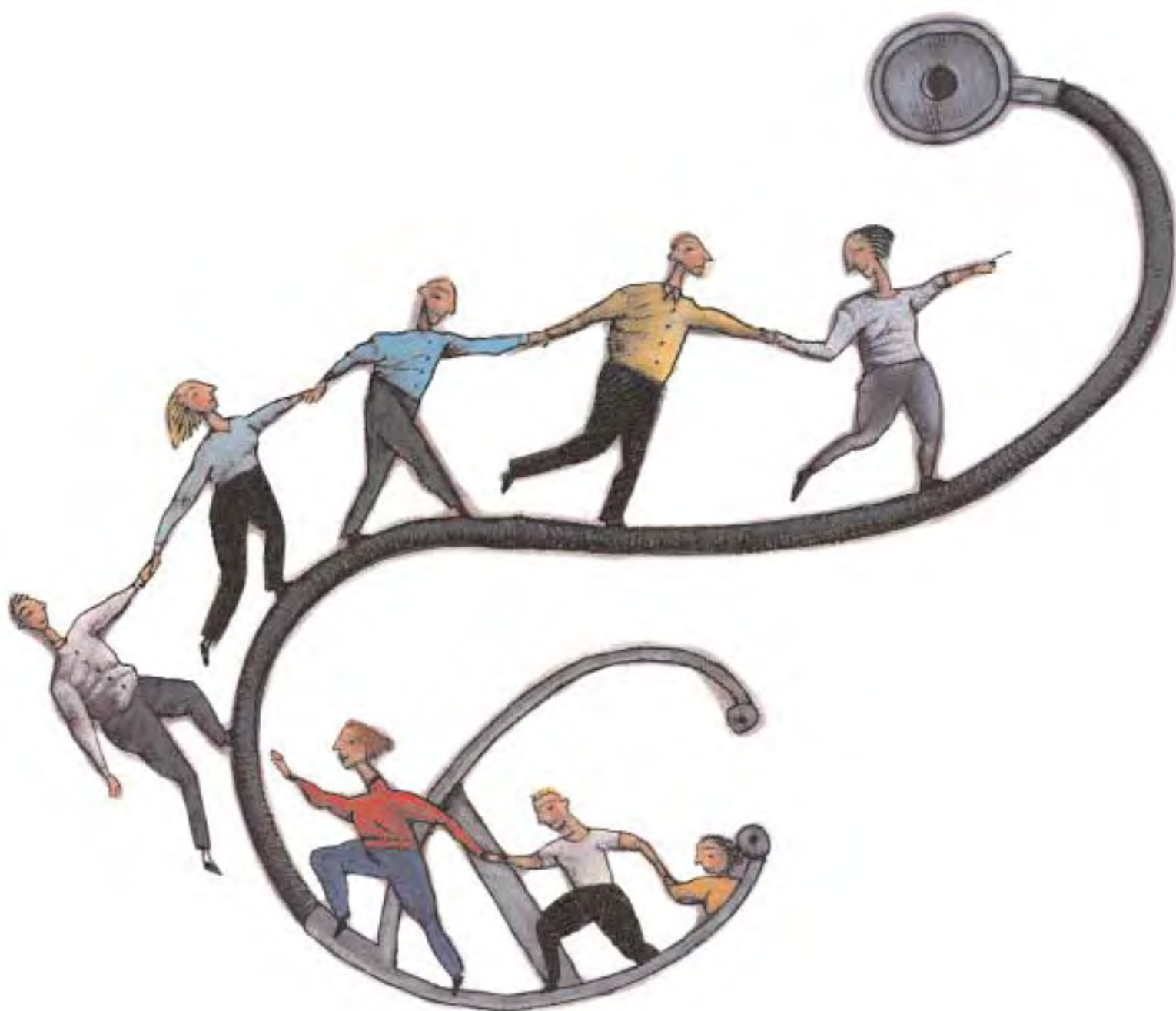
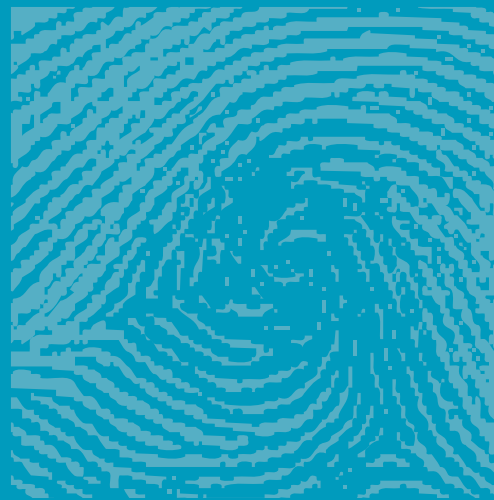


# Improving patient transition from hospital to the community

A good practice guide for hospitals



## **Improving patient transition from hospital to the community: a good practice guide**

Published by the Continuing Care Unit, Metropolitan Health and Aged Care Division,  
Victorian Government Department of Human Services, Melbourne, Victoria.

© Copyright State of Victoria, Department of Human Services, 2003.

This publication is copyright. No part may be reproduced by any process except in  
accordance with the provisions of the Copyright Act 1968.

This document may also be downloaded from the Department of Human Services  
web site at: [www.health.vic.gov.au/discharge](http://www.health.vic.gov.au/discharge)

(030601)

Authorised by the State Government of Victoria, 589 Collins Street, Melbourne.

Printed by Big Print, 520 Collins Street, Melbourne 3000

## Foreword from the Minister for Health

The Patient transition from hospital to the community – a good practice guide, has been produced for hospitals to improve the care provided to patients when they leave hospital.

The Government recognises that transition planning has a significant impact on the way patients recover after they leave hospital. Over the past five years the Government has initiated a range of projects with hospitals to improve patient transition back to the community. This has resulted in a range of improvements including better assessment and planning for patients' post discharge needs and stronger networking with community service providers and general practitioners.

These initiatives will improve communication with patients and family members and provide increased support to the patient on returning home, resulting in improved health outcomes. Hospitals will benefit by reduced re-admissions, improved patient flow, and increased patient and staff satisfaction.

The guide brings together examples of excellent initiatives by Victorian hospitals. The guide is a resource tool for hospitals so they can continue to better meet the needs of patients. It is presented in a simple, easy-to-use format containing up to date evidence of good practice in patient transition with tips and information resources for hospitals.

I encourage you to use this resource to help build better relationships with general practitioners and services in the community and improve patient care for people leaving hospital.



**The Hon Bronwyn Pike  
Minister for Health**

## Working party

The members of the working party were:

Janet Laverick (Chair)  
Manager  
Continuing Care  
Metropolitan Health and Aged Care  
Services  
Department of Human Services

Vivien Adler  
Manager  
Continuity Unit  
Continuing Care  
Metropolitan Health and Aged Care  
Services  
Department of Human Services

Ruth Crawford  
Quality Manager, Nursing  
Alfred Hospital, Alfred Health

Petrina Halloran  
Project Officer  
Continuing Care  
Metropolitan Health and Aged Care  
Services  
Department of Human Services

Joe Ibrahim  
Geriatrician  
Williamstown Hospital  
Western Health

Chris Jones  
Program Manager  
Post Acute Care  
Dandenong Hospital  
Southern Health

Lenora Lippmann  
Division Consultant  
General Practice Division Victoria

Julie Nankervis  
Policy Worker  
Carer's Victoria

Judith Perrin  
Manager Service Coordination  
Primary and Community Health  
Rural and Regional Health and Aged Care  
Services  
Department of Human Services

Jannie Selvidge  
Project Officer  
Continuing Care  
Metropolitan Health and Aged Care  
Services  
Department of Human Services

Gillian Smith  
Project Officer  
Continuing Care  
Metropolitan Health and Aged Care  
Services  
Department of Human Services

Peter Waxman  
Senior Advisor General Practice  
Primary and Community Health Branch  
Rural and Regional Health and Aged Care  
Services  
Department of Human Services

# Section one

## Sharing skills, resources and knowledge

### Contents

1.1. Development of the guide	1
Introduction	1
Background	2
Good practice – means better care and a better health system	3
Identifying good practice	3
Evidence levels	4
Who was involved in developing the guide?	4
Finding good practice examples	5
Using the Good Practice Guide	5
How the guide is structured	5
1.2. Facilitating good transition planning	7
Essential elements of good transition planning	7
How hospitals can successfully improve their transition practice	7
The benefits of improving transition practices in hospitals	9
Good transition planning means better health outcomes	9
1.3. Models of care to assist patient transition	12
Care coordination and case management	12
Emerging trends in models of care	13
The care coordination model	13
The case management model	15
Tips for using models of care	19
Patient management units	19
Tips for patient management units	20
Case conferences – promoting better communication and better care	20
Tips for case conferences	23
Levels of evidence for models of care	23
1.4. Good practice in educating hospital staff	25
Information hospitals should provide to staff	25
The benefits of transition planning education	26
Tips for educating hospital staff	26
Information sharing and working together	27
Tips for involving community providers	27
Evidence levels for staff education	30
1.5. References for section one	31

## Section one

### Sharing skills, resources and knowledge

#### 1.1. Development of the guide

##### Introduction

*“Awareness that acute care facilities can no longer simply discharge patients without adequate planning has been high on Australian health policy agendas in recent years. Complete understanding that hospitalisation is but one stage in an ongoing continuum of care remains a somewhat elusive goal but one that is moving closer as health care funders and hospitals place greater emphasis on appropriate planning in transitioning patients from hospital to the community”...<sup>1</sup>*

Effective transition practice is a core business of hospitals. Transition (discharge) planning occurs when hospitals, health services, general practitioners (GPs) and other community service providers coordinate patient care for the patient’s discharge from hospital and return to the community. Transition practices in Victoria needed to improve, so as to better integrate the acute and primary and community care sectors, enhance the continuity of patient care, and reduce the length of hospital stay.

To address these issues and the variation in transition practices within and among hospitals, the Department of Human Services developed the Effective Discharge Strategy. The strategy was a five-year initiative that commenced in 1998-99. It was a systematic approach to understanding, measuring and improving transition planning processes and their outcomes and involved:

- assisting health care providers to review and improve transition processes and practices
- developing robust performance indicators that measure the effectiveness of transition processes.

Patient transition from hospital to the community: a good practice guide for hospitals contains good practice examples from the literature and good practice examples (as decided by the working party) of transition planning in Victorian hospitals.<sup>2</sup> The aim of the guide is to assist clinical managers to improve the transition planning within their hospital via reference to what has been effective in other hospitals. The guide uses the term transition to describe the continuity of care as the patient moves from hospital to the community, while the term discharge is used only to denote specific processes or documents that relate to the patient leaving hospital.

Good practice in patient transition involves the following elements: an efficient transition planning process, timely transition, stakeholder satisfaction and the management of impediments to transition.<sup>3,4</sup> Underpinning this is the need for good communication between patients, carers, community service providers, GPs and hospital staff. When patient transition successfully incorporates these

elements, the patient's physiological, psychological, social and cultural needs may be met with or without community support. Further, the patient and carer feel safe about the patient returning home. As a result, improved patient transition may have the following outcomes:

- increased patient and carer satisfaction with hospital care
- reduced length of hospital stay
- reduced length of hospital stay in subsequent admissions
- the prevention of unplanned readmissions.

## Background

The Effective Discharge Strategy has had a significant impact on the way in which hospitals manage patient care. A number of developments are now standard practice in some hospitals throughout Victoria, including the continual review of transition policies and procedures, the publication of community service directories and the development of patient information systems. All hospitals have implemented the four recommended key processes of care: (1) risk screening, (2) the commencement of transition planning, (3) the notification of community services and (4) the dispatch of discharge summaries to GPs.

The Effective Discharge Strategy has encouraged hospitals within metropolitan health services and rural health regions to combine their resources and skills to develop and implement transition systems. This effort appears to have improved the understanding of hospital staff of the required transition processes and assisted hospital compliance with those processes. Patients moving through the health care system are experiencing a standardisation of care, which is likely to lead to increased confidence in the system.

By networking to establish intra-regional transition processes, hospitals have found an avenue for sharing skills and resources to solve other problems. As a result, hospitals and health services are more aware of each other's differences and specialisations, leading to more appropriate patient transfers and referrals.

## Good practice – means better care and a better health system

The working party for the development of the guide agreed that good practice in patient transition has the following features:

1. The transition practice enhances continuity of care.
2. The transition practice leads to good patient outcomes.
3. The hospital's internal stakeholders helped develop the transition practice.
4. Community providers, consumers and GPs helped develop the transition practice.
5. The patient and carer are involved in all aspects of care, including development and review of the patient's transition plan.
6. The transition practice can be adapted across the hospital's units/departments and to other hospitals.
7. The hospital has integrated the transition practice into patient care.
8. The transition practice undergoes ongoing measurement or regular review.
9. There is management support within the hospital for the transition practice.
10. The hospital has a plan to sustain the improvements that it makes to its transition practice.

Good practice helps everyone. Improved transition planning is now embedded practice in Victorian public hospitals, but most hospitals could further improve in this area. The department has developed the good practice guide to:

- **collate knowledge** about good practice in patient transition from hospital to the community
- **provide examples** of good practice in a range of settings and patient groups
- **help hospital staff improve** their transition practices and processes by sharing information.

## Identifying good practice

In developing the guide, an extensive review of the local and international literature to identify good practice in patient transition from hospital to the community was undertaken. The review, including searches of MEDLINE, the Cochrane Library and CINAHL, involved using a comprehensive, standardised protocol as well as an extensive search of white papers, reports and conference papers to identify material that could answer the question: what is good practice in transition planning?

## Evidence levels

To grade the evidence provided by the research information in the guide, the working party used the National Health and Medical Research Council's levels of evidence. Level of evidence tables can be found at the end of each section.

Type of evidence	Level
Evidence obtained from a systematic review of all relevant randomised controlled trials (RCTs)	I
Evidence obtained from at least one properly designed RCT	II
Evidence obtained from well designed controlled trials without randomisation	III-1
Evidence obtained from well designed cohort or case control analytic studies, preferably from more than one centre or research group	III-2
Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments could also be regarded as this type of evidence.	III-3
Opinions of respected authorities, based on clinical experience, descriptive studies or reports of expert committees	IV

*National Health and Medical Research Council's Quality of Care and Health Outcomes Committee. Guidelines for the development and implementation of clinical practice guidelines. Canberra: AGPS, 1995.*

## Who was involved in developing the guide?

The department notified each Victorian public hospital, general practice divisions, primary care partnerships and post acute care services, asking for examples of good practice in patient transition planning and received 41 written submissions. Fifty-four hospitals were visited with 82 interviews conducted, documenting the details of good practice. A working party was established to provide expert advice and to oversee the development of the guide.

## Finding good practice examples

Sources used to identify good practice within hospitals included:

- The Patient Satisfaction Monitor
- Past performance on discharge audits
- Feedback from the Effective Discharge Strategy review
- Effective Discharge Strategy discharge improvement plans
- Effective Discharge Strategy program reports
- The Victorian Effective Discharge Strategy Group
- Post Acute Care services
- Designing Care projects
- Primary Care Partnerships
- General Practice Division of Victoria and Victorian divisions of general practice
- The Hospital Demand Management Unit
- Consumer/carer organisations
- Hospital visits

*“I feel that cultural change is occurring,  
but like all changes, it takes time.”*

*Staff member,  
Metro hospital, EDS Review*

## Using the Good Practice Guide

This guide is a reference and resource tool for improving transition processes in hospitals. It contains up to date information on good practice that can be used to assess the areas of transition processes that need to be improved in your organisation. The examples contain contact details that you may use to obtain first-hand information on how the good transition practice was achieved and also provide an opportunity to discuss the strategies that were used to create the necessary changes. If you wish to expand your understanding of each of the themes, you may wish to consult the references and further reading provided at the end of this guide.

## How the guide is structured

The guide contains three parts. Designed to stand alone, parts 1 and 2 contain:

- Evidence from the literature relevant to the section’s topic
- Examples of good practice in Victorian hospitals
- Tips for implementing good practice
- A table summarising the level of evidence.

Part 3 contains the long form of all examples cited in the document, in addition to further resources and references that may be useful for those wishing to obtain additional information.



## 1.2. Facilitating good transition planning

### Essential elements of good transition planning

Facilitating good transition planning involves establishing **processes** and **systems**. The process of transition planning incorporates the following steps:

1. Risk screening that identifies those patients who require comprehensive transition planning.
2. Patient assessment that is thorough and covers pathological, physiological, psychological, social and cultural needs (including the patient's home and social circumstances).
3. Planning that the patient, carer, nurse, doctor and other appropriate members of the multidisciplinary team conduct together. The documentation of this transition plan is filed in the patient record and regularly revised.
4. The plan's implementation, which involves patient and carer education, referrals to hospital-based and community services, and communication with community service providers and general practitioners (GPs).
5. The follow-up of patients after transition, to evaluate the effectiveness of the planned interventions and ensure continuity of care.<sup>5</sup>

*"You cannot rest on your laurels, you need to continuously improve. This process [effective discharge] is part of the quality cycle"*

*CEO, MPS,  
Good Practice Guide Interviewee*

Supporting this process, the transition planning systems include:

- the allocation of responsibilities across health services (which involves defining roles and identifying and reviewing communication channels)
- well-defined transition policies, procedures and activities
- discharge documentation that accompanies the patient throughout the hospital episode of care
- provision for stakeholder feedback and response to that feedback
- methods for managing impediments to good transition practice.

### How hospitals can successfully improve their transition practice

Successful implementation of good practice is not a simple transfer of what has worked in one hospital to another hospital. However, hospitals do not need to reinvent good practice; they need to adapt good practice to suit their local environment and thus improve their patient transition.

Successful improvement of patient transition involves the championing and clinical leadership of improved patient care processes. Everyone involved in the transition process needs to participate in the improvement effort. Professional groups may need to be convinced that change is required and need encouragement to align their roles and responsibilities with that change. Further, hospital staff need to be involved in the change process to ensure that it matches the required patient care in your hospital.

Hospitals should test a new practice within a unit or department before releasing it on a wider scale. Staff should be informed and educated about the new transition practice. Management needs to support the change and review new transition policies and procedures for integration into routine care.

The implementation of good practice relies on designing care principles such as:

- quality improvement
- system thinking and organisational learning
- change management
- education and training.

This involves:

- actively involving clinicians, management and consumers in meaningful and sustainable work practice change that either directly or indirectly improves patient care
- providing ongoing support of work practice change by involving practitioners and encouraging them to learn from examples of success
- giving clinicians, managers and, where appropriate, consumers the knowledge, skills and tools to identify and implement real improvement in health services
- evaluating whether change improves patient care, reduces delays, reduces duplication and increases patient and staff satisfaction
- generating a culture that is comfortable with change and seeks continuous improvement.

*“It is necessary for us to learn from others’ mistakes. You will not live long enough to make them all yourself.”*

*Hyman G. Rickover*

To accelerate process improvement, hospitals can use the **plan–do–study–act (PDSA) cycle**. This cycle involves promoting quick, simple changes by trying, testing and integrating one improvement step before moving on to the next improvement.

### Privacy alert

Much of the effectiveness of transition planning depends on accurate and timely communication within hospitals and between hospitals and community service providers. To develop and implement a successful transition plan and to follow up patients, health services must collect and transfer relevant patient information. *The Health Records Act 2001* and the *Information Privacy Act 2001* in Victoria are intended to protect the privacy of individuals. They cover:

- the collection of health information
- the use and disclosure of health information
- data quality
- data security and retention.

Hospitals must gain patient consent before sharing a patient's health information with community service providers and GPs. They need to develop systems and processes for integrating this legislation into practice. Details of the Acts appear at <http://healthrecords.health.vic.gov.au>.

### The benefits of improving transition practices in hospitals

The published research revealed that the key outcomes affected by interventions in patient transition are:

- post-transition destination
- patients' and carers' satisfaction
- number of unplanned readmissions
- length of hospital stay
- cost of patient transition
- cost of health care.

### Good transition planning means better health outcomes

A combination of transition processes (described as discharge risk screening, discharge assessment, early commencement of the discharge plan, early referral for in-hospital and post-discharge allied health services, and post-discharge support including general practitioners and community services) significantly improves patient care. The following box illustrates the findings on outcomes of transition planning.

## The positive effects of good transition practice in hospitals

### Reduced length of stay

- Discharge intervention reduced the hospital length of stay for elderly medical patients.<sup>7,8,9,10,11</sup>
- Patients who received post acute care and subsequently were readmitted had a shorter length of stay for the readmission.<sup>12</sup>

### Fewer unplanned readmissions

- Intervention significantly reduced the risk of hospital readmission. This effect was preserved where a single professional (rather than a team) provided the intervention and where the intervention occurred in both the hospital and the patient's home.<sup>13,14</sup>
- A 2001 systematic review identified a trial that reported the positive effects of discharge planning on readmission rates.<sup>15</sup>
- A 2000 systematic review of research (to the end of 1997), that evaluated the effect on older subjects of supporting their discharge from hospital to home, found 'relative certainty that more elderly people remained at home 6–12 months after admission if their discharge has been supported'.<sup>16</sup>
- For patients supported by community care post transition, the Post Acute Care Study: Evaluation of Outcomes in Older Patients demonstrated no significant change in their readmission rate within six months of the previous admission.<sup>17</sup> The post acute care did, however, reduce the emergency readmission rate in the six months after patient transition.

### Transition intervention increases return-to-home rates

- A trial that included both medical and surgical patients reported that a significantly greater proportion of patients subject to transition interventions went home after hospital, compared with those who received no formal transition planning.<sup>18</sup>

### Increased patient and carer satisfaction

- Patients with medical conditions reported increased satisfaction with care at the one-month and three-month follow-up.<sup>19,20</sup>
- Elderly medical patients reported a 27 per cent increase in satisfaction rating when hospitals used transition interventions.<sup>21</sup>
- The 2002 Cochrane Review found that patients who received discharge planning were more satisfied with care, spent less time in hospital and, in some cases, were less likely to be readmitted to hospital after discharge.<sup>22</sup>

### Cost savings in an acute health care setting

- A post acute care study found a significant cost saving for the patients who received post acute care compared with the control group, given the reduced hospital bed days of the former group.<sup>23</sup>
- A study found that patients receiving discharge interventions used fewer laboratory services than needed for patients whose discharge was unplanned.<sup>24</sup>
- A study found that discharge planning resulted in no significant difference in the cost of the initial hospital stay.<sup>25</sup> The total charges (including readmission costs at the two-week follow-up), however, were significantly lower for medical patients receiving discharge interventions. Discharge planning did not significantly alter costs for patients with surgical conditions in the same study.

### Cost savings in a community health care setting

- Post acute care was found to produce benefits at a lower cost than would be the case without that care. The significance of this cost difference, however, depends on the level of care and the community cost.<sup>26</sup>

### Health outcomes

- A post acute care study demonstrated an improvement in the quality-of-life scores for patients aged over 65 years who had received post acute care following hospitalisation.<sup>27</sup> The general health domain (as measured by the SF-36), however, was found to decline for this group.

### 1.3. Models of care to assist patient transition

Many patients need services from several disciplines, such as nursing, medicine, allied health and diagnostic health professionals. So ‘the correct interventions are applied in the correct order and... complications, delays and duplications are avoided, a large number of decisions... have to be coordinated’.<sup>28</sup> Decisions for effective transition planning need to reflect a full understanding of many patient issues, including the hospital’s routines and processes, and the resources that the patient can access after leaving hospital. The published research supports the delegation of responsibility for transition planning, showing that this approach smooths patient transition.<sup>29</sup> Models of care used by hospitals since 1990 include: (1) care coordination, (2) case management, (3) patient management units and (4) case conferences.

#### Care coordination and case management

This guide describes care coordination and case management. (The literature uses various names for these models of care, including ‘care coordination’, ‘case management’, ‘discharge coordination’, and ‘disease management’.)

Both care coordination and case management have been found to result in positive outcomes for the patient, through the facilitation of better and more timely decision-making processes in transition planning.<sup>30,31</sup> Both models have also been shown to reduce service duplication and prevent unnecessary admissions to the hospital.<sup>32,33,34</sup> Health professionals working with either model require:

- the ability to advocate on behalf of the patient and family/carer
- the ability to educate patients, family/carer and other staff
- advanced clinical knowledge in the speciality area
- well-developed communication and negotiation skills
- the ability to work as a member of the multidisciplinary team
- detailed knowledge of what services are available and to whom.

The two models of care facilitate communication between the ward staff, patient and their carer/s, within the multidisciplinary team, between the ward staff and community service providers, and between the ward staff and general practitioners (GPs).<sup>35</sup> In particular, the care coordinators/case managers within these models will:

- work with the patient and carer to involve them in all discussions and decisions about their care
- increase the cohesiveness of care that is required when patient care involves input from multiple members of health care teams and services. The care coordinator/manager coordinates the multidisciplinary team meetings at which team members discuss and plan patient care.

*“The best ideas are everyone’s property.”*

*Seneca*

- facilitate the formation of links with community service providers and GPs by acting as a single point of contact for those providers and GPs. Where some hospitals have more fully integrated the model(s), GPs now contact the care coordinator/manager before a patients' admission to discuss patient care needs and plans.

### Emerging trends in models of care

Western Hospital recently introduced a new model of patient management.

Nurses work as care coordinators for a service, either medical or surgical.

These care coordinators attend ward rounds and ensure the decisions made on the rounds are enacted. Their role also involves ensuring patient care is coordinated and not fragmented. The care coordinators aim to help patients navigate a complex hospital system. They do not undertake the work of transition planning, however, they help ward staff to ensure timely and effective transition. They also help develop systems and processes for effective transition across the hospital.

*“We have terms of reference and minutes, but we keep it simple, it is about the patient not the meeting.”*

*EDS Project Officer, EDS Review*

### The care coordination model

The care coordination model (also called the discharge coordination model and discharge planning model) involves coordinating care across the hospital system but does not deal with clinical care. It may target particular patient groups.

The role of care coordinators is to:

- ensure patient care occurs in the most appropriate environment for their health care needs
- facilitate multidisciplinary team discussion of transition planning needs, throughout the patients' hospital stay
- provide a consultation service to hospital nurses, which includes providing expertise on the needs of patients in the target group and on the availability of community services and resources to meet the patients' post-transition needs
- liaise with community services to improve patient access to health services
- educate hospital departments about transition planning
- promote the hospital's transition policies and practices, and assist staff to understand and comply with the transition process
- promote a transition planning focus at patient care discussions
- assist ward staff to learn the skills of coordinating and negotiating with community service providers.<sup>36</sup>

## Good practice example 1.3A

### Discharge planning unit provides a single point of contact for hospital staff.

#### Western District Health Service

Key results:

- Fewer unplanned readmissions
- Better coordination of post-hospital services
- Better links with community service providers

Western District Health Service multidisciplinary Discharge Planning Unit was established to improve patient transition planning. The unit manages both Post Acute Care and Hospital in the Home services – and helps staff by providing a single access point to obtain transition education and home care services.

For further information see: Appendix A

### Care coordination in the emergency department

Some patients are admitted to hospital from the emergency department because they require further assessment or they need additional community services. Care coordinators target interventions for medical and surgical patients with complex care issues, aiming to prevent unnecessary admission and to streamline the episode of care.

### Care coordination teams

The care coordination team is usually a multidisciplinary team comprising a nurse, occupational therapist, physiotherapist and social worker. The team provides a more thorough assessment than a single discipline could achieve. It cooperates to develop a comprehensive plan of care, including a transition plan, which has been shown to positively affect patient outcomes.

## Good practice example 1.3B

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

#### Peninsula Health

Key results:

- Reduction in admissions and re-presentations
- Improved links between the Emergency Department and community service providers

The multidisciplinary approach of the Rapid Assessment and Discharge Program at Frankston Hospital's Emergency Department ensures that patients are quickly assessed and home care services are coordinated, so that patients can go home rather than being admitted.

All team members have been educated in the necessary assessment skills.

This means patients can see health professionals of any discipline – and receive the same assessment.

For further information see: Appendix A

#### The case management model

Case management is a clinical process where an identified person coordinates a patient's care and monitors the outcomes. Like a care coordinator, a case manager undertakes a comprehensive assessment of the patient and develops a plan with the patient to meet the needs of that patient and their carer. During this process, the case manager may facilitate a meeting with all the health professionals involved in a patient's care.

Case management differs from other models of care in that it is more 'hands on' and often long-term, with more frequent patient contact.<sup>37</sup> The case manager works with the patient and their family/carer to understand the disease process and necessary self-management skills. The case manager arranges community services for the patient and communicates patient needs across the service transition points.

The benefit of case management is that patients receive individualised care designed to meet their specific needs. The information given to patients is coordinated, patients are at the centre of care and their needs and wishes are the focus of all planning. Patients can discuss the information (which includes patient self-management plans for dealing with issues such as diet, weight management and medication management). The case manager follows up patients with home visits to review case management, answer questions and address concerns. Patients and their carer receive the contact details of the case manager so they have a single point of contact within the hospital.

The Case Management Society of America defines case management as 'a collaborative process which assesses, plans, implements, coordinates, monitors and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality cost effective outcomes'.<sup>38</sup> Evidence of the effectiveness of case management is weak and inconsistent,<sup>39</sup> yet hospitals regard case management as a significant way to deliver quality, cost-effective health care.

Victorian hospitals have developed additional case management roles as part of the Hospital Admission and Risk Prevention projects. Studies have examined how such case managers target care to specific patient groups.<sup>40,41,42,43,44</sup> Case managers are supporting patients in disease-specific groups (such as groups with chronic heart failure or chronic obstructive pulmonary disease) or other target groups (such as older patients, general medical patients or general surgical patients). In some hospitals, case managers work with patients to coordinate the patients' care across the continuum of acute, sub-acute and community services.

Risk screening on entry to hospital identifies patients with chronic or complex conditions that require case management. They are referred to the case manager, who undertakes a more detailed assessment of the patients' post-transition needs and coordinates a smooth transition back to the community.

The role of the case manager is to:

- Undertake or coordinate a detailed assessment of the patient, their premorbid function and social situation
- Liaise with the patient and their carer to develop a plan of care
- Determine the expectation of success of particular interventions/services
- Determine the benefit of services for the patient based on the assessment
- Gain the patient and their family/carer's informed agreement to the transition plan
- Educate the patient and their family/carer about the patient's health issue and its management, as well as about available health services
- Arrange specialist assessments, if required, such as occupational therapy and physiotherapy
- Develop a transition plan in consultation with the patient and the multidisciplinary team
- Coordinate community services referrals, which involves discussing the transition plan with the patient's GP
- Liaise with community service providers to provide services
- Provide a home visit, if necessary
- In some instances, provide transport when the patient is leaving hospital
- Monitor the transition plan once the patient is in the community.<sup>45</sup>

## Case management in action

In the National Demonstration Hospitals Program Phase 3, the Nepean Hospital, Sydney, introduced a case management model for orthopaedic patients who were having hip and knee replacements. The principles of the model included:

*“The person who says it  
can’t be done should not  
interrupt the person doing it.”*

*Chinese Proverb*

- working with the patient and their carer
- maintaining clear and accurate lines of communication with all members of the health care team and
- including the patient and their GP as a part of the team.

The model focused on achieving optimal wellness for the patient through early intervention and assessment. The patient was at the centre of this case management model and the case manager was ‘the glue’ that linked the team. The case manager promoted patient involvement in the care and recovery planning. The case manager also had direct communication with the GP during admission and before transition. The project demonstrated that case management reduced length of stay by more than five days, reduced the fragmentation of patient care and improved both patient and staff satisfaction.

## Good practice example 1.3C

### Case management model a success with heart patients

#### Eastern Health

Key results:

- Increased patient satisfaction levels
- Reduction in emergency department presentations, inpatient admissions and the readmission rates of the target patient group
- Improved links with GPs

Box Hill Hospital introduced the chronic heart failure case manager position in December 2001 to improve the management of this patient group.

The case manager assesses each patient admitted with this condition, develops a management plan in conjunction with the patient and their carer, and provides ongoing support to the patient after discharge. The case manager also consults with the multidisciplinary team to develop the management plan and arrange post-hospital services.

For further information please see: Appendix A

## Good practice example 1.3D

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

#### Northeast Health Wangaratta

Key results:

- High levels of client satisfaction and maternal & neonatal safety measures equal or better than the state average.
- Improved communication between the patient, midwife, general practitioner and obstetric consultant

In Northeast Health Wangaratta's named midwife model of care, the midwife case-manages the patient from first presentation until post-delivery and patients have 24-hour access to the midwife.

There are three streams of care, from midwife only care for low risk pregnancy, midwifery and general practitioner care for medium risk patients and obstetrician care with midwife support for high risk pregnancies.

This credentialed primary midwifery model has now been published and attracts many students from all over Australia

For further information please see: Appendix A

### Tips for using models of care

- Determine the hospital need: does the hospital want to coordinate the navigation of more patients through the service system or case manage a targeted group of patients?
- Choose the model that will meet the needs of the patient and the hospital.
- Decide what needs improving: transition planning as a whole or the transition planning for target patient groups?
- Measure what is happening now.
- Review the literature.
- Develop a position description for the care coordinator/manager, determining the boundaries of the role. Will the coordinator/manager's responsibility cover only the patient's hospital episode of care? Will it be ongoing each time the patient returns to hospital? Will it include follow-up of the patient after transition?
- Ensure all staff are aware of the role before its implementation.
- Pilot the model, measure the outcomes and evaluate the model before integrating it into general hospital practice.

### Patient management units

Hospitals also use other care-related approaches to assist patient transition. Some hospitals have established patient management units, for example, to develop expertise in addressing the needs of particular patient groups (such as stroke patients and acutely ill older persons). The purpose of these units is to provide patient care by a dedicated team of specifically skilled allied health, nursing and medical staff.

The team approach to care improves patient transition because (1) specialist patient management units can develop a particular understanding of a patient group and (2) the combination of skills in a multidisciplinary unit leads to increased expertise, which helps streamline the provision of care.

### Tips for patient management units

- Determine the best management structure for the identified patient group or specific care process.
- Involve key stakeholders in the development of the unit.
- Determine how the unit will be resourced; for example, will the function of the unit enable the service to become cost neutral?
- Develop evidenced based patient management pathways and protocols.
- Integrate the unit into the hospital.
- Educate and train the staff to the specialty or employ staff skilled in the specific speciality.
- Educate and inform all hospital staff about the unit's functions and objectives.
- Develop smooth transition systems for patient flow to ensure that care is consistent across settings for example, care pathways, case management.

### Case conferences – promoting better communication and better care

Many studies have demonstrated that poor interdisciplinary communication has an impact on health care.<sup>46,47</sup> Case conferences (or multidisciplinary team meetings) are an effective mode of communicating for patient management. Patients with complex problems, who need care and treatment by a variety of health care professions, require a coordinated plan of care. A case conference is a forum for professionals to develop and review such plans. It helps deliver the components required for successful multidisciplinary care: a high level of cooperation and communication among team members, respect for each team member and an understanding of the role of each team member.

*“...my ward has seen a reduction in LOS due to the focus by multi disciplinary team on discharge planning from day one.”*

*Nurse Unit Manager, EDS Review*

### Case conferences lead to more effective care

Case conferencing provides an opportunity for the multidisciplinary team to meet with the patient and discuss the patients' care needs, including transition needs. The team develops shared goals with the patient. Patients who may benefit from a case conference vary across clinical settings but usually include patients with complex needs.

When all members of the health care team attend the case conferences, and when the conference outcomes are documented, the team is likely to follow the plan of patient care. Further, when team members meet regularly and develop shared goals with the patient, they develop better working relationships which leads to more effective care.

### Improving transition planning with case conferences

Effective interdisciplinary communication will help the health care team to formulate a transition plan with the patient soon after admission. Communication is characterised by open verbal exchange, a commitment to problem solving and conflict management, and coordination among hospital units.<sup>48</sup>

Timely, accurate and coordinated transition planning results in improved continuity of care, better functional status, reduced length of hospital stay, less service duplication and improved patient education. However, it has been shown that delays in convening case conferences disadvantage both the hospital and the patient.<sup>49,50,51,52</sup>

Involving patients and families in case conferences is essential when the conference discussion concerns complex transition planning needs. When they are involved in the transition planning, the patient and their family/carer are able to identify their desired goals and any obstacles to returning to the community.<sup>53,54</sup>

### GPs and case conferences – an important link

The Commonwealth Government's Enhanced Primary Care Items (the Medicare Benefits Schedule Items introduced in 1999) mean that GPs can now be reimbursed for their involvement in transition planning for chronic complex patients prior to their transition home. A hospital can invite a patient's GP to attend a case conference at the hospital or via teleconferencing or electronic methods. The benefits of involving the GP in transition planning for complex patients are that patient care is more continuous and service duplication is reduced. The GP knows the patient and their health issues, and can help resolve those issues.<sup>55</sup>

## Good practice example 1.3E

### Case conferences improve transition planning and communication with patients

#### Western Health

Key results:

- Patients and families/carers more involved in transition planning
- Team approach improves meeting outcomes

The Aged Care Unit at Williamstown Hospital, Western Health has redesigned their case conferences as a means of taking a team approach to patient care.

Case coordinators discuss needs and goals with the patient prior to the case conference. The coordinator presents the goals to the team and facilitates the development of a patient orientated plan.

The outcomes of the meeting are documented on a case conference sheet so that after hours staff can provide consistent feedback to the patient and their family/carer.

For further information: see Appendix A

## Good practice example 1.3F

### Medically led discharge meetings result in better transition planning

#### Northern Health

Key results:

- Early identification of patient care needs and transition issues
- Reduced length of hospital stays
- Increased cooperation with community aged care service providers

Each medical unit at the Northern Hospital now runs weekly medically led discharge meetings.

Rather than focusing on treatment, these multidisciplinary meetings determine the transition plans for the patients within the unit. Issues are identified and resolved. Hospital staff have gained an increased understanding of the services available to patients after hospitalisation.

For further information: see Appendix A

### Tips for case conferences

- Select a chairperson and decide whether to rotate or retain the role holder.
- Develop guidelines for the conduct of case conferences.
- Ensure all team members know when the conference occurs. This is particularly important if the team members rotate responsibilities to other health care units.
- Decide whether team building is required. Determine, for example, whether everyone shares the same interpretation of 'ready for transition' as it applies to the various aspects of care. (The dietician may assess that a patient is ready for transition when they understand the diet requirements. An occupational therapist may establish readiness from a patient's ability to safely transfer from one position to another.)
- Ensure each member of the team understands the role and responsibilities of all other members.
- Document all decisions made at the conferences.
- Ensure one person is responsible for completing the patient's plan of care and that they are aware of that responsibility.
- Invite the medical head of the unit or a clinical champion to attend a conference to facilitate team decisions.
- Determine who will attend the meetings: the patient? the patient's carer? the nurse unit manager or the primary nurse? All members of the multidisciplinary team? Community service providers? GPs?

*I = Evidence obtained from a systematic review of all relevant randomised controlled trials (RCTs)*

*II = Evidence obtained from at least one properly designed RCT*

*III-2 = Evidence obtained from well designed cohort or case control analytic studies, preferably from more than one centre or research group*

*III-3 = Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments could also be regarded as this type of evidence.*

### Levels of evidence for models of care

Effects of models of care	Level
Care coordination can reduce the length of hospital stay and prevent readmissions <sup>56</sup> .	II
Case management can improve the patient's quality of life and reduce readmissions <sup>57</sup> .	II
Case management for specific diseases can reduce costs and readmissions <sup>58</sup> .	I
Multidisciplinary team interventions can reduce the rate of readmissions in certain patient groups <sup>59</sup> .	II
Multidisciplinary collaboration can improve patient care	III-3
Open, continuous and timely communication between the multidisciplinary team is vital for effective transition planning	III-2



## 1.4. Good practice in educating hospital staff

### Information hospitals should provide to staff

Many patients who are admitted to hospital have complex needs and are more likely to require community services once they return home. Hospital staff need to be skilled in transition planning and have up-to-date knowledge of the wide range of community services that are available and how they are accessed. It is important that hospital staff fully understand how to assess, develop, implement and follow-up a care plan (see section 1.1. for further details).

The following information should be delivered to staff via a staff education program on transition planning:

- How to undertake:
  - patient assessment
  - development of the care plan
  - implementation of the plan
  - telephone follow-up<sup>60</sup>
- How to involve patients, their families and their carers as equal partners in transition processes
- Information about the patient's recovery path, which the patient should receive before transition
- Information about community services and programs available to the patient following transition
- How to time transition to link with the responsiveness of community services
- The importance of communication and coordination between hospitals and community services for transition planning<sup>61</sup>
- Case presentations of patients with complex transition needs, which provide good learning examples to staff.

*“Education and a hands-on approach to discharge planning by project staff has been invaluable”*

*Manager, Metro Health Service,  
EDS Review*

## The benefits of transition planning education

When staff are educated about transition planning, they produce better patient assessments, more timely and appropriate referrals,<sup>62,63</sup> and better transition plans.

## Ways to educate staff

Hospitals can use a variety of education forums, as shown by the following examples:

- **Staff orientation** includes an introduction to the hospital policies and procedures for transition planning.
- **On-the-job learning** occurs in the ward environment, where the details of the transition process—including the documentation and transition checklists—are apparent.
- **A mentorship program**<sup>64</sup> involves more senior staff (who have been trained in transition planning) providing education and support to a more junior practitioner.
- **In-service education** provides a less formal learning opportunity for staff. It can provide updates on innovations and feedback on current procedures.
- **Regular staff forums** can occur in a ward or hospital-wide. They are useful for delivering education or information to a large, diverse group of staff.
- **A competency-based program** that provides a self-directed learning package can help staff members to become competent at transition planning. The competency program guides the participants through the principles and practices of transition planning. It also contains self-assessment to help determine their level of understanding before moving on to a new level.

*“The education program has motivated staff...and has made all staff feel more confident in discharge planning.”*

*Nurse Unit Manager, EDS review*

## Tips for educating hospital staff

- Identify the target audience.
- Identify their learning needs.
- Determine the educational goals, objectives and content.
- Use the principles of adult education when developing the education program.
- Select a format for the education presentation.
- Decide on the expected outcomes of the education program.
- Measure the effectiveness of the education program.
- Consider the introduction of transition planning undergraduate/postgraduate training for all professional disciplines within the hospital.

*“We saturated the staff with education about the new process and then removed all the old forms, we have 100% compliance.”*

*EDS Project Officer,  
Good Practice Guide Interviewee*

## Information sharing and working together

Education about transition planning clarifies roles, programs, services and the care needed—information that helps hospital staff, GPs and community service providers to work together. Care providers need to work cooperatively to achieve continuity of care for patients across the health care settings. A transition plan can be more effective if hospital staff and the primary care team help develop that plan, leading to benefits for patients and their families.<sup>65</sup>

Staff from a number of disciplines can facilitate cross-discipline education and discussion. Different members of the health care team gain an insight into the work of team members and their roles in patient care. Such communication can foster respect within the team and lead to improved cooperation.<sup>66</sup>

Hospital staff, GPs and community providers benefit from understanding the roles and responsibilities of each other. Hospitals will gain benefits from working with other community organisations such as divisions of general practice and Primary Care Partnerships when educating staff.

## Tips for involving community providers

*“If you train people properly, they won’t be able to tell a drill from the real thing. If anything, the real thing will be easier.”*

*Richard Marcinki,  
‘Leadership Secrets of the Rogue Warrior’.*

- Work with community providers and GPs to develop education programs about transition practice
- Provide information and education to the community service providers in a number of ways, such as:
  - Producing written newsletters and fact sheets containing examples and outcomes of good practice
  - Producing news articles for community providers (including the General Practice Divisions Victoria newsletter)
  - Sending memos to update service providers about changed processes
  - Conducting forums to discuss transition issues
  - Conducting formal education sessions for particular community provider groups or services.

## Good practice example 1.4A

### Training staff in transition practices increases patient satisfaction

#### Wodonga Regional Health Service

Key results:

- Significantly improved patient satisfaction
- Staff members know the ‘who’, ‘when’, and ‘how’ to refer patients to community and allied health providers

Wodonga Regional Health Service developed a comprehensive staff education package to increase hospital staff’s knowledge of transition planning policies and processes. The referral process to the main internal (allied health) and community service providers is clearly mapped.

As a result of the education program, staff have changed their work practices and introduced innovative work practices such as daily discharge planning meetings.

For further information see: Appendix A

## Good practice example 1.4B

### Video helps improve interdisciplinary team meetings

#### St. Vincent’s Health

Key results:

- Team members gain greater understanding of each other’s roles
- Staff training provides ability to train others
- Patients benefit from a more coordinated approach to transition planning

To improve the effectiveness of interdisciplinary team meetings, St Vincent’s Health developed a ‘train the trainer’ program, including a video that demonstrates how to conduct effective multidisciplinary team meetings.

With the focus on patient outcomes and transition planning, the training package aims to improve team communication and the effectiveness of meetings.

For further information: see Appendix A

## Good practice example 1.4C

### Educating staff in transition practices leads to higher patient satisfaction

#### Colac Community Health Service

Key results:

- Improved patient satisfaction with transition planning
- Reduction in hospital readmission rates

Representatives of each unit or department attended a two-day workshop on how to undertake good transition planning as part of Colac Hospital's staff education program. The hospital's admission and discharge coordinator runs the program. Once trained, they became qualified to teach transition planning to others.

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

For further information: see Appendix A

## Good practice example 1.4D

### Successful integration of psychiatric care into an acute hospital unit

#### Mt Alexander Hospital

Key results:

- 80% of psychiatric patients able to be treated locally
- All unit staff educated in psychiatric care

Mt Alexander hospital's model of care has effected major changes for psychiatric patients in a rural community.

80% of psychiatric patients can now be admitted locally rather than transferred to a regional hospital. This allows them to maintain their community links and contact with carers/families and GPs. Ongoing management is integrated into the local community support systems.

For further information: see Appendix A

## Evidence levels for staff education

Effect of staff education	Level
Education improves staff members' assessment and referral skills <sup>67</sup> .	IV
A mentorship program involves experienced staff providing education to junior staff <sup>68</sup> .	IV

*IV = Opinions of respected authorities, based on clinical experience, descriptive studies or reports of expert committees*

## 1.5. References for section one

- 1 Centre for General Practice Integration Studies (School of Community Medicine, University of New South Wales). GP-hospital integration. What have we learnt? (Appendix 3). Sydney: UNSW Sydney White Paper, [www.commed.unsw.edu.au/cgpris](http://www.commed.unsw.edu.au/cgpris), 2001.
- 2 This guide discusses good practice as opposed to 'best practice'. Despite several systematic reviews of discharge planning, 'there is much international and Australian literature identifying the perceived benefits of good discharge planning...yet there remains limited analysis of the impact of discharge planning on measurable health outcomes or lower health care costs' (see note 1). There is a paucity of high-level evidence to support any single or definable discharge intervention that will result in improved discharge outcomes for the patient.
- 3 Ibrahim, J. Identifying and developing performance indicators based on the processes of care associated with effective discharge planning. Effective discharge strategy: performance indicators development project discussion document. Monash University Health Services Research Unit, Department of Epidemiology and Preventative Medicine, Faculty of Medicine. Melbourne; Department of Human Services, Acute Health Division, Victoria, May 2000.
- 4 Newell S, Edelman L, Scarbrough H, Swan J, Bresnen M. Best practice development and transfer in the NHS: the importance of process as well as product knowledge. *Health Services Management Res* 2003; 16: 1–12.
- 5 Grimmer K, Gill T, Moss J. Cost efficient discharge planning: satisfaction for all. Final report. Adelaide: Centre for Allied Health Research, University of South Australia, 1999.
- 6 Newell S, Edelman L, Scarborough H, Swan J, Bresnan M. Best practice development and transfer in the NHS: the importance of process as well as product knowledge. *Health Services Management Research* 2003; 16: 1–12.
- 7 Parkes J, Shepperd S. Discharge planning from hospital to home. In: *The Cochrane Database of Systematic Review*. Adelaide: The Cochrane Library, Flinders University, 2001.
- 8 Kennedy L, Neidlinger S, Scroggins K. Effective comprehensive discharge planning for the hospitalised elderly. *Gerontologist* 1987; 27 (5): 577–80.
- 9 Moher D, Weinberg A, Hanlon R, Runnalls K. Effects of a medical team coordinator on length of hospital stay. *Canadian Med Assoc J* 1992; 146 (4): 511–15.
- 10 Naughton BJ, Moran MB, Feinglass J, Falconer J, Williams HE. Reducing hospital costs for the geriatric patient admitted from the emergency department: a randomised trial. *J Amer Geriatrics Soc* 1994; 42 (10): 1045–9.
- 11 Naylor MD, Brooten D, Jones R, Lavizzo-Mourney R, Mezey M, Pauly M. Comprehensive discharge planning for the hospitalised elderly. A randomised clinical trial. *Anal of Internal Med* 1994; 120 (12): 999–1006.
- 12 Post Acute Care Program Health Outcomes and Cost Benefit Study: final report. Melbourne: Bundoora Centre for Applied Gerontology and the Acute Health Division, Department of Human Services, April 2001.
- 13 Parker SG, Peet SM, McPherson A, Cannaby AM, Abrams K, Baker R, et al. A systematic review of discharge arrangements for older people. *Health Tech Assess (journal of the NHS National Coordinating Centre for Health Technology Assessment)* 2002; 64 (4): 183.
- 14 Evans RL, Henricks RD. Evaluating hospital discharge planning: a randomised clinical trial. *Med Care* 1993; 31 (4): 358–70.
- 15 Parkes, Shepperd. op. cit.
- 16 Hyde CJ, Robert IE, Sinclair AJ. The effects of supporting discharge from hospital to home in older patients: systematic review. *Age & Ageing (journal of British Geriatric Society)* 2000; 29: 271–9.
- 17 Post Acute Care Program Health Outcomes and Cost Benefit Study: final report. op. cit.
- 18 Evans, Henricks. op. cit.
- 19 Moher, Weinberg, Hanlon, Runnalls. op. cit.

- 20 Weinberger M, Oddone EZ, Henderson WG. Does increased access to primary care reduce hospital readmissions? Veterans Affairs Cooperative Study Group on Primary Care and Hospital Readmission. *New Eng J Med* 1996; 334 (22): 1441–7.
- 21 Evans, Henricks, op. cit.
- 22 Parker, Peet, McPherson, Cannaby, Abrams, Baker, et al. op. cit.
- 23 Post Acute Care Program Health Outcomes and Cost Benefit Study: final report. op. cit.
- 24 Naughton, Moran, Feinglass, Falconer, Williams. op. cit.
- 25 Naylor, Brooten, Jones, Lavizzo-Mourney, Mezey, Pauly. op. cit.
- 26 Post Acute Care Program Health Outcomes and Cost Benefit Study: final report. op. cit.
- 27 Post Acute Care Program Health Outcomes and Cost Benefit Study: final report. op. cit.
- 28 Zwarenstein M, Stephenson B, Johnston L. Case Management: effects on professional practice and health care outcomes. In: *The Cochrane Library*, Issue 1, 2003. Oxford.
- 29 Egan E, Clavarino A, Burrige L, Teuwen M, White EA. A randomised control study of nursing based case management for patients with chronic obstructive pulmonary disease. *Lippincott's Case Management* 2002; 7 (5): 170–9.
- 30 Driver H, Hinegardner C, Rea M, Reed P, Ward K. Whose patient is it anyway? Coordinating nursing case management services. *Lippincott's Case Management* 2001; 6 (6): 256–62.
- 31 Dunn S, Sohl-Kreiger R, Marx S. Geriatric case management in an integrated care system. *J Nursing Admin* 2001; 31 (2): 60–2.
- 32 Salazar MK, Graham KY. Evaluation of a case management program: summary and integration of findings. *AAOHN J* 1999; 47 (9): 416–23.
- 33 Hammer DL, Kerrson TS. Reducing the number of days for which insurers deny payment to the hospital: one primary objective for a newly configured department of case management. *Social Work in Health Care* 1998; 28 (2): 31–49.
- 34 Khanghani F. Case management within Kaiser Permanente. California: Pepperdine University, unpublished doctoral dissertation, 1995.
- 35 Anderson M, Helms L. An assessment of discharge planning models: communication in referrals for home care. *Orthopedic Nursing* 1993; 12 (4): 41–4.
- 36 McNamara ST, Sullivan MK. Patient care coordinators: successfully merging utilisation managements and discharge planning. *JONA* 1995; 25 (11): 33–8.
- 37 Lyddall-Smith S, O'Connor C, Tenni C. Victorian Coordinated Healthcare Trial: the roles of the service co-ordinator and clinical services manager in Phase II Coordinated Healthcare Melbourne: Unpublished report, November 2002
- 38 Huber D. The diversity of case management models. *Vole* 2002; 7 (6): 213 of 212–20.
- 39 Frankel AJ, Heft-La Prote H. Tracking case management accountability: a system approach. *J Case Management* 1998; 7 (3): 105–11.
- 40 Rich MW, Beckham V, Wittenberg C, Leven C, Freedland K, Carney R. A multidisciplinary intervention to prevent the readmission of elderly patients with congestive heart failure. *New Eng J Med* 1995; 333 (18): 1190–5.
- 41 Naylor, Brooten, Jones, Lavizzo-Mourey, Mezey, Pauly. op. cit.
- 42 Dunn, Sohl-Kreiger, Marx. op. cit.
- 43 Harrison M, Browne G, Roberts J, Tugwell P, Gafni A, Graham I. Quality of life of individuals with heart failure: a randomised trial of the effectiveness of two models of hospital to home transition. *Med Care* 2002; 40 (4): 271–82.
- 44 Egan, Clavarino, Burrige, Teuwen, White. op. cit.
- 45 Lyddall-Smith, O'Connor, Tenni. op. cit.
- 46 Hatcliffe S, Smith P. Palliative care at home. *Nursing Times* 1996; 91 (41): 36–7.
- 47 Street A, Blackford J. Communication issues for the interdisciplinary community palliative care team. *J Clin Nursing* 2001; 10 (5): 643–50.

- 48 Hansen H, Bull M, Gross C. Interdisciplinary collaboration and discharge planning communication for elders. *J Nursing Admin* 1998; 28 (9): 37-46.
- 49 Anderson M, Helms L. Quality improvement in discharge planning: an evaluation of factors in communication between health care providers. *J Nursing Care Qual* 1994; 8 (2): 62-72.
- 50 McGinley S, Baus E, Gyza K. Multidisciplinary discharge planning: developing a process. *Nurse Manager* 1996;27(10):55, 57-60.
- 51 Bull MJ. Patients' and professionals' perceptions of quality in discharge planning. *J Nursing Care Qual* 1994; 8 (2): 47-61.
- 52 Wertheimer D, Kleinman L. A model for interdisciplinary discharge planning in a university hospital. *Gerontologist* 1990; 30 (6): 837-40.
- 53 Hibberd P. The primary/secondary interface. Cross-boundary teamwork-missing link for seamless care? *J Clin Nursing* 1998; 7: 274-2.
- 54 Biala K. Case conferencing for wound care patients. *Home Healthcare Nurse* 2002; 20 (2): 120-6.
- 55 Information on the Enhanced Primary Care Items appears at the Department of Human Services web site ([www.health.vic.gov.au/discharge](http://www.health.vic.gov.au/discharge)) and the Commonwealth Government web site ([www.health.gov.au/pubs/mbs/index.htm](http://www.health.gov.au/pubs/mbs/index.htm)).
- 56 Naylor M, Brooten D, Jones R, Lavizzo-Mourey R, Mezey M, Pauly M. Comprehensive discharge planning for the hospitalised elderly. *Annals of Internal Med* 1994; 120: 999-1006.
- 57 Egan, Clavarino, Burrridge, Teuwen, White. op. cit
- 58 Zwarenstein M, Stephenson B, Johnston L. Case Management: effects on professional practice and health care outcomes. In: *The Cochrane Library*, Issue 1, 2003. Oxford
- 59 Rich MW, Beckham V, Wittenberg C, Leven C, Freedland K, Carney R. A multidisciplinary intervention to prevent the readmission of elderly patients with congestive heart failure. *New Eng J Med* 1995; 333 (18): 1190-5.
- 60 Department of Human Services, Victoria. *The Effective Discharge Strategy background paper: a framework for effective discharge*. Melbourne: 1998.
- 61 NSW Health Department. Department circular. Sydney: April 1996.
- 62 Hansen D, Matt-Hensrud N, Holland D, Severson M. Development of a discharge planning mentorship program. *J Nurses in Staff Development* 2000; 16 (1): 11-16.
- 63 Brymer C, Cavanagh P, Denomy E, Wells K, Cook C. The effect of a geriatric education program on emergency nurses. *Journal of Emergency Nursing*. 2001; 27 (1): 27-32.
- 64 Ibid.
- 65 Hibberd P. The primary/secondary interface. Cross boundary teamwork-missing link for seamless care? *J Clin Nursing* 1998; 7: 274-82
- 66 Tilus S. The influence of nursing education on collaborative discharge planning. *J Nurses in Staff Development* 2002; 18 (5): 274-81.
- 67 Brymer C, Cavanagh P, Denomy E, Wells K, Cook C. The effect of a geriatric education program on emergency nurses. *Journal of Emergency Nursing*. 2001; 27 (1): 27-32.
- 68 Hansen D, Matt-Hensrud N, Holland D, Severson M. Development of a discharge planning mentorship program. *J Nurses in Staff Development* 2000; 16 (1): 11-16.



## Section two

### Systems and strategies: assessing, managing and improving patient care Contents

2.1 Good practice in patient information and education	1
Patient education improves transition planning	1
How hospitals can communicate better with patients	3
Educating non-English speaking patients	5
Early education is the key	5
Pre-admission	6
In hospital	6
After hospital separation	6
Emerging trends in patient communication	7
Tips for informing patients	7
Tips for educating patients	8
Evidence levels for patient information	9
Evidence levels for patient education	10
2.2 Good practice in assessing discharge risk	11
Discharge risk screening	11
Discharge assessment	11
Emerging trends in discharge assessment	12
Tips for assessing discharge risk	13
Caring for Carers	15
Evidence levels for assessment	15
2.3 Good practice in using care pathways	17
Care pathways create positive outcomes	17
Variance analysis	19
Patient pathways - creating goals and expectations	20
Evidence levels for care pathways	23
2.4 Good practice in medication management	25
Improving medication management	25
Australian guidelines for medications	25
The importance of home medication review	26
Pharmaceutical reform in Victorian public hospitals	27
Tips for medication compliance	29
Evidence levels for quality use of medication	31
2.5 Good practice in communicating with general practitioners	33
Communication between GPs and hospital staff is critical	33
The General Practitioner Register	35
Timely and informative discharge summaries improve patient transition	35
A template for discharge summaries	37
Computer-generated discharge summaries	38

Improving communication between nurses, allied health professionals and GPs	38
Emerging trends in communication with GPs	38
Tips for communicating with GPs	39
Evidence levels for communicating with GPs	39
2.6 Good practice in communicating between community service providers and hospitals	41
Information exchange is vital to good practice	41
Good communication is the key to successful transition	44
Identifying which community services are used by patients	44
Community service directories – a vast resource	45
Simplifying communication processes helps everyone	46
When should information be exchanged?	47
Tips for communicating with community providers	47
Evidence levels for communicating with community providers	48
2.7 Good practice in communicating with carers	49
Carers need information and support to help them care	49
The role of patients and carers in program and practice development	52
Helping carers to manage post transition	53
Getting patient and carer feedback	53
Helpful resources for patients and carers	54
Carer Checklists	54
Communication checklist	55
When the patient consents to sharing information with the carer - further tips	56
Evidence levels for communicating with carers	56
2.8 Good practice in telephone follow-up	65
Telephone follow-up is important for patients and the hospital	65
Identifying patients for follow-up	66
Tips for a telephone follow-up	66
Evidence levels for telephone follow-up	68
References section two	71

## Section two

### Systems and strategies: assessing, managing and improving patient care.

#### 2.1 Good practice in patient information and education

Traditionally, hospitals have structured their patient education such that patients and families have been passive recipients of education rather than active participants. However, patients today have far greater access to information resources than ever before and consequently providers must change their conventional perceptions of patient and family/carer education. Providers have a responsibility to provide a variety of ways to engage patients so that they fully understand their health care situation.

Many hospital patients used to be unprepared for their admission and unsure about their procedure, their diagnosis and how to manage when they returned home. They often felt intimidated about asking doctors and nurses for information, and any information they did receive was filled with medical jargon that they did not understand.

Patients who know more about their health status and care requirements are empowered to self-manage both in hospital and at home.<sup>1</sup> Those who learn about their hospital procedure can better understand what is happening and what outcomes are expected. For patients going home, education about self-management can reduce re-presentations and readmissions to hospital. Part of this education should deal with medication, since re-presentation to hospital is often associated with medication mismanagement. Patients who know what to do once they return home are more likely to have improved outcomes.<sup>2,3,4,5</sup>

*“Broadly speaking, the short words are the best, and old words best of all.”*

*Sir Winston Churchill*

Good written information reduces patients’ anxiety and increases their compliance with their treatment plan.<sup>6</sup> When patients understand their health status and health system, they are better equipped to participate in decision making about their ongoing care.

Patients and families are unlikely to remember new information that they have read once. Information that is read, heard, seen and acted upon in multiple sessions is likely to lead to effective learning and changes in health related behaviour.<sup>7</sup> For this reason, an education plan that can be used both in the hospital and at home should be developed.

#### Patient education improves transition planning

Patient education prior to admission can improve outcomes for the patient and reduce the length of stay.<sup>8,9,10</sup> Evidence suggests, however, that many patients do not receive adequate teaching to prepare them for leaving hospital. Education before transition can be limited for a number of reasons, including the patient being too ill and distracted by events in hospital to digest the information. Another reason could be that clinicians’ may be too busy to provide comprehensive patient education. If this is the case, the hospital needs to explore other methods of education and information provision.

### The patient charter – the right to information

Patients need information so that they are empowered to make decisions about their health care. The patient charter<sup>11</sup> outlines a patient's rights and responsibilities in public hospitals and should be given to every patient on presentation to the hospital.

The charter states that:

- The patient has the right to be fully involved in decision making about their health care and to ask questions and discuss treatments, so that they understand what is happening. This includes deciding how and when they will leave the hospital.
- The patient is entitled to be fully informed about treatment, given enough time to ask questions and get more information, talk to family and friends before making any decision, and to obtain a second opinion from another qualified health professional.

Patient information needs to be easily accessible. Information may come from various sources, including:

- the patient's general practitioner (GP) before admission
- telephone advisory services
- the Internet, which has sites such as the Better Health Channel
- local libraries, which provide literature, Internet access and journals
- hospital pamphlets at the pre-admission clinic/outpatient department
- local community services
- special interest or support groups
- carers, neighbours and friends.

By the time a patient is in hospital, it is anticipated that they will already know a good deal about their illness, treatment, care options and available community services. Some patients, however, need assistance to access and understand health information, particularly in stressful situations.<sup>12</sup>

One patient stated:

*"It would be good to have someone to sit down and talk with people about their lifestyles and what sort of support they will need and the different services that are available to them, how they can tap into them, and also to take some of the pressure off the person by organising some of these services for them."<sup>13</sup>*

## How hospitals can communicate better with patients

Information given to patients must be evidence-based and accurate. It also needs to be readable by patients and carers.

### Writing style

*“Speak properly, and in as few words as you can, but always plainly; for the end of speech is not ostentation, but to be understood.”*

*William Penn*

- Patient information should be written for a reading age of 10 years to ensure it is understandable.<sup>14</sup>
- The text size should be a minimum of 12-point type.<sup>15</sup>
- The document should have clear headings.<sup>16</sup>
- The information should be legible when reproduced. The poor photocopying quality of documents may mean that the patient cannot read useful information.
- Avoid medical terminology wherever possible
- Use short sentences
- Use the second person pronoun
- Use the active voice rather than the passive voice.

### Information content

- Patient information needs to be practical and specific, answering questions such as:
  - What’s wrong with me?
  - What does my treatment involve?
  - When will I be admitted and go home from hospital?
  - How long should my recovery take – what can I do and when can I do it?
  - Who can I contact to obtain more information?

### Other methods of presenting information to patients

Written information may not be suitable for patients who are visually impaired or from culturally and linguistically diverse backgrounds. Audiotapes and videos may be more effective means of communicating to some patients. Another option is to demonstrate a procedure to the patient and their carers, for example, safe transfer of a patient or dressing a wound.

### How hospitals can develop high quality information material for patients

*The Communicating with consumers good practice guide to providing information*, by the Metropolitan Health and Aged Care Services (Department of Human Services) contains good practice examples in developing high quality information material for patients. You can access this guide at the web site: [www.patientcharter.health.vic.gov.au/comms.htm](http://www.patientcharter.health.vic.gov.au/comms.htm)

The following are key features of good information provision:

- Patient and carers are involved in developing process for providing information and resources.<sup>17</sup>
- Patient and carers are engaged in learning about their health issues and health care.
- Patient and carers become partners in problem solving and are not simply passive recipients of information.
- The hospital provides information that is relevant to the social context and lifestyle of patients and their carers.
- Patients and carers have many opportunities to receive information, ask questions and build on their knowledge across the care continuum.
- Patients receive information that is individualised and that reflects the impact of the condition and treatment on their health.
- Health care providers from different disciplines provide patient information that is relevant to their expertise.
- The hospital develops strategies to overcome hospital structures and cultures that impede consistent provision of quality information. Senior management and clinical staff support the development and roll out of innovative models of information provision.
- The hospital considers revising staff job descriptions to include the involvement of patients and carer in developing any patient information materials.<sup>18</sup>
- Making sure patients get the right information

*“By learning you will teach;  
by teaching you will learn.”*  
*Latin Proverb*

## Good practice example 2.1A

### Communications guide assists staff to produce better patient information

#### Austin Health

Key results:

- Patients receive well presented, clear information
- Improved patient understanding of their procedure, condition and discharge planning
- Patient involvement in the development of information

Austin Health has developed a comprehensive best practice guide for hospital staff who are creating patient education material.

For further information see: Appendix A

*“More compassion is required, particularly to our elderly or lonely patients and their carers. With less emphasis on the question—How are we going to get them out of hospital? And ask the question, Why are they in hospital? And why do they want to be in hospital? This is my new challenge. I hadn't thought of this until now, thank you for the opportunity to consider this.”*

*Rural GP, EDS Review*

The Communicating with consumers, good practice guide to providing information, published by the Department of Human Services in 2001, suggests that when hospitals develop patient information they should seek to:

- develop strategies to ensure patients and carers receive information across the care continuum
- train and educate the health care workforce
- improve communication among members of multidisciplinary teams
- improve communication among staff on different wards and units
- improve communication with providers outside the hospital
- develop and maintain information about services to the community
- consider employment issues (such as the employment of trained bilingual health care providers)
- use community consultation so information provision models are relevant to the needs of community members
- develop data collection processes to facilitate the provision of culturally and linguistically appropriate information and to identify gaps in information provision.

### **Educating non-English speaking patients**

Patient education will be more effective if it is culturally sensitive. Teaching outcomes are improved when education addresses the intended audience's language, logic and experiences.<sup>19</sup> Below are some suggestions to accommodate non-English speaking patients:

Ensure interpreter services are used when required.

Ensure all public information about the hospital (its services, policies, procedures) is provided and disseminated in community languages.

Develop written information in conjunction with patients from a non-English speaking background, and test it with these patients for readability.

### **Early education is the key**

The hospital should give information to the patient at diagnosis or the beginning of treatment. Relatives or friends who attend pre-operative education benefit as this learning helps the patient's recovery.<sup>20</sup> Further, if nurses discuss transition plans with the patient and a relative or carer, they can facilitate early identification of any post-hospitalisation needs. Consequently, fewer delays should occur at the time of transition.<sup>21</sup>

## Pre-admission

Pre-admission patient material helps patients to prepare for their hospital stay and ask questions before going to hospital.

For patients who are reviewed in outpatients before surgery, the medical officer can provide pre-operative education in groups or individual sessions.

The hospital can give brochures and pamphlets to patients by post or in person.

Wards can provide pre-admission classes to orient patients and carers to the ward environment. These classes can also provide information from the multidisciplinary team about a patient's treatment and recovery expectations.

## In hospital

Ward staff can educate each individual by following a patient education plan. Hospitals can include patient education as part of a care pathway to ensure the patient knows what to expect each day of their admission.

## After hospital separation

Some speciality units use group education sessions, such as cardiac rehabilitation and diabetes courses, which patients attend after hospitalisation. Hospitals and, more commonly, community providers deliver these courses.

Home nursing services provide education in the home on a range of topics such as diabetes, wound management and continence management.

Other community organisations, such as the Asthma Foundation and Arthritis Victoria, provide education and support to people with these diseases.

## Good practice example 2.1B

### Poster leads to improved transition planning and higher patient satisfaction

#### Gippsland Regional Consortia

Key results:

- Patient satisfaction has increased and complaints have decreased
- Patients are more prepared for their hospital stay and going home
- Community services respond more effectively to patient referrals

A consortia of 4 hospitals in the Gippsland region developed a transition planning poster and brochure aimed at encouraging patients to plan and discuss their transition process from hospital to the community as part of the pre-admission process.

For further information see: Appendix A

## Good practice example 2.1C

### Pulmonary patient rehabilitation program records 96 per cent patient satisfaction

#### Kerang and District Hospital

Key results:

- Improved patient health outcomes
- Dramatic fall in rate of readmissions
- Reduced length of stay in hospital

Patients who experienced frequent admissions due to their pulmonary conditions were invited to attend an eight-week course on respiratory management. The focus of the course was better self-management skills to prevent exacerbations of their condition.

For further information see: Appendix A

### Emerging trends in patient communication

Email is a new method of communicating with patients. Many health care providers, policy makers and funding bodies 'view electronic patient-provider communication as an important vehicle to improve clinical practice by reducing resource use and improving clinical outcomes'.<sup>22</sup> A recent study found that half the surveyed patients (52.1 per cent) were email users and 70 per cent would be willing to use email to communicate with their doctors.<sup>23</sup> Patients were concerned, however, about whether their emails would reach the right person and whether they would receive a response. The study concluded that the uptake of patient-provider email may be slow and that both patients and providers would need to promote appropriate email use.

### Tips for informing patients

- Develop a patient information policy to guide best quality in the development of patient information brochures.
- Develop patient-held records so the patient has all the information about their continued care in a written format.
- Develop a 'transition folder' in which to keep all information brochures and sheets for the patient. Include standard hospital and privacy information and, as required, specific information that pertains to the patient's condition or social circumstance. (Hepburn Health Services and the Commonwealth Carelink Centre have developed this type of folder.)

- Provide training for staff who work with interpreters.
- Ensure patients and carers are involved in determining what information should be provided.
- Develop the patient information with patients, to ensure it is relevant, legible and understandable.
- In the information pack that a patient takes home, include:
  - the names and telephone numbers of hospital contacts in case the patient has questions
  - details about the patient’s medical condition
  - details about the patient’s health management, including activity and diet advice
  - the names and telephone numbers of services to be used after leaving hospital
  - details about ongoing investigations, including any special instructions
  - the date, time and location of the appointments for any investigations
  - medication information, including instructions on administration, the management of side- effects, and storage
  - details about follow-up outpatient appointments, including the address and name of the practitioner, the date and time of the appointment and the reason for the appointment.
- Provide both information and education to improve learning. This approach is more effective than providing only information.<sup>24</sup>
- Consider the needs of patients with poor vision.
- Provide information sessions for carers to facilitate improved understanding of what is involved in being a carer.<sup>25</sup>
- Place a high priority on understanding patients’ needs and preferences, and helping patients’ access and understand relevant, appropriate information.<sup>26</sup>

### **Tips for educating patients**

- Assess which method of education is best for the patient population or a specific individual.
- Find out how much the patient knows and then provide individualised information.
- Find out what is important to the patient and what are their greatest concerns.
- Do not lecture patients. Rather, have an interactive discussion with them.
- Focus on teaching behaviours and skills.
- Clearly define any medical terms.
- Share only enough anatomy and physiology to support your teaching.

- Teach in conversational style: that is, listen as well as speak. Ensure your teaching accounts for cultural beliefs.
- Involve family and carers in education sessions.
- Allow the patient to interrupt the presentation as you go.
- Use other resources within the hospital such as the palliative care team, the cardiac nurse and allied health to educate patients and carers.
- Use community resources for education, such as the district nurse or organisations like the asthma foundation.
- Evaluation is important as another opportunity to listen, ask and answer questions. Ask the patient to demonstrate the new skill. Watch them perform the skill at least three times.
- Evaluate the patient's understanding of what they need to do and when.
- Check that the patient understands the information.
- Rather than asking 'Do you have any questions?' try 'Is there anything I didn't say clearly?'

### Evidence levels for patient information

Effects of patient information	Level
Providing patient information alone does not affect mood, perceived health status or quality of life for patients or carers.	I
Providing information along with education sessions improves knowledge and is more effective than providing only information.	I
The most common complaints made by people with a carer are about poor communication and inadequate information.	I
Patients cannot be involved in decision making about their care, or choose not to be involved, unless they are given sufficient and appropriate information.	I
Health professionals need to know how to determine a patient's need and readiness for information, as well as their desire to be involved in decision making about their own care.	I
Health professionals are likely to need training and support in meeting a patient's information needs.	I

**I** = Evidence obtained from a systematic review of all relevant randomised controlled trials (RCTs)

## Evidence levels for patient education

Effects of patient education	Level
Readable education material allows patients with limited reading skills to have control over their personal health.	IV
Patient education assists patients to make more informed decisions that affect their health.	IV
Patient education can improve patient outcomes.	III-1

*III-1 = Evidence obtained from well designed controlled trials without randomisation*

*IV = Opinions of respected authorities, based on clinical experience, descriptive studies or reports of expert committees.*

## 2.2 Good practice in assessing discharge risk

### Discharge risk screening

Discharge risk screening is an organised method of identifying patients that require ongoing care and additional support after leaving hospital, so that they are able to manage their activities of daily living and health needs.

Hospitals should complete a risk screen for all patients who present to hospital either electively or as an emergency. The risk screen tool developed, for the Department of Human Services, by Thomas and Associates is commonly used in Victorian hospitals is a valid and reliable tool for identifying patients who may require post-hospital care.<sup>36</sup>

### Discharge assessment

Discharge assessment is a full assessment of a patient's post-hospital care needs. When the assessment is undertaken early in the patient's hospital stay, timely referral to allied health and community service providers occurs.<sup>37</sup>

Hospitals should conduct a full discharge assessment of any patients with a positive risk screen. This assessment ideally occurs in the pre-admission clinic for elective patients and shortly after admission for other patients.

Comprehensive discharge assessment considers the patient's physiological, psychological, social and cultural needs. It requires an understanding of the patient's home and social circumstances, such as:

- the patient's home situation and any obstructions in the home that may influence recovery
- the patient's capacity to perform activities of daily living
- the community services that the patient used before admission
- existing responsibilities that the patient cannot meet because they are in hospital
- the availability of family/carer or others to assist the patient after leaving hospital
- the patient's cultural, linguistic and religious needs.

The hospital may use a number of sources to collect discharge assessment information, including the patient, family members, carers, community service providers and general practitioners (GPs). It is worthwhile documenting the patient assessment on an easy-to-use assessment tool that contains prompts for action. To reduce the times that a patient is asked the same or similar questions, the hospital should make the assessment tool available to the multidisciplinary team. All members of the health team need to contribute to the assessment document.

*“Health service providers are more aware, and identifying patients needs post discharge much earlier in the admission...”*

*Community Provider – EDS Review*

Discharge assessments need to be linked to action plans and goals. Planned actions usually include referrals to allied health or community service providers. If, for example, the assessment reveals that the patient has a mobility deficit and requires transport to the shopping centre on Wednesdays, then the action would be referral to the local council.

The discharge assessment should also reflect changes in the patient's condition, such as a change in the capacity for self-care or a change in the family/carer's ability to provide assistance. Good transition practice involves assessing patients' needs and then developing and implementing a transition plan.<sup>38</sup> An ongoing process of assessment provides the opportunity to refine the transition plan.

## Good practice example 2.2

### Patients benefit from regionally aligned assessment documentation

#### Stawell Regional Health

Key results:

- Transferred patients do not need to be reassessed
- Assessment documentation is concise, easy to use and regionally aligned

To overcome the variations in assessment documentation, East Grampians Health Service developed regionally aligned assessment documentation. This standardised documentation is concise, and easy to use and has now been introduced across the region.

For further information see: Appendix A

## Emerging trends in discharge assessment

The primary care partnerships introduced a common **Service Coordination Tool** template, which is designed to support the existing suite of tool templates.

These include the Initial Contact Tool, the Initial Needs Identification Tool, the Care Planning Tool and the referral tools used by service providers. The tools incorporate core consumer information, as well as social, psychological, medical and physical information to determine risk and consumer needs, and to trigger referral and assessment. Refined through extensive consultation, they are designed to be easy to use and understand.

The advantage of using these tools is that they standardise practice and reduce the duplication of assessment. The Service Coordination Tool will facilitate the development of a coordinated plan that meets patient and carer needs.<sup>36</sup> Hospitals should use these tools when communicating with community providers (see Section 2.6).

### Tips for assessing discharge risk

- Use the Thomas and Associates tool to risk screen adult patients.
- Further enhance the risk screen tool by customising it suit the particular patient population.
- Begin patient assessment either prior to admission or at first presentation to the hospital and complete within 24 hours.
- Ensure the assessment tool is multidisciplinary and outcome focused.
- Ensure patient assessment continues throughout the patient's hospital stay whenever the patient's condition changes.
- Consider developing a discharge checklist, such as the one developed to assist hospitals in preparing elderly patients to return to the community (see below).

## Checklist: planning the transition of elderly patients

### Home consideration

1. Do you have the keys to your home with you?
2. Are there groceries at home in preparation for your return (for example, bread, milk, fruit and vegetables)? Is there anyone who can organise this for you?
3. Pets? What arrangements have been made while you are in hospital and for when you go home?
4. Can you manage the housework and gardening after hospitalisation? Is there anyone who can assist you?
5. Do you have heating/cooling at home?
6. Is there anyone who can give you a phone call every day for the first week you are home?
7. Do you have adequate lighting in your house?
8. Do family/carers need to be contacted to advise them that you are going home?
9. Does anything worry you about going home and managing?
10. Would you like a brochure or information about personal alarms to take home?
11. How will you get home from hospital?

### **Services**

- 12. Do you receive any services that assist you at home?  
Do they know you are in hospital?
- 13. Do they know the date that you will be returning home?

### **Carer**

- 14. Do you have a carer?
- 15. Does the carer reside at the same address as you?

### **General practitioner**

- 16. Do you have a regular GP?
- 17. Do you see more than one GP?
- 18. Does the doctor do home visits?
- 19. Who will let the doctor know you are coming home from hospital?

### **Medications**

- 20. Do you feel that you may need some education or assistance with your medication?
- 21. Do you have enough medication to last the weekend?  
You will need to plan a GP visit (for prescriptions) and transport to a pharmacy.

### **Equipment**

- 22. In your opinion, do you feel you need any equipment?

### **Driving/transport**

- 23. Do you drive a car? What alternatives are available to you for transport?

## Caring for Carers

*“Carers are usually family members who provide support to children or adults who have a disability, mental illness, chronic condition or who are frail aged. Carers can be parents, partners, brothers, sisters, friends or children of any age. Carers may care for a few hours a week, or all day every day”.*  
(Carer’s Victoria)

*“Risk screening of all inpatients has certainly increased staff’s awareness of clients needs on discharge.”*

*Rural hospital staff, EDS Review*

Many patients will need the assistance of a carer to return back to their home after a stay in hospital. Also, with around one in five people in Australia being a carer (Carers Victoria), the chances are that many patients will have caring responsibilities for others. It is essential that hospital staffs assess, and make adequate arrangements for patients who are themselves carers, or for the carer who will be responsible for the patient being sent home.

Throughout Australia there are a number of organisations that provide advice and support to carers. In addition organisations such as Carers Victoria have a range of courses for hospital staff wanting to be more pro-active in involving carers in patient care and the transition back to the community. Carers Victoria have developed a useful discharge checklist to prompt staff in considering the patient who may be a carer or who may need a carer (see Section 2.7).

### Evidence levels for assessment

*IV = Opinions of respected authorities, based on clinical experience, descriptive studies or reports of expert committees*

Effect of assessment	Level
Patient assessment can improve patient outcomes.	IV



## 2.3 Good practice in using care pathways

A care pathway is an evidence-based care plan that details the essential steps in patient care, describing the expected progress in the patient's recovery. It has the following characteristics:

- It addresses a specific diagnosis, surgical procedure or a phase in the care needed.
- It represents a time line of care activities based on the particular condition the patient is admitted for.
- It includes well-defined milestones that help expedite care and indicate an impending change in care activities.
- Its length depends on a predetermined length of stay, which is based on the usual course of care and recovery for the diagnosis or procedure.
- It delineates the responsibilities of various healthcare team members as they relate to each department.
- It identifies the outcome indicators or quality measures used to evaluate the appropriateness and effectiveness of care.
- It may include a variance tracking section to evaluate delays in care activities/processes/outcomes.
- It is interdisciplinary in nature, reinforcing seamless delivery of care.
- It can be used as an educational tool for staff, students, beginning practitioners and new employees.
- It improves performance in patient and family/carer teaching, service coordination, cooperation and communication among the health care team members, and transition planning.

### Care pathways create positive outcomes

A care pathway provides a standardised format for patient care that prevents major fluctuations in treatment. In particular, it can guide care delivery across service settings (including acute, sub-acute and community services) to ensure the continuity and consistency of health care.<sup>42</sup>

Care pathways address patient outcomes from pre-admission to post-transition. A pathway guides care from pre-admission clinics, which educates patients about their procedure, the expected length of hospital stay and transition planning. A study showed that when patients were told they would be hospitalised for a certain number of days, those patients worked hard to reach that goal and in many cases, they were able to go home earlier.<sup>43</sup> The inclusion of transition planning in the care pathway ensures: (1) referrals to allied health services are planned and timely, and (2) all members of the health care team are involved in assessing patients' readiness to go home.

Benefits of care pathways include:

- improved quality of care<sup>44,45</sup> and patient satisfaction<sup>46</sup>
- improved continuity of patient information and education<sup>47</sup>
- delineation of responsibilities<sup>48,49,50</sup>
- better resource allocation and service coordination, reducing the fragmentation and duplication of care activities<sup>51,52</sup>
- cost-effectiveness of the hospital stay and reduced length of hospital stay.<sup>53,54,55,56,57</sup>

A care pathway is usually directed towards a specific disease or procedure, for example, asthma, a hip or knee replacement or a cardiac condition. It links the processes of care to the expected/desired outcomes. In this way, it assists the novice practitioner by providing a checklist of the intervention for each day of the patient's stay.<sup>58</sup> The care pathway provides a communication tool for all members of the care team; the members document completed tasks and any variation to the expected outcomes, thus recording the patient's progress/deterioration.

It is important that the interventions listed on care pathways are evidence-based. Pathways that are not evidence-based lack value and credibility, and clinicians will avoid or reject their use.<sup>59</sup> Clinicians are likely to comply, however, with a pathway of interventions that both the literature and the multidisciplinary team agree are effective in producing good patient outcomes.

## Good practice example 2.3A

### A coordinated approach to stroke rehabilitation

#### Goulburn Valley Health

Key results:

- Consistent approach for each patient
- Increased patient satisfaction with care and post-hospital arrangements

Goulburn Valley Health developed a clinical stroke rehabilitation pathway that follows the patient from admission to the rehabilitation unit, through transition to home or residential care.

The multidisciplinary pathway ensures all patients receive the best evidence-based care and includes ongoing monitoring.

For further information see: Appendix A

## Variance analysis

A variance is a mismatch between a patient's condition or treatment and the expected pathway outcomes. Any variance is recorded on the pathway or variance sheet, which details what is different than expected, what actions have been taken, what further actions are planned and what are the expected outcomes. Variances that occur during a patient's stay can be indicators of a complication of the condition, or a system problem.

Variance analysis can be a means of reviewing and improving care practices. If, for example, the most common variance in the hip replacement pathway is that patients have a post-operative wound infection, then the care team may decide to review wound care, surgical technique and sterility and microbiology processes to identify how to decrease the incidents of this variance type.

Variance analysis can also be used to provide feedback to staff about the care they provide, for example, to let staff know the number of patients who were well enough to leave hospital on the planned date.

## Good practice example 2.3B

### Increasing patient empowerment and clinical and clinical leadership through pathways

#### Bayside Health

Key results:

- Daily update empowers patients
- Improved level of consistency
- Clear measurement tools inform future action

The Alfred, Bayside Health, has developed medical and surgical clinical pathways as a documentation tool to manage patient care from the point of admission to either the next level of care or a return to the community.

The multidisciplinary team caring for a patient plays a key role in developing the pathway. It is supported by a dedicated Clinical Pathway Coordinator and ongoing executive support.

For further information see: Appendix A

## Patient pathways - creating goals and expectations

There is now a high degree of patient involvement in clinical decision-making, which creates a demand for patient friendly information. The patient pathway is a patient held document that is complementary to the care pathway. The pathway should emphasise hospital programs and services the patient may use and also incorporate community services that are available.

It should contain:

- information regarding the disease/ condition
- an outline of the process of care with explanation of any investigations
- patient goals
- expected outcomes
- discharge information.<sup>60</sup>

*“The importance of clear documentation altered our focus from the hospital episode, to the patient as part of the community and part of the continuum.”*

*EDS Project Officer, EDS Review*

The pathway gives the patient and their carer/family realistic expectations for each day of their hospital stay, and allows them to become involved in their care, including transition planning. It can also assist the patient to obtain a clear understanding of their treatment plan. With the pathway outlining what treatment at what time and on which day it is planned, the patient is empowered to participate in decision making and able to comply with regimes.

Patients should receive a patient pathway at a pre-admission clinic or in the doctor's rooms when the hospital stay is arranged. This practice ensures the patient has time to prepare for the hospital stay, have any questions answered prior to admission and arrange post-hospital needs. If the admission is unplanned, the pathway can be given to the patient/carer when the diagnosis is known, and the clinical pathway commenced.

Hospitals can develop patient pathways in conjunction with care pathways.

A multidisciplinary team including patients and carers can develop the pathways. The pathway needs patient involvement so that it meets their needs, contains the information they require and is user friendly. Flexibility in approach and a clear definition of the target audience is essential. For example, when making a patient pathway for a paediatric group, two layouts may be required: one a simple picture based guide for the child and another containing written information for the parents.

## Steps to developing a care pathway

### Decide on the pathway format

The format of the pathway guides the development of its content. The format should be easy for everyone to read and use. The Health Information Service (Medical Records Department) needs to approve the format before the content is developed.

When choosing a format, consider:

- whether the pathway will be used for documentation
- the number of disciplines represented in the pathway
- the complexity of the diagnosis/procedure
- the care area or service using the pathway
- whether the pathway replaces any existing patient care forms
- plans for computerisation of medical records.

### Organise the multidisciplinary team

To ensure the success of the pathway and reduce resistance to its development, members of the multidisciplinary team need to be involved in the planning stages. The planning team should include:

- members who demonstrate good communication skills
- representatives of all disciplines involved in the pathway, to ensure that the plan is thorough and well written
- the medical head of the unit (recommended as chairperson) as well as other medical staff. Hospitals have found that medical staff who participate in a planning team often become champions for the cause
- a facilitator who can guide the planning process, remove obstacles and answer questions
- a community representative
- a consumer representative.

### Educate/train the team

Education of the team before pathway development is vital. Topics to cover include:

- an overview of care pathways
- the process for developing a care pathway
- the responsibility of the team leader, team facilitator and team members
- examples of existing pathways.

Allow team members to ask questions about the pathway process.

### **Conduct a literature review**

A thorough literature review will provide team members with information about the latest trends in patient care. The team should use the research to validate pathway recommendations. This approach ensures the content of the pathway is evidence based.

### **Examine current practice**

An important step in establishing pathway content is to examine current practice. This step involves brainstorming about patient care, focusing on what is usual practice and what barriers or delays interrupt the process of care. The next step is to develop a flow chart of the usual process, reflecting the care of a patient from pre-admission to post-hospitalisation.

A review of medical records is also useful for collecting data on the process of care. Particularly important are care activities that are critical milestones of care or trigger points for a change in the treatment plan.

### **Determine the length of the pathway**

The length of the pathway depends on (1) the current length of hospital stay for the diagnosis/procedure and (2) the team's assessment of what the length of stay should be.

### **Set the development time**

The time needed to develop a care pathway depends on the:

- complexity of the diagnosis or procedure
- number of practitioners who will use the plan
- extent of practitioners' disagreements over the pathway content
- number of disciplines involved
- experience of the team members
- availability of the team members, as well as their level of involvement and commitment
- presence or absence of a support person to assist the planning team.

### **Write the content of the plan**

Collate all the data collected in the previous stages. Team members write a draft for their respective section of the pathway, following the agreed format. The team can then discuss and finalise a compiled version of the drafts. The content of the pathway should reflect best practice as agreed by the team. The finished pathway should undergo review by a group of medical, nursing and allied health staff, and then a final review by the team.

### Pilot the pathway

Piloting the pathway with a small number of patients in one clinical area provides information about the pathway's usability and any unexpected problems with its use. The multidisciplinary team can then address and resolve any issues that arise.

### Staff education

Once the plan has been piloted (and any subsequent changes made), staff information and education should be provided. Mechanisms should be in place for staff to provide continuous feedback on the plan, with regular up-dating as required.

### Evidence levels for care pathways

*II = Evidence obtained from at least one properly designed RCT*

Effects of care pathways	Level
Care pathways can be cost effective and reduce length of hospital stay <sup>61</sup> .	II
Care pathways can improve patient outcomes and satisfaction <sup>62</sup> .	II



## 2.4 Good practice in medication management

Medication management is central to successful health outcomes. Good medication management can decrease readmission and improve patient outcomes<sup>63</sup> and efforts to assist patients with medication compliance improve the benefits and efficiency of health care.

Problems with medication lead to two to three per cent of all hospital admissions.<sup>64</sup> It has been estimated that 80,000<sup>65</sup> hospital admissions a year are the result of people taking medicines incorrectly. People over the age of 65 have higher rates of medication incidents, partly because patients in this age group are taking one or more medications. Patient's medications are often also changed during hospitalisation. Once the patient has returned to the community "they may forget the instructions given to them in hospital, become confused about their continuing medication and may resume medication prescribed prior to hospitalisation."<sup>66</sup>

### Improving medication management

The quality use of medicines is part of total patient care during admission, inpatient stay and transition to the community.<sup>67</sup> Adverse events and drug related misadventures are more likely to occur when changes to medications are made.

The hospital needs to inform the patient about their medications and how to manage them safely.<sup>68</sup> Hospitals also need to communicate the patient's medication regime to GPs and other relevant community providers.

The differing types of medication incidents show that no single factor is responsible for the high incidence of medication misadventure. A systems approach is being implemented in Australia to address medication safety. This is now possible through the Pharmaceutical Reform Program.

Patient or carer's inability to obtain further ongoing supplies within a reasonable timeframe should not interrupt medication regimes. The hospital must supply adequate medication for patients.

### Australian guidelines for medications

Guidelines to achieve the continuum of quality use of medicines between hospital and the community were released in January 1998. The guidelines consist of broad principles upon which standard procedures can be based.

These principles are:

- Hospitals need to develop and coordinate a medication discharge plan for each patient. Hospital staff should obtain an accurate medication history, including prescription and over the counter medicines and other therapies such as herbal products, at the time of admission.

- Patient's admission medication should be reviewed in consultation with the patient's GP, with a view to:
  - identifying the appropriateness and effectiveness of current medication, and rationalising current medication if appropriate
  - paying particular attention to any problems associated with current drug therapy, including any possible relationship with the current medical condition
  - documenting allergies and any previous adverse drug reactions.
- Medication discharge plans should be developed in consultation with the patient and/or carer. The plan should form part of the overall care plan or critical pathway.
- Medication review and dispensing of adequate medication should take place in a planned and timely fashion before the patient leaves the hospital. Adequate medication means sufficient medication to carry the patient through to the next arranged review (by their GP, outpatient clinic or some other arrangement), or to complete the course of treatment.
- At the time of leaving the hospital, each patient should be provided with a discharge folio containing relevant information such as Consumer Medicine Information, a medication record, patient/carer plan, and information on the availability and future supply of medication.
- No patient should leave the hospital until the details of admission, medication changes (including addition/deletions) and arrangements for follow up have been communicated to the healthcare provider(s) nominated by the patient as being responsible for his or her ongoing care.

*“Generally speaking clients are discharged with more information about medication and follow up treatments than prior to the commencement of EDS.”*

*PAC coordinator, EDS Review*

## The importance of home medication review

The Home Medicine Review is a program provided by the Commonwealth Department of Health and Ageing, also known as the Domiciliary Medication Management Review (DMMR). This program targets:

- patients who have recently been hospitalised and for whom quality use of medicines may be an issue
- patients who are at risk of medication misadventure because of their co-morbidities, age and social circumstances, the characteristics of their medicines, the complexity of their medication treatment regimens or because of a lack of knowledge and skills to use medicines to the best effect.

Home medication review can be a valuable service to provide to patients after hospitalisation. The review requires a GP referral. The process involves the GP who, in consultation with the patient, completes a referral to the community pharmacist for a thorough review of the patient's medication. The community pharmacist conducts the review with the patient, preferably in the patient's home and in collaboration with community nurses where appropriate. A report is completed

and given to the GP. The GP then develops a medication management plan with the patient.

Hospital medical officers must consult with GPs to initiate a home medication review and medication management plan after hospitalisation. The GP will then discuss the process with the patient and complete a referral for a home medicine review.

This service ensures a thorough review of patient's entire medication regimen within the home environment. The interview results in improved patient understanding of their medication and how to manage it, including compliance, storage and administration techniques. The service is provided by, or under the supervision of, an accredited pharmacist, by the patient's nominated community pharmacy.

### **Pharmaceutical reform in Victorian public hospitals**

Over the past five years there has been a major emphasis in Victoria on improving the continuum of care for patients moving between the hospital and community setting. As part of this strategy, the Commonwealth and Victorian governments have been working together to improve the way patients receive their medication by bringing the Commonwealth's Pharmaceutical Benefit Scheme (PBS) to public hospitals.

The reforms are designed to make it safer, easier and more convenient for patients to receive adequate medication, and to bring public hospitals on to a more equal footing with private hospitals. Some of the key objectives of the reforms are to:

- provide patients with up to one month's supply of medications on leaving hospital and when attending a public hospital as an outpatient, rather than the two to seven day supply they receive currently
- to improve continuity of pharmaceutical care by allowing public hospitals to access the same pharmaceutical scheme that operates in the community, the PBS, thereby decreasing confusion and possible over-consumption by patients
- to improve communication with both patients and primary health care providers through the implementation of the Australian Pharmaceutical Advisory Council guidelines on the continuum of pharmaceutical care
- to allow sufficient time for paperwork to be sent from hospitals and received by primary health care providers before patients present for their first post-hospital visit.

PBS reforms are being implemented gradually in a staged process across the state. The following health services are participating in the reforms:

- Barwon Health
- Southern Health
- Bayside Health
- The Mercy Hospital for Women
- Peter MacCallum Cancer Centre
- Central Gippsland Health Service
- Goulburn Valley Health Service
- Melbourne Health
- Royal Dental Hospital, Parkville
- Eastern Health
- Women and Children's health
- Austin Health

*For further information visit the website <http://www.health.vic.gov.au/pbsreform/>*

## **How has access to the PBS changed?**

Under the new scheme, hospitals are able to prescribe PBS medication to all non-admitted patients and patients leaving hospital, and will provide up to one-month's (or clinically appropriate) supply of pharmaceuticals. These medications will be able to be dispensed at the hospital pharmacy or at a community pharmacy.

## **Do patients need to pay for medication?**

Under the National Health Act 1953, collection of a patient co-payment is required whenever a PBS prescription is dispensed. The amount of the co-payment will be different for general and concession patients. At present, most public hospitals collect payments for pharmaceuticals dispensed to outpatients so there will be minimal change. However, most hospitals do not currently charge patients for their take home medications because only a few days medication is provided. Under the new system, a co-payment will be collected. This is the same practice as in the community where a charge is levied whenever a prescription is dispensed.

The benefits are that patients will be able to visit their local doctor for their first post-hospital visit when it is convenient and appropriate for them, and not for the sole purpose of obtaining more medication. It also means that hospital paperwork, such as the discharge summary, should have reached a patient's usual doctor before they present for their first visit, thereby keeping the community doctor better informed and improving the patient's overall level of care.

## How should hospitals prescribe PBS medications?

Writing and dispensing of PBS prescriptions will be a new task for some staff. Prescription forms need to be written and dispensed accurately in all cases, otherwise the claim will not be processed for reimbursement by the Health Insurance Commission (HIC). Training and education programs will take place in all public hospitals where PBS prescriptions will be written, even if there is no pharmacy dispensary on site.

A new prescription form has been designed specifically for public hospitals wishing to access the PBS reforms.

A hospital identifier number will be pre-printed on each prescription. This allows every prescription to be linked to a particular hospital. Hospital prescriptions can only be used by doctors employed by that hospital and for patients seen at the hospital.

All doctors must attend a training session run by the HIC in order to obtain a Prescriber Number.

## Options available for the dispensing of PBS medications

Hospitals are not obliged to dispense PBS items and may elect to send patients to a community pharmacy. However, in these circumstances the prescription will still be charged to the hospital. Hospital prescriptions dispensed in the community include professional fees, which will be attributed to the hospital's claim by the HIC and therefore contribute towards the hospital's ceiling level.

Small and rural hospitals may find it economically viable to send patients to community pharmacies for dispensing. Metropolitan hospitals might also find it convenient to send patients to their local pharmacy for dispensing on weekends and after hours.

Under the National Health Act 1953 public hospital pharmacies are prevented from dispensing PBS prescriptions that originate in the community. Hospitals are able to dispense hospital PBS prescriptions that originate from another participating hospital.

## Tips for medication compliance

- Take a complete medication history, including over-the-counter and complementary medicines. Check for contraindications, allergic reactions and interactions between medications.
- Simplify dosing where possible.
- Provide patients and carers with verbal and written information (see sections 2.1 and 2.7), including:
  - medicine contents
  - how to take the medicine
  - actions of the medicine
  - adverse effects, side effects and benefits of the medicine.

- Consumer Medicine Information (CMI) should be provided to every patient commencing on new medication. The CMI contains consumer readable information about the medication and its use, the precautions and possible side effects as well as how and where to store it.
- The physician, nurse and/or pharmacist can provide medication advice and assistance.<sup>69</sup>

## Education

- Teach the patient and carer to monitor their medication use.
- Teach the patient and carer self-monitoring skills (for example peak flow measurement, blood glucose readings, blood pressure).
- Help the patient and carer to learn how to obtain their test results (for example, drug levels, blood glucose tests, clotting times).
- Explain the changes in labels and containers to the patient when giving them their medication to take home.
- Provide the patient with medication charts.
- Reinforce medication regimes.
- Use special reminder packaging to help the patient adhere to the regimes (for example, calendered blister packaging).
- Provide counselling and family/carer therapy for complex medication regimes (for example, insulin, antidepressants).

## Follow up

- Consider automated telephone assessment and self-care education calls with nurse/pharmacist follow up.
- Arrange supervision by community providers for patients identified as needing further assistance (for example, HACC services and community pharmacist (Home Medicines Review program)).
- Ensure the patient is followed up in the outpatient or community setting (this has been considered the most important single intervention that has proven effective in maintaining medication adherence and treatment outcomes<sup>70</sup>).

## Good practice example 2.4

### Home visit from pharmacist results in safer use of medication

#### Bayside Health and Austin Health

Key results:

- Patients feel reassured
- Number of adverse effects has fallen
- Rate of readmissions related to medication has declined

A community pharmacy liaison officer visits patients at home, providing patients with a review of all their medication and its storage.

For further information see: Appendix A

### Evidence levels for quality use of medication

*I = Evidence obtained from a systematic review of all relevant randomised controlled trials (RCTs)*

*II = Evidence obtained from at least one properly designed RCT*

*IV = Opinions of respected authorities, based on care experience, descriptive studies or reports of expert committees*

Effects of care pathways	Level
Efforts to assist patients with medication compliance improve the benefits and efficiency of health care. <sup>71</sup>	I
When hospital pharmacists communicate medication regimes to community pharmacist, interventions continue after hospitalisations. <sup>72</sup>	II
A medication profile received by the General Practitioner prior to the first post hospital review assures the appropriate prescriptions are completed before the patient runs out of the medications. <sup>73</sup>	IV
Recalling patients who miss appointments post hospitalisation is an effective and simple way of increasing medication regime compliance and treatment outcomes in short and long-term treatments. <sup>74</sup>	I



## 2.5 Good practice in communicating with general practitioners

*“Discharge practices directly impact on patient outcomes, including the ability of GPs and other community providers to provide quality care. A 1998 study of adverse events within Australian general practice found that one of the major contributing factors to adverse events was poor communication between health professionals including clinical information about the outcomes of hospital referrals or admissions and the expected role of GPs in post discharge care.”<sup>75</sup>*

Governments, hospital staff, community providers and general practitioners (GPs) recognise that quality and timely communication when the patient is leaving hospital is the key to ensuring continuity of care, better health outcomes and a reduced readmission rate.<sup>76,77</sup> Effective communication between hospitals and GPs is essential for continuity of patient care, including medication regimes.<sup>78,79</sup>

*“What is most interesting in family practice is not what the problem is but what motivates people to seek help for it. Something in the family, a hidden factor, will make the mundane interesting.”*

*Dr Sandy Burstein,  
New Yorker 23 Jul 84*

Australian literature contains examples of poor hospital–GP communication, such as inaccurate or illegible discharge summaries that led to the patient receiving incorrect medication and poor continuity of care.<sup>80</sup> Computer technology may eliminate problems with the receipt and legibility of discharge summaries but other transition issues also present challenges, for example, how to improve hospital staff understanding of the roles of GPs in patient care.<sup>81</sup>

### Communication between GPs and hospital staff is critical

There are many anecdotal reports about poor relationships between hospital medical staff and GPs.<sup>82</sup> However, studies of this relationship have found a high level of ‘mutual respect between the two branches of the profession and a strong desire to build a personal relationship’.<sup>83</sup>

On the other hand, many hospital registrars perceive GPs as monitors of care rather than proactive participants in developing patient and family/carer management plans and social support.<sup>84</sup> GPs often feel alienated from the patient’s hospital episode, even though they could help patient management and share information about the patient’s premorbid health status.<sup>85</sup>

Some Victorian metropolitan hospitals have established GP liaison roles. Most of these officers work in hospital-based positions funded by the Department of Human Services, the hospital or a division of general practice. Their main roles are to facilitate communication with GPs and to promote hospital staff understanding of GP roles.

## Good practice example 2.5A

### Good communication with GPs improves continuity of care

#### Bayside Health

Key results:

- Realistic recuperation goals can be set
- Improved patient welfare through the continuity of medication regimes

Aged Care Services at Caulfield General Medical Centre contacts GPs at patient admission to discuss patient health status and premorbid functioning (including medication regimes) and dispatches discharge summaries to GPs within 24 hours of patient separation. The patients feel more confident that they will receive optimum treatment as the health providers are fully informed of their medical needs.

For further information please see: Appendix A

## Good practice example 2.5B

### 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

Key results:

- Patients benefit from a consistent approach and better continuity of care
- Increased understanding of GP role by hospital staff

The hospital and three divisions of general practice have established a process of communication between acute health medical officers and GPs at admission to and discharge from hospital.

With the patient's consent, the hospital medical officer contacts the GP and, using this input, the hospital develops and records a care plan. Throughout the patient's stay, a multidisciplinary team contributes information on the patient's health status to a database, which creates a discharge summary. This is faxed to the GP.

For further information see: Appendix A

## The General Practitioner Register

The General Practitioner Register is an initiative of General Practice Divisions Victoria, funded by the Department of Human Services and the Commonwealth Department of Health and Ageing. The register is a repository of accurate information about GPs and their work contact details. It was developed in response to the demand for accurate GP contact information for automated notifications and electronic discharge summaries. The register is audited and validated annually to ensure its information is up to date.

The register is accessible to only registered Victorian hospitals. It includes the following information about GPs:

- name
- gender
- primary practice address and alternative practice locations
- telephone and fax numbers
- email address
- preferred contact method
- provider number.

Subscribers can use the web interface provided on the General Practice Divisions Victoria web site ([www.gpdv.com.au](http://www.gpdv.com.au)). Alternatively, they can download the database in CSV, Microsoft Excel or Microsoft Access format to integrate with the hospital's information systems.

## Timely and informative discharge summaries improve patient transition

The flow of information between hospitals and GPs may be inconsistent, unpredictable, illegible and not sufficiently informative.<sup>86,87</sup> Further, GPs may receive information when it is too late to be useful.<sup>88,89</sup> Hospitals often give discharge summaries to patients to deliver to their GP, yet studies have shown that over 70 per cent of summaries never reach the intended destination.<sup>90,91</sup> For effective management of post-hospitalised patients, it is 'imperative that full information about patient treatment and care is conveyed' to the GP before the patient's post-hospital review.<sup>92</sup>

*"There is a much higher respect and level of tolerance of each others professional role and contribution."*

*Nurse Unit Manager,  
Rural Hospital, EDS Review*

## Good practice example 2.5C

### Electronic recording enables discharge summaries to be dispatched within an hour

#### Barwon Health

Geelong Hospital and the Grace Mackellar Rehabilitation and Aged Care Service have accelerated the speed of dispatch of discharge summaries. A comprehensive discharge summary of the patient's hospital episode can now be dispatched to GPs and community providers within an hour of the patient leaving hospital.

For further information see: Appendix A

## Good practice example 2.5D

### Improving communication between hospital staff and primary care providers

#### Austin Health

A Primary Care Liaison Unit was established to improve communication between the hospital and the primary care sector, including GPs. The unit provides a single point of contact for hospital staff on primary care issues.

For further information: see Appendix A

## A template for discharge summaries

In August 1999, General Practice Divisions Victoria developed a minimum data set for hospitals to provide to GPs when their patients are admitted to or leave hospital. The hospital admission and separation notifications contain the following information:

Admission details	Discharge details
Hospital name	Hospital name
GP details	GP details
Patient's name	Patient's name
Patient's identifier	Patient's identifier
Patient's date of birth	Patient's date of birth
Admission date	Admission date
Hospital unit	Hospital unit
Contact number of GP for further information	Discharge date
Admission diagnosis	Discharge destination
	Contact number of GP for further information
	Discharge diagnosis
	Complete list of current medication
	List of investigations
	Unreported pathology results
	Outpatient appointments
	Requests/instructions/comments to GPs, including hospital plans for follow-up

## Computer-generated discharge summaries

Information technology is considered to be useful for communicating hospital information to community-based health practitioners<sup>93</sup> but there is little evidence that computer-generated discharge summaries improves outcomes.<sup>94</sup> Computerised systems do, however, improve the efficiency and timeliness of audits of discharge information.<sup>95</sup>

*“A significant focus of discharge communication in Australia by both divisions [of general practice] and hospitals has been on the development of technological and computerised solutions...despite the level of activity there is no good evidence, either from these projects or the international literature to suggest that information technology can improve the quality of discharge communication.”<sup>96</sup>*

The main information management/technology strategies that hospitals use to facilitate better communication are:<sup>97</sup>

- automatic notification systems such as DOCFAX in New South Wales (and email equivalents) that notify GPs of admissions, separations, transfers and deaths
- discharge faxes or emails from the hospital to the GP and faxed or emailed referral forms from GPs to the hospital
- GPs’ electronic access to hospital databases such as pathology and imaging databases.

## Improving communication between nurses, allied health professionals and GPs

Nurses and allied health professionals can provide information about patient care that is relevant to the follow-up care provided by GPs. When the input of nurses and allied health professionals is added to the discharge summary, GPs receive information of better quality and greater accuracy.<sup>98</sup>

## Emerging trends in communication with GPs

The Division of General Practice Northern Tasmania and three hospitals have undertaken a project to ensure better communication between hospitals and GPs. They are developing a four-stage model of electronic communication. The model uses events—including booking, presentation, admission and separation—to trigger the forwarding of information to the GP. The transfer of information uses database, encryption and emailing/faxing systems.<sup>99</sup>

## Tips for communicating with GPs

- Obtain patient consent to disseminate information about the hospital stay to the GP and community services when the patient first presents.
- Communicate with GPs when admitting and discharging patients.
- Consider using electronic systems to automate these processes.
- Involve the GP liaison officer (where available) in developing a communication system.
- Work with the local division of general practice to implement Enhanced Primary Care Items and encourage GP input to admission assessment and transition planning.
- Consider communication systems that ensure both the quality and the timeliness of information exchange with GPs.
- Consider privacy and confidentiality issues when implementing information systems.
- Use the General Practitioner Register or other similar database to maintain current GP contact details.

## Evidence levels for communicating with GPs

*IV = Opinions of respected authorities, based on clinical experience, descriptive studies or reports of expert committees*

Effects of communication with GPs	Level
Electronic medical records can facilitate cheap and rapid feedback about the quality of discharge information given to providers. <sup>100</sup>	IV
General Practice Divisions Victoria has developed minimum information levels for admission and discharge notification of GPs. <sup>101</sup>	IV
Nurses and allied health professionals can enhance the quality and accuracy of information sent to GPs. <sup>102</sup>	IV



## 2.6 Good practice in communicating between community service providers and hospitals

A range of providers and agencies may deliver care to a patient during an episode of illness. Good transition planning requires coordination and detailed, timely communication among providers,<sup>103</sup> which leads to continuity of care. Good communication thus helps identify and meet patient needs, as well as avoiding errors and adverse events.<sup>104</sup> Communication difficulties are common across health care disciplines and sectors.<sup>105,106,107,108,109</sup> A suggested solution is to use a uniform approach to information management across the public and private sectors and in acute, primary and community care.<sup>110</sup>

### Information exchange is vital to good practice

#### Information hospitals should provide to community services

Community service providers require a variety of information, depending on the type of service. A service such as Meals on Wheels needs information about the type of diet, the size of meals and the numbers of delivery days. Nursing services may need information on the diagnosis, prognosis, patient's self-care ability and other services initiated.<sup>111,112</sup> The patient or their carer may offer additional information, such as the details of any psycho-social issues that influence the patient's wellbeing and ability to self care. Community service providers welcome further information, such as the amount of support that the patient's family/carer/neighbours can provide, as this will assist their assessment and admission processes.

All community service providers need to know:

- When a client who is currently receiving services is admitted to hospital
- the expected date of discharge
- the patient's demographic details
- the name(s) of a contact for further information.

Clinical information technology systems are rarely used in community care,<sup>113</sup> even though written or electronic communication could significantly improve communication between hospitals and community services.<sup>114</sup> That said, combined electronic/manual systems have been developed in Victoria. These include common referral tools that individual hospitals use to communicate with multiple community services, common referral tools that entire regions of hospitals and community services can use, and electronic referral systems that single units/disciplines of care across a health network can use.

## Good practice example 2.6A

### Generic inter-hospital transfer process improves patient care

#### Goulburn Valley Health

Key results:

- Receiving hospitals receive better information about patients' health needs and status
- Patients are asked fewer repetitive questions when transferred
- Fewer adverse events from poor information sharing

The Goulburn Valley Health has developed a generic, inter-hospital transfer document, with specialty service modules. The transfer document provides the receiving hospital with all the information they will require about the transfer.

The process has been implemented in health services both within and outside the region.

For further information see: Appendix A

### Information that community services should provide to hospitals

Hospital staff rarely contact community service providers to obtain information about how the patient and their carer managed at home prior to the hospital admission. However, this information can be important in assessing a patient's health and psycho-social status both in respect to the hospital admission, and the assessment for the patient's post-discharge needs.<sup>115</sup> Within some of Victoria's rural hospitals, however, close liaisons occur between the staff in community and hospital settings. Staff often work in the same building or across services. This proximity provides opportunities for communication about patients, thus assisting continuity of care across the acute service and the community services.

Some metropolitan hospitals employ community service liaison personnel that attend transition planning meetings and hospital discharge rounds and/or visit the patient and their family/carer in the hospital setting. The liaison officer provides hospital staff with information about the patient's ability to manage in the home environment and about the community services available in the patient's region.

*"I feel that the cultural change is occurring, but like all changes it takes time."*

*Metro Hospital Staff, EDS Review*

Community service providers can inform hospitals about:

- the patient's premorbid status
- the current patient care/management plan
- the patient's social support system
- the services that the patient receives
- the patient's ability to manage in the community using current service levels
- the patient's ability and willingness to comply with their health management plans (for example their medication, exercise and diet plans).

## Good practice example 2.6B

### Universal transfer policy a success all round

#### Barwon Sub Region Consortia

Key results:

- Improved continuity of care
- Streamlining of patient assessments
- Increased flexibility around transfer times and medications being dispensed appropriate to the needs of the aged care facilities

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.

For further information see: Appendix A

## Good communication is the key to successful transition

The transition from hospital to the community may influence patient outcomes, yet the information flow is perceived to be the poorest at this stage.<sup>116</sup> Networking, communication and input from key individuals are fundamental to effective discharge practice.<sup>117</sup> They allow timely and adequate information exchange between the hospital and community service providers. As a result:

- the required equipment for patient care is available when required
- community services are available when required
- community staff are able to provide appropriate care.

The Department of Human Services review of the Effective Discharge Strategy revealed that 61 per cent of community services in the metropolitan regions and 71 per cent in the rural regions considered written communication from hospitals to be satisfactory.<sup>118</sup> The following are examples of good communication:

- referral letters that include complete and accurate documentation
- medications that are correctly transcribed
- communication that is legible
- community service providers receive the communication on time
- electronic discharge summaries that are available to GPs and community service providers.

*"Meeting with community service providers provided insight into their issues, and a clearer understanding of service levels."*

*Good Practice Guide Interviewee*

## Identifying which community services are used by patients

Patients and carers may have difficulty in identifying which community services assisted them before admission, giving only vague descriptions such as 'Rosie comes to vacuum and dust'. Hospital staff need to know the community service delivery systems within their region so they can contact the appropriate provider to clarify service arrangements.

Many patients with complex care needs have a case manager in the community. Hospital staff should liaise with the case manager, who can contact existing community services and assist the hospital staff with transition planning. Most hospitals have also developed an assessment and referral tool that guides hospital staff in making internal and external service referrals (see Attachment 1).

## Good practice example 2.6C

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

#### Swan Hill District Hospital

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 hospital contacts the MCHN by telephone and informs them of the child's changed needs. The MCHN provides ongoing education and advice to the family when the child leaves hospital.

For further information: see Appendix A

*“It (communication with community providers) has raised awareness...of the impact on these services and clients if information doesn't flow...”*

*MPS, EDS Review*

### Community service directories – a vast resource

Many hospitals, community services, and state and Commonwealth departments have developed community resource files. These resources are available as wall charts, manuals, web pages, CD-ROMs and interactive web sites. Those available on the Internet include state and national directories, and specific resources for local government areas or target disease/needs groups. These references can help hospital staff, patients and carers identify relevant community services.

The resources contain contact information, service hours, service descriptions and eligibility criteria (for local services). A list of service directories is available in Appendix C.

#### Local service directories

Most Victorian hospitals have developed local service directories. These directories include process information in addition to the contacts and service descriptions found in general service directories. They also usually contain referral forms and a description of the eligibility criteria for each service.

## Good practice example 2.6D

### Poster aids referrals to medical, allied health and community providers

#### Wodonga Regional Health Service

Wodonga Regional Health Service has developed a services poster that shows referral processes and criteria. The hospital's Emergency Department and wards and departments display this tool for easy reference.

For further information see: Appendix A

## Simplifying communication processes helps everyone

Many hospitals and community services have been working together within their regions to develop uniform referral tools with agreed information that provides consistency across the local service system. Hospitals should use the primary care partnership suite of tools for all referrals to community services.

## 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

Key results:

- Patient services commence promptly after discharge
- Improved information content of referrals

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 and referral information.

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

For further information see: Appendix A

## When should information be exchanged?

With the patient's consent, the hospital needs to communicate with community service providers at the following points of care:

### At admission

- Perioperative services or pre-admission clinics need to communicate planned admissions to community service providers before admission.
- The hospital should notify community service providers of unplanned admissions at the time of hospitalisation.
- Once notified of a patient's admission, community service providers should contact the hospital department to discuss pre-morbid health status to ensure continuity of care while the patient is in hospital.

### When the discharge date is known

- The hospital needs to advise community services of the planned discharge date as soon as possible to enable them to plan the necessary post-hospital service commencement.
- Some community services have processes that require earlier notification of the plan for patient transition, such as a patient assessment that the provider needs to do before accepting the referral. This assessment can be done at pre-admission for elective patients and 48 hours prior to separation for other patients.

*“Meeting with community service providers provided insight into their issues, and a clearer understanding of service levels.”*

*Good Practice Guide Interviewee*

### On separation from the hospital

- Hospitals need to confirm with community services that the patient has left the hospital and that service provision needs to commence.

### Tips for communicating with community providers

- Inform community service providers as early as possible of a patient's admission and their expected date of discharge. For elective hospitalisation, provide this information before admission.
- Ensure community service directories are accessible to staff and up-to-date, and encourage staff to use them.
- Develop links with the health service's liaison officer (the community liaison officer/GP liaison officer/discharge planner/care coordinator).
- Formalise the role of any community liaison personnel within each ward and unit, and ensure staff are aware of how and when to contact them.<sup>119</sup>
- Identify information needed to help staff communicate with community services.
- Educate hospital staff about the community services available in the region.
- Invite community service representatives to educate hospital staff about the services they provide and to establish networks.

## Evidence levels for communicating with community providers

Effects of communication with community services	Level
Good transition planning requires coordination and detailed, timely communication among providers. <sup>120</sup>	II
Good communication helps identify and meet patient needs, as well as avoid potential errors and adverse clinical events. <sup>121</sup>	I
A uniform approach to communicating with community providers is recommended. <sup>122</sup>	IV

*I = Evidence obtained from a systematic review of all relevant randomised controlled trials (RCTs)*

*II = Evidence obtained from at least one properly designed RCT*

*IV = Opinions of respected authorities, based on clinical experience, descriptive studies or reports of expert committees*

## 2.7 Good practice in communicating with carers

Successful patient transition from hospital requires ‘open, honest, continuous and timely communication among health care professionals and between health care professionals, patients and their carers’.<sup>123</sup> Failure to include carers and family members in transition planning can place patients (particularly older persons) at risk of readmission,<sup>124,125</sup> yet this exclusion often occurs.

The post-hospitalisation period can be a time of escalating responsibilities for carers, when they often put their lives on hold to attend to care giving.<sup>126</sup> It may mean having to quit or cut back on work, studies, social or community activities. Time with and care of other family members may also be sacrificed to meet patient care needs. These strains, combined with practical and emotional care responsibilities can place considerable burden on the carer’s own physical and emotional wellbeing.<sup>127</sup>

Hospital admission can be a difficult time for a carer because it often heralds a change in the patient’s condition and care needs.<sup>128</sup> It may mean that:

- a family member is unexpectedly thrust into the caring role as the result of an accident or major event, such as stroke or heart attack
- the carer’s role changes from short term to ongoing,
- the carer faces additional care giving responsibilities, particularly if the patient’s condition has deteriorated,
- the carer feels unable to manage an extra burden of care, if exhausted after many years of caring or is themselves in poor health,
- the carer needs to adjust their role, if the patient requires residential care or palliative care.

*“We cannot separate the health of the individual from the health of the family, the community, the world.”*

*Patch Adams*

Choices in taking on these new or additional care responsibilities are infrequently discussed with carers by hospital staff.<sup>129</sup>

Health professionals, patients and their carers often have different expectations of a patient’s health status and self-care during and following hospitalisation.<sup>130</sup> These differences can arise because during hospitalisation patients and carers receive different information about the care requirements, or because the carer is not recognised, involved or provided with adequate information.<sup>131,132</sup>

### Carers need information and support to help them care

To manage the post-hospital period, carers need to be well informed, be provided with choice and supported in ways appropriate to their particular circumstances. Carers manage most effectively when they feel competent and in control.

The provision of information, education and ongoing communication (including post-hospital nursing visits) can facilitate carers’ skills and confidence.<sup>133</sup> These interventions can help carers accept assistance, feel less vulnerable about their decision-making and be more able to undertake the caring role.

A transition plan should identify who is the patient's main carer and consider the carer's ability to provide ongoing care. The carer needs time to consider how much and what type of care they can provide. The carer may have personal issues, such as poor health, a strained relationship with the patient or difficulty in finding the time to provide care. Such strains can be heightened for carers of older patients who have functional and cognitive impairment.<sup>134</sup> The carers' willingness, availability and ability to provide post-hospital care should not be assumed. These can change, so must be reviewed with each admission.

Carers Victoria gives the following advice about carer involvement in transition planning.<sup>135</sup>

*“The hospital needs to recognise and engage the carer at the time of the patient's admission. Hospital staff need to identify whether the patient has a carer (and who that person is) or needs a carer (and who that is likely to be). Be aware that carers may not view themselves as carers but as partners, parents, sons, daughters, friends etc, nor live with the patient.”*

### What carers need

- Carers require meaningful involvement in the patient's care, from the admission assessment through to transition planning.<sup>136,137</sup> This involvement should be based on a partnership approach and may include:
  - contributing information about preadmission care arrangements and how they were managing (that is, whether they required further help).
  - helping health professionals to understand the patient's pre-admission health status and self-care ability and progress/deterioration during the hospital stay.
  - considering the carer's individual needs and specific circumstances, including cultural, religious, geographic, health and age.
  - exploring options with the multidisciplinary team for the patient's care post-hospitalisation, including family members and formal services.
- Carers need timely preparation for the patient leaving the hospital. They may need:
  - training in care management, including safety, medication and use of equipment, and behaviour management.
  - information and understanding about the carer experience, in particular grief and loss and self care strategies
  - information about community, residential and carer services and the assistance that these can provide.
- Carers need an estimated discharge date and time so they can make arrangements to be available, for example, arranging time off work.
- Staff need to ensure that health and practical assistance is in place before discharge occurs

*“Discharge checklist ensures all requirements for discharge occur especially to support patients/carers in the community.”*  
CEO Metro Hospital, EDS Review

### What the hospital should provide

Providing carers with the following information at admission helps them understand the hospital system and be more involved in transition planning

- written and verbal information about the hospital and the discharge process when the patient is admitted
- Such information may include car parking, accommodation close to the hospital, meals and meal times, visiting hours, counselling services, the location of the social work department, transport availability, and contact names and numbers for the discharge co-ordinator and other members of the health team (including the medical officer, the nurse and allied health personnel).
- Copies of the patient rights and responsibility brochures and information relating to the complaints mechanisms.

Providing carers with the following information helps them manage post-hospital care:<sup>138,139,140,141,142,143,144,145,146</sup>

- the patient's medical condition and possible complications
- the expected recovery time
- the treatment plan
- the patient's dietary requirements
- the patient's mobility and activity restrictions
- instruction on medication, including the possible side-effects and administration techniques
- strategies to assist the patient to adhere to treatment regimes, how to manage and difficult behaviours arising from cognitive or psychological factors associated with the illness
- how to recognise signs of complications and emergency numbers to contact
- how and when to use equipment and aids; where to access these and subsidies available if not provided by the hospital
- what to expect in terms of general practitioner (GP) involvement and specialist follow-up.
- patient appointments
- community services referrals (including contact names and numbers, the types of service and the commencement dates).
- names of organisations and services that may be useful (such as condition specific organisations, Carers Victoria, support groups, respite services).

The provision of new information needs to be in formats and language appropriate to different patient and carer groups. Information, either written or verbal, needs to be timely, repeated and checked out to ensure patients and carers understand that information. Follow-up education and discussion about ongoing care are essential in helping patients and carers learn. One suggestion is that the education provided to cardiac surgery patients the day before leaving hospital could include a class for family/carer and patients.<sup>147</sup> The class could provide the patient and family/carer with education materials and emergency/non-emergency contact numbers. It should include adequate opportunity for general discussion and questions. Post discharge home visits and community appointments can also effectively clarify and reinforce earlier information to patients and carers.

Involving patients and carers in decision-making facilitates positive results. Participation in decision-making enables the patient and their carer to have a sense of control, which decreases their psychological distress and increases their confidence in hospital and community services.<sup>148</sup> This involvement is particularly important in transition planning for a patient moving to an aged care residential facility. Changes in living and care giving arrangements can have far reaching effects on the patient, their carer and extended families. Significant grief and loss issues may need to be addressed. However, change in health status often creates an ideal opportunity for hospitals to discuss and re-assess a patient's circumstances which can include visiting the patient's home, reviewing carer arrangements, visiting a new residential facility.

*“Patient and family/carer member satisfaction with traditional discharge planning has consistently been linked with their degree of involvement in the decision making process; increased involvement resulted in enhanced satisfaction...family caregivers who were more involved in this process also reported better health and were more accepting of the caregiver role.”<sup>149</sup>*

## **The role of patients and carers in program and practice development**

As yet, few health services have developed effective working partnerships with patients and family/carers or delegated control to them to enable shared decision making.<sup>150</sup> Hospitals invite patient and carer feedback and participation in project implementation, but they rarely involve patients and carers as active participants in problem solving and project development.<sup>151</sup>

## Helping carers to manage post transition

To decrease the burden of care and maintain the carer's wellbeing, the hospital may need to provide (or facilitate the provision of) the following:<sup>152</sup>

- help with problem solving
- preparation for the care giving role through education, information and support groups
- counselling or support to address grief and loss and other personal or relationship changes
- advice on maintaining the carer's good health
- regular time out for the carer, including day and overnight respite if required.
- Information about Centrelink carer entitlements or other avenues of financial assistance to manage care related costs

## Getting patient and carer feedback

Hospitals can learn about the effectiveness of their transition planning by obtaining patient and carer feedback on the quality of discharge processes in the acute hospital setting. They can use this information to give feedback to staff (particularly positive reinforcement of activities that meet patient and carer needs) and identify how to improve patient and carer transition. Most hospitals use patient and carer satisfaction surveys that provide either unit-specific feedback or organisational feedback. The Victorian Patient Satisfaction Monitor provides the latter and allows for comparison with the results of similar health services.

The P.R.E.P.A.R.E.D tool (see Attachment 1) offers a comprehensive way of completing the quality cycle. The tool can be copied from this guide, however, if is to be utilised in a research capacity or as an ongoing measurement, it is advised that contact is made with the University of South Australia (see reference) to clarify the statistical implications. The tool has identified four domains in which hospitals may improve their processes:<sup>153</sup>

- information exchange (regarding community services and equipment)
- medication management
- preparation for coping after hospitalisation
- control of the transition circumstances.

## Helpful resources for patients and carers

- The services and Internet sites that provide carer-specific information and support include:
- Carers Australia ([www.carers.asn.au/](http://www.carers.asn.au/))
- Carers Victoria ([www.carersvic.org.au/](http://www.carersvic.org.au/) , or Freecall 1800 242 636)
- Carer Services (of the Rural and Regional Health and Aged Care Division, Department of Human Services) ([www.dhs.vic.gov.au/rrhacs/index.htm](http://www.dhs.vic.gov.au/rrhacs/index.htm))
- Carer Respite and Support Services – regionally across Victoria (<http://vcsn.infoxchange.net.au/> , or Freecall 1800 059 059)
- Carer Support (a disability service) ([www.advocacyhouse.org/vicnord/about.html](http://www.advocacyhouse.org/vicnord/about.html))
- National Resource Centre for Consumer Participation in Health ([www.participateinhealth.org.au/about\\_us/how\\_we\\_work.htm](http://www.participateinhealth.org.au/about_us/how_we_work.htm))
- Health Insite ([www.healthinsite.gov.au/](http://www.healthinsite.gov.au/))

*“We now know more about our patients socially are able to help them cope with problems that could be worrying them about going home.”*

*DON Rural Hospital, EDS Review.*

A key resource for carers and hospital staff is the statewide Commonwealth funded Carer Resource Centre auspiced by Carers Victoria. The centre provides written information for carers on a range of topics in English and community languages and can provide ward staff with sample discharge kits. Assistance to carers and staff is also provided through the Freecall line, educational programs and carer counselling.

Another useful resource for hospitals and carers is the National Resource Centre for Patient and Carer Participation in Health. This is a Commonwealth funded centre that acts as a clearinghouse for information about methods and models of community and patient feedback and participation, including examples of good practice.

Regarding patient and carer feedback and participation, the centre identifies emerging issues, informs and influences policy and practices, and supports the implementation of effective processes within the health sector.<sup>154</sup>

## Carer Checklists

Checklists are a useful tool that hospital staff can use to ensure that all required areas have been covered. Carers Victoria has developed a checklist for health providers to use when planning for discharge (Attachment 2).

Similarly, hospital staff can use the following checklist when communicating with carers.

## Communication checklist

- Determine the carer's preferred language.
- Decide whether an accredited signer or interpreter is necessary.
- Check whether a medical condition is complicating poor English proficiency.
- Allow time and encourage the carer to tell you about any issues, needs or problems they may be experiencing.
- Check whether the carer and family members understand what is causing the patient's health problem.
- Check whether the carer is aware of the patient's health care priorities.
- Ask the carer and other family members about the level of involvement they would like.
- Search for any other support networks that may be available to the carer (for example, religious networks, friends, community organisations, self-help groups).
- Check that the carer understands the diagnosis, the reason for particular treatments and how to perform or use treatments. Use plain language and avoid medical jargon as terms familiar to hospital staff may be confusing or misattributed by families. Ask the carer to explain in their own words (via the interpreter if necessary) or show you how a treatment works,.
- Check whether the carer is using any alternative treatments.
- Check whether the carer understands what and why follow-up is required.
- Give the carer and family members an opportunity to ask questions.
- Confirm that you and the carer have a shared understanding of the problem and the plan of action.
- Confirm that the carer agrees with the plan of action.

*Source: Adapted from [www.health.qld.gov.au](http://www.health.qld.gov.au)*

## When the patient consents to sharing information with the carer—further tips

- Create a ward environment that is welcoming and supportive of carers and family members
- Help the carer communicate with the treatment team. Invite them to be present at the patient's medical review or arrange a consultation with the medical officer.
- Involve the carer in the transition planning through facilitated meetings between the health care team, the patient and the carer. Utilise the EPC Medicare items to include both GPs and carers in discharge case conferencing and planning
- Follow up patients and carers after hospitalisation (see Section 2.8).
- Consider providing education and networking for carers of specific patient groups.
- Review the hospital's approach to patient and carer communication, for example, the use of written and verbal communication tools and the post-hospital follow-up call.<sup>155</sup>
- Standardise information packages, using best practice templates.
- Work with other health services to share resources for communicating with carers.
- Facilitate the translation of information packages in languages other than English.
- Develop information sessions that prepare patients and their carers for the transition.

## Evidence levels for communicating with carers

Effects of communication with carers	Level of evidence
Successful patient transition from hospital requires 'open, honest, continuous and timely communication among health care professionals, and between health care professionals, patient and their carers'. <sup>156</sup>	II
Failure to include carers and family members in transition planning can place patients (particularly older persons) at risk of readmission. <sup>157</sup>	III-2
The provision of information, education and ongoing communication (including post-hospital nursing visits) can facilitate a carer's confidence. <sup>158</sup>	III
Providing carers with information helps them manage post-hospital care. <sup>159</sup>	II
Participation in decision-making enables the patient and their carer to have a sense of control, which decreases their psychological distress and increases their confidence in hospital and community services. <sup>160</sup>	I
Education should be timely and provided in writing (for example, written information on the resumption of normal activity, diet, medication, exercise, follow-up arrangements and emergency contacts). <sup>161</sup>	II

*I = Evidence obtained from a systematic review of all relevant randomised controlled trials (RCTs)*

*II = Evidence obtained from at least one properly designed RCT*

*III-1 = Evidence obtained from well designed controlled trials without randomisation*

*III-2 = Evidence obtained from well designed cohort or case control analytic studies, preferably from more than one centre or research group*



**PREPARED**

CAREER DEVELOPMENT SURVEY

PAGE 2

**WE ARE INTERESTED IN HOW MUCH INFORMATION YOU RECEIVED IN HOSPITAL TO PREPARE YOU FOR COPING AT HOME WITH THE PATIENT**

**SECTION II: WHILE THE PATIENT WAS IN HOSPITAL:-**

- |   |  |   |  |
|---|--|---|--|
| 1 | How much information did <b>you</b> receive about what medications were to be taken home by the patient?<br><i>Please tick only one box</i>  | As much as I needed<br>Some, but not enough<br>None<br>Patient is not taking <b>any</b> medications | <input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/> |
| 2 | How much information did <b>you</b> receive about the side-effects of the medications to be taken home by the patient?<br><i>Please tick only one box</i>  | As much as I needed<br>Some, but not enough<br>None<br>Patient is not taking <b>any</b> medications | <input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/> |
| 3 | How much information did <b>you</b> receive on how <b>you</b> would manage the patient with personal care? <i>(i.e. how you would help the patient with personal care, bathing, dressing, toileting, feeding, walking, transportation etc)</i> <i>Please tick only one box</i> | As much as I needed<br>Some, but not enough<br>None   | <input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/>                             |
| 4 | How much information did <b>you</b> receive about <b>community health services</b> the patient might use at home? <i>(e.g. Domestic Care, District Nurse, Meals on Wheels etc)</i> <i>Please tick only one box</i>   | As much as I needed<br>Some, but not enough<br>None<br>Patient does not need any services           | <input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/> |
| 5 | How much information did <b>you</b> receive on any <b>equipment</b> the patient might use at home? <i>(e.g. rails, shower chair, walking aids etc)</i> <i>Please tick only one box</i>   | As much as I needed<br>Some, but not enough<br>None<br>Patient does not need any equipment          | <input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/> |

6 Comments: Would you like to add anything to your answers on this page?  
.....  
.....

**Instrument Authors**  
Dr Karen Grimmer  
Centre for Health Research, University of South Australia  
Telephone: (08) 8302 2769 Facsimile: (08) 8302 2769  
Email: Karen.Grimmer@unisa.edu.au



Mr John Moor  
Department Public Health  
Adelaide University (operating through Lambert Pty. Ltd.)  
Telephone: (08) 8305 4600 Facsimile: (08) 8323 4075  
Email: john.moor@adelaide.edu.au

**PREPARED**

CARE QUESTIONNAIRE

PAGE 4

**SECTION III:  
BEFORE THE PATIENT WAS DISCHARGED FROM HOSPITAL:-**

**1** Did anyone arrange community health services for the patient? (e.g. Domestic Care, District Nurse, Meals on Wheels etc) Yes   
No   
No-one needed to:-   
*Please tick only one box* Services were already in place   
No-one needed to:   
No services needed

If YES, have community services commenced yet? Yes   
No

**2** Did anyone arrange any equipment for the patient? Yes   
No   
No-one needed to:-   
*Please tick only one box* Equipment already in place   
No-one needed to:   
No equipment needed

If YES, do they have this equipment? Yes   
No

**3** Did anyone talk to you about how you would manage your usual duties while caring for the patient? (e.g. shopping, showering, bathing, dressing, milking, feeding, mobility, transportation) Yes   
No   
*Please tick one box only*

Please tell us more about this  
 .....  
 .....  
 .....

**4** Comments: Would you like to add anything to your answers on this page?  
 .....  
 .....  
 .....

**Instrument Authors**  
 Dr Karen Grimmer  
 Centre for Allied Health Research, University of South Australia  
 Telephone: (08) 8302 2769 Facsimile: (08) 8302 2709  
 Email: Karen.Grimmer@unisa.edu.au



Mr John Moss  
 Department Public Health  
 Adelaide University (operating through Linnell Pty. Ltd.)  
 Telephone: (08) 8309 4620 Facsimile: (08) 8329 4076  
 Email: john.moss@adelaide.edu.au

**PREPARED**

CAREERQUESTIONS.009

PAGE 7

**SECTION IV:  
AFTER THE PATIENT WAS TOLD HE/SHE COULD LEAVE HOSPITAL:**

- 1 How confident did **you** feel about managing at home? Very confident   
*Please tick only one box* Not very confidence   
Not at all confident

Please tell us more about this

.....

.....

.....

- 2 Were there any delays? Yes   
*Please tick* No

- 3 If YES, what were the delays? Transport   
*Please tick as many as you wish* Medications   
Don't know   
Other

4 Comments: Would you like to add anything to your answers on this section?

.....

.....

.....

**SECTION V:  
NOW THE PATIENT HAS BEEN OUT OF HOSPITAL A WHILE:-**

- 1 Do **you** have any health problems which make it harder Yes   
for **you** to look after the patient? No   
*Please tick*

Please tell us more about this

.....

.....

.....

**Instrument Authors**

Dr Karen Grimmer  
Centre for Allied Health Research | University of South Australia  
Telephone: (08) 8302 2769 Fax: (08) 8302 2769  
Email: Karen.Grimmer@unisa.edu.au



Mr John Moss  
Department Public Health  
Flinders University (operating through Lumina Pty. Ltd.)  
Telephone: (08) 8303 4620 Facsimile: (08) 8323 4075  
Email: john.moss@flinders.edu.au

draft

**PREPARED**

CARE OF ESTIMABLE

PAGE 7

**SECTION V: (continued)  
NOW THE PATIENT HAS BEEN OUT OF HOSPITAL A WHILE:-**

2 Has anything been worrying **you** about managing the patient at home? Yes   
*Please tick* No

Please tell us more about this

.....

.....

.....

3 Has anything been done to deal with your worries? Yes   
*Please tick* No

Please tell us more about this

.....

.....

.....

3 Have any unexpected problems occurred since the patient left hospital to make **you** feel less confident about managing? Yes   
*Please tick* No

Please tell us more about this

.....

.....

.....

4 If the patient has already received community services, are **you** satisfied with the help **you** received from these services? Yes   
*Please tick* No

Please tell us more about this

.....

.....

.....

5 If equipment was provided for the patient, did it make things easier for **you**? Yes   
*Please tick* No

Please tell us more about this

.....

.....

.....

draft

**Instrument Authors**  
 Dr Karen Grimmer  
 Centre for Allied Health Research - University of South Australia  
 Telephone: (08) 8302 2769 Facsimile: (08) 8302 2769  
 Email: Karen.Grimmer@unisa.edu.au



**Dr John Moss**  
 Department Public Health  
 Adelaide University (operating through Laminex Pty. Ltd.)  
 Telephone: (08) 8303 4620 Facsimile: (08) 8225 4075  
 Email: j.moss@hde.adelaide.edu.au

**PREPARED**

CAREER DEVELOPMENT

PAGE 8

**SECTION VI:  
IN THE FIRST SEVEN DAYS AFTER THE PATIENT LEFT HOSPITAL:-**

**1** Did **your** health suffer so that **you** had to see any of the following people **more often** than usual? *(Please put the number of times on each line)*

Your local doctor	_____	Your specialist doctor	_____
Physiotherapist	_____	Chemist	_____
Occupational Therapist	_____	Meals on Wheels	_____
Domiciliary Care	_____	Other health professionals	_____
District Nurse	_____	Any other people who have helped you	_____
Hospital outpatient/ Emergency clinic	_____	<i>Please write who they were on the line below</i>	_____

**3** Have **you** had to spend any extra money as a result of the patient's visit to hospital? *(such as taxi fares, petrol etc)* Yes   
No   
*Please tick*

If so, what are these costs approximately?

Taxi fares	\$ _____	Petrol	\$ _____
Extra shopping	\$ _____	Gap payments for health services	\$ _____
Extra chemist costs	\$ _____	Private Health Services	\$ _____
Other	_____	<i>Please write what it was on the line below</i>	_____

**4** Have **you** had to use any extra electricity as a result of looking after the patient? Yes   
No   
*Please tick*

If **YES**, what have you used it for?

.....  
.....

**Interview Authors**

Dr Karen Grimmer  
Centre for Allied Health Research, University of South Australia  
Telephone: (08) 8332 2768 Fax: (08) 8332 2769  
Email: Karen.Grimmer@unisa.edu.au



Mr John Moss  
Department Public Health  
Adelaide University (operating through Lancelot Pty. Ltd.)  
Telephone: (08) 8332 4620 Fax: (08) 8332 4275  
Email: john.moss@adelaide.edu.au

**PREPARED**  
CORE QUESTIONNAIRE

PAGE 18

**SECTION VII: LOOKING BACK TO THE TIME YOU LEFT HOSPITAL:**

- 1 Overall, how prepared did you feel for caring for the patient at home? Totally prepared   
*Please tick* Could have been better prepared   
Unprepared
2. Were there any particular aspects of the patient's preparation for discharge whilst in hospital, that **you** would like to further comment on?

.....

.....

.....

.....

.....

**SECTION VII:  
LOOKING BACK TO THE TIME YOU LEFT HOSPITAL:**

3. Were there any particular aspects of the patient's care after leaving hospital, that you would like to further comment on?

.....

.....

.....

.....

.....

.....

There is also space for you to write on the back of this page if you require

**THANK YOU FOR TAKING THE  
TIME TO COMPLETE THIS QUESTIONNAIRE  
PLEASE PUT IT IN THE ENVELOPE PROVIDED**

## Attachment 2: Carers Victoria discharge check list



### Remembering Carers in Discharge- Some prompts

A **Carer** is 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

*Have you identified if the patient is a carer, has a family carer or will need one on discharge?*

*If the patient is a carer, -*

Have you discussed whether

- the person(s) they care for has adequate alternative care arrangements while the carer is in hospital
- they have any concerns about how they will manage their care responsibilities on discharge and what impacts these may have on their recovery
- additional supports may be required to support their caring responsibilities and recovery on discharge

*If the patient has/will have a carer, -*

Have you talked/discussed with the carer about?

- How confident and able they feel about their caring responsibilities after discharge?
- Their own health, emotional concerns or other issues that arise from or affect their caring (eg poor health; work or other family commitments; grief reactions, stress or intimacy issues)
- the supports they may need from other family members or services after discharge (eg respite, carer education, assistance with household tasks, equipment)
- discharge arrangements with the carer (date, time, transport) and given 24hr notice about discharge

**Have you provided the carer with**

- Service information and made referred (eg regional carer service) to address carer support needs
- Plain language information to the carer about the patients illness, prognosis, treatments, medication and care management
- Contact name and 24 hr contact number to carer if they have worries post discharge
- A follow-up date when they will be contacted to see how they are managing and services working out

\\Svr001pd\c\DataPublic\Carer Representation\Education&Training&Community Development\Discharge check list 1.do

## 2.8 Good practice in telephone follow-up

The transition from an acute hospital to the community can be a difficult time for patients and their carers. Back in the community, patients may feel confused about the information they have received. They may not know, for example, how to manage their medication and equipment, or how to contact the community services they will be using. Further, if their social circumstances have changed, then patients may need more assistance than that arranged while they were in hospital. For all these reasons, a telephone call from the hospital can help a patient by providing reassurance, information and service referral.

### Telephone follow-up is important for patients and the hospital

Patients and carers are receptive to being telephoned after hospitalisation and it completes the episode of care.<sup>162</sup> Telephone follow-up:

- provides feedback to clinicians about patient and carer's progress.<sup>163</sup>
- gives patients an opportunity to resolve their post-transition issues.<sup>164,165</sup> Patients are unlikely to contact the hospital for information they need after leaving hospital.<sup>166</sup>
- increases the number of patients who keep outpatient appointments and follow their discharge instructions.<sup>167,168</sup>
- can reduce the readmission rate and the cost of care.<sup>169,170</sup>
- is quick, cheap and effective.<sup>171</sup>

Follow-up calls may involve a discussion of the following issues and interventions.<sup>172,173,174,175</sup>

#### Issues include:

- health/social/financial problems
- safety and medication
- difficulty in accepting a changed health status.

#### Interventions include:

- guidance and support
- instructions
- referral to a general practitioner (GP) or other health professional
- education.

## Identifying patients for follow-up

Hospital staff have conducted both formal and informal telephone follow-up for many years. Telephone follow-up is part of routine care for day surgery patients in Victorian public hospitals but not for all patients going home. Studies have examined the benefit of follow-up calls to patient groups who received either a specialist service (such as ophthalmology or cardiology) or accident and emergency services, and to vulnerable patients (patients over the age of 75 years). Hospitals should identify which patient and carer groups would most benefit from telephone follow-up.

### Tips for a telephone follow-up

- Determine which patients need follow-up. Patient groups that may benefit include:
  - all patients who have a positive risk screen for discharge and/or
  - all patients who have a negative risk screen and are unlikely to receive post-transitional services and/or
  - patients who receive case management (such as post acute care or midwifery visits).
- Determine who should telephone the patient post hospitalisation: a ‘named nurse’, pharmacist, social worker, medical officer, allied health professional or administrative staff. The team members can make this decision.
- Provide staff with special telephone skills/training (or identify a staff member who already has the skills) for communicating with patients who have hearing deficits, mental illness or memory disorders.<sup>176</sup> The specially trained staff can then follow up these patient types.
- Develop an interview tool (see examples from Beechworth Hospital or The Alfred).
- The tool should contain the patient’s name, unique identifier and telephone number, the preferred call time, questions to ask, any requirements (such as interpreting services) and an area for recording responses and referral details.
- Some tools also collect audit information (for example, the number of calls to the patient before getting a response).
- Before the patient leaves the hospital:
  - obtain the patient’s/carer’s consent for the follow-up call
  - ask them to nominate a call time
  - check that their telephone details are correct<sup>177</sup>
  - check their language skills and record any special needs for the telephone follow-up.
- Ensure translation and interpreter services are available for calls to patients from a non-English speaking background.<sup>178</sup>

## Good practice example 2.8A

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

#### 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.

Actions from the call are documented and the hospital takes all care to maintain confidentiality when contacting patients.

The ward staff audit the data sheets each month for feedback.

For further information see: Appendix A

## Good practice example 2.8B

### Post-discharge telephone calls improve patient satisfaction

#### East Grampians Health Service

All patients going home from East Grampians Health Service, Ararat Base receive a telephone call to assess whether their post-hospital needs are being met. The hospital routinely includes information from the call in the patient's medical record and the nurse follows up any issues from the call.

The hospital developed and trialed the follow-up process in 1998 then expanded its use across the health service network in 2000.

For further information see: Appendix A

## Good practice example 2.8C

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

#### Otway Health and Community Services

Key results:

- Increased patient, GP and staff satisfaction
- Increased patient compliance with treatment plans
- Reduction in unplanned readmissions

All patients going home from Otway Health and Community Services receive a follow-up call within one to five days of leaving hospital. The call addresses post-discharge issues and patient satisfaction.

The hospital immediately follows up all issues and these are documented on the patient's clinical pathway form.

For further information: see Appendix A

### Evidence levels for telephone follow-up

Effect of telephone follow-up	Level of evidence
-------------------------------	-------------------

Telephone calls are a low-cost, effective intervention that has the potential to reduce the readmission rate. <sup>179</sup>	II
--	----

*II = Evidence obtained from at least one properly designed randomised controlled trial (RCT)*

## Attachment 1: Example of telephone follow-up. The Alfred 'Patient call back data sheet'

<b>THE ALFRED Patient Call Back Data Sheet</b>		U.K. <input style="width: 50px;" type="text"/>
Diagnosis : _____		<b>Surname</b> <input style="width: 90%;" type="text"/>
Discharge date: _____ Discharging ward: _____		<b>Given Names</b> <input style="width: 90%;" type="text"/>
Unit: _____ Nurse to make call: _____		<input style="width: 90%;" type="text"/>
<b>Patients discharged home</b> (including hostel, SRS etc) <b>should be called if</b> : 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: _____		
<b>OR: Patient does not need to be called for one of the following reasons</b> : 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 &amp; 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>		
<b>Status of Call</b> : 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		
<b>Questions relating to Health status of the patient</b>		
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: _____		
<b>Questions evaluating the effectiveness of The Alfred's discharge planning</b>		
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: _____		
<b>No action required</b> : <input type="checkbox"/>		
<b>Action required</b> :		
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 : _____		
_____		
<b>Other comments</b> :    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 Record Copy



## References section two

- 1 Nicklin, J. 2002 Improving the quality of written information for patients. *Nursing Standard* 2002; 16 (46): 39–44.
- 2 Rifas E, Morris R, Grady R. Innovative approach to patient education. *Nursing Outlook* 1994; 42 (5): 214–16.
- 3 Nelson E, McHugo G, Schnurr P, Devito C, Roberts E, Simmons J, Zubkoff W. Medical self-care education for elders: a controlled trial to evaluate impact. *Amer J Public Health* 1984; 74 (12): 1357–62.
- 4 Rich M, Beckham V, Wittenberg C, Leven CL, Freedland KE, Carney RM. A multidisciplinary intervention to prevent the readmission of elderly patients with congestive heart failure. *New England J Med* 1995; 333 (18): 1190–5.
- 5 Wilson S, German D, Lulla S, Hughes GW, Coss S. A controlled trial of two forms of self-management education for adults with asthma. *Amer J Med* 1993; 94: 564–75.
- 6 Audit Commission. What Seems to be the matter? Communication between hospital and patients. London: HMSO, 1993.
- 7 Cravener, P. Principles of adult health education. *Gastroenterology Nursing*. 1996; 19 (4): 140-145.
- 8 Basa R, McCleod B. Evaluation of a diabetes speciality centre: structure, process and outcome. *Patient Education and Counselling* 1995; 25: 23–9.
- 9 Roach J, Tremblay L, Bowers D. A perioperative assessment and education program: implementation and outcomes. *Patient Education and Counselling* 1995; 25: 83–8.
- 10 Hjelm-Karlsson K, Effects of information to patients undergoing intravenous pyelography: an intervention study. *J Advanced Nursing* 1989; 14: 853–62.
- 11 <http://patientcharter.health.vic.gov.au/patients.htm>
- 12 Merriman B, Ades T, Seffrin J. *CAA Cancer J for Clinicians* (journal of the American Cancer Society) 2002; 52: 130–3.
- 13 Department of Human Services, Victoria. Communicating with consumers: a good practice guide to providing information. Melbourne: 2001. [www.health.vic.gov.au/consumer](http://www.health.vic.gov.au/consumer)
- 14 Estey A, Musseau A, Keehn L. Comprehension levels of patients reading health information. *Patient Education and Counselling* 1991; 18: 165–9.
- 15 Petterson T. How readable are the hospital information leaflets available to the elderly? *Age and Ageing* 1994; 23 (1): 14–16.
- 16 Nicklin. op. cit.
- 17 Department of Human Services. op. cit.
- 18 Johnson A, Silburn K. Community and consumer participation in Australian health services—an overview of organisational commitment and participation processes. *Aust Health Rev* 2000; 23 (3): 113–21.
- 19 Wilson, German, Lulla, Hughes, Coss. op. cit
- 20 Ralieggh EH, Lepczyk M, Rowley C. Significant others benefit from pre-operative education. *J Advanced Nursing* 1990; 15: 941–5.
- 21 Sutcliffe A, Potter A. Multidisciplinary pre-admission clinics for orthopaedic patients. *Nursing Standard* 2002; 16 (21): 39–42.
- 22 Moyer CA, Stern, DT, Dobias KS, Cox DT, Datz SJ. Bridging the electronic divide: patient and provider perspective on email communication in primary care. *Amer J Managed Care* 2002; 8 (5): 427–33.
- 23 Ibid.
- 24 Forster A, Smith J, Young J, Knapp P, House A, Wright J. Information provision of stroke patients and their caregivers. In: *The Cochrane Database of Systematic Review*. Adelaide: Cochrane Library, Flinders University, 2003.
- 25 Ibid.

- 26 University of York. NHS Centre for Reviews and Dissemination Informing, communicating and sharing decisions with people who have cancer. *Effective Health Care* 2000; 6 (6). 8.
- 27 Forster A, Smith J, Young J, Knapp P, House A, Wright J. 2003. op cit.
- 28 Ibid
- 29 University of York. op. cit.
- 30 NHS Centre for Reviews and Dissemination. Informing, communicating and sharing decisions with people who have cancer. York: NHS Centre for Reviews and Dissemination. 2000: 8. (NHSCRD)
- 31 Op cit.
- 32 Op cit.
- 33 Estey A, Musseau A, Keehn L. Comprehension levels of patients reading health information. *Patient Education and Counselling* 1991; 18: 165–9
- 34 Rifas E, Morris R, Grady R. Innovative approach to patient education. *Nursing Outlook* 1994; 42 (5): 214–16.
- 35 Nicklin, J. 2002 op. cit
- 36 Thomas and Associates. Final report of the development of a risk screening tool for service needs following discharge from acute care project. Melbourne: Department of Human Services Victoria, Victoria, 1998.
- 37 Waters K. Discharge planning: an exploratory study of the process of discharge planning on geriatric wards. *J Advanced Nursing* 1987; 12: 71–83.
- 38 Department of Human Services, Victoria. Effective Discharge Strategy. Background paper: a framework for effective discharge. Melbourne: 1998.
- 39 Information about the suite of tools and their implementation appears at the primary care partnerships website: <http://hnb.dhs.vic.gov.au/rhacs/phkb/phkb.nsf/headingpagesdisplay/home>.
- 40 Grimmer K, Falco J, Moss J, Kumar S. Independent community living after discharge from hospital. Adelaide: Aging and Department of Human Services, South Australia; Centre for Allied Health Research, University of South Australia; and Department of Public Health, University of Adelaide, 2002.
- 41 ibid
- 42 Simpson P. Clinical outcomes in transition program for older adults with hip fracture. *Outcomes Management* 2002; 6 (2): 86–92.
- 43 Wammack, Mabrey. op. cit
- 44 Wammack, Mabrey. op. cit.
- 45 Renholm M, Leino-Kilpi H, Suominen T. Critical pathways: a systematic review. *J Nursing Admin* 2002; 32 (4): 196–202.
- 46 Simpson. op. cit.
- 47 Keetch D, Buback D. A clinical care pathway for decreasing hospital stay after radical prostatectomy. *Brit J Urology* 1998; 81 (3): 398–402.
- 48 Tahan H. A ten-step process to develop case management plans. *Lippincott's Case Management* 2002;7(6):231–42.
- 49 Ibarra V. Spine update: clinical pathways. *Spine* 1997;22:352–7.
- 50 Johnson K, Blaisdell C, Walker A, Eggleston P. Effectiveness of a clinical pathway for inpatient asthma management. *Pediatrics* 2000; 106 (5): 1006–12.
- 51 Wammack, Mabrey. op. cit.
- 52 Guiliano H, Poirer C. Nursing case management: critical pathways to desirable outcomes. *Nursing Management* 1991; 22 (3): 52–5.
- 53 Parker C. Patient pathways as a tool for empowering patients. *Nursing Case Management* 1999; 4 (2): 77–81.

- 54 Wammack L, Mabrey J. Outcome assessment of total hip and total knee arthroplasty: critical pathways, variance analysis and continuous quality improvement. *Clin Nurse Specialist* 1998; 12 (3): 122-9.
- 55 Benson L, Bowes J, Cheesebro K, Stasa C, Horst T, Blyskal S, et al. Using variance to track to improve outcomes and reduce costs. *Dimensions of Critical Care Nursing* 2001; 20 (2): 34-42.
- 56 Wentworth D, Atkinson R. Implementation of an acute stroke program decreases hospitalisation costs and length of stay. *Stroke* 1996; 27 (6): 1040-3.
- 57 Phillips K, Crain H. Effectiveness of a pneumonia clinical pathway: quality and financial outcomes. *Outcomes Management for Nursing Prac* 1998; 2 (1): 16-23.
- 58 Tahan. op. cit.
- 59 Tahan. op. cit.
- 60 Goulbourn Valley Health. A framework for the design and management of clinical pathways at Goulbourn Valley Health
- 61 Wammack, Mabrey. op. cit
- 62 Simpson. op. cit.
- 63 Schneider JK, Hornberger S, Booker J, Davis A, Kralicek R. A medication discharge planning program: measuring the effect on readmissions *Clinical Nursing Research* 1993; 2 (1): 41-53
- 64 Australian Safety and Quality in Health care. Safe and Quality Council. Second National Report on Patient Safety, Improving Medication Safety. Canberra 2002
- 65 Dr Libby Roughhead, University of South Australia, The Nature and Extent of Drug Related Hospitalisation in Australia Report quoted in the media release "New Service Helps People take medicines safely, Senator Patterson March 2002. [www.senatorpatterson.webcentral.com.au](http://www.senatorpatterson.webcentral.com.au)
- 66 Vuong Tam. Interim Report, Implementation of Community Liaison Pharmacy Services within two major referral centres, College of Pharmacy, Melbourne.
- 67 National guidelines to achieve the continuum of quality use of medicines between hospital and community. Australian Pharmaceutical Advisory Council. Commonwealth Department of Health and Family Services, Canberra January 1998
- 68 Australian Safety and Quality in Health care. Op sit
- 69 Haynes RB, McDonald H, Garg AX, Montague Interventions for helping patients to follow prescriptions for medication. *The Cochrane Library*, Oxford Issue 4, 2002.
- 70 Ibid
- 71 Ibid.
- 72 Keuhl AD, Chrischillies EA, Sorofman BA. System for exchanging information among pharmacists in different practice environments. *J Amer Pharm Assoc* 1198; 28 (3): 317-324
- 73 Burns JM, Sneddon I, Lovell M, McLean A, Martin BJ. Elderly patients and their medication: a post discharge follow-up study. *Age & Ageing* 1992; 21: 178-81.
- 74 Hayned RB, MCDonald H, Garg Ax, Montague P. 2003, op. cit.
- 75 NSW Health Department. Shared responsibility for patient care between hospitals and the community. An effective discharge policy: setting the scene. Sydney: July 2001.
- 76 Centre for General Practice Integration Studies (School of Community Medicine, University of New South Wales). GP-hospital integration. What have we learnt? (Appendix 3). Sydney: UNSW Sydney White Paper, [www.commed.unsw.edu.au/cgpis](http://www.commed.unsw.edu.au/cgpis), 2001.
- 77 Editorial. E- health: evolving at a hospital near you. *Hospital and Healthcare* 2000; June:12-13.
- 78 Centre for General Practice Integration Studies. op. cit.
- 79 Wilson S, Warwick R, Chapman M, Miller R. General practitioner-hospital communications. A review of discharge summaries. *J Qual Clin Prac* 2001; 21: 104-8.
- 80 Centre for General Practice Integration Studies. op. cit.
- 81 Bull MJ. Managing the transition from hospital to home. *Qualitative Health Res* 1992; 2: 27-41.

- 82 Marshall MN. How well do general practitioners and hospital consultants work together? A qualitative study of cooperation and conflict within the medical profession. *Brit J Gen Prac* 1998; 48; 1379–82.
- 83 Centre for General Practice Integration Studies, School of Community Medicine, University of New South Wales. GP-Hospital Integration. What have we learnt? (Appendix 3) <http://www.commed.unsw.edu.au/cgpis> 76 *General Practice Hospital Integration Studies* 2001; 1379.
- 84 Balla J, Jamieson W. Improving the continuity of care between general practitioners and public hospitals. *Med J Aust* 1994; 161 (11-12): 656–9.
- 85 *Ibid.*
- 86 Bull MJ, Roberts J. Components of a proper hospital discharge for elders. *J Advanced Nursing* 2001; 35 (4); 571–81.
- 87 Clark A, Barbour R, McIntyre P. Preparing for change in the secondary prevention of coronary heart disease: a qualitative evaluation of cardiac rehabilitation within a region of Scotland. *Journal of Advanced Nursing* 2002; 39 (6): 589–98.
- 88 Ieraci S, Cunningham P, Talbot-Stern J, Walker S. Emergency medicine and ‘acute’ general practice: comparing apples with oranges. *Aust Health Rev* 2000; 23 (2): 152–61.
- 89 Bull, Roberts. *op. cit.*
- 90 Wilson, Warwick, Chapman, Miller. *op. cit.*
- 91 Isaac, Cunningham, Talbot-Stern, Walker. *op. cit.*
- 92 Hibberd P. The primary/secondary interface. Cross-boundary teamwork—missing link for seamless care? *J Clin Nursing* 1998; 7 (3): 276 of 274–82.
- 93 Bolton P. A review of the role of information technology in discharge communications in Australia. *Aust Health Review* 1999; 22 (3): 56–64.
- 94 *Ibid.*
- 95 *Ibid.*
- 96 Bolton P, Usher H, Mira M, Harding L. Information technology and general practice: a survey of general practitioners attitudes toward computerisation. *Aust Family Physician* 1999; 28 (1): 519–21.
- 97 Harris M, Powel Davies G. Integration between GPs, hospitals and community health services. In: *General practice in Australia*. Canberra: Department of Health and Aged Care, 2000.
- 98 Wilson, Warwick, Chapman, Miller. *op. cit.*
- 99 Centre for General Practice Integration Studies, School of Medicine, University of New South Wales, Division of General Practice Northern Tasmania Case study: GP–hospital electronic communication trial. Commonwealth Department of Health and Aged Care. Sydney. November, 2000; 37–40.
- 100 Bolton P, Usher H, Mira M, Harding L. 1999. *op. cit.*
- 101 [www.health.vic.gov.au/discharge/hosimp.htm](http://www.health.vic.gov.au/discharge/hosimp.htm)
- 102 Wilson, Warrick, Chapman, Miller. *op. cit.*
- 103 Kearney J. Removing the boundaries: hospital discharge practices and older people returning to the community. Melbourne: Council on the Ageing, 1994.
- 104 Naylor MD. Transitional care of older adults. *Settings for elder care. Annual Rev of Nursing Research* 2002; 20: 127–47.
- 105 Podesta JR, Watt RG. A quality assurance review of the patient referral process and user satisfaction of outpatient general anesthesia services for dental treatment. *Community Dental Health* 1996; 13: 228–31.
- 106 Shroeder RE, Morrison EE, Cavanagh C, West MP, Montgomery J. Improving communication among health professionals through education: a pilot study. *J Health Admin* 1999; 17: 175–98.
- 107 Cox S. Improving communication between care settings. *Professional Nurse* 2000; 15: 267–71.

- 108 Gandhi TK, Sittig DF, Franklin M, Sussman AJ, Fairchild DG, Bates DW. Communication breakdown in the outpatient referral process. *J General Internal Med* 2000; 15: 626–31.
- 109 Clark A, Barbour R, McIntyre P. Preparing for change in the secondary prevention of coronary heart disease: a qualitative evaluation of cardiac rehabilitation within a region of Scotland. *Journal of Advanced Nursing* 2002; 39 (6): 589–98.
- 110 Editorial. E-health—evolving at a hospital near you. *Hospital and Healthcare* 2000; June: 12–13.
- 111 Worth A, Tierney AJ, Macmillan MS, King C, Atkinson FI. A national survey of community nursing staff's experience relating to discharge of elder people following acute hospital care. Report on discharge of patients from hospital. Edinburgh, Scotland: Nursing Research Unit, Department of Nursing Studies, University of Edinburgh, 1993.
- 112 Anderson MA, Helms LB. Communication between continuing care organizations. *Res Nursing and Health* 1995;18:49–57.
- 113 Walsh N, Gough P. From profession to commodity. *Nursing Times* 1997; 93: 34–6.
- 114 Illman J. Telemedicine. *The Guardian (Education supplement)* 1996; 26 November: 8–9.
- 115 Cox. *op. cit.*
- 116 Clark, Barbour, McIntyre. *op. cit.*
- 117 Vaughan J. Good practice in earlier discharge. Sydney: Council of Social Service of New South Wales and NSW Health, 2002.
- 118 Department of Human Services, Victoria. A review of the Effective Discharge Strategy. Melbourne: 2002.
- 119 McKennar H, Keeney S, Glen A, Gordon P. Discharge planning: an exploratory study. *J Clin Nursing* 2000; 9 (4): 594–601.
- 120 Naylor 2002, *op. cit.*
- 121 *Ibid*
- 122 Editorial. E-health—evolving at a hospital near you. *Hospital and Healthcare* 2000; June: 12–13.
- 123 Bull MJ, Roberts J. Components of a proper hospital discharge for elders. *J Advanced Nursing* 2001;35(4);571–81.
- 124 Bull MJ, Jervis LL, Her MA. Hospitalised elders: the difficulties families encounter. *J Gerontological Nursing* 1995;21:13–23.
- 125 Holzhausen, E. You can take him home now – Carers experiences of hospital discharge. Carers National Association, 2001, London
- 126 Guillemin, M. A women's work is never done: the impact of shifting care out of hospitals. Health Issues Centre, Melbourne. 1997
- 127 Grimmer K, Moss R & Gill T. Discharge planning quality from the carer perspective. *Quality of Life Research* 2000; 9:1005-1013
- 128 Nankervis J. Taking carers issues into account in discharge planning. Melbourne: White paper presentation at the Victorian Effective Discharge Planning Group Meeting, February 2001.
- 129 Hill M & Macgregor G. Health's forgotten partners? How carers are supported through hospital discharge. Carers UK. London. October 2001
- 130 Naylor MD. Transitional care of older adults. Settings for elder care. *Annual Rev of Nursing Research* 2002;20:127–47.
- 131 Driscoll A. Managing post-discharge care at home: an analysis of patients' and their carers' perceptions of information received during their stay in hospital. *Journal of Advanced Nursing*. 2000;31(5): 1165-73
- 132 Levine, C. Rough Crossings: Family caregivers' odysseys through the health care system. United Hospital Fund of New York. 1998
- 133 Hall W, Carty E. Managing the early discharge experience: taking control. *J Advanced Nursing* 1993;18:574–82.

- 134 Bull M, Jervis L. Strategies used by chronically ill older women and their caregiving daughters in managing post hospital care. *J Advanced Nursing* 1997;25(3):541–7.
- 135 Nankervis. op. cit.
- 136 Nankervis op cit
- 137 Hill & Macgregor op cit
- 138 Shyu Y-l Lotus. The needs of family caregivers of frail elders during the transition from hospital to home: a Taiwanese sample. *J Advanced Nursing* 2000;32(3):619–25.
- 139 Bull MJ. Managing the transition from hospital to home. *Qual Health Res* 1992;2:27–41.
- 140 Bull, Jervis, Her. op. cit.
- 141 Tierney A, Closs S, Hunter H, MacMillan M. Experiences of elderly patients concerning discharge from the hospital. *J Clin Nursing* 1993;2:179–85.
- 142 Michels N. The transition from hospital to home: An exploratory study. *Home Health Care Services Quarterly* 1988;9(1):29–44.
- 143 Watters KR. Outcomes of discharge from the hospital for elderly people. *J Advanced Nursing* 1987;12:347–55.
- 144 McWilliam C, Sangster J. Managing patient discharge to home: the challenges of achieving quality of care. *Inter J Qual Health Care* 1994;6(2):147–61.
- 145 Bull, Jervis. op. cit.
- 146 Bull, Roberts. op. cit.
- 147 Weaver L, Doran K. Telephone follow-up after cardiac surgery: facilitating the transition from hospital to home. *Amer J Nursing* 2001;101(5):24QQ, 24SS–24UU.
- 148 Naylor. op. cit.
- 149 Bull MJ, Hansen HE, Gross CR. A professional-patient partnership model of discharge planning with elders hospitalised with heart failure. *Applied Nursing Research* 2000;13:19–28.
- 150 Johnson A, Silburn K. Community and consumer participation in Australian health services – an overview of organisational commitment and participation process. *Aust Health Rev* 2000;23(3): 113-21.
- 151 Ibid.
- 152 Bull, Jervis. op. cit.
- 153 Grimmer K, Moss J. The development, validity and application of a new instrument to assess the quality of discharge planning activities from the community perspective. *International Journal for Quality in Health Care* 2001; 13(2): 109-16.
- 154 Johnson A, Silburn K2000 opsit.
- 155 Department of Human Services, Victoria. A review of the Effective Discharge Strategy. Melbourne: 2002.
- 156 Bull MJ, Roberts J. op.sit
- 157 Bull, Jervis. op. cit.
- 158 Hall W, Carty E. op. cit.
- 159 Bull, Jervis. Her. op. cit.
- 160 Naylor op.cit
- 161 Daly S, Staley C. Final report. Hospital processes of care: discharge planning, multidisciplinary clinical pathways. Melbourne: AXA Australian Health Insurance, 2000.
- 162 Berry C. Telephone follow-up by nurses reduced hospital readmission among people with chronic heart failure. *Evidence-based Healthcare* 2002; 6 (4): 152–3.
- 163 Nelson JR. The importance of post discharge telephone follow-up for hospitalists: a view from the trenches. *Amer J Med* 2001; 111 (9B): 43S–44S.
- 164 Weaver L, Doran K. Telephone follow-up after cardiac surgery: facilitating the transition from hospital to home. *Amer J Nursing*. 2001; 101 (5): 24QQ, 24SS–24UU.

- 165 Keeling, Dennison. op. cit.
- 166 Bistro J, Caldwell J, McGuire K, Everson D. Telephone follow-up after discharge from the hospital: does it make a difference? *Applied Nursing Res* 1996; 9 (2): 47-52.
- 167 Nelson. op. cit.
- 168 Dudas V, Bookwalter T, Kerr K, Pantilat S. The impact of follow-up telephone calls to patients after hospitalization. *Amer J Med* 2001; 111 (9B): 26S-30S.
- 169 Ibid.
- 170 Poncia HDM, Ryan J, Carver M. Next day telephone follow up of the elderly: a needs assessment and critical incident monitoring tool for the accident and emergency department. *J Accident and Emergency Med* 2000; 17 (5): 337-40.
- 171 Turner D. Clinical. Can telephone follow-up improve post discharge outcomes? *Brit J Nursing* 1996; 5 (22): 1361-2.
- 172 Boter H, Mistiaen P, Goenewegen I. A randomised trial of a Telephone Reassurance Programme for patients recently discharged from an ophthalmic unit. *J Clin Nursing* 2000; 9 (2): 199-206.
- 173 Weaver, Doran. op. cit.
- 174 Poncia, Ryan, Carver. op. cit.
- 175 Keeling, Dennison. op. cit.
- 176 Boter, Mistiaen, Goenewegen. op. cit.
- 177 Allen D. Telephone follow up for older people discharged from A&E. *Nursing Standard* 1997; 11 (46): 34-7.
- 178 Ibid.
- 179 Turner D. op.cit.



## 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

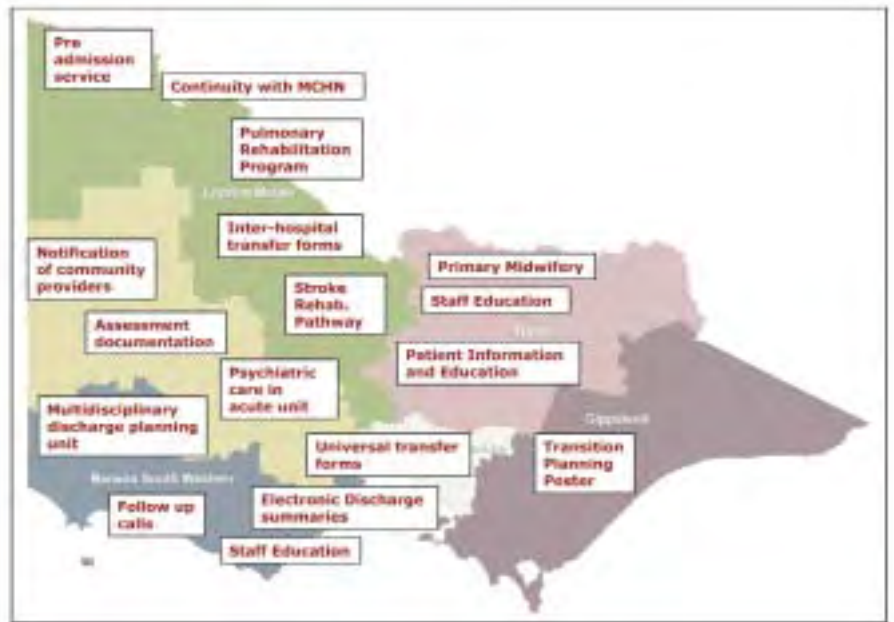
Good practice example 1.4D	15
Successful integration of psychiatric care into an acute hospital unit	15
Mt Alexander Hospital	15
Good practice example 2.1A	16
Guide assists staff to produce better patient information	16
Austin Health	16
Good practice example 2.1B	17
Poster leads to improved transition 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

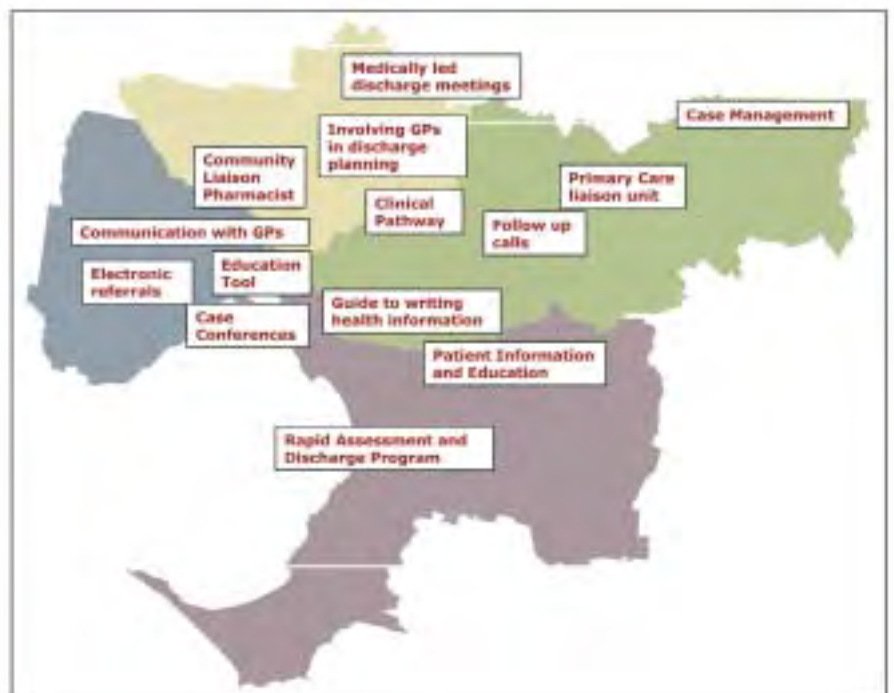
Attachments	37
Attachment 1 – The Alfred ‘Patient call back data sheet’	37
Attachment 2 – Wodonga Regional Health Service ‘How to refer to services’	38
Appendix B – Good practice Guide Contributors	41
Case study contributors	41
General contributors	42
Appendix C – Service directories	43
Victorian service 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

### Contact for further information

Gillian Jenkins CNC  
Manager  
Discharge Planning Unit  
Western District Health Service  
Telephone: 03 5571 0504  
Fax: 03 5571 0323  
Email: Gillian.Jenkins@wdhs.net

### 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.

#### Contact for further information

Pauline Ferguson

Frankston Hospital

Telephone: 03 9784 7283

Email: [pferguson@phcn.vic.gov.au](mailto:pferguson@phcn.vic.gov.au)

**Contact for further information**

Jan O'Reilly  
 Heart Failure Case Manager  
 Box Hill Hospital  
 Telephone: 03 9895 4996  
 Email: jan.o'reilly@boxhill.org.au

## Good practice example 1.3C

### 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

### Contact for further information

Helen Haines or Maternity Services  
Community Midwife Program  
Northeast Health  
Wangaratta  
Telephone: 03 5722 0256  
Email: hhaines@dragnet.com.au

### 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

### Contact for further information

Robyn Power  
Nurse Unit Manager, Aged Care Unit  
Western Health  
Telephone: 03 9393 0193  
Email: robyn.power@wh.org.au

### 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.*

**Contact for further information**

Maree Glynn  
 The Northern Hospital  
 Telephone: 03 8405 8025  
 Fax: 03 8405 8038  
 Email: maree.glynn@nh.org.au

## 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.

##### Contact for further information

Janice Doyle

Nurse Manager, Discharge Planning

Wodonga Regional Health Service

Telephone: 02 6051 7448

Email: [Janice.doyle@wrhs.org.au](mailto:Janice.doyle@wrhs.org.au)

## Good practice example 1.4B

### Contact for further information

Gaye Moore  
St Vincent's Health  
Telephone: 03 9288 3735  
Email: [gaye.moore@svhm.org.au](mailto:gaye.moore@svhm.org.au)

### 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.

##### Contact for further information

Kate Beach

Colac Area Health

Admissions and Discharge Planning  
Coordinator (2000-2002)

Telephone: 03 5230 0275

Fax: 03 5230 0205

Email: [klbeach@swarh.vic.gov.au](mailto:klbeach@swarh.vic.gov.au)

## Good practice example 1.4D

### Contact for further information

Barb Gregory  
Associate Unit Manager  
Mt Alexander Hospital  
Telephone: 03 5471 1470  
Fax: 03 5471 1530  
Email: [acute@mtalexhosp.vic.gov.au](mailto:acute@mtalexhosp.vic.gov.au)

### 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."

#### Contact for further information

Fiona Sammut

Austin Hospital

Project Manager, Patient Education  
Materials

Telephone: 03 9496 5011

Email: [fiona.sammut@austin.org.au](mailto:fiona.sammut@austin.org.au)

**Contact for further information**

Peter Green  
 Coordinator  
 South West Gippsland Post Acute  
 Care Program  
 Telephone: 03 5625 0245  
 Fax: 03 5625 0295  
 peter.green@wghg.com.au

## 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

### Contact for further information

Yvonne Fabry  
Kerang and District Hospital  
Telephone: 03 5450 9200  
Email:  
quality.coord@kerhosp.vic.gov.au

### 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.

#### Contact for further information

Lyn Mackenzie  
Post Acute Care Coordinator  
Stawell Regional Health  
Telephone: 03 5358 8587  
Fax: 03 5358 8512  
Email: [lmackenzie@srh.org.au](mailto:lmackenzie@srh.org.au)

## Good practice example 2.3A

### Contact for further information

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

### 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.

#### Contact for further information

Ruth Crawford  
Quality Manager, Nursing  
The Alfred  
Telephone: 03 9276 3010  
Email: [r.crawford@alfred.org.au](mailto:r.crawford@alfred.org.au)

## Good practice example 2.4

### Contact for further information

Tam Vuong (BPharm,  
BPharmSc(Hons))  
PhD Candidate  
Department of Pharmacy Practice,  
Monash University  
Honorary Research Fellow,  
Austin Health and The Alfred  
Telephone: 03 9903 9057  
Email:  
tam.vuong@vcp.monash.edu.au

### 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](mailto: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  
Telephone: 03 9288 2257  
Fax: 03 9288 2091  
Email: [renae.otoole@svhm.org.au](mailto: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](mailto: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](mailto: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](mailto: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](mailto: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

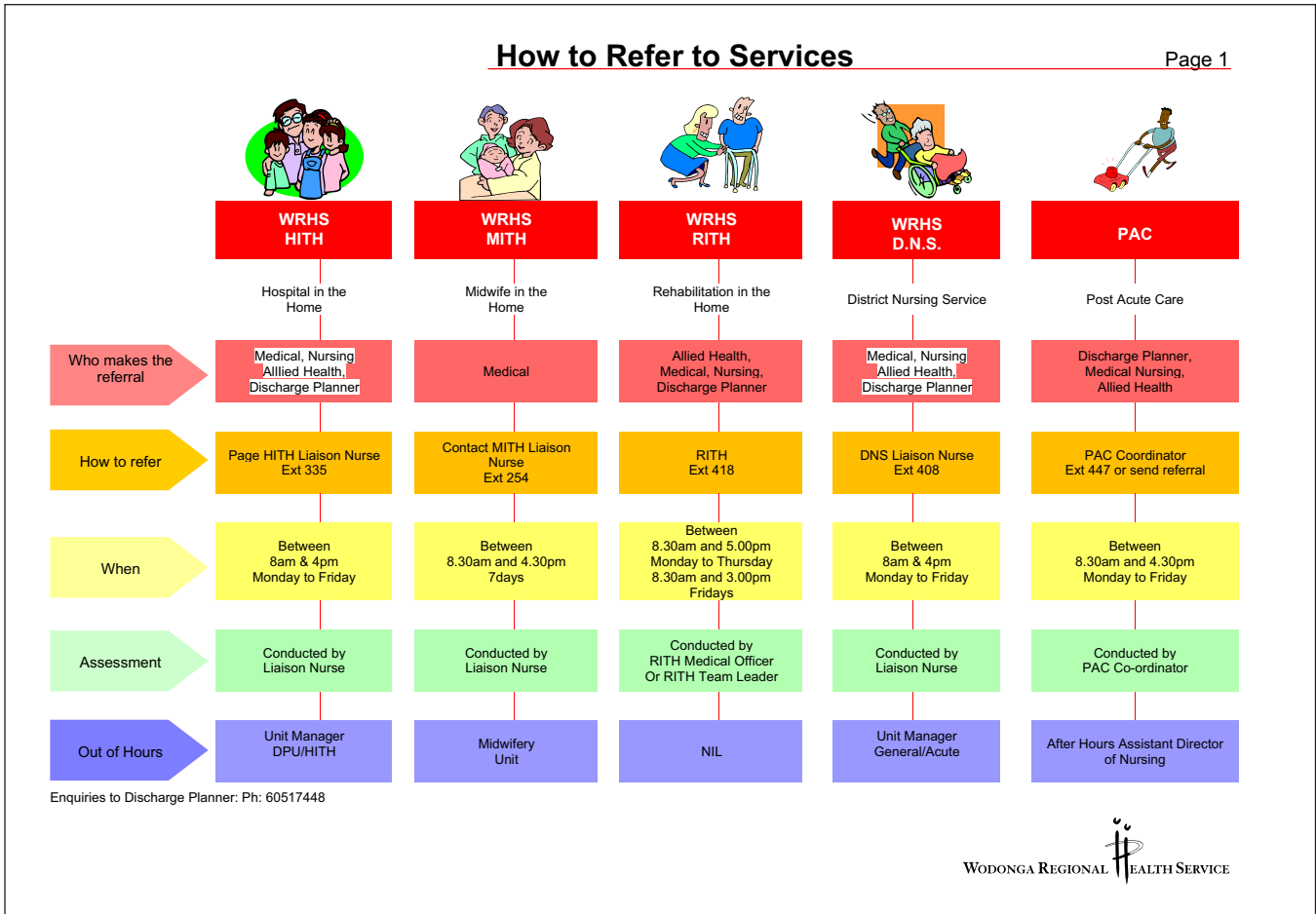
## Attachment 1 – The Alfred ‘Patient call back data sheet’

<b>THE ALFRED Patient Call Back Data Sheet</b>		U.K. <input style="width: 50px;" type="text"/>
Diagnosis : _____		<b>Surname</b> <input style="width: 90%;" type="text"/>
Discharge date: _____ Discharging ward: _____		<b>Given Names</b> <input style="width: 90%;" type="text"/>
Unit: _____ Nurse to make call: _____		<input style="width: 90%;" type="text"/>
<b>Patients discharged home</b> (including hostel, SRS etc) <b>should be called if</b> : 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: _____		
<b>OR: Patient does not need to be called for one of the following reasons:</b> 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 &amp; 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>		
<b>Status of Call:</b> 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		
<b>Questions relating to Health status of the patient</b>		
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: _____		
<b>Questions evaluating the effectiveness of The Alfred's discharge planning</b>		
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: _____		
<b>No action required:</b> <input type="checkbox"/>		
<b>Action required:</b>		
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 : _____		
_____		
<b>Other comments:</b> 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

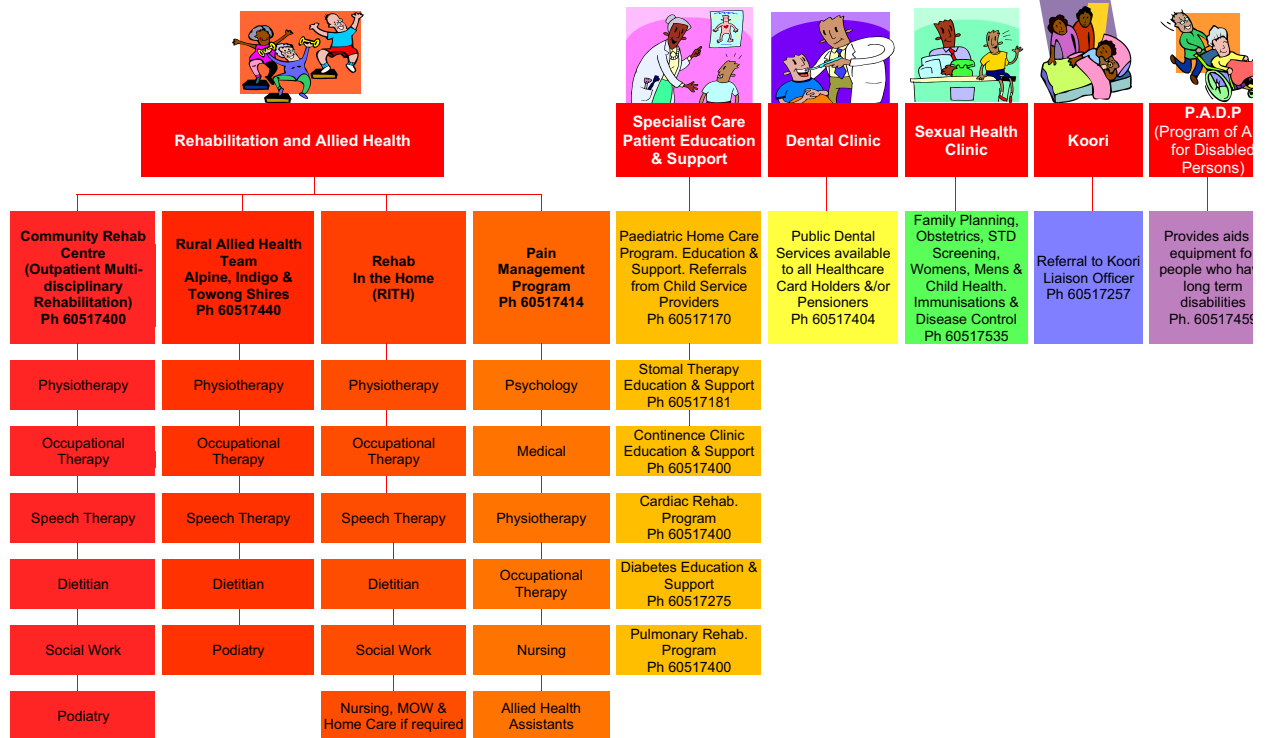
Medical Records Copy

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



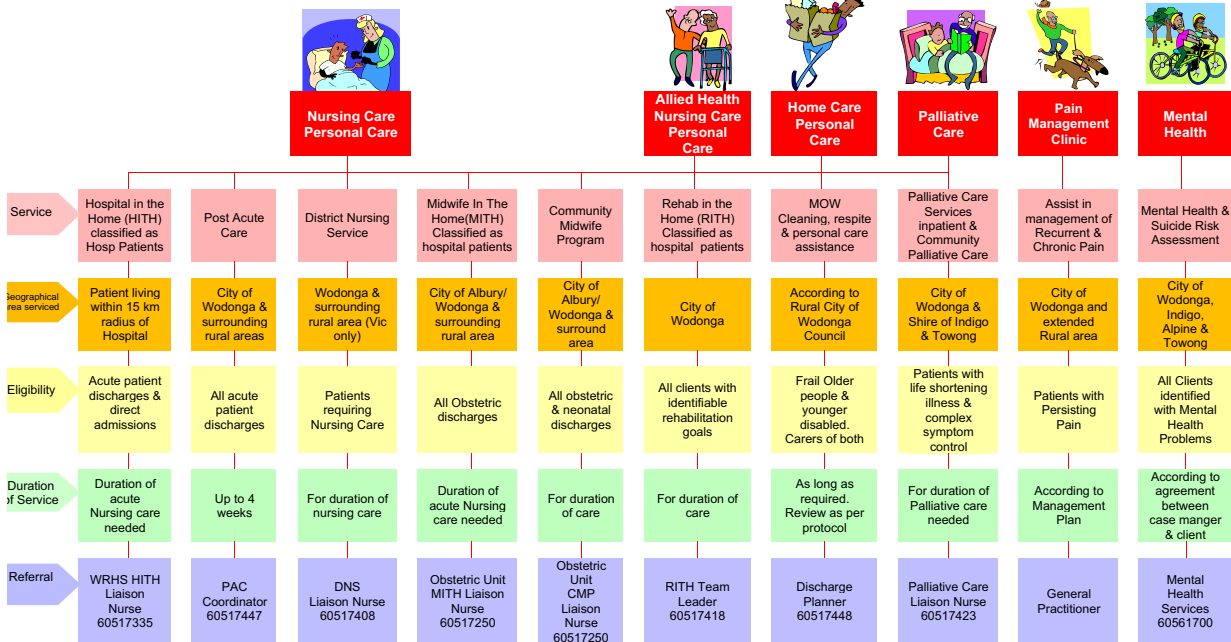
## Additional Services Available

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

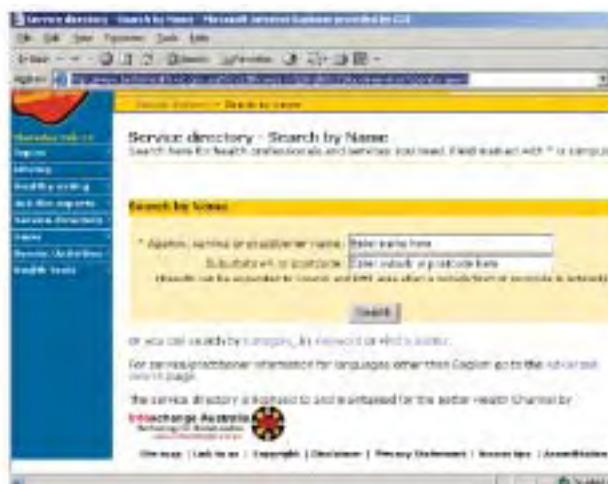
#### Victorian service directories

##### 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](http://www.serviceseeker.com.au)



The Victorian service directory Better Health Channel can be found at: [www.betterhealth.vic.gov.au](http://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](http://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](http://www.disability.vic.gov.au/dsonline/dssite.nsf?open)



## Health Insite

Health Insite ([www.healthinsite.gov.au/index.cfm](http://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.
- Anthony M, Hudson-Barr D. Successful patient discharge: a comprehensive model of facilitators and barriers. *J Nursing Admin* 1998; 28 (3): 48-4.
- Armitage S, Kavanagh K. Hospital nurses' perceptions of discharge planning for medical patients. *Aust J Advanced Nursing* 1996; 14 (2): 17-23.
- Ashton CM, Kuykendall D, Johnson M, Wray N, Wu L. The association between the quality of inpatient care and early readmission. *Annals of Internal Med* 1995; 122 (6): 415-21.
- Atwal A., Nurses' perceptions of discharge planning in acute health care: a case study in one British teaching hospital. *J Advanced Nursing* 2002; 39 (5): 450-8.
- Australian Institute for Primary Care. HARP: the community hospital interface draft 2. Melbourne: Latrobe University, 2002.
- Australian Pharmaceutical Advisory Council. National guidelines to achieve the continuum of quality use of medicines between hospital and community. Canberra: Commonwealth Department of Health and Family Services, 1998.
- Australian Resource Centre for Hospital Innovations  
[www.archi.net.au/topic/index.phtml/id/316](http://www.archi.net.au/topic/index.phtml/id/316)
- Australian Resource Centre for Hospital Innovations. Linking general practice, hospital and community. 2002 seminar report.  
[www.archi.net.au/archi/seminar/index.phtml/id/16/topic\\_id/211](http://www.archi.net.au/archi/seminar/index.phtml/id/16/topic_id/211)
- Australian Safety and Quality in Health care. Safety and Quality Council. Second National Report on Patient Safety, Improving Medication Safety. Canberra, 2002
- Ball L, Withers C. Developing multidisciplinary profiles in a day hospital. *Nursing Standard* 2001; 15 (20): 38-40.
- Balla J, Jamieson, W., Improving the continuity of care between general practitioners and public hospitals. *Med J Aust* 1994; 161 (5/19): 656-9.
- Basa R, McLeod B., Evaluation of a diabetes speciality centre: structure, process and outcome. *Patient Education and Counselling*; 1995; 25: 23-9.

- Benson L, Bowes J, Cheesebro K, Stasa C, Horst T, Blyskal S et al. Using variance tracking to improve outcomes and reduce costs. *Dimensions of Critical Care Nursing* 2001; 20 (2): 34-42.
- Berry C. Telephone follow-up by nurses reduced hospital readmission among people with chronic heart failure. *Evidence-based Healthcare* 2002; 6 (4): 152-3.
- Biala K. Case conferencing for wound care patients. *Home Healthcare Nurse* 2002; 20 (2): 120-6.
- Blaylock A, Cason C. Discharge planning: predicting patients' needs. *J Gerontological Nursing* 1992; 18: 5-10.
- Bolton P. A review of the role of information technology in discharge communications in Australia. *Aust Health Rev* 1999; 22 (3): 56-64.
- Bolton P, Usher H, Mira M, Harding L. Information technology and general practice: a survey of general practitioners attitudes toward computerisation. *Aust Family Physician* 1999; 28 (1): 519-21.
- Bostrom J, Caldwell J, McGuire K, Everson D. Telephone follow-up after discharge from the hospital: does it make a difference? *Applied Nursing Research* 1996; 9 (2): 47-52.
- Boter H, Mistiaen P, Groenewegen I. A randomised trial of a Telephone Reassurance Programme for patients recently discharged from an ophthalmic unit. *J Clin Nursing* 2000; 9 (2): 199-206.
- Bowles KH, Naylor MD, Foust JB. Patient characteristics at hospital discharge and a comparison of home care referral decisions. *J Amer Geriatrics Soc* 2002; 50 (2): 336-42.
- Bragg R. Earlier discharge – monitoring the outcomes of hospital discharge. Sydney: NSW Health, 2002.
- Brewer B, Jackson L. A case management model for the emergency department. *J Amer Nursing* 1997; 23 (6): 618-21.
- Bristow D, Herrick C. Emergency department case management: the dyad of nurse case manager and social worker improve discharge planning and patient and staff satisfaction while decreasing inappropriate admissions and costs: a literature review. *Lippincott's Case Management* 2002; 7 (6): 243-51.
- British Geriatrics Society. Discharge of elderly persons from hospital to community care.  
[www.bgs.org.uk/compendium/compd2.htm](http://www.bgs.org.uk/compendium/compd2.htm)
- Bull MJ. Managing the transition from hospital to home. *Qual Health Research* 1992; 2: 27-41.
- Bull MJ. Patient's and professionals' perceptions of quality in discharge planning. *J Nursing Care Quality* 1994; 8 (2): 47-61.

- Bull MJ, Hansen HE, Gross CR. A professional-patient partnership model of discharge planning with elders hospitalised with heart failure. *Applied Nursing Research* 2000; 13: 19-28.
- Bull M, Jervis L. Strategies used by chronically ill older women and their caregiving daughters in managing post hospital care. *J Advanced Nursing* 1997; 25 (3): 41-7.
- Bull MJ, Jervis LL, Her MA. Hospitalised elders: the difficulties families encounter. *J Gerontological Nursing* 1995; 21: 13-23.
- Bull MJ, Maruyama G, Luo D. Testing a model for post-hospital transition of family caregivers for elderly persons. *Nursing Research* 1995; 44: 1232-38.
- Bull MJ, Roberts J. Components of a proper hospital discharge for elders. *J Advanced Nursing* 2001; 35 (4): 571-81.
- Bundoora Centre for Applied Gerontology. Post acute care study: evaluation of outcomes in older patients. White paper. Melbourne: Acute Health Division, Department of Human Services, Victoria, 2001.
- Bundoora Centre for Applied Gerontology. Post acute program health outcomes and cost benefit study. Final report. Melbourne: Acute Health Division, Department of Human Services, Victoria, 2001.
- Burns JM, Sneddon I, Lovell M, McLean A, Martin BJ. Elderly patients and their medication: a post discharge follow-up study. *Age and Ageing* 1992; 21: 178-81.
- Byles JE. A thorough going over: evidence for health assessments in the older person. *Aust and NZ J Public Health* 2000; 24: 117-23.
- Campbell SE, Campbell MK, Grimshaw JM, Walker AE. A systematic review of discharge coding accuracy. *J Public Health Med* 2001; 23 (3): 205-11.
- Caplan G, Brown A, Croker W, Doolan J. Risk of admission within 4 weeks of discharge of elderly patients from the emergency department - the DEED study. *Age and Ageing* 1998; 27: 697-702.
- Caplan GA, Brown A, Crowe PJ, Yap S-J, Noble S. Re-engineering the elective surgical service of a tertiary hospital: a historical controlled trial. *Med J Aust* 1998; 169: 247-51.
- Carer Services (Rural and Regional Health and Aged Care Division, Department of Human Services, Victoria). [www.dhs.vic.gov.au/rrhacs/index.htm](http://www.dhs.vic.gov.au/rrhacs/index.htm)
- Carer Support (disability). [www.advocacyhouse.org/vicnord/about.html](http://www.advocacyhouse.org/vicnord/about.html)
- Carer Support Services Victoria. [vcsn.infoxchange.net.au/](http://vcsn.infoxchange.net.au/)
- Carers Australia. [www.carers.asn.au/](http://www.carers.asn.au/)
- Carers Victoria. [www.carersvic.org.au/](http://www.carersvic.org.au/)
- Carine F, Walker A. Establishing electronic patient record standards using paper-based record functions and standards. *Health Info Management* 1997; 27 (2): 78-82.

Centre for General Practice Integration Studies, School of Medicine, University of New South Wales, Division of General Practice Northern Tasmania Case study: GP-hospital electronic communication trial. Commonwealth Department of Health and Aged Care. Sydney. November, 2000; 37-40.

Centre for General Practice Integration Studies (School of Community Medicine, University of New South Wales). GP-hospital integration: what have we learnt? (Appendix 3). <http://sphcm.med.unsw.edu.au/>

Cheah G, Martens K. Coudamin knowledge deficits: do recently hospitalised patients know how to safely manage the medication? *Home Healthcare Nurse* 2003; 21 (2): 94-100.

Cheek J, Ballantyne A. Coping with crisis: how Australian families search for and select an aged care facility for a family member upon discharge from an acute care setting. *Contemporary Nurse* 2001; 10 (1-2): 12-20.

Clark A, Barbour R, McIntyre P. Preparing for change in the secondary prevention of coronary heart disease: a qualitative evaluation of cardiac rehabilitation within a region of Scotland. *J Advanced Nursing* 2002; 39 (6): 589-98.

Commonwealth of Australia. How to review the evidence: systematic identification and review of the scientific literature. Handbook series on preparing clinical practice guidelines. Canberra: National Health and Medical Research Council, 2000.

Cooper L. Adult discharge planning and nursing home placement: a study of risk factors for quality assurance. *Aust Clin Rev* 1991; 11: 95-102.

Council on the Ageing (Victoria). Removing the boundaries – hospital discharge planning procedure guidelines. Melbourne: 1994.

Council of Social Services of New South Wales: [www.ncoss.org.au/bookshelf](http://www.ncoss.org.au/bookshelf). The go to Health.

Cox S. Improving communication between care settings. *Professional Nurse* 2000; 15: 267-71.

Cravener P. Principles of adult health education. *Gastroenterology Nursing* 1996; 19 (4): 140-5.

Cummings SM. Adequacy of discharge plans and rehospitalization among hospitalized dementia patients. *Health & Social Work* 1999; 24 (4): 249-59.

Daly S, Staley C. Final report on hospital processes of care: discharge planning, multidisciplinary clinical pathways. Melbourne: AXA Australian Health Insurance, 2000.

Department of Human Services, Victoria. Effective Discharge Strategy: a framework for effective discharge. Background paper. Melbourne: 1999.

Department of Human Services, Victoria. A review of the Effective Discharge Strategy. Melbourne: 2002.

Department of Human Services, Victoria. Background paper: Hospital Admission Risk Program (HARP). Melbourne: Emergency Demand Coordination Group, 2002.

Department of Human Services, Victoria. Primary Care Partnerships: service coordination tool templates. Melbourne: 2002.

Deutschendorf A. From past paradigms to future frontiers: unique care delivery models to facilitate nursing work and quality outcomes. *J Nursing Admin* 2003; 33 (1): 52-9.

Driver H, Hinegardner C, Rea M, Reed P, Ward K. Whose patient is it anyway? Coordinating nursing and case management services. *Lippincott's Case Management* 2001; 6 (6): 256-62.

Dudas V, Bookwalter T, Kerr K, Pantilat S. The impact of follow-up telephone calls to patients after hospitalization. *Amer J Med* 2001; 111 (9B): 26S-30S.

Dunn S, Sohl-Kreiger R, Marx S. Geriatric case management in an integrated care system. *J Nursing Admin* 2001; 31 (2): 60-2.

Early Supported Discharge Trials. Services for reducing duration of care for acute stroke patients, *Cochrane Review* 2000:3:61.

Ebert V, Bethal S. Mission accomplished: a system for discharge planning. *Nursing Management* 1996; August: 27-9.

Editorial. E-health – evolving at a hospital near you. *Hospital and Healthcare* 2000; June: 12-13.

Egan E, Clavarino, A, Burridge L, Teuwen M, White E. A randomised control trial of nursing-based case management for patients with chronic obstructive pulmonary disease. *Lippincott's Case Management* 2002; 7 (5): 170-9.

Einstadter D, Cebul RD, Franta PR. Effect of a nurse case manager on post discharge follow up. *J General Internal Med* 1996; 11 (11): 684-8.

Evans RL, Henricks RD. Evaluating hospital discharge planning: a randomised clinical trial. *Medical Care* 1993; 31 (4): 358-70.

Fairhurst K, Blair M, Cutting J, Featherstone M, Hayes B, Howarth M, et al. The quality of hospital discharge: a survey of discharge arrangements for the over-65s. *Inter J Qual Health Care* 1996; 8: 167-74.

Farren E. Effects of early discharge planning on length of hospital stay. *Nursing Economics* 1991;9(1):25-9.

Fox K, Wood D, Wright M, Bond S, Nuttall M, Arora B, et al. Evaluation of a cardiac prevention and rehabilitation programme for all patients at first presentation with coronary artery disease. *J Cardio Risk* 2002; 9 (6): 355-9.

Frankel AJ, Heft-La Prote H. Tracking case management accountability: a system approach. *J Case Management* 1998; 7 (3): 105-11.

- Frankl SE, Breeling JL, Goldman L. Preventability of emergent hospital readmission. *Amer J Med* 1991; 90 (6): 667-74.
- Florey CV, Yule B, Fogg A, Napier A, Orbell S, Cuscjoero A. A randomised trial of immediate discharge of surgical patients to general practice 1994; (16): 455-64.
- Gair G, Hartley T. Medical dominance in multidisciplinary teamwork: a case study of discharge decision-making in a geriatric assessment unit. *J Nursing Management* 2001; 9: 3-11.
- Galloway P. Designing a discharge planning program that fits. *Caring Magazine* 1997; October: 42-5.
- Gandhi TK, Sittig DF, Franklin M, Sussman AJ, Fairchild DG, Bates DW. Communication breakdown in the outpatient referral process. *J General Internal Med* 2000; 15: 626-31.
- Gautam P, Macduff C, Brown I, Squair J. Unplanned readmissions of elderly patients. *Health Bulletin*. 54(6): 449-57, 1996.
- General Practice Divisions Victoria. Minimum requirements for the transfer of information between hospitals and GPs. [www.gpdv.com.au/integ/paper2.html](http://www.gpdv.com.au/integ/paper2.html) (or contact the General Practice Divisions Victoria: 03 9341 5200).
- Gow P, Berg S, Smith D, Ross D. Care co-ordination improves quality-of-care at South Auckland Health. *J Qual Clin Prac* 1999; 19 (2): 107-10.
- Gregory M. Planning safe discharge from hospital – the importance of interprofessional collaboration and communication. *J Interprofessional Care* 1992; 6 (2): 133-40.
- Griffiths P. Nursing-led in-patient units for intermediate care: a survey of multidisciplinary discharge planning practice. *J Clin Nursing* 2002; 11 (3): 322-30
- Grimmer K, Falco J, Moss J, Kumar S. Independent community living after discharge from hospital. Adelaide: Aging and Department of Human Services, South Australia; Centre for Allied Health Research, University of South Australia; and Department of Public Health, University of Adelaide, 2002.
- Grimmer K, Moss J. The development, validity and application of a new instrument to assess the quality of discharge planning activities from the community perspective. Oxford: International Society for Quality in Health Care and Oxford University Press, 2001.
- Grimmer KT, Moss J. Final report: cost efficient discharge planning: satisfaction for all. Adelaide: Centre for Allied Health Research, University of South Australia, 1999.
- Guiliano H, Poirer C. Nursing case management: critical pathways to desirable outcomes. *Nursing Management* 1991; 22 (3): 52-5.
- Hall W, Carty E. Managing the early discharge experience: taking control. *J Advanced Nursing* 1993;18:574-82.

Halm E, Fine M, Kapoor W, Singer D, Marrie T, Siu A. Instability on hospital discharge and the risk of adverse outcomes in patients with pneumonia. *Archives of Internal Med* 2002; 162: 1278-84.

Hammer DL, Kerrson TS. Reducing the number of days for which insurers deny payment to the hospital: one primary objective for a newly configured department of case management. *Social Work in Health Care* 1988; 28 (2): 31-49.

Hansen H, Bull M, Gross C. Interdisciplinary collaboration and discharge planning communication for elders. *J Nursing Admin* 1998; 28 (9): 37-46.

Hansen D, Matt-Hensrud N, Holland D, Severson M. Development of a discharge planning mentorship program. *J Nurses in Staff Dev* 2000; 16 (1): 11-16.

Harris RD, Henschke PJ, Popplewell PY, Radford AJ, Bond MJ, Turnbull RJ, Hobbin ER, Chalmers JP, Tonkin A, Stewart AM, et al. A randomised study of outcomes in a defined group of acutely ill elderly patients managed in a geriatric assessment unit or a general medical unit. *Australian & New Zealand Journal of Medicine*. 1991; 21 (2): 230-4.

Harris M, Powel Davies G. Integration between GPs, hospitals and community health services. In: *General practice in Australia*. White paper. Canberra: Department of Health and Aged Care, 2000.

Harrison M, Browne G, Roberts J, Tugwell P, Amiran G, Graham I. Quality of life of individuals with heart failure. A randomised control trial of the effectiveness of two models of hospital-to-home transition. *Medical Care* 2002; 40 (4): 271-82.

Harrison S, Dowsell G, Wright J. Practice nurses and clinical guidelines in a changing primary care context: an empirical study. *J Advanced Nursing* 2002; 39 (3): 299-307.

Hart B, Birkas J, Lachmann M, Saunders L. Promoting positive outcomes for elderly persons in the hospital: prevention and risk factor modification. *AACN clinical issues advanced practice in acute critical care*. *Acute Care of the Ageing Client* 2002; 13 (1): 22-33.

Hatcliffe S, Smith P. Palliative care at home. *Nursing Times* 1996; 91 (41): 36-7.

Haynes RB, McDonald H, Garg AX, Montague P. Interventions for helping patients to follow prescriptions for medication. *The Cochrane Library*, Oxford Issue 4, 2002.

Haynes RB, McDonald H, Garg AX, Montague P. Interventions for helping patients to follow prescriptions for medication (Cochrane Review) *The Cochrane Library*, Oxford. Issue 1, 2003.

Health Services Research Unit, Department of Epidemiology and Preventive Medicine (Faculty of Medicine, Monash University). Identifying and developing performance indicators based on processes of care associated with effective discharge planning. *Effective Discharge Strategy: performance indicators development project discussion document*. Melbourne: Department of Human Services, Victoria, 2000.

- Health Services Research Unit (Department of Epidemiology and Preventive Medicine, Faculty of Medicine, Monash University). Effective Discharge Strategy performance indicator development project. Literature review. Melbourne: Department of Human Services, Victoria, 2000.
- Health Technology Assessment (England) 2002; 6 (4): 1-83.  
[www.hta.nhsweb.nhs.uk/execsumm/summ604.htm](http://www.hta.nhsweb.nhs.uk/execsumm/summ604.htm)
- Hedges G, Grimmer K, Moss J. Staff perceptions of discharge planning: a challenge for quality improvement. *Aust Health Rev* 1999; 22 (3): 95-109.
- Hedges G, Grimmer K, Moss J, Falco J. Performance indicators for discharge planning: a focused review of the literature. *Aust J Advanced Nursing* 1999; 16 (4): 20-8.
- Hedges G, Grimmer K, Moss J, Falco J. Performance indicators for discharge planning: a focused review of the literature. *Advanced J Nursing* 1999; 28 (9): 37-46.
- Hibberd P. The primary/secondary interface. Cross-boundary teamwork – missing link or seamless care? *J Clin Nursing* 1998; 7 (3): 274-82.
- Hjelm-Karlsson K. Effects of information to patients undergoing intravenous pyelography: an intervention study. *J Advanced Nursing* 1989; 14: 853-62.
- Holliman DC, Dziegielewska SF, Datta P. Discharge planning and social work practice. *Social Work in Health Care* 2001; 32 (3): 1-19.
- Hoskins L, Thiel L, Walton-Moss B, Clark H, Schroeder M. Clinical pathway versus a usual plan of care for patients with congestive heart failure: what's the difference? *Home Healthcare Nurse* 2001; 19 (3): 142-50.
- Hoskins L, Thiel L, Walton-Moss B, Clark H, Schroeder M. A clinical pathway for congestive heart failure. *Home Healthcare Nurse* 2001; 19 (4): 207-17.
- Hyde CJ, Robert IE, Sinclair AJ. The effects of supporting discharge from hospital to home in older patients: systematic review. *Age and Ageing* 2000; 29: 271-9.
- Huber D. The diversity of case management models. *Lippincott's Case Management* 2002; 7 (6): 212-20.
- Hurst S. Multidisciplinary discharge planning. *Professional Nurse* 1996;12(2):113-16.
- Hwang T, Wilkins E, Lowery J, Gentile J. Implementation and evaluation of a clinical pathway for TRAM breast reconstruction. *Plastic and Reconstructive Surgery* 2000; 105 (2): 541-8.
- Ibarra V. Spine update: clinical pathways. *Spine* 1997; 22: 352-7.
- Ibrahim J. Quality of care and unplanned readmission. Melbourne: Monash Medical School, Department of Epidemiology and Preventive Medicine. Monash University, 1998.
- Ibrahim J. Final report: performance indicators for effective discharge. Melbourne: Department of Human Services, Victoria, 2000.

- Ibrahim, J. Identifying and developing performance indicators based on the processes of care associated with effective discharge planning. Effective discharge strategy: performance indicators development project discussion document. Monash University Health Services Research Unit, Department of Epidemiology and Preventative Medicine, Faculty of Medicine. Melbourne; Department of Human Services, Acute Health Division, Victoria, May 2000.
- Ieraci S, Cunningham P, Talbot-Stern J, Walker S, Emergency medicine and 'acute' general practice: comparing apples with oranges. *Aust Health Rev* 2000; 23 (2): 152-61.
- Iezzoni LI, Davis RB, Palmer RH, Cahalane M, Hamel MB, Mukamal K, et al. Does the Complications Screening Program flag cases with process of care problems? Using explicit criteria to judge processes. Oxford: International Society for Quality in Health Care and Oxford University Press, 1999.
- Illman J. Telemedicine. *The Guardian (Education supplement)* 1996; 26 November; 8-9.
- Institute for Clinical Evaluative Sciences. Early discharge planning strategies. [www.ices.org.ca/docs/maro1.htm](http://www.ices.org.ca/docs/maro1.htm)
- Department of Health and Human Services, Health Care Financing Administration. [www.dischargedirect.com/regulations/guidelines.asp](http://www.dischargedirect.com/regulations/guidelines.asp)
- Jackson A, Johnson B, O'Toole M, Auslander G. Discharge planning for complex paediatric cases. *Social Work Health and Mental Health* 2001; 34 (1/2): 161-75.
- Jackson M. Discharge planning: issues and challenges for gerontological nursing. A critique of the literature. *J Advanced Nursing* 1994; 19: 492-502.
- Jewell S. Discovery of the discharge process: a study of patient discharge from a care unit for elderly people. *J Advanced Nursing* 1993; 18: 1288-96.
- Johnson A, Silburn K. Community and consumer participation in Australian health services – an overview of organisational commitment and participation process. *Aust Health Rev* 2000; 23 (3): 113-21
- Johnson K, Blaisdell C, Walker A, Eggleston P. Effectiveness of a clinical pathway for inpatient asthma management. *Paediatrics* 2000; 106 (5): 1006-12.
- Jones D, Lester C. Hospital care and discharge: patients' and carers' opinions. *Age and Ageing* 1994; 23: 91-6.
- Kantz B, Wandel J, Fladger A, Folcarelli P, Burger S, Clifford J. Developing patient and family education services: innovations for the changing healthcare environment. *J Nursing Admin* 1998; 28 (2): 11-18.
- Kearney J. Removing the boundaries: hospital discharge practices and older people returning to the community. Melbourne: Council on the Ageing, 1994.
- Keeling A, Dennison P. Nurse-initiated telephone follow-up after acute myocardial infarction. A pilot study. *J Acute and Critical Care* 1995; 24 (1): 45-9.

- Keetch D, Buback D. A clinical care pathway for decreasing hospital stay after radical prostatectomy. *Brit J Urology* 1998; 81 (3): 398-402.
- Kennedy L, Neidlinger S, Scroggins K. Effective comprehensive discharge planning for the hospitalised elderly. *Gerontologist* 1987; 27 (5): 577-80.
- Keuhl AD, Chrischillies EA, Sorofman BA. System for exchanging information among pharmacists in different practice environments. *Journal of the American Pharmaceutical Association* 1998; 28(3): 317-24.
- Khaghani F. Case management within Kaiser Permanente. [Doctoral Dissertation. Research] Pepperdine University. (124 p) 1995.
- KPMG Consulting. Second effective discharge patient record. Final revised report. Melbourne: Department of Human Services, Victoria, 2000.
- Krairiksh M, Anthony M. Benefits and outcomes of staff nurses participation in decision making. *J Nursing Admin* 2001; 31 (1): 16-23.
- Kvamme OJ, Olesen F, Samuelsson M. Improving the interface between primary and secondary care: a statement from the European Working Party on Quality in Family Practice (EQUIP). *Quality in Health Care* 2001; 10: 33-9.
- Panis LGG, Verheggen F, Pop P. To stay or not to stay. The assessment of appropriate hospital stay: a Dutch report. *Inter J Qual Health Care* 2002; 14 (1): 55-67.
- Levinson W, D'Annunzio T, Gorawarra-Bhat R, Stein T, Reifsteck S, Egener B, Dueck R. Patient-physician communication as organizational innovation in the managed care setting. *Amer J Managed Care* 2002; 8 (7): 622-30.
- Lewis S, Morath D. Keys to effective information management in the new millennium. *JAHIMA* 1999; 70 (10): 28-31.
- Lissing J, Powel Davis G. Bridging the gap – the Impact of GP-hospital liaison officers in Australia. Integration Support and Evaluation Resource Unit, Centre for General Practice Integration Studies. Sydney. 2000. White Paper.
- London, F. Take the Frustration Out of Patient Education. *Home Healthcare Nurse*. 2001; 19 (3): 158-163.
- Long A, Kneafsey R, Ryan J, Berry J. The role of the nurse within the multi-professional rehabilitation team. *Journal of Advanced Nursing*. 2002; 37 (1): 70-78.
- Lydall-Smith S, O'Connor C, Tenni C. Victorian coordinated healthcare trial: the role of the service coordinator and clinical services manager in phase II. Unpublished, 2002.
- Malek C, Olivieri R. Pain management: documenting the decision making process. *Nursing Case Management* 1996; 1 (2): 64-74.
- Marshall MN. How well do general practitioners and hospital consultants work together? A qualitative study of cooperation and conflict within the medical profession. *Brit J General Prac* 1998; 48: 1379-82.

- Martin F, Oyewole A, Moloney A. A randomised controlled trial of a high support hospital discharge team. *Age and Ageing* 1994; 23 (3): 228-34.
- Maynard A. Preparing readable patient education handouts. *J Nurses in Staff Dev* 1999; 15 (1): 11-18.
- McAllister F, Lawson F, Teo K, Armstrong P. A systematic review of randomised trials of disease management programs in heart failure. *Amer J Med* 2001; 110 (5): 378-84.
- McCallum J. Improving post acute care outcomes for older people. Sydney: Cambelltown Centre for Health Outcomes and Innovative research, University of Western Sydney, 1998.
- McCusker J, Verdon J, Tousignant P, Poulin de Courval L, Dendukuri N, Belzile E. Rapid emergency department intervention for older people reduces risk of functional decline: results of a multicenter randomised trial. *J Amer Geriatrics Soc* 2001; 49: 1272-81.
- McGee P, Ashford R. Nurses' perceptions of roles in multidisciplinary teams. *Nursing Standard* 1996; 10 (45): 34-6.
- McGinley S, Baus E, Gyza K, Johnson K, Lipton S, Magee M, et al. Multidisciplinary discharge planning: developing a process. *Nursing Management* 1996; 27 (10): 55-60.
- McHale S. Implementation of a patient discharge policy. *Professional Nurse* 1995; 10 (9): 590-2.
- McInnes E, Mira M, Atkin N, Kennedy P, Cullen J. Can GP input into discharge planning result in better outcomes for the frail aged: results from a randomized controlled trial. *Family Prac* 1999; 16 (3): 289-93.
- McKenna H, Keeney S, Glenn A, Gordon P. Discharge planning: an exploratory study. *J Clin Nursing* 2000; 9 (4): 594-601.
- McNamara S, Sullivan M. Patient care coordinators: successfully merging utilization management and discharge planning. *J Advanced Nursing* 1995; 25: 33-6.
- McWilliam C, Sangster J. Managing patient discharge to home: the challenges of achieving quality of care. *Inter J Qual Health Care* 1994; 6 (2): 147-61.
- Merriman B, Ades T, Seffrin J. *CAA Cancer J for Clinicians* (journal of the American Cancer Society) 2002; 52: 130-3.
- Michels N. The transition from hospital to home: an exploratory study. *Home Health Care Services Quarterly* 1988; 9 (1): 29-44.
- Miller D, Lewis L, Nork M, Morely J. Controlled trial of a geriatric case-finding and liaison service in an emergency department. *J Amer Geriatrics Soc* 1996; 45: 513-20.
- Mistiaen P, Duijnhouwer E, Prins-Hoekstra A, Ros W, Blaylock A. Predictive validity of the BRASS index in screening patients with post-discharge problems. *J Advanced Nursing* 1999; 30 (5): 1050-6.

- Mistiaen P, Duijnhouwer E, Wijkel D, de Bont M, Veeger A. The problems of elderly people at home one week after discharge from an acute care setting. *J Advanced Nursing* 1997; 25 (6): 1233-40.
- Moher D, Weinberg A, Hanlon R, Runnalls K. Effects of a medical team coordinator on length of hospital stay. *Canadian Med Assoc J* 1992; 146 (4): 511-15.
- Morton W, Edwards L, Holmes L. Patient discharge planning documentation in an Australian multidisciplinary rehabilitation setting. *Rehab Nursing* 1992; 17 (6): 327-31.
- Moss J, Flower C, Houghton L, Moss D, Nielsen D, Taylor D. A multidisciplinary care coordination team improves emergency department discharge planning practice. *Med J Aust* 2002; 177 (8): 435-9.
- Moyer CA, Stern, DT, Dobias KS, Cox DT, Datz SJ. Bridging the electronic divide: patient and provider perspective on email communication in primary care. *Amer J Managed Care* 2002; 8 (5): 427-33.
- Mumford M. A descriptive study of the readability of patient information leaflets designed by nurses. *J Advanced Nursing* 1997; 26 (5): 985-91.
- Murray C, Jolley G. Initiatives in primary health care: evaluation of a South Australian program. *Aust Health Rev* 1999; 22 (3): 155-61
- Nankervis J. Taking carers issues into account in discharge planning. White paper prepared for Victorian Effective Discharge Planning Group meeting. Melbourne: Carers Victoria, 2001.
- National Audit Office. Ensuring the effective discharge of older patients from NHS acute hospitals. Report by the Comptroller and Auditor General HC 392 Session 2002-03. London: 2003.
- National guidelines to achieve the continuum of quality use of medicines between hospital and community. Australian Pharmaceutical Advisory Council. Commonwealth Department of Health and Family Services, Canberra January 1998.
- Narsavage G, Naylor M. Factors associated with referral of elderly individuals with cardiac and pulmonary disorders for home care services following hospital discharge. *J Gerontological Nursing* 2000; May: 14-20.
- National Demonstration Hospitals Program. Managing beds better: balancing supply and demand. The NDHP-2 experience 1997-1998. Canberra: Commonwealth Department of Health and Aged Care, 1999.
- National Demonstration Hospitals Program. Phase 3: Health services research reports. Canberra: Commonwealth Department of Health and Aged Care, 2001.
- National health and Medical Research Council:  
<http://www.nhmrc.gov.au/publications/pdf/ac3.pdf>
- National Health and Medical Research Council. How to review the evidence: systematic identification and review of the scientific literature. Canberra: Commonwealth of Australia, 2000.

National Hospital Outcomes Program. Quality and outcome indicators for acute healthcare services. Draft final report. London: 1996.

National Resource Centre for Consumer Participation in Health.

[www.participateinhealth.org.au/about\\_us/how\\_we\\_work.htm](http://www.participateinhealth.org.au/about_us/how_we_work.htm)

Naughton BJ, Moran MB, Feinglass J, Falconer J, Williams HE. Reducing hospital costs for the geriatric patient admitted from the emergency department: a randomised trial. *J Amer Geriatrics Soc* 1994; 42 (10): 1045-9.

Naylor M. A decade of transitional care research with vulnerable elders. *J Cardio Nursing*. 2000; 14 (3): 1-14.

Naylor M, Bowles K, Brooten D. Patient Problems and Advanced Practice Nurse Interventions During Transitional Care. *Public Health Nursing*. 2000; 17 (2): 94-102.

Naylor MD. Transitional care of older adults. Settings for elder care. *Annual Rev Nursing Research* 2002; 20: 127-47.

Naylor MD, Brooten D, Campbell R, Jacobsen BS, Mezey MD, Pauly MV, et al. Comprehensive discharge planning and home follow up of hospitalized elders. *J Amer Med Assoc* 1999; 281 (7): 613-20.

Naylor MD, Brooten D, Jones R, Lavizzo-Mourney R, Mezey MD. Comprehensive discharge planning for the hospitalised elderly. A randomised clinical trial. *Anal of Internal Med* 1994; 120 (12): 999-1006.

Naylor MD, McCauley KM. The effects of a discharge planning and home follow-up intervention on elders hospitalised with common medical and surgical cardiac conditions. *J Cardio Nursing* 1999; 14 (1): 44-54.

Nazarko L. Improving discharge: the role of the discharge coordinator. *Nursing Standard* 1998; 12 (49): 35-7.

Nelson EA, Maruish ME, Axler JL. Effects of discharge planning and compliance with outpatient appointments on readmission rates. *Psychiatric Services* 2000; 51 (7): 885-9.

Nelson EC, McHugo G, Schnurr P, Devito C, Roberts E, Simmons J, Zubkoff W. Medical self-care education for elders: a controlled trial to evaluate impact. *Amer J Public Health*; 74 (12): 1357-62.

Nelson JR. The importance of post-discharge telephone follow-up for hospitals: a view from the trenches. *Amer J Med* 2001; 111 (9B): 43S-44S.

Newell S, Edelman L, Scarbrough H, Swan J, Bresnen M. Best practice development and transfer in the NHS: the importance of process as well as product knowledge. *Health Services Management Research* 2003; 16: 1-12.

Nicklin J. Improving the quality of written information for patients. *Nursing Standard* 2002; 16 (49): 39-44.

Nixon A, Whitter M, Stitt P. Audit in practice: planning for discharge from hospital. *Nursing Standard* 1998; 12 (26): 35-8.

NSW Health.

[www.health.nsw.gov.au/policy/gap/publications/pdf/disch\\_policy.pdf](http://www.health.nsw.gov.au/policy/gap/publications/pdf/disch_policy.pdf)

NSW Health. Best practice guidelines for patient management. Sydney: 1998.

NSW Health. Better practice guidelines for admission and discharge of patients for elective procedures. Sydney: 1998.

NSW Health. Shared responsibility for patient care between hospitals and the community. An effective discharge policy: setting the scene. Sydney: 2001.

Nugent K. The clinical nurse specialist as a case manager in a collaborative practice model: bridging the gap between quality and cost of care. *Clin Nurse Specialist* 1992; 6: 106-11.

O'Hare P, Terry M. Discharge planning: strategies for assuring continuity of care. Maryland: Aspen Publishers, 1998.

Palmer H, Armistead N, Elnicki M, Halperin A, Ogershok P, Manivannan S, et al. The effect of a hospitalist service with a nurse discharge planner in an academic teaching hospital. *Amer J Med* 2001; 111: 627-32.

Parfrey PS, Gardner E, Vavasour H, Harnett JD, Mc Manamon C, McDonald J, et al. The feasibility and efficacy of early discharge planning initiated by the admitting department of two acute care hospitals. *Clinical and Investigative Med (Medicine Clinique et Experimentale)* 1994; 17 (2): 88-96.

Parker C. Patient pathways as a tool for empowering patients. *Nursing Case Management* 1999; 4 (2): 77-82.

Parker SG, Peet SM, McPherson A, Cannaby AM, Abrams K, Baker R, et al. A systematic review of discharge arrangements for older people. *Health Tech Assess* 2002; 6 (4): 183.

Parkes J, Shepperd S. Discharge planning from hospital to home. In: *The Cochrane Database of Systematic Review*. Adelaide: The Cochrane Library, Flinders University, 2001.

Payne T, Flanagan E, Dallam L. The dilemma of the hasty discharge. *J Nursing Admin* 1996; 26 (6): 7-9.

Peters P, Fleuren M, Wijkel D. The quality of the discharge planning process: the effect of a liaison nurse. *Inter J Quality in Health Care* 1997; 9 (4): 283-7.

Phillips K, Crain H. Effectiveness of a pneumonia clinical pathway: quality and financial outcomes. *Outcomes Management for Nursing Prac* 1998; 2 (1): 16-23.

Podesta JR, Watt RG. A quality assurance review of the patient referral process and user satisfaction of outpatient general anesthesia services for dental treatment. *Community Dental Health* 1996; 13: 228-31

Poncica HDM, Ryan J, Carver M. 2000 Next day telephone follow up of the elderly: a needs assessment and critical incident monitoring tool for the accident and emergency department. *J Accident and Emer Med*; 17 (5): 337-40.

Queensland Health. Guidelines to practice:

<http://www.health.qld.gov.au/phs/Documents/pas/1340dmp.htm>

Raghupathi W, Tan J. Strategic uses of information technology in health care: a state-of-the-art survey. *Top Health Info Management* 1999; 20 (1): 1-15.

Raleigh EH, Lepczyk M, Rowley C. Significant others benefit from preoperative information. *J Advanced Nursing* 1990; 15 (8): 941-5.

Reed RL, Pearlman RA, Buchner DM. Risk factors for early unplanned hospital readmission in the elderly. *J General Internal Med* 1991; 6 (3): 223-8.

Reedy L, Bragg R, Earlier discharge issues paper. Sydney: Council of Social Services of New South Wales (NCOSS) and NSW Community Health Association, 2000.

Reiley P, Iezzoni L, Phillips R, Davis R, Tuchin L, Calkins D. Discharge planning: comparison of patients' and nurses' perceptions of patients following hospital discharge. *J Nursing Scholarship* 1996; 28 (2): 143-7.

Reiley P, Pike A, Phipps M, Weiner M, Miller N, Stengrevic S, et al. Learning from patients: a discharge planning improvement project. *J Quality Improvement* 1996; 22 (5): 311-22.

Reimanis C, Cohen E, Redman R. Nurse case manager role attributes: fifteen years of evidence-based literature. *Lippincott's Case Management* 2001; 6 (6): 230-9.

Renholm M, Leino-Kilpi H, Souminen T. Critical pathways: a systematic review. *J Nursing Admin* 2002; 32 (4): 196-202.

Rich M. Heart disease management programs: efficacy and limitations. *Amer J Med* 2001; 110 (5): 410-12.

Rich MW, Beckham V, Wittenberg C, Leven C, Freedland K, Carney R. A multidisciplinary intervention to prevent the readmission of elderly patients with congestive heart failure. *New Eng J Med* 1995; 333 (18): 1190-5.

Rich MW, Vinson JM, Sperry JC, Shah AS, Spinner LR, Chung MK, et al. Prevention of readmission in elderly patients with congestive heart failure: results of a prospective, randomised pilot study. *J General Intern Medicine* 1993; 8 (11): 585-90.

Richards SH, Coast J, Gunnell D, Peters TJ, Pounsford J, Barlow MA. Randomised control trial comparing effectiveness and acceptability of an early discharge, hospital at home scheme with acute hospital care. *BMJ* 1998; 316 (7147): 1796-801.

Roach J, Tremblay L, Bowers D. A perioperative assessment and education program: implementation and outcomes. *Patient Education and Counselling* 1995; 25: 83-8.

- Royal Melbourne Hospital, North West Hospital, Moreland Community Health Services and the Community of Moreland. Home from hospital: experiences of older people from the Community of Moreland. Melbourne: 1998.
- Rudd AG, Wolfe DA, Tilling K, Beech R. Randomised control trial to evaluate early discharge scheme for patients with stroke. *BMJ* 1997; 315 (7115): 1039-44.
- Ruland C, Kresevic D, Lorensen M. Including patient preferences in nurses' assessment of older people. *J Clin Nursing* 1997; 6 (6): 495-504.
- Runciman P, Currie C, Nicol M, Green L, McKay V. Discharge of elderly people from an accident and emergency department: evaluation of health visitor follow-up. *J Advanced Nursing* 1996; 24 (4): 711-18.
- Saddler D. Education for the gastroenterology cancer patient. *Gastroenterology Nursing* 1999; 22 (3): 121-6.
- Salazar MK, Graham KY. Evaluation of a case management program: summary and integration of findings. *AAOHNJ* 1999; 47 (9): 416-23.
- Saltz C, Schaefer T. Interdisciplinary teams in health care: integration of family caregivers. *Social Work in Health Care* 1996; 22 (3): 59-70.
- Schneider JK, Hornberger S, Booker J, Davis A, Kralicek R. A medication discharge planning program: measuring the effect on readmissions *Clinical Nursing Research* 1993; 2 (1): 41-53
- Schriefer J, Botter M. Clinical pathways and guidelines for Case management. *Outcomes Management for Nursing Prac* 2001; 5 (3): 95-8.
- Scott E, Cowen B. Multidisciplinary collaborative care planning. *Nursing Standard* 1997; 12 (1): 39-42.
- Sennett C. Ambulatory care in the new millennium: the role of consumer information. *Managed Care Quarterly* 2001; 9 (1): 61-5.
- Shardien K. Multidisciplinary discharge rounds ensure continuity of care. *Oncology Nursing Forum* 1997; 24 (6): 967.
- Sheppard S, Parkes J. A systematic review of discharge planning. Oxford: Health Services Research Unit (NHS Executive Anglia) and Oxford R&D Programme, 2002.
- Shroeder RE, Morrison EE, Cavanagh C, West MP, Montgomery J. Improving communication among health professionals through education: a pilot study. *J Health Admin* 1999; 17: 175-98.
- Shyu Yea-Ing Lotus. The needs of family caregivers of frail elders during the transition from hospital to home: a Taiwanese sample. *J Advanced Nursing* 2000; 32 (3): 619-25.
- Simpson P. Clinical outcomes in transition program for older adults with hip fracture. *Outcomes Management* 2002; 6 (2): 86-92.

- Sloggett M. Discharge planning. *Inforum* 1986; July: 22-3.
- Smalley R. Taking charge: patient education: we have a better system now. *RN* 1997; 60 (6): 19-24.
- Smith G. Critical pathway and patient and family teaching protocol for major depression. *Nursing Case Management* 1997; 2 (1): 23-32.
- Snow L, Walker M, Ahern M, O'Brien E, Saltman DC. Functional status and health service planning. *J Qual Clin Prac* 1999; 19 (2): 99-102.
- South Australian Health Commission. *Hospital today, community tomorrow*. Adelaide: 1998.
- Stormon M, Mellis C, Van Asperen P, Kilham H. Outcome evaluation of early discharge of asthmatic children from hospital: a randomized control trial. *J Qual Clin Prac* 1999; 19: 149-54.
- Street A, Blackford J. Communication issues for the interdisciplinary community palliative care team. *J Clin Nursing* 2001; 10 (5): 643-50.
- Styborn K. Early discharge planning for elderly patients in acute hospitals – an intervention study. *Scandinavian J Social Med* 1995; 23 (4): 273-85.
- Sutcliffe A, Potter A. Multidisciplinary pre-admission clinics for orthopaedic patients. *Nursing Standard* 2002; 16 (21): 39-42.
- Tahan H. A ten-step process to develop case management plans. *Lippincott's Case Management* 2002; 7 (6): 231-42.
- Tanielian TL, Pincus HA, Dietrich AJ, Williams JW, Oxman TE, Nutting P, Marcus SC. Referrals to psychiatrists. Assessing the communication interface between primary and secondary care. *Psychosomatics* 2000; 41: 245-52.
- Tappen RM, Muzic J, Kennedy P. Preoperative assessment and discharge planning for older adults undergoing ambulatory surgery. *AORNJ* 2001; 73 (2): 464, 467, 469.
- Taylor DM, Cameron PA. Continuity of care in the transition from emergency department to general practitioner: is it adequate? *Emer Med* 1999; 11: 244-9.
- Tennier D. Discharge planning: an examination of the perceptions and recommendations for improved discharge planning at the Montreal General Hospital. *Social Work in Health Care* 1997; 26 (1): 41-60.
- Terry L. Educational care path for the endoscopic patient. *Gastroenterology Nursing* 2001; 24 (1): 34-7.
- Thomas and Associates. Final report of the development of a risk screening tool for service needs following discharge from acute care project. Melbourne: Department of Human Services Victoria, Victoria, 1998.
- Tierney A, Closs S, Hunter H, MacMillan M. Experiences of elderly patients concerning discharge from the hospital. *J Clin Nursing* 1993; 2: 179-85.

- Tilus S. The influence of nursing education on collaborative discharge planning. *J Nurses in Staff Dev* 2002; 18 (5): 274-81.
- Timms J, Parker V, Fallatt E, Johnson W. Documentation of characteristics of early hospital readmission of elderly patients: a challenge for in-service educators. *J Nurses in Staff Dev* 2002; 18 (3): 136-43.
- Townsend J, Piper M, Frank AO, Dyer S, North WR, Meade TW. Reduction in hospital readmission stay of elderly patients by a community based discharge scheme: a randomised control trial. *BMJ* 1998; 297 (6647): 544-7.
- Tran M, Young L, Phung H, Hillman K, Willcocks K. Quality of health services and early postpartum discharge: results from a sample of non-English-speaking women. *J Qual in Clin Prac* 2001; 21: 135-43.
- Vaughan J. Good practice in earlier discharge. Sydney: Council of Social Services of New South Wales (NCOSS), NSW Health, 2002.
- Victor CR, Vetter NJ. Preparing the elderly for discharge from hospital: a neglected aspect of patient care? *Age and Ageing* 1988; 17: 155-63.
- St Vincent's Hospital. Victorian Patient Satisfaction Monitor. In: St Vincent's Hospital Melbourne Ltd report (six months ending March 2001). Melbourne: 2001.
- Victor CR, Vetter NJ. Preparing the elderly for discharge from hospital: a neglected aspect of patient care? *Age and Ageing* 1988; 17: 155-63.
- Vuong Tam. Interim Report, Implementation of Community Liaison Pharmacy Services within two major referral centres, College of Pharmacy, Melbourne
- Walsh N, Gough P. From profession to commodity. *Nursing Times* 1997; 93: 34-6.
- Wammack L, Mabrey J. Outcomes assessment of total hip and total knee arthroplasty: critical pathways, variance analysis, and continuous quality improvement. *Clin Nurse Specialist* 1998; 12 (3): 1222-9.
- Waters K. Discharge planning: an exploratory study of the process of discharge planning on geriatric wards. *J Advanced Nursing* 1987; 12: 71-83.
- Waters K, Allsopp D, Davidson I, Dennis A. Sources of support for older people after discharge from hospital: 10 years on. *J Advanced Nursing* 2001; 33 (5): 575-82.
- Weaver L, Doran K. Telephone follow-up after cardiac surgery: facilitating the transition from hospital to home. *Amer J Nursing* 2001; 101 (5): 24QQ, 24SS-24UU.
- Weinberger M, Oddone EZ, Henderson WG. Does increased access to primary care reduce hospital readmissions? Veterans Affairs Cooperative Study Group on Primary Care and Hospital Readmission. *New Eng J Med* 1996; 334 (22): 1441-7.
- Weir R, Browne G, Byrne C, Roberts J, Gafni A, Thompson A, et al. The quick response initiative in the emergency department: who benefits? *Health Case Management Science* 1999; 2: 137-48.

- Wentworth D, Atkinson R. Implementation of an acute stroke program decreases hospitalisation costs and length of stay. *Stroke* 1996; 27 (6): 1040-3.
- Wertheimer D, Kleinman L. A model for interdisciplinary discharge planning in a university hospital. *Gerontologist* 1990; 30 (6): 837-40.
- Williams E, Fitton F. Factors affecting early unplanned readmission of elderly patients to hospital. *BMJ* 1988; 297 (6651): 784-7.
- Wilson F. Are patient information materials too difficult to read? *Home Healthcare Nurse* 2000; 18 (2): 107-15.
- Wilson K, Pateman B, Beaver K, Luker KA. Patient and carer needs following a cancer-related hospital admission: the importance of referral to the district nursing service. *J Advanced Nursing* 2002; 38 (3): 245-53.
- Wilson S, Warwick R, Chapman M, Miller R. General practitioner-hospital communications. A review of discharge summaries. *J Quality Clin Prac* 2001; 21: 104-8.
- Wilson S, Scamagas P, German D, Hughes G, Lulla S, Coss S, et al. A Controlled Trial of Two Forms of Self-Management Education for Adults With Asthma. *American Journal of Medicine*. June 1993; 94(6): 564-576.
- Winslow, E. Patient education materials: can patients read them, or are they ending up in the trash? *Amer J Nursing* 2001; 101 (10): 33-8.
- Worth A, Tierney AJ, Macmillan MS, King C, Atkinson FI. A national survey of community nursing staff's experience relating to discharge of elder people following acute hospital care. Report on discharge of patients from hospital. Edinburgh, Scotland: Nursing Research Unit, Department of Nursing Studies, University of Edinburgh, 1993.
- Wright J, Strang JR. Reducing the risk after coronary artery bypass surgery: documentation of risk factors and communication between hospital and general practice. *Public Health* 1997; 111: 157-60.
- Wright SM, Durbin P, Barker LR. When should learning about hospitalised patients end: providing house staff with post discharge follow up information. *Academic Med* 2000; 75 (4): 380-3.
- Yingling L, Trocino L. Strategies to integrate patient and family education into patient care redesign. *AACN Clinical Issues* 1997; 8 (2): 246-52.
- Zander K, McGill R. Critical and anticipated recovery paths: only the beginning. *Nursing Management* 1994; 25(8): 34-7.
- Zwarnstein M, Stephenson B, Johnston L. Case management: effects on professional practice and health care outcomes. In: *The Cochrane Library*, Issue 1, 2003. Oxford.



## 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.

