Record

The survey questions cover how the patient is feeling, whether the arranged services have commenced and whether the patient and/or carer is satisfied with the care.

Monthly audits under the health service's Effective Discharge Strategy program monitor the process, which is overseen by the hospital's quality group. The hospital uses staff feedback to refine the tool and process.

Staff education about the process is regular, ongoing and begins at induction.

Benefits and outcomes

Patient care has improved, including more timely notification of community services.

The hospital's relationships with GPs and community service providers have improved because hospital staff have gained insight into post-hospital issues and are communicating more appropriately when referring patients to community services.

There is increased patient, GP and staff satisfaction, increased patient compliance with treatment plans, reduced unplanned readmissions and timely notification of community services.

Staff view the process as a completion of the acute care episode for the patient. They feel empowered to identify, discuss and action any issues raised by patients.

Contact for further information

Debbie Tovey
EDS Manager, Acute
dtovey@swarh.vic.gov.au, or

Director of Nursing
Otway Health and Community
Services

Telephone: 03 5237 8500

Fax: 03 5237 6172

Email: otwayhealth@bigpond.com

Attachment 1 – The Alfred ‘Patient call back data sheet’

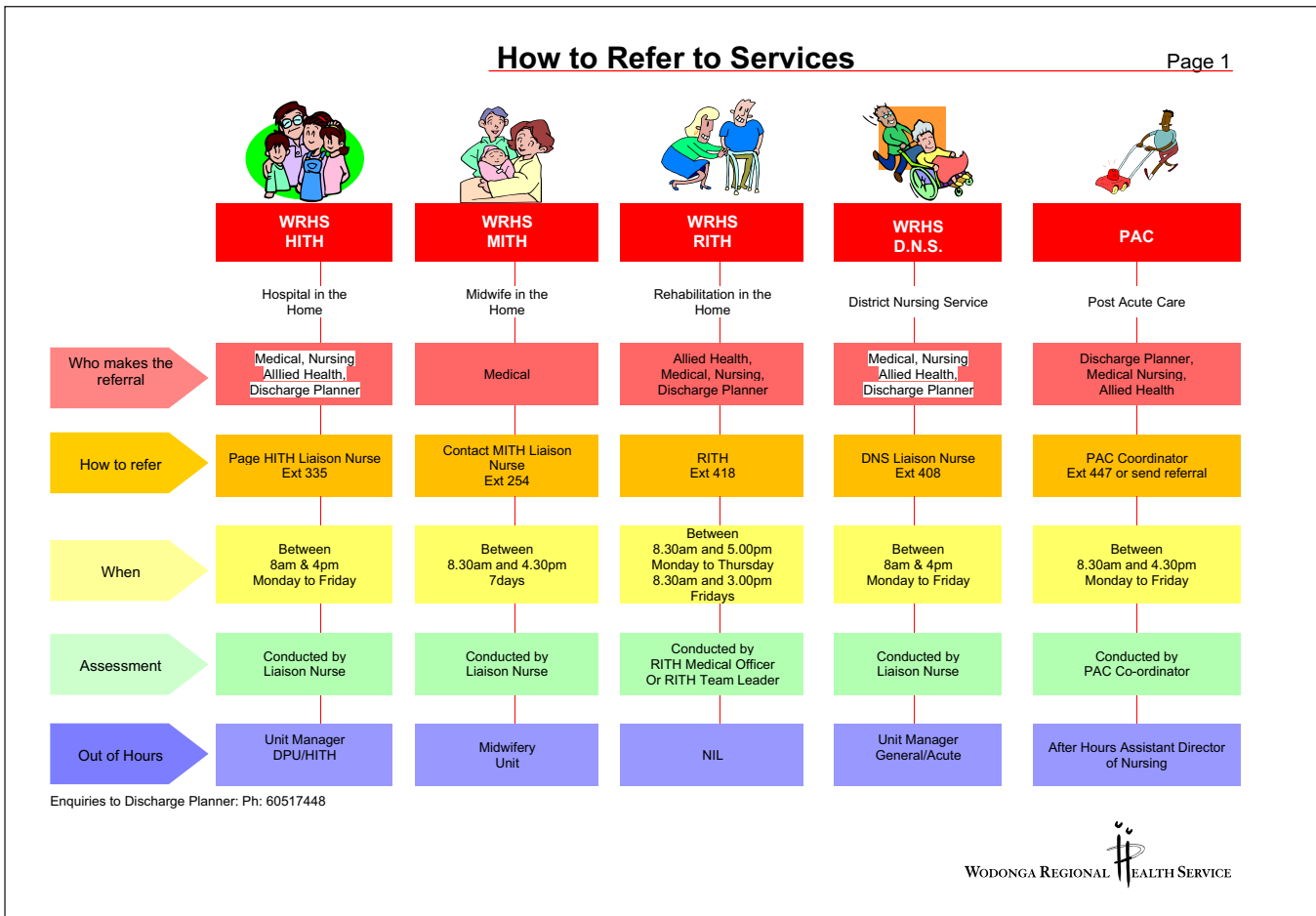
THE ALFRED Patient Call Back Data Sheet		U.K. <input style="width: 50px;" type="text"/>
Diagnosis : _____		Surname <input style="width: 90%;" type="text"/>
Discharge date: _____ Discharging ward: _____		Given Names <input style="width: 90%;" type="text"/>
Unit: _____ Nurse to make call: _____		<input style="width: 90%;" type="text"/>
Patients discharged home (including hostel, SRS etc) should be called if : tick all that apply		
<input type="checkbox"/> Positive discharge risk screen <input type="checkbox"/> Community services arranged for post discharge <input type="checkbox"/> First presentation to a hospital <input type="checkbox"/> Discharged home via Medihotel <input type="checkbox"/> Multiple/unplanned readmission(s) in previous 6 months <input type="checkbox"/> Complex needs <input type="checkbox"/> Other as determined by professional judgement eg other 'at risk' factors Please specify: _____		
OR: Patient does not need to be called for one of the following reasons: tick all that apply & sign/date/print name at bottom of form		
<input type="checkbox"/> Patient does not meet any of the above criteria and is not considered to be 'at risk' <input type="checkbox"/> Patient refused call Specify reason: _____ <input type="checkbox"/> Follow up via other areas/units eg RAS, A@H, heart failure unit, heart/lung transplant etc. Specify area/unit: _____ <input type="checkbox"/> Ongoing readmission where treatment is part of the same episode of care eg ongoing renal dialysis <input type="checkbox"/> Other Specify reason: _____		
Person to receive call: <input type="checkbox"/> Patient <input type="checkbox"/> Family/Relative <input type="checkbox"/> Carer <input type="checkbox"/> Friend Name: _____		
Please specify why an alternative person has been nominated (eg NESB, deaf, speech disorder etc): _____		
Contact number (if different to Patient label): _____ Date of call (within 10 days post discharge): _____		
RN: _____ Signature: _____ Date: _____		
Please review & refer to the Discharge Plan MR E-66 prior to & during the follow-up phone call (Note also follow-up ph call guidelines re confidentiality)		
<i>"Hello, this is, may I please speak with(nominated contact person) ". Once speaking with the nominated person, reintroduce self & continue: "I have a few questions to ask you relating to your recent hospital stay at The Alfred, which will only take a few minutes of your time."</i>		
Status of Call: Spoke with: <input type="checkbox"/> Patient <input type="checkbox"/> Family/Relative <input type="checkbox"/> Carer <input type="checkbox"/> Friend <input type="checkbox"/> Other		
<input type="checkbox"/> No answer <input type="checkbox"/> Answering machine <input type="checkbox"/> Patient readmitted before call <input type="checkbox"/> Patient deceased		
Questions relating to Health status of the patient		
1. Do you (or your family/carer) have any questions or are you experiencing any difficulties relating to your recovery from your "condition for which you were in hospital"? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, Details: _____		
Questions evaluating the effectiveness of The Alfred's discharge planning		
2. Have the Community Services arranged for you started as expected? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
If No, Reason/details: _____		
3. Have you needed to arrange services other than those arranged by The Alfred? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, Reason/details: _____		
4. Do you have the details or have you already attended your GP / Outpatient appointments? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
If No, Reason: _____		
5. Do you have any questions about your medications &/or are you having any problems with them? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
If Yes, Reason/details: _____		
6. Do you have any other concerns? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, Details: _____		
No action required: <input type="checkbox"/>		
Action required:		
a) Referral back to staff member/department involved during the admission to follow up services or reinforce education (tick appropriate box): <input type="checkbox"/> Unit HMO/Registrar <input type="checkbox"/> Outpatients <input type="checkbox"/> RDNS <input type="checkbox"/> Post Acute Care <input type="checkbox"/> Social Work <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Pharmacy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Care Co-ordinator <input type="checkbox"/> Other _____		
b) If a new or multiple need(s) has arisen, call the Rapid Assessment Service Help/advice line. Referral to: <input type="checkbox"/> RAS help/advice line (x6561) If it is after hours & a medical issue, contact the Unit Medical staff (see (a)) &/or advise the patient to visit their local GP/hospital Recommendation made for patient to visit (tick appropriate box): <input type="checkbox"/> Local GP <input type="checkbox"/> Emergency/Local hospital		
c) Advice given/Instructions & patient's response : _____		

Other comments: All elements of the Discharge plan appropriate and in place as arranged <input type="checkbox"/> Yes <input type="checkbox"/> No If No, please explain		

PATIENT CALL BACK DATA SHEET

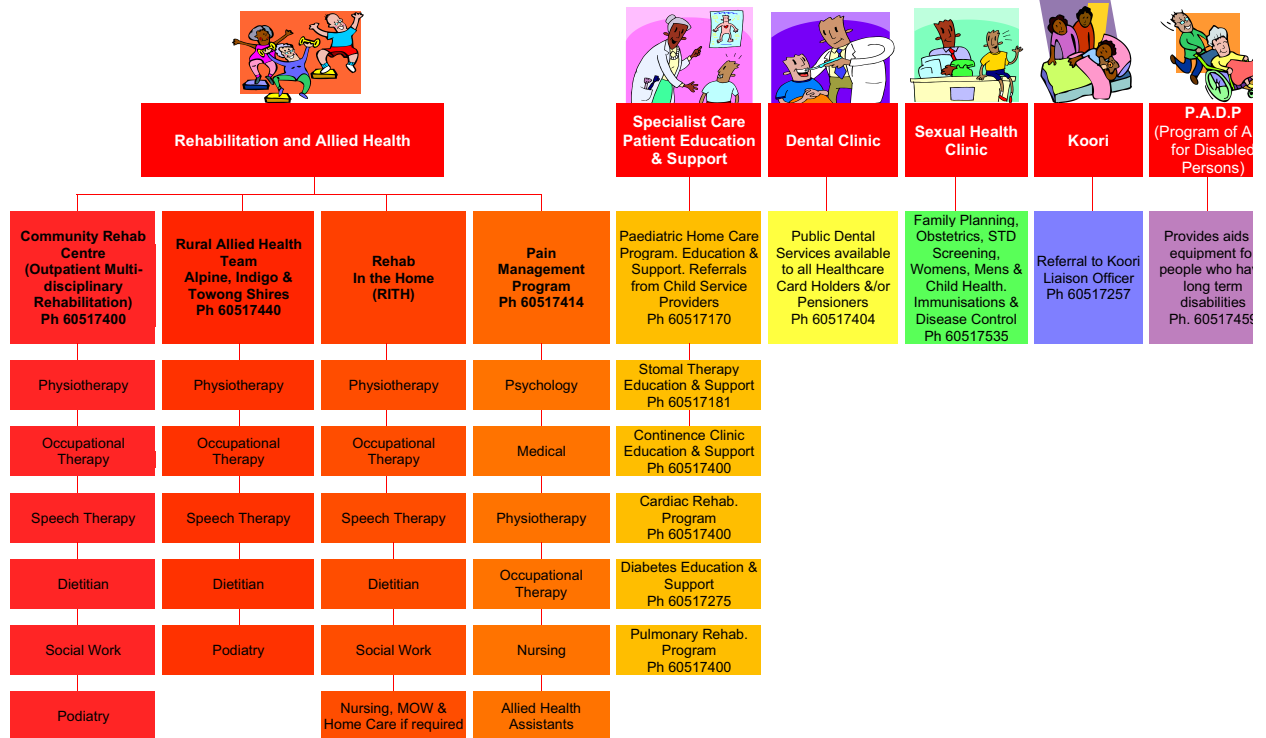
Medical Records Copy

Attachment 2 – Wodonga Regional Health Service 'How to refer to services'



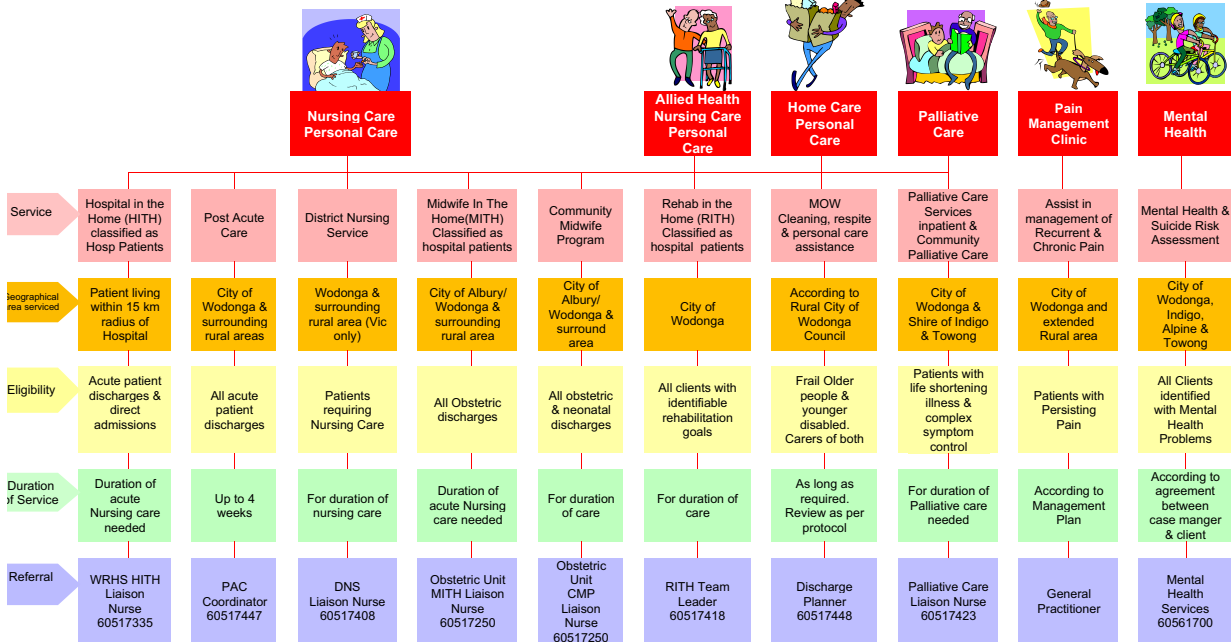
Additional Services Available

Paç



Enquiries to Discharge Planner Ph: 60517448

Frequently Used Services



Inquiries to Discharge Planner: Ph: 60517448

Appendix B

Good practice Guide Contributors

Case study contributors

Many different hospitals and health services submitted examples of good practice for this guide. We would like to thank those people who took the time to send in their submissions.

Alpine Health
 Austin Health
 Bairnsdale Regional Health Service
 Barwon Health
 Bayside Health
 Beechworth Health Service
 Bendigo Health Care Group
 Bethlehem Hospital Inc.
 Cobram District Hospital
 East Grampians Health Service
 Echuca Regional Health
 Gippsland Southern Health Service
 Goulburn Valley Health
 Kooweerup Regional Health Service
 Kyneton District Health Service
 Melbourne Health
 Mercy Public Hospitals Inc.
 Murrindindi Community Health Service
 Northern Health
 Otway Health and Community Services
 Pathways Rehabilitation and Support Services Inc.
 Peter MacCallum Cancer Centre
 Portland and District Hospital
 Rochester and Elmore District Health Service
 Southern Health
 Stawell Regional Health Service
 St Vincent's Health
 Tallangatta Health Service
 Timboon and District Healthcare Service
 Upper Murray Health and Community Health Service
 Wannon Post Acute Care Program
 West Victoria Division of General Practice
 West Wimmera Health Service
 Western District Health Service
 Wimmera Health Care Group

General contributors

Following the identification of examples of good practice in Victorian hospitals, the project officers visited the hospitals below and interviewed hospital staff. We would like to thank the staff that gave their time so generously.

Austin Health	Seymour District Memorial Hospital
Bairnsdale Regional Health Service	Southern Health
Ballarat Health Services	Swan Hill District Hospital
Barwon Health	Stawell Regional Health
Bayside Health	St Vincent's Health
Beechworth Health Service	Tallangatta Health Service
Benalla and District Memorial Hospital	Timboon and District Healthcare Service
Bendigo Health Care Group	Upper Murray Health and Community Health Service
Beaufort and Skipton Health Service	Northeast Health Wangaratta
Carers Victoria	Wannon Post Acute Care Program
Central Gippsland Health Service	South West Healthcare
Cobram District Hospital	Western District Health Service
Colac Area Health	Western Health
Dunmunkle Health Services	Wimmera Health Care Group
East Grampians Health Service	Wodonga Regional Health Service
East Wimmera Health Service	Yarrawonga District Health Service
Eastern Health	
Echuca Regional Health	
Gippsland Southern Health Service	
Goulburn Valley Health	
Hepburn Health Service	
Kerang District Health	
Kooweerup Regional Health Service	
Kyneton District Health Service	
Latrobe Regional Hospital	
Maryborough District Health Service	
Melbourne Health	
Mercy Public Hospitals Inc.	
Mildura Base Hospital	
Mount Alexander Hospital	
Northern Health	
Otway Health and Community Services	
Peter MacCallum Cancer Centre	
Rural Northwest Health	

Appendix C

Service directories

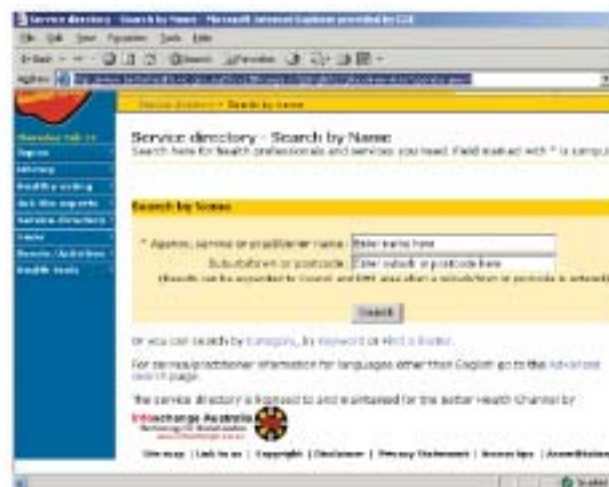
Victorian service directories

Infoxchange

The Primary Care Partnership Program website contains many of the necessary referral sources. Hospitals can contribute to the content of the site: www.serviceseeker.com.au



The Victorian service directory Better Health Channel can be found at: www.betterhealth.vic.gov.au



Specific-need service directories

National aged care service directory

The Commonwealth Carelink Centres' web site can be found at www.commcarelink.health.gov.au.

Users can also call a national telephone service (**freecall 1800 052 222**) to find information about services in their local area. The network of Commonwealth Carelink Centres across Australia provides a central point of contact for information on a wide range of community care and other health-related services.



Disability Online

The national disability services directory can be found at: www.disability.vic.gov.au/dsonline/dssite.nsf?open



Health Insite

Health Insite (www.healthinsite.gov.au/index.cfm) is a Commonwealth Government initiative. A consumer services directory, it also includes health information for patients and carers.



Appendix D

The Good Reading Guide

Useful Reading

- Agency for Health Care Research and Quality? AHCPR guidelines – post stroke rehabilitation <http://www.ahrq.gov>
- Anderson MA, Helms L. An assessment of discharge planning models: communication in referrals for home care. *Orthopaedic Nursing* 1993; 12 (4): 41-9.
- Anderson MA, Helms LB. Communication between continuing care organizations. *Research in Nursing and Health* 1995; 18: 49-57.
- Anderson M, Helms L. Quality improvement in discharge planning: an evaluation of factors in communication between health care providers. *J Nursing Care Quality* 1994; 8 (2): 62-72.
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Glossary

aged care assessment services (ACAS): work to assess the needs of frail older people and to facilitate access to available care services appropriate to their needs. A comprehensive assessment by an ACAS may result in the person's approval for entry into a residential aged care service or a referral to other community-based services, for example, those provided by the HACC program or a range of medical or health services. An approval or referral from an ACAS does not necessarily mean that the person will receive that care.

aged persons mental health services: mental health services for older people, generally co-located and operationally integrated with sub-acute facilities and aged care assessment services (ACAS). These services provide assessment, treatment, rehabilitation, continuing care and consultation, preferably in the community wherever possible. They use a system of case management that aims to ensure integrated care for the individual across community, inpatient and residential components of the service.

assessment: a decision-making method based on collecting, weighing and interpreting relevant information about the patient. Assessment is not an end in itself, but part of a process of delivering care and treatment. It is investigative, using professional and interpersonal skills to uncover relevant issues and to develop a care plan.

care coordination: coordination of the services required by the patient so they are delivered in the most efficient and effective way for meeting that individual's needs. Care coordination enables continuity of care, avoids duplication of services and ensures program boundaries do not hamper service providers in fulfilling the patient's needs.

care pathways: an integrated care pathway determines locally agreed, multidisciplinary practice based on guidelines and evidence where available for the treatment of a specific patient/client group .

carer: someone (usually a family member) who provides support to children or adults who have a disability, mental illness, chronic condition or who is frail aged. Carers can be parents, partners, sons, daughters, brothers, sisters or friends of any age.

case management: the use of a case manager who helps the patient and their carer work through care and related issues, as well as providing a single point of accountability for service provision. Case management involves care coordination.

clinical audit: the systematic and critical analysis of the quality of clinical care, including the procedures for the diagnosis, treatment and care, the associated use of resources and the resulting outcome and quality of life for the patient.

clinical effectiveness: the application of the best available knowledge, derived from research, clinical expertise and patient preferences, to achieve optimum processes and outcomes of care for patients.

clinical governance: the framework through which health organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

clinical guidelines: systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances.

community: A person's normal residence, whether an independent house, a supported residential service or an aged residential facility.

comprehensive assessment of older people: A multidimensional process designed to assess an older person's functional ability, physical health, cognitive and mental health and socio-environmental situation

department: Department of Human Services

design features brief: provides guidelines for the planning and design of health and aged care facilities. Design features briefs are developed by the Department of Human Services.

Effective Discharge Strategy (EDS): the strategy was funded by the Department of Human Services for a period of 5 years from 1998/1999 to improve discharge practices from public hospitals.

evidence-based practice: a process through which professionals use the best available evidence, integrated with professional expertise, to make decisions regarding the care of an individual. It requires practitioners to seek the best evidence from a variety of sources; critically appraise that evidence; decide what outcome is to be achieved; apply that evidence in professional practice; and evaluate the outcome. Consultation with the client is implicit in the process.

Health Service: the acute, sub-acute and primary care campuses of a Health Service, as well as the additional services that it provides in the community. The term 'Health Services' is capitalised in this paper to differentiate it from general health care and ongoing support community services delivered by various providers in the community.

Home and Community Care (HACC): is a joint Commonwealth State Government program that provides services to support frail older people, younger people with disabilities and carers. HACC funds a range of basic support services that enable people to stay in the community and live as independently as possible, where otherwise they might have felt the only choice was to move into a residential facility. HACC services are provided by local governments, Community Health Services, public hospitals, community and voluntary organisations.

hospital: acute or sub-acute inpatient facilities.

Hospital in the Home (HITH): is the provision of hospital care in the comfort of the person's own home. Patients are regarded as hospital inpatients and remain under the care of their treating doctor in the hospital.

interim care: The care service provided to some people who have completed their acute or sub-acute treatment, had their needs assessed by the aged care assessment team and have been recommended for residential care. These people are described as ‘awaiting long term care options’.

older people-friendly hospitals: Health Services that promote an attitude of catering for the specific needs of older people and that have modified their environment, and their staff expertise and mix, to reflect this attitude.

ongoing community support services: are supportive care services such as assistance with personal care, meals, and home maintenance. These services are provided in the person’s home and are ongoing. Community support services are aimed at promoting independence and maintaining the person in the community.

post-acute care: the service provided to people after a hospital admission or emergency department presentation. It provides time-limited, individually tailored packages of supportive care to assist people to recuperate in the community.

primary care partnership (PCP): a voluntary alliance of primary care providers that work together to improve health and wellbeing in their local communities. There are 32 PCPs in Victoria.

sub-acute community care: sub-acute care delivered in the community exclusively – that is, in a patient’s home (home-based care) and/or at a centre (centre-based care). This care type was previously referred to by the department as ‘sub-acute ambulatory care’.

sub-acute care: goal-oriented, time-limited interventions, generally provided in a multidisciplinary environment to patients who require evaluation, treatment and management for post-acute or chronic conditions.

transdisciplinary assessment: an assessment tool that any trained member of a multidisciplinary team can use. Where the assessment flags specific issues, the appropriate professional will then provide specialist intervention.

Victorian patient satisfaction monitor: provides regular, ongoing monitoring and reporting of patient satisfaction with Victorian public hospitals in key areas of service delivery. There are currently 95 hospitals participating in Victoria.

