

Health independence programs guidelines

Preface

Ensuring a person receives the appropriate health care, at the right time and in the right place, can be a challenge. To achieve this goal there is an ongoing need for health services to provide a more responsive, integrated and flexible approach to service provision. In line with future health policy the *Health independence programs guidelines* (the guidelines) have been developed to provide health and community services with direction for more closely aligning health independence programs. Common policy and procedures between health independence programs will ensure a less complicated journey for people who require multiple health services.

Purpose

The guidelines have been developed by the Department of Human Services for health independence programs that include:

- Post-Acute Care (PAC) services
- Sub-acute Ambulatory Care Services (SACS), including centre-based, home-based and specialist clinics
- Hospital Admission Risk Program (HARP) services
- Hospital Admission Risk Program – Better Care for Older People (HARP-BCOP) services.

For the purpose of these guidelines, HARP and HARP-BCOP will be referred to as HARP.

The guidelines build on the HARP guidelines, draft SACS guidelines and recommendations from the PAC service model review.

Acknowledgements

These guidelines were developed in consultation with health independence programs services, other health service providers and related Department of Human Services program areas.

The department gratefully acknowledges the considerable time and effort of those involved in the planning and formulation of the guidelines.

Contents

Our vision	ii
Preface	iii
Contents	v
Introduction	1
A better client journey	1
Health independence programs model of care	1
Policy context	4
Supporting principles	5
Guidelines overview	5
Health independence programs overview	7
Post-acute care services	7
Background	7
Target population	7
Types of services	8
Sub-acute ambulatory care services	9
Background	9
Target population	9
Types of services	9
Hospital Admission Risk Program services	11
Background	11
Target population	11
Types of services	11
Facilitating health independence program alignment	14
Implementation of the guidelines	14
1. Service delivery	15
1.1 Client journey	15
1.1.1 Access	16
1.1.2 Initial needs identification	19
1.1.3 Assessment	21

1.1.4	Client consent	23
1.1.5	Care planning and implementation	25
1.1.6	Monitoring and review	27
1.1.7	Transition and exit	29
1.2	Elements of program delivery	31
1.2.1	Interdisciplinary approach	32
1.2.2	Care coordinator	34
1.2.3	Appropriate setting	36
1.2.4	Evidence-based practice	37
1.2.5	Health promotion	38
1.2.6	Consumer involvement	39
1.2.7	Self-management	40
1.2.8	Client and staff safety	41
1.2.9	Engagement with general practitioners	42
1.3	Person-centred care	44
1.3.1	Accessing external services	45
1.3.2	Flexible service provision	47
1.3.3	Human rights and responsibility	49
1.3.4	Working with people from culturally and linguistically diverse backgrounds	50
1.3.5	Working with Aboriginal and Torres Strait Islander peoples	52
1.3.6	Working with people with a disability	53
1.3.7	Paediatrics	55
1.3.8	Transition to adult services	57
1.3.9	Psychosocial issues	58
1.3.10	Medication management	60
1.3.11	Advance care planning and palliative care	63

2. Program management	65
2.1.1 Recruitment	65
2.1.2 Performance appraisal	66
2.1.3 Learning and development	67
2.1.4 Client record management	68
2.1.5 Data management	69
2.1.6 Research and evaluation	70
2.1.7 Quality improvement	71
2.1.8 Compliment, incident and complaint management	72
3. Corporate services	75
3.1.1 Corporate governance	75
3.1.2 Risk management	76
3.1.3 Private specialist ambulatory care services in public hospitals	78
3.1.4 Transport	79
3.1.5 Infection control	80
3.1.6 Emergency and disaster management	81
Glossary	83
Resources	93

Introduction

Introduction

The *Health independence programs guidelines* (guidelines) have been developed to provide direction for, and facilitate the alignment of, Post-Acute Care (PAC) services, Sub-acute Ambulatory Care Services (SACS), and Hospital Admission Risk Program (HARP) services.

A better client journey

The PAC, SACS and HARP programs encompass many of the services that deliver health care to support the transition from hospital to the home. These services can also prevent the need for a hospital presentation or stay, with many people accessing these services directly from the community.

Inpatient stays in hospitals continue to be shorter due to advances in medical treatment and consumer expectations to be treated in the community, where possible. Subsequently, demand for health independence programs will increase as future health services and consumer expectations continue to demand more emphasis on community treatment.

A person can require one or a combination of services delivered by health independence programs to meet their care needs. During an episode of care this may involve moving between health independence programs. The challenge is to ensure that the person receives the right care, in the right place, at the right time, unhampered by program boundaries.

Integrated PAC, SACS and HARP guidelines have been developed to enable a better client journey across the care continuum in transition from hospital to home or preventing hospitalisation. Each health independence program will continue to have its particular role but will be underpinned by common processes that facilitate improved health outcomes and community integration.

Health independence programs model of care

The client journey through the service system

The health independence programs model of care outlined in the service delivery section of the guidelines is conceptualised in terms derived from the *Victorian service coordination practice manual*. The health independence programs model of care is illustrated in Figure 1.

Figure 1: Health independence programs model of care



Alignment of health independence programs

The alignment of PAC, SACS and HARP is underpinned by seven key objectives:

- to simplify the service system
- to produce efficiencies in service delivery
- to minimise duplication
- to improve equity
- to enhance coordination
- to reduce fragmentation of service delivery across funding streams
- to enhance flexibility in service delivery.

Collaboration and coordination across the care continuum are key success factors for providing the best experience for clients enrolled in health independence programs. To provide integrated and coordinated care the inherent competencies and capabilities of the acute, sub-acute and community sectors must be consolidated. It is imperative that health independence programs within an organisation/geographical area establish effective working relationships with each other.

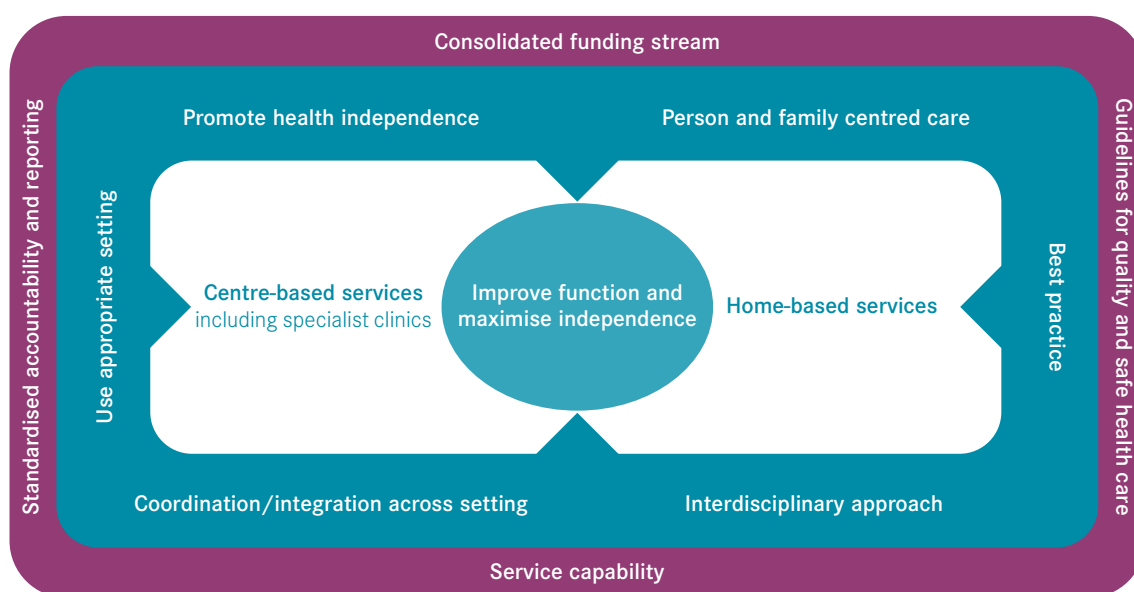
Health independence programs must work collaboratively with each other and other services, including Home and Community Care (HACC) and other community health services, to ensure that people have access to an appropriate range of services to meet their post-hospital and ongoing care needs.

These guidelines outline processes for aligning PAC, SACS and HARP. These processes include:

- a defined point of access to link a client into the range of services that a client needs
- common assessment practices and protocols, including sharing assessment and care planning information across different programs
- common referral practices and protocols to facilitate transition between programs
- coordination of services between programs
- guidelines for programs that are complementary and consistent
- processes that support continuity of care.

Figure 2 illustrates the integrated service platform that the department and health services are working towards for health independence programs. Common processes and core principles underpin the platform and will assist health independence programs in integration.

Figure 2: Health independence programs framework diagram



Aligned processes between health independence programs within an organisation or geographical area will also mean the limited health workforce is more efficiently used. Aligned programs will assist in minimising duplication for staff in transactions such as initial needs identification, assessment, care planning and implementation. The future ambulatory care workforce needs to be flexible and multi-skilled and able to deliver care in a variety of settings, including centre and home-based settings. Intervention should be delivered according to a client's need and not be constrained by program boundaries.

Policy context

Future policy direction is focused on aligning and integrating community-based programs to support the discharge from inpatient services and preventing or substituting for hospitalisation. These guidelines have been developed in line with relevant state policies and planning frameworks.

Improving care for older people: a policy for health services (2003)

www.health.vic.gov.au/older/improvingcare.pdf

A policy framework for the effective care of older people by health services, which focuses on integrating care across settings to ensure people have the appropriate care in the appropriate place.

Directions for your health system: Metropolitan Health Strategy (2003)

www.health.vic.gov.au/metrohealthstrategy/index.htm

A policy and planning framework for providing health care services across metropolitan Melbourne, including an expanded role for ambulatory care services as a cornerstone in the configuration of health care services.

Rural directions for a better state of health (2005)

www.health.vic.gov.au/ruralhealth

A policy and planning framework for developing rural health services in Victoria. Three broad directions have been identified: promote the health and wellbeing of rural Victorians; foster a contemporary health system and models of care for rural Victoria; and strengthen and sustain rural health services.

Care in your community: A planning framework for integrated ambulatory health care (2006)

www.health.vic.gov.au/ambulatorycare/downloads/care_in_your_community.pdf

A policy and planning framework for ongoing development of Victorian health services. The framework encompasses all community-based ambulatory care services. The vision is for a modern, integrated and person-centred health system aimed to meet the future needs and expectations of communities and individual users of health care services, and to provide integrated and accessible services in local communities.

Improving care: Hospital Admission Risk Program public report (2006)

www.health.vic.gov.au/harp-cdm/improvingcare.pdf

This report is an independent evaluation of HARP that outlines the characteristics of HARP projects and the integration into ongoing services. It identifies key outcomes of HARP and provides direction for further development of HARP services.

Victorian services coordination practice manual (2007)

www.health.vic.gov.au/pcps/downloads/sc_pracmanual.pdf

This manual defines the practices, processes, protocols and systems that support service coordination across Victoria.

Supporting principles

The following core principles underpin health independence programs. The principles are considered essential to delivering an effective service system, achieving better outcomes for clients and ensuring the right services are delivered at the right time and right place.

Person and family-centred care

Clients and their family and carers receive services that place the client at the centre of their care. A collaborative and respectful partnership exists between the service provider and client.

Quality, evidence-based and timely services

Clients and their family and carers receive services where practice meets quality standards, is based on the best available evidence and delivered in a timely manner.

Equity of access to services

Clients and their family and carers receive services that meet the needs of the client. Access to services is determined on clinical need.

Coordination and integration

Clients and their family and carers receive services that are coordinated and integrated across all settings ensuring a seamless transfer of care across acute, sub-acute and community settings.

Interdisciplinary approach

Clients, families and carers receive services that are based on an interdisciplinary approach.

Appropriate setting

Clients and their family and carers receive services that are delivered in the most clinically and culturally appropriate setting.

Promoting health independence

Clients and their family and carers receive services that promote health independence.

Guidelines overview

These guidelines outline the minimum requirements for developing a person-centred service model that promotes efficiency and effectiveness across the continuum of care.

The key components of service provision required of health independence programs by the department are stated within these guidelines. The guidelines will support consistency in health independence programs across the service system. The interventions and level of care identified as requirements to meet the guidelines are not prescriptive, allowing for individual services to structure their programs according to local needs.

The guidelines have been developed in accordance with the Evaluation and Quality Improvement Program 4 (EQulP 4) framework used by the Australian Council on Healthcare Standards.

The guidelines have been organised into three sections, service delivery, program management and corporate services.

- *Service delivery* includes requirements associated with model of care, program delivery and person-centred care practice.
- *Program management* includes requirements associated with human resource management, information management, research, and quality improvement.
- *Corporate services* include requirements associated with corporate governance, safe practice, environment and risk management.

Each component of the guidelines is structured in the following manner:

- program guideline, which is a description of the required service component
- context, which outlines the reasons for the guideline
- minimum requirements, which include recommendations to assist services in implementing the guidelines.

The guidelines are supported by a resource section and glossary. Resources have also been embedded into each guideline.

These guidelines should be used in conjunction with organisational quality standards of care, professional codes of conduct, legislative requirements and other regulatory and accreditation health care bodies.

It is anticipated that the guidelines will be reviewed and revised over time to ensure they reflect future development of the service system.

Health independence programs overview

Post-acute care services

Background

Post-acute care services aim to assist people discharged from a public hospital, including emergency departments, acute services and sub-acute services, who have been assessed as requiring short-term, community-based supports to assist them to recuperate in the community and to ensure a safe and timely discharge.

Admission to PAC is based on an assessment of the person's need for short-term community-based services and takes into account the person's health care needs and psychosocial factors that may impact on their capacity to safely recuperate in the community.

The key features of PAC are to:

- provide a rapid response to referrals for services to facilitate safe and timely discharge from a public hospital
- purchase and coordinate short-term, community-based services in response to individually assessed needs
- facilitate referral to longer term service providers where required.

The PAC service supports hospitals to manage bed demand by ensuring that people who no longer need acute care are able to safely return to the community with an appropriate package of community-based supports.

Target population

Post-acute care services provide individually tailored packages of services to people who have one or a combination of:

- a short-term need that requires community-based supports such as personal care and home care
- a short-term need for community nursing intervention such as wound dressing or a need for a short-term, single discipline allied health intervention
- caring responsibilities that they are unable to fully or partially meet in the short term. For example, a carer of a person with a disability who may need access to respite, or a woman discharged after a complex birth needing assistance with child care services.

The need for these services must be linked to their hospital presentation to qualify for PAC. PAC services are not available to private patients discharged from private hospitals.

Post-acute care services may also provide support when:

- a person cannot be safely discharged home because the physical home environment is unsuitable and services are required to support safe and timely discharge, for example, the home requires an industrial clean before the person can be safely returned there
- a person requires health care intervention while they are awaiting access to a program of rehabilitation and services are required to support safe and timely discharge. In this situation the PAC service would work in conjunction with the rehabilitation program to deliver the required care
- a person has longer term care needs and they are awaiting access or readmission to appropriate community-based services, such as HACC and district nursing, and services are required to support safe and timely discharge. In these situations the PAC service would work in conjunction with the community-based services to deliver the required care.

Types of services

Post-acute care has flexible funding to provide a broad range of services to meet individual needs. Services commonly provided include community nursing, personal care and home care, but the program is not limited in the types of services it can fund to meet individual short-term recuperation needs.

Sub-acute ambulatory care services

Background

Sub-acute ambulatory care services are available to people of all ages and may follow a hospital stay, hospital day attendance, or may be accessed directly from the community. SACS extend and complement inpatient services. SACS can be delivered in a client's home or at an ambulatory care centre.

The features of SACS are:

- a flow of care, where therapy in a community setting follows an inpatient hospital stay to assist people in achieving the maximum level of reintegration into their community
- individualised, time-limited, goal-centred episodes of care that aim to improve health outcomes
- the ability to reduce inpatient length of stay and prevent admissions and readmissions to inpatient services by providing people with home-based or centre-based therapeutic interventions, which prevent the deterioration of an existing condition and/or improve a client's functioning
- an interdisciplinary approach in which team members from different disciplines collectively set goals and share resources and responsibilities.

Target population

The aim of SACS are to help people who have a physical disability, are frail, chronically ill or recovering from traumatic injury or illness to regain and/or maintain optimal function, and to allow people to maximise their independence and return to, or remain in, their usual place of residence. Also, SACS aim to help people with newly emerging and chronic symptoms or concerns that require assessment, diagnosis and treatment, through a range of specialist clinics.

Types of services

Community rehabilitation: centre-based and home-based

Community rehabilitation services are time-limited and delivered according to a care plan that is based on goals negotiated with the client and their carer(s). The services should form part of an integrated team, working with clients where it best suits their need and preference for treatment and recovery. To maximise the opportunity for care continuity, community rehabilitation services are delivered in a number of settings including a client's home (home-based) or at a centre (centre-based).

Specialist clinics

Specialist clinics provide specialist assessment, diagnosis, intervention, management, education, advice and support to clients with specific conditions. Clinics commonly provide time-limited, specialist diagnosis and intervention to the client and referral onto appropriate mainstream services for ongoing management. They also provide consultancy, education and support to carers, relatives and professional service providers. Specialist clinics are delivered in a number of settings including a client's home and at a centre. Specialist clinics include:

- Continence clinics: for clients with bladder and/or bowel function difficulties. Continence clinics assess the need for, prescribe, and assist clients to access continence aids and equipment.
- Falls and mobility clinics: for clients with falls, mobility and balance problems. Falls and mobility clinics assess the need for, prescribe and assist clients to access falls prevention and mobility aids.
- Pain management clinics: for clients with chronic, non-malignant, persistent and ongoing pain. Management strategies are developed to assist clients.
- Cognitive dementia and memory services (CDAMS): for clients with newly emerging cognitive difficulties causing confusion, memory loss or thinking problems.

Other

There are a range of other clinical SACS. Such services focus on specialist clinical care areas, such as movement disorders, polio and wounds, and/or specific groups, such as young adults with complex care needs that are also part of the SACS service system.

Victorian paediatric rehabilitation services

Victorian paediatric rehabilitation services (VPRS) are for children and adolescents who, as a result of injury, medical/surgical intervention, or functional impairment, will benefit from a program of developmentally appropriate, time-limited, goal-focused interdisciplinary rehabilitation. The VPRS provide inpatient rehabilitation services at two tertiary sites in addition to ambulatory rehabilitation services. The VPRS model of care can be found at:

www.health.vic.gov.au/subacute/paed_rehab_model.htm.

Hospital Admission Risk Program services

Background

Hospital Admission Risk Program (HARP) services manage people with chronic disease, aged and/or complex needs who frequently use hospitals or are at risk of hospitalisation.

The key objectives of HARP are to:

- improve patient outcomes
- provide integrated seamless care within and across hospital and community sectors
- reduce avoidable hospital admissions and emergency department presentations
- ensure equitable access to health care.

Target population

The two streams of care provided by HARP are chronic disease and aged and complex care.

The chronic disease stream includes:

- chronic heart disease
- chronic respiratory disease
- diabetes
- other chronic disease.

The aged and complex care stream includes:

- complex aged care
- people with complex psychosocial needs
- people with complex needs requiring integrated care.

In 2007 HARP was expanded into rural hospitals through the HARP Better Care for Older People (HARP-BCOP) initiative. These services are Commonwealth funded and focus on people aged 65 years and older (or 45 years and older for Aboriginal and Torres Strait Islander people) with chronic and complex conditions who frequently present, or are at risk of presenting, to hospitals. For the purpose of these guidelines, HARP will be inclusive of HARP-BCOP.

Types of services

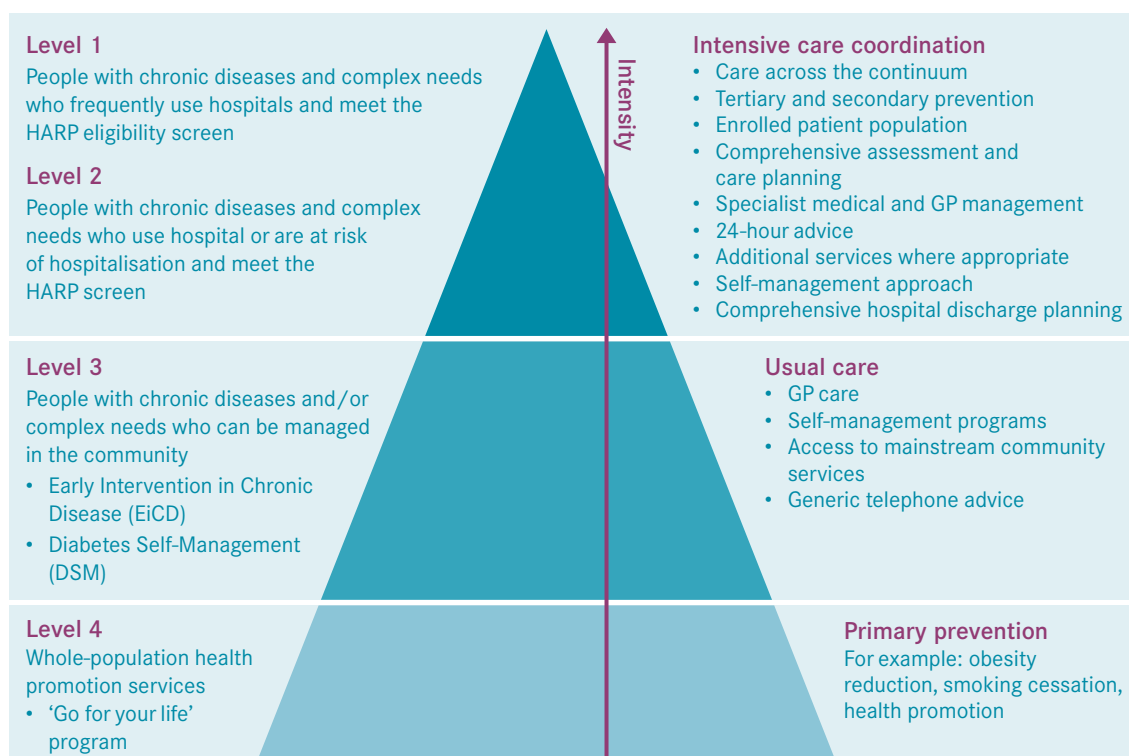
Hospital Admission Risk Program services are patient-centred, based on meeting clients' individual needs, which can include physical and mental health, psychosocial, and environmental needs. HARP services include hospital-based and community-based services.

Hospital Admission Risk Program services target people with high care needs, with a focus on chronic disease and complex conditions. HARP services include intensive community care coordination.

Figure 3 provides a diagrammatical representation of the differing service provision for people with chronic and complex care needs, ranging from intense service provision to generalist care. HARP services target people in levels 1 and 2, providing intensive care coordination. Within levels 1 and 2 the intensity of care coordination will vary depending on the client's needs. In some instances, clients may need significant input from the care coordinator, while others may need more emphasis on referral to appropriate services.

Management of chronic disease and complex conditions encompasses the continuum of care from prevention through to treatment and care management. As a client's condition and circumstances change, their needs will change and they will likely require different services (moving between the different levels in Figure 3). Therefore, health independence programs are required to work closely with other programs and initiatives to ensure the client's journey to different services is integrated and coordinated.

Figure 3: Levels of complex care and chronic disease management



Other initiatives targeting chronic disease management and complex care

Other programs and initiatives health independence programs make work with are described here, however the list is not exhaustive.

The Early Intervention in Chronic Disease (EiCD) and Diabetes Self-Management (DSM) initiatives target people at level 3 who are at early stages of their disease progression. It is acknowledged that the health situation of people with chronic disease and complex needs may fluctuate. It is imperative that HARP, EiCD and DSM initiatives complement each other and have established protocols for collaboration. Guidelines for EiCD and DSM can be found at:

www.health.vic.gov.au/communityhealth/cdm_guidelines.htm and
www.health.vic.gov.au/communityhealth/cdm/diabetes.htm.

Health promotion initiatives target the whole population and promote healthy lifestyle choices and are represented at level 4. The 'Go for your life' strategy promotes healthy and active lifestyles aimed at reducing people developing chronic disease. Further information in regards to 'Go for your life' can be found at www.goforyourlife.vic.gov.au.

Primary Care Partnerships (PCPs) also have an integral role in supporting the service system design required to support clients with chronic and complex care needs. PCPs work with agencies to improve the service system responsiveness to meet the needs of this client group. The work has an emphasis on change management, capacity building and is underpinned by a partnership approach.

Facilitating health independence program alignment

Health independence programs within an organisation and/or geographical area will need to establish partnership arrangements to facilitate alignment, where they do not already exist. Aligning health independence programs will improve knowledge of what others do and reduce duplication. Agency leadership and commitment, including executive engagement, appropriate governance and coordination arrangements, are important factors in assisting the partnerships between health independence programs to work.

Implementation of the guidelines

Aligning health independence programs across an organisation/geographic area will take time and may involve significant change. It is acknowledged that services are at different stages in terms of meeting the guidelines outlined in this document. The department has an expectation that all services will work towards implementing the guidelines during 2008–09.

1. Service delivery

The purpose of health independence programs is to deliver services to clients in need of ambulatory care. Common across the health independence programs is the model of care in which services are provided to clients. The model of care defines key points in the client's journey through a program, from entry, assessment, care planning and exit. The model of care is supported by key principles, including interdisciplinary care and evidence based practice, and is underpinned by person-centred care.

Section 1 defines the model of care and service delivery requirements of health independence programs

Section 1 is divided into three sub-sections:

- Client Journey
- Elements of program delivery
- Person-centred care

1. Service delivery

1.1 Client journey

It is important that clients have access to health services in a timely and seamless way. A client's journey will be improved by ensuring each person has access to initial screening for service requirements, streamlined access to appropriate assessment, care planning and services, and a planned transition and exit. Program guidelines in this section outline the health independence programs services' model of care.

Guidelines in this section:

- Access
- Initial needs identification
- Assessment
- Client consent
- Care planning and implementation
- Monitoring and review
- Transition and exit

1.1.1 Access

Program guideline

Form a defined point of access for all health independence programs within an organisation/ geographical area to simplify entry and support initial needs identification for clients, carers and referrers. Health independence programs will work towards an integrated access unit with a common telephone, facsimile and electronic referral system.

Context

Every health independence program service site staff member provides an initial entry point to the full suite of services. Each service site staff member will facilitate referral to a health independence program's defined point of access for initial needs identification to determine eligibility, prioritisation and services required. Undertaking the initial needs identification at the defined point of access will enable direct access for clients, and their families and carers, to appropriate services, intervention and information.

A defined point of access facilitates a smooth process for providers referring clients to health independence programs. It provides a point for coordination of referrals from emergency departments, hospital services, community services, clients and their carers.

A defined point of access facilitates patient flow from hospital by coordinating discharge planning referrals for any of the health independence program services. It provides for equity around referral management by screening all incoming referrals with the same process. A defined point of access provides consistency for referrers and assurance that the referral is received by the appropriate service for assessment and care.

Equity of access is paramount and should be independent of referral source. All referrals should be processed and then accepted or declined and prioritised based on clinical need. Health independence programs should accept clients if they are the closest service site to where a client lives.

A defined point of access eliminates confusion and ensures ease of contact to health independence programs for clients and carers.

Timely dissemination of referrals is essential, particularly where a same-day response to referrals is required to facilitate discharge from inpatient hospital services or to prevent a hospital admission.

Hospital and community-based health independence programs within a geographical area should collaborate to develop and implement a defined point of access. Health independence programs should also implement options that allow for efficient management of referrals across programs, including ward-based referrals. For example, where a health independence program staff member assists with a referral at a ward, it should be representative of all health independence programs and not individual programs.

Minimum requirements

Related program	
All	Establish or maintain a health independence programs defined point of access.
All	Coordinate all referrals through a defined point of access. This includes all referrals to health independence programs from emergency departments, inpatient and ambulatory services, general practitioners, medical specialists, clients and their carer/family and the community.
All	Inform referrers and services of the contact details for the defined point of access, including telephone, e-referral, email and facsimile details.
All	Develop policy and procedures that describe the referral process including referral documentation, information requirements, response times, reporting of referral outcomes and dispute resolution processes.
All	Processes are documented for gathering adequate information regarding the referral for registration and to inform decisions of eligibility, acceptance, prioritisation and the service(s) most appropriate.
All	Process all referrals received at the defined point of access. Where a client is not suitable for enrolment in a health independence program, the referrer, client and carers will be advised of a more suitable service, if available.
All	Notify referrers of the outcome of their referral including the reasons why a referral was not accepted.
All	Conduct initial needs identification (<i>refer to guideline 1.1.2 Initial needs identification</i>).
All	Staff the defined point of access with an appropriate skill mix to undertake initial needs identification for health independence program services.
All	Develop policy and procedures for referring clients to health independence programs closer to where the client lives.
All	Notify clients, and their general practitioners, of their enrolment into the health independence program when the referral is accepted.
All	Written information outlining the various health independence programs is available to all referring agencies and the community, in a variety of modes and languages, and is included in the <i>Human Services Directory</i> .
All	Provide continuing education, promotion and information of health independence program services to all referrers and potential referrers. This includes hospital staff who should be encouraged to undertake early discharge planning commencing at the time a client presents to hospital, as appropriate.
All	Adopt a common referral instrument. The service coordination template tools (SCTT) forms are recommended.
All	Collect and share referral information in accordance with the <i>Health Records Act 2001</i> and other requirements, such as mandatory reporting and duty of care.

Resources

Victorian service coordination practice manual: www.health.vic.gov.au/pcps/publications

Service coordination template tools (SCTT): www.health.vic.gov.au/pcps/coordination

Human services directory: <http://humanservicesdirectory.vic.gov.au>

Health Records Act 2001: www.health.vic.gov.au/healthrecords

Children, Youth and Families Act 2005:

www.office-for-children.vic.gov.au/every-child-every-chance/library/legislation

Health Services Act 1988: www.austlii.edu.au/au/legis/vic/consol_act/hsa1988161/

Mental Health Act 1986: www.austlii.edu.au/au/legis/vic/consol_act/mha1986128/

1.1.2 Initial needs identification

Program guideline

Initial needs identification will commence at the defined point of access to determine a client's need for services with consideration given to priority, risks, eligibility and the type and breadth of assessment and services to be provided by health independence programs.

Context

Initial needs identification is an initial screening process where the underlying issues and presenting issues are determined to the greatest extent possible. It is not a diagnostic process but is a determination of the client's risk, eligibility and priority for service and is a balancing of the service capacity and the client's needs.

Initial needs identification will commence at the defined point of access. The initial needs identification process facilitates appropriate acceptance of referrals and identifies the likely level of a client's need and priority. The process will determine if the client is eligible for a health independence program, including which program or combination of programs is most suitable to deliver the service. Once the initial needs identification process is completed, only clients that meet the eligibility criteria will be referred for further assessment.

Enrolment in a health independence program implies that the client has the potential to benefit from early diagnosis, advice, support and targeted interventions designed to optimise their ability to return to, and/or function in, the community.

Programs collect and use a range of information to make decisions about the most appropriate response for a client. Initial needs identification will assist in prioritising referrals according to clinical need and determining the level of assessment required. The process assists clinicians to identify the needs, risks, capabilities, existing supports and eligibility of the client.

Minimum requirements

Related program	
All	Processes and tools for screening a client's eligibility and risk for programs, obtaining a client's consent and prioritising referrals are defined and documented.
All	Criteria for eligibility and prioritisation of referral are disseminated to relevant referrers and are available to clients and carers.
All	Upon receipt of referral, the defined point of access screens to determine the prioritisation, the level of assessment (common, comprehensive or specialist) and clinical setting required.
All	Determine and document if interpreter services are required.
HARP SACS	Upon receipt of a referral, notify clients within three working days. Inform clients of the approximate waiting time for the service, if applicable.
All	Screening involves using predetermined criteria to identify those clients most likely to benefit from a comprehensive assessment.

Related program	
All	Referrals that will facilitate safe and timely discharge from hospital or prevent a hospital admission are triaged as a priority.
All	Initial safety risk screening is completed by a defined point of access for all clients referred for health independence program services (<i>refer to guidelines 1.2.8 Client and staff safety and 3.1.2 Risk management</i>).
All	Notify clients when services will commence (when known).

1.1.3 Assessment

Program guideline

On enrolment, an assessment that builds on information collected through initial needs identification is conducted for every client. The level of assessment (common, comprehensive or specialist) will depend on the purpose of the referral and the clinical judgement of the client's need. Reassessment may be required if there is a significant change in medical or functional status or the client has been on the program for an extended period of time.

Context

Assessment ensures that the current and ongoing needs of the client are identified and documented. All clients should receive either a common or comprehensive assessment followed by a specialist assessment where required.

In determining the level of assessment required (common, comprehensive or specialist) the following should be considered:

- reason for referral to program
- recent assessment and intervention that has occurred by referring service and if the health independence program has access to this information
- whether client has multiple and complex needs.

In determining the level of assessment, duplication of assessments should be avoided, as it is inconvenient for the client and inefficient.

Assessing the needs of a client's carer may assist to prevent carer stress and carer crises and thereby assist in preventing client readmissions.

A common assessment is appropriate where a client has been referred for a specific intervention and the initial needs identification has indicated a comprehensive assessment is not required. Common assessments will include key medical, functional and social information and should be used across clinical disciplines.

A specialist assessment builds upon a common assessment and is appropriate where a potential health issue, such as a chronic disease, dementia, pain or complex psychosocial needs, has been identified. It is often required to reach a diagnosis, develop a care plan, undertake interventions and, where necessary, facilitate referrals.

A comprehensive assessment is appropriate where a client may have multiple medical, physical and psychosocial problems impacting on their health. Many of these problems can go unreported, unrecognised and untreated. It is often older clients and clients with multiple and complex needs who would most benefit from a comprehensive assessment. Performing a comprehensive, multidimensional, interdisciplinary assessment is recognised as the best means for identifying these problems and informing the development and implementation of an appropriate care plan.

Minimum requirements

Related program	
All	Processes for assessment are defined and documented.
All	Obtain client consent for assessment (<i>refer to guideline 1.1.4 Client consent</i>).
All	A health independence programs safety risk assessment is completed (<i>refer to guidelines 1.2.8 Client and staff safety and 3.1.2 Risk management</i>).
All	All clients are assessed at the beginning of any health independence program to identify issues for care planning.
All	Clients are provided with either a common or comprehensive assessment that may result in referral for a specialist assessment.
All	Avoid duplication, where possible, by reducing multiple assessments.
All	Assessment may be conducted by a single clinician or multiple clinicians across disciplines, depending on the nature of the referral and the client's perceived problems.
All	All clients and carers' assessments are documented within the client record.
All	A comprehensive assessment generally considers the following: <ul style="list-style-type: none"> • functional ability • cognitive ability • psycho-social issues • functional communication ability • living environment • access to transport • social supports and client/carer goals • medical status and medications.
All	Obtain information for the assessment from the client, referrer, carer/family, general practitioner or other external service providers.
All	Identify clients who require more specialised care and link them with other services, as appropriate (<i>refer to guideline 1.3.1 Accessing external services</i>).
All	Inform all members of the health independence program team involved with the client of the findings of the common, comprehensive or specialist assessment.

Resources

A guide for assessing older people in hospitals Australian Health Ministers' Advisory Council's Care of Older Australian Working Group, Melbourne. See the Metropolitan Health and Aged Care Services Division website at: www.health.vic.gov.au/acute-agedcare.

1.1.4 Client consent

Program guideline

Informed consent for assessment and treatment is obtained before commencing a health independence program intervention or participation. Consent to sharing personal information, including when referring between services, is also obtained.

Context

In line with the *Victorian public hospital patient charter* clients and their families have the right to be fully involved in decisions about their care. Clients have the right to protect the privacy and confidentiality of their own information without impacting on their right to ongoing treatment and care. Clients also have the right to decide who their information is shared with.

Clients have the right to be informed about the consent process and to consent to assessment and treatment. Clients require information about the purpose of sharing their information in order to make an informed decision about releasing their information.

The client must have the capacity to understand the nature of what they are consenting to and the implications for providing or withholding consent. Where the clinician is satisfied that the client does not have the capacity to make a decision about disclosure of their information, consent can only be sought from the client's 'authorised representative'. Refer to Section 85(6) of the *Health Records Act 2001*, which defines the classifications of individuals that may act as 'authorised representatives'. In all instances, proof of the representative's authority must be sighted and a copy of that document placed in the client's medical record.

The Act requires that information about an individual is used or disclosed only for the primary purpose in which that information was collected. When collecting personal information for that primary purpose, the Act requires that an organisation obtains consent from a person to use the information in a particular way or to provide the information to particular people. If the individual or an authorised representative cannot give consent, collection, use or disclosure of personal information may be authorised if it is necessary in order to provide a health service to the individual.

An organisation must not use or disclose information for a secondary purpose unless the individual consents to the disclosure or one of a number of other exceptions under the Act apply. Of particular relevance to health independence programs' clients are the following exceptions:

- the secondary purpose is directly related to the primary purpose and the client would have reasonably expected the organisation to use or disclose the information in such a way
- the client has consented to the secondary use or disclosure
- the use or disclosure of the information is necessary for providing a health service to the client that was not considered when the information was first collected. The client lacks the capacity to consent and an authorised representative cannot be reasonably located or does not exist.

Minimum requirements

Related program	
All	Obtain consent from clients for, and prior to, assessment, treatment and to share their information. Inform clients of the purpose for sharing their information.
All	Obtain consent from clients before referring any information to other agencies.
All	Use the SCTT consent form (or other appropriate documentation).
All	Consent forms for sharing client information are consistent across health independence programs within an organisation.
All	Ensure that staff are aware that consent from clients must be documented.
All	Documentation of consent is filed in the client's record.
All	Adhere to privacy laws and organisational policy.
All	Assist clients with making an informed decision about consent by discussing: <ul style="list-style-type: none"> • the nature of the assessment, intervention and the proposed care offered • the probability of assessment outcomes, achieving care and treatment goals • any negative aspects of the assessment and treatment • reasonable alternatives to the proposed assessment, care and treatment, including the possible results of receiving no assessment, treatment or care • any limitation on the confidentiality of information learned from or about the client.
All	Develop a policy for consent for health independence programs that addresses: <ul style="list-style-type: none"> • the process used to obtain consent • how consent is documented in the client's record • how a client's capacity to provide informed consent is determined, including clients with a disability • when a carer, family member, medical power of attorney or person responsible may give consent • using interpreters when the client is not proficient in English, and assistance for people with communication difficulties.
All	Process and procedures are in place for clients who do not consent to sharing their information between services.
All	Ensure the transfer of client record information is confidential, secure and adheres with privacy laws.

Resources

SCTT consent form: www.health.vic.gov.au/pcps/coordination/sctt2006.htm

Victorian public hospital patient charter: www.health.vic.gov.au/patientcharter

Health Records Act 2001: www.health.vic.gov.au/healthrecords

Consent information brochure in different languages, can be found at: www.health.vic.gov.au/pcps/publications/languages_privacy.htm

1.1.5 Care planning and implementation

Program guideline

Services meet the individual needs and goals of clients. A care plan is developed and implemented following the initial assessment and is provided to all relevant parties with the client's consent.

Context

Care planning is a process to outline how the issues identified in an assessment or review of the client's needs will be managed. This may involve linking into a range of services, identifying how self-management and education will be provided, and setting up communication between the general practitioner and other people involved in providing care to the client. Care planning involves balancing competing needs and assisting clients to make decisions that are appropriate to their needs, wishes, values and circumstances.

Each client will have different needs and expectations. A consultative, collaborative approach to care that actively involves the client, their family/carers and an interdisciplinary team ensures the best possible outcomes for the client. The purpose of care planning is to set out the goals with the client and establish how these goals will be met through a range of interventions.

Following the initial assessment, a care plan is developed to ensure all people involved in implementing the care plan are working towards the same goals.

Care plans may take slightly different forms. For example, for PAC services care plans will encompass developing a service plan including linkages with ongoing service providers. For specialist clinics the care plan would encompass developing a diagnosis for those with emerging symptoms, managing a chronic condition and referral to ongoing service providers.

When developing a care plan for clients with chronic and complex needs, case conferences with the client, and their family and carers, should be considered. Proactive interventions for chronic disease management should also form part of the care plan. For example, notify a physician and request a medication review for clients with chronic heart failure with fluid weight gain.

Involving the general practitioner, with the client's consent, is essential to facilitate continuity of care. General practitioners remain responsible for the medical management of clients while they are receiving services from health independence programs.

Care plans will evolve in response to changes in the client's circumstances, diagnosis or as additional issues present.

To ensure appropriate expectations are created, a timely plan of discharge and transfer of information are important components of the care plan.

Minimum requirements

Related program	
All	Processes for developing a care plan are defined and documented.
All	Initial care plans are developed within 10 working days of the initial assessment and dated.
All	The care plan is goal-oriented, time-limited and based on the best available evidence.
All	Develop a care plan that includes the client's goals and meets their needs including: <ul style="list-style-type: none"> • issues • effect of issues • required intervention • self-management strategies • carer needs • ongoing proactive monitoring of progress and achievement of goals • regular review mechanisms • appropriate recommendations from evidence-based clinical guidelines • discharge strategy and transfer of information • linkages with ongoing service providers and their contact details.
All	The client, interdisciplinary team, general practitioner and carer/family work in partnership to develop the care plan. The care plan may also be developed with relevant community services involved in providing care.
All	The care plan may involve interventions by only one staff member or may require input from the entire team. If many people are involved in implementing the care plan consider a case review or case conference.
All	Provide a copy of the care plan to the client, in an appropriate language or format, to ensure the client is aware of the goals of their treatment plan.
All	Provide a copy of the care plan to all other relevant parties for reference throughout the client's involvement with the services (with client consent).
All	Allocate a care coordinator to each client. Inform the client, their carer and family of the care coordinator's name, contact details and role (<i>refer to guideline 1.2.2 Care coordinator</i>).
All	Provide adequate information to the client, and their family and carers, to enable them to understand and manage their condition.

1.1.6 Monitoring and review

Program guideline

In conjunction with the client, monitor and review their care plan during implementation and when goals have been achieved, or at completion of the specialist assessment.

Context

As the needs of a client can change, it is important to regularly review (in conjunction with the client) their needs and their care plan. Regular reviews of a client's care needs throughout their intervention will ensure that appropriate care continues. The need for, and timing of, a review should be determined as part of the care plan.

Proactive monitoring can disclose any warning signs of deterioration as well as the need for alternative or additional service provision. Proactive monitoring can also reduce the need for, or extent of, acute health care utilisation.

Continuous review of the care plan and the goals set ensure that implementation remains person centred and that the client remains motivated to participate. Updating the client's goals, and setting new goals as others are achieved, ensures that client's goals continue to provide a focus for treatment.

Evaluation at the end of intervention ensures that all aspects of the care plan were delivered and assessed for their effectiveness.

Case conferences provide a time to reflect on a client's achievements against their care plan and to review the care plan in terms of the client's latest goals. Specialist clinics may require a case conference once a diagnosis has been made. Clients enrolled in PAC services, where intervention is less complex, may not require a case conference. Priority for case conferences should be directed to clients in crisis, long-term clients and clients being discharged.

All health independence programs should review the care plan using an interdisciplinary approach (*refer to guideline 1.2.1 Interdisciplinary approach*).

Minimum requirements

Related program	
All	Processes for monitoring and reviewing care plans are defined and documented.
SACS HARP	The care plan and goals for each client are reviewed. This may be in a case review or in a case conference.
SACS HARP	Criteria and processes for case conferences are defined and documented.
All	Changes in the care plan are communicated adequately to all concerned.

Related program	
All	Mechanisms for monitoring and reviewing may include: <ul style="list-style-type: none"> • client self-monitoring • reassessment • telephone contact • community-based clinic • general practitioner review • teleconferencing or videoconferencing • outreach and home visit • case conference • case review • family and carer meetings • a combination of the above.
All	Consider the frequency at which reviews should occur as appropriate for clients, and develop standards and pathways. Ensure all clients are reviewed in an ongoing manner until discharged and that all contacts are documented within the client record and care plan. Ensure crisis reviews can be undertaken.
All	Care plans are reviewed on an ongoing basis.
All	Care is evaluated by the interdisciplinary team following discussion with the client and, when appropriate, with the carer and family.
All	Care plan reviews consider client and staff risk (<i>refer to guideline 1.2.8 Client and staff safety</i>).
All	Care plan reviews consider the changing needs of the clients and/or their carer.
All	Facilitate prompt review by appropriate services, including general practitioners, where deterioration in a client's condition is noted.
All	The care plan and achievement of the client's goals are reviewed following the completion of the intervention to determine effectiveness.

1.1.7 Transition and exit

Program guideline

The process of discharge from health independence programs includes addressing a client's ongoing care needs, and is planned and coordinated in partnership with the client, carer and family. The discharge plan is communicated to relevant parties including the client's general practitioner.

Context

Services provided by health independence programs are goal orientated and time limited therefore adequate processes for safe discharge are required, including setting up the provision of care to address the ongoing needs of the client when required. The potential for clients to re-enter the service is, in part, dependent on the effectiveness of the client's transition and exit out of the program. The process of reenrolment to the service for further assessment or care should be based on clinical need.

Health independence program clients are often facing a change in their health status and frequently require ongoing care and management, including self-management. Referral to ongoing care providers can assist the client to live in the community and self-manage.

A planned approach, with appropriate communication and transfer of information to service providers of ongoing care, is essential to alleviate delays in meeting a client's care needs. Established and agreed referral processes between services will facilitate smooth and timely referrals, avoiding delays in care and service duplication.

Following up clients prior to discharge by the care coordinator is an important part of facilitating transition from health independence programs and reviewing discharge plan arrangements.

Discharging clients assists with throughput and access for new clients.

Minimum requirements

Related program	
All	Discharge planning commences on the client's admission to the service, is regularly reviewed and is documented as part of the care plan.
All	Discharge occurs when: <ul style="list-style-type: none"> • the client has achieved all the goals documented in their care plan and no more goals are identified (for some specialist clinics this may be when diagnosis has been completed) • the client is not complying with the program and all appropriate attempts to address issues have been made (in this instance inform the general practitioner and provide them with a copy of the care plan) • the client no longer wishes to take part in the program • the client has been referred to another service that is more appropriate to meet their needs • the client has moved from their place of residence and has been referred to services closer to their new residence • following a review (which could be via a phone call or face to face) it is decided that there will be no more measurable benefit from continuing the service • potential risk to the client or staff prevents service provision • the client dies.

Related program	
All	Where required, link clients with ongoing community services (such as HACC) or ongoing support programs to improve or maintain their level of function.
All	The SCTT is used across all health independence programs for transferring client information and referring clients.
All	Check that all aspects of the discharge plan have been achieved and referrals are followed up prior to discharge.
All	In consultation with the client's general practitioner, consider accessing chronic disease management Medicare items for access to private allied health and nursing items if ongoing support is required.
All	The discharge summary includes a summary of the interventions provided and outcomes achieved, as well as where required arrangements for transfer of care, including referral to other community and support services. Any relevant risks identified should also be included.
All	A copy of the discharge summary is filed in the client's record.
All	Clients should receive information about their discharge in an appropriate form they can understand.
All	The discharge summary is provided to the client's general practitioner and any other appropriate associated services within five working days of discharge from the health independence program, with the client's consent (<i>refer to guideline 1.1.4 Client consent</i>).
All	A process for transferring care, including transferring information, is documented.
HARP SACS	Develop a management plan, in conjunction with the client, to access appropriate services if they deteriorate post-discharge.
SACS HARP	Planned reenrolment, at regular intervals, for a period of rehabilitation or clinical review may be appropriate for some client groups, particularly clients with degenerative neurological conditions or chronic disease.

Resources

Improving patient transition from hospital to the community. A good practice guide for hospitals, November 2003: www.health.vic.gov.au/discharge/patrans.htm

SCTT: www.health.vic.gov.au/pcps/coordination/sctt2006.htm

Chronic disease management Medicare items (previously known as enhanced primary care or EPC items): www.health.gov.au/internet/wcms/publishing.nsf/Content/pcd-programs-epc-chronicdisease

1.2 Elements of program delivery

A number of core components underpin service delivery to support a seamless client journey and appropriate care.

Guidelines in this section:

- Interdisciplinary care
- Care coordinator
- Appropriate setting
- Evidence-based practice
- Health promotion
- Consumer involvement
- Self-management
- Client and staff safety
- Engagement with general practitioners

1.2.1 Interdisciplinary approach

Program guideline

Provide an interdisciplinary approach to client care, with access to a multidisciplinary team that works across hospital and community settings.

Context

In an interdisciplinary approach, team members from different disciplines collectively set goals and share resources and responsibilities. The shift towards an interdisciplinary approach to care better reflects the person-centred model of care.

An interdisciplinary approach is characterised by:

- the provision of effective and efficient care from health team members with expertise specific to a client's problem
- optimal care planning with the client's goals as the focus of the care plan
- improved collaboration and quality of care as a result of individual disciplines using their knowledge of other disciplines
- coordination through teamwork to ensure all aspects of the client's care are addressed
- reducing delays in care provision and eliminating duplication by providing well-integrated and coordinated care based on the client's needs.

Clients may require expertise from multiple disciplines to comprehensively meet their care needs. An interdisciplinary approach facilitates teamwork and coordination to ensure all the aspects of the client's care are addressed. Where a program consists of only a single discipline, an interdisciplinary approach to care is still possible and should be used.

Health independence programs require an interdisciplinary team that works across hospital and community settings.

Minimum requirements

Related program	
All	Provide an interdisciplinary approach to care with access to a multidisciplinary team that may include hospital providers, community providers, general practitioners and other medical specialists working in partnership. The client and their carer/family form part of the interdisciplinary team.
All	Encourage team building where team members share knowledge from their discipline and where team members appreciate the unique skill set that each discipline contributes in the overall provision of care.
All	Each client should receive a common or comprehensive assessment and be referred for specialist assessment where appropriate (<i>refer to guideline 1.1.3 Assessment</i>).

Related program	
All	Foster an interdisciplinary approach by ensuring all members of the team are aware of the findings of, and have the opportunity to contribute to, the assessment, care plan and monitoring and review process. Members should participate in case review or case conferences where appropriate.
All	Form links with other services and build capacity through education, mentoring and skills sharing, particularly where there are workforce shortages.
All	Where clinicians identify the need for additional specialised skills arrange joint assessment/ treatment sessions and seek additional professional development and education sessions to develop the required skills.

1.2.2 Care coordinator

Program guideline

Allocate a care coordinator for each client. The care coordination role can vary in intensity and will depend on the needs of the client.

Context

The HARP and PAC programs routinely have care coordinators employed as part of the service. In SACS, the role of care coordinator is usually performed by one of the treating therapists as a function of their role. This role is often termed key contact person or liaison person. The term care coordinator is used to replace key contact person throughout this guideline. The care coordinator's level of involvement will vary depending on the client's needs.

A care coordinator facilitates appropriate supports and services for clients and carers. This role ensures continuity of care, integrated care, and development of a collaborative care plan. This role fosters communication between the client, carer and all providers across the episode of care ensuring continuity of care and reduces duplication of services.

A care coordinator provides one main point of contact that will assist clients and carers to navigate the service system and facilitates the provision of proactive care. A care coordinator provides one main point of contact for general practitioners and other service providers if they have any questions or seek an update on a client's progress.

At any time a client may be receiving services from more than one health independence program. Ideally a client will have one care coordinator across the health independence programs who is responsible for coordinating the client's care and services overall.

A care coordinator may change during a client's episode, however the care coordinator is responsible for notifying the client, carer, general practitioner and other health independence programs staff of the change and the new care coordinator's details. The defined point of access should also have a record of each enrolled client's care coordinator to ensure that appropriate service providers and stakeholders can contact them.

Minimum requirements

Related program	
All	A care coordinator is allocated to each client on enrolment into health independence programs. Where possible appoint one care coordinator across all the services.
All	The care coordinator liaises and communicates with the client, service providers and key stakeholders.
All	The care coordinator coordinates the assessment, implementation of the care plan (including case conferences), monitoring, review, transition and exit.
HARP	The care coordinator is responsible for conducting the comprehensive assessment.
All	The care coordinator facilitates access to a specialist assessment, where required, to ensure early identification of risk, exacerbation or decline.

Related program	
All	The care coordinator is responsible for ensuring that a care plan is developed. This plan should address the client's goals and needs, and carer needs, and include self-management strategies and appropriate recommendations from evidence-based clinical guidelines. The care coordinator is responsible for proactively monitoring the care plan, including regular review.
HARP	The care coordinator prepares an emergency care plan and disseminates it to the client and carers.
All	The care coordinator is responsible for ensuring that supports and services for clients and carers are initiated.
All	The care coordinator is responsible for ensuring that information, education and self-management interventions are provided and facilitates client empowerment where appropriate.
All	The care coordinator may operate across hospital and community settings. The care coordinator is located in the most appropriate setting to best meet clients' needs and their own needs in relation to having access to decision making, peer support and communication.
All	The defined point of access has a record of who the care coordinator is and their contact details (<i>refer to guideline 1.1.1 Access</i>).
All	The care coordinator notifies the client, carer, general practitioner, other practitioners, the defined point of access and relevant health independence program staff when a client's care coordinator changes and provides the new care coordinator's contact details.

1.2.3 Appropriate setting

Program guideline

Clients have access to centre-based and home-based services, with their care delivered in the most appropriate clinical setting.

Context

The decision about whether a client receives their care at home¹, a centre, or a combination of both settings, is determined by clinical criteria and should be subject to review as determined by the client's needs. The setting needs to be convenient for the client but also clinically appropriate for the providers and enable them to provide high-quality care.

SACS and HARP services will be staffed by an integrated team across settings. The treating clinicians provide home-based or centre-based services to the client, determined by the client's need. This maximises the opportunity for service continuity to clients. Wherever possible the choice of venue should take into consideration the client's needs, goals and preferences.

Minimum requirements

Related program	
All	Clearly define the initial needs identification process for identifying the most appropriate setting.
All	Provide care in the setting agreed to by the client (home or centre), where it is safe, appropriate and cost-effective.
All	Consider the client's carer and family in the choice of setting for care provision.
All	Match a client's needs for assessment and treatment with the setting in which it should be provided to determine the appropriate setting for care.
All	Where a client is suitable for a group program or requires special equipment, centre-based rehabilitation is recommended.
All	Check that the client's home environment is suitable for care provision and in line with <i>guidelines 1.2.8 Client and staff safety and 3.1.6 Risk management</i> before providing care in this setting.
All	Care coordinators operate across hospital and community settings and are located in the most appropriate setting to best meet clients' needs.

1. Home is inclusive of school, workplace and other community-based settings relevant to the client.

1.2.4 Evidence-based practice

Program guideline

Services are planned and delivered based on the best available evidence and in the most effective way.

Context

The effectiveness of health care relates to the extent to which a treatment, intervention or service achieves the desired outcome. There is a large volume of research-based evidence available to inform health services of the strategies and methods that should be employed in order to provide the most effective care, services and interventions. Evidence-based care results in improved health outcomes for clients.

Health independence programs should ensure services are delivered in line with this evidence to ensure they are as effective as possible. Health independence programs should foster a culture of evidenced-based treatment practices among staff.

Minimum requirements

Related program	
All	Services and treatment interventions are based on the best available evidence.
All	Evidence-based clinical practice guidelines are used, when available.
All	Interventions that are most effective are utilised, whenever possible.
All	Key processes within health independence program services are well documented to ensure consistency.
All	Evaluate health independence program services and procedures regularly to ensure care is delivered effectively.

1.2.5 Health promotion

Also refer to guideline 1.2.7 Self-management

Program guideline

Provide health promotion interventions, where appropriate, and develop close links with community health services and other providers of health promotion interventions.

Context

The aim of health promotion is to enable individuals to increase control over and improve their health. Health promotion should be addressed across the care continuum, from prevention through to treatment and management. Health independence programs should ensure that access to appropriate health promotion and prevention strategies is available to all clients. This will involve determining what activities should be provided and where activities are best delivered, as well as providing information about the community services that offer health promotion activities. Clients, their family and carers should be empowered to take more responsibility for their health care.

Health promotion is considered a core quality dimension of health services. Providing health promotion services is an important factor for sustained health, quality of life and efficiency.

Minimum requirements

Related program	
All	Recognise the importance of health promotion in the holistic management of clients.
All	Provide health promotion and community education programs, where appropriate.
All	Refer clients to, or provide information regarding, community services that provide health promotion activities.

Resources

Department of Human Services health promotion website: www.health.vic.gov.au/healthpromotion

Care in your community: www.health.vic.gov.au/ambulatorycare/careinyourcommunity/index.htm

Health promoting hospitals: www.euro.who.int/healthpromohosp

1.2.6 Consumer involvement

Program guideline

Seek input from clients, carers and the community in planning, delivering and evaluating health independence program services.

Context

Consumer participation is the process of involving clients and their carers in decision making about their own care, in health service planning, policy development, priority setting and addressing quality issues in service delivery. Consumer participation is recognised as an essential component of quality care. There is increasing evidence that consumer participation in health care leads to better health outcomes and quality of life.

Health independence program services should recognise the importance of consumer involvement in the service. Services should have a strong consumer focus and be involved in enhancing and responding to consumer participation. This process enables consumers to be involved with services in problem solving, improves service quality and allows the services to be more responsive to the needs of consumers.

Mechanisms for obtaining consumer feedback include surveys, forums, focus groups and involving consumers in committees, including the Health Services Community Advisory Committee.

Minimum requirements

Related program	
All	Mechanisms are in place for obtaining regular feedback from clients and carers. Processes are documented.
All	The process for collecting clients' feedback is of minimal inconvenience to clients.
All	Consumer feedback is gathered, collated and evaluated on an ongoing basis.
All	Recommendations are acted on in a timely manner.
All	Communication from health independence program services regarding consumer feedback is transparent, frequent and summarises changes made as a result of consumer participation.
All	Consumer consultation processes are inclusive of all client groups including clients from culturally and linguistically diverse backgrounds, Aboriginal and Torres Strait Islander peoples, clients with a disability and clients with cognitive impairment.
All	Conduct consumer forums when evaluating and redesigning components of health independence program services. A yearly consumer forum is recommended as a minimum.

Resources

Consumer participation: www.participateinhealth.org.au

Doing it with us not for us participation policy (2006–09): www.health.vic.gov.au/consumer

1.2.7 Self-management

Also refer to guideline 1.2.5 Health promotion

Program guideline

The principles of self-management underpin interactions between clients/their family/carers and clinicians. There is a range of ways in which self-management principles can be delivered; clinicians should explore the most effective method for the individual client.

Context

There is growing recognition that people have enormous potential to influence their own health outcomes if they are actively involved in decision making and are provided with quality information and appropriate self-management skills.

Improving the capacity of people to manage their own health also reduces their need to receive health services.

Minimal requirements

Related program	
All	Assess the client's and carer's suitability for self-management programs.
All	Encourage clients to educate and self-manage themselves, where appropriate.
All	Tailor self-management strategies to the needs of the client. Consider the client's stage of disease progression, comorbidities, level of education and literacy, cultural and language needs, personality, motivation, mobility, psychosocial factors, emotional situation, cognition and carer involvement when determining the most effective self-management approach.
All	Educate the client's carer and family, where appropriate.
All	Suggest to clients to use symptom diaries and action plans in their self-management, where appropriate.
All	Ensure action plans for self-management and education are documented in each client's record and care plan. Document level of self-management and behaviour change.
All	Encourage collaboration between clients/their family/carers and clinicians to facilitate self-management and ensure all are actively involved in decision making.
All	Provide information that is consistent across the interdisciplinary team.

1.2.8 Client and staff safety

Also refer to guideline 3.1.2 Risk management

Program guideline

Consider the safety of clients and staff when determining the intervention and setting for service delivery.

Context

Each agency has a duty of care to protect the safety of clients, staff and others.

It is the responsibility of health independence program organisations to provide safe care to all clients and a safe environment for staff and clients. Ensure that efforts are made to reduce the possibility of harm to clients and staff within the service. Identify the risk of harm to clients and develop strategies and safeguard to prevent risk.

Determine and address the key components of safety for the services based on the client mix and known and potential risks.

Minimum requirements

Related program	
All	Identify risks and manage them in order to minimise adverse events and optimise the safety of clients and staff.
All	When conducting an assessment and/or developing a care plan, assess and document the foreseeable risk to the client of participating in certain activities.
All	At-risk behaviours are clearly communicated with the client and documented.
All	Consider the safety of clients and staff when deciding whether home-based or centre-based intervention is more appropriate.
All	For clients to be treated at home, they must have a suitable home environment with safe access and carer support available when required (<i>refer to guideline 3.1.2 Risk management</i>).
All	Refer clients who are assessed as at risk of harm to the appropriate service for management.
All	Where the client does not have the capacity to make a decision consult with the client's 'authorised representative' (<i>refer to guideline 1.1.4 Client consent</i>).

1.2.9 Engagement with general practitioners

Program guideline

Actively engage with a client's general practitioner; for some clients this may also encompass engaging with other general practice staff including the practice manager or practice nurse. Actively engage with other medical practitioners, such as a paediatrician or physician.

Context

General practitioners are integral to client management and ensuring coordinated care in the community. The exchange of client information and shared care planning with general practitioners will improve continuity of care for clients. General practitioners play an important role in initial needs identification, assessment, referral, medical management, medication review, care planning and review.

Minimum requirements

Related program	
All	Request clients provide details of their general practitioner.
All	Assist clients who do not have a general practitioner to nominate a general practitioner. The <i>Human services directory</i> may assist.
All	Obtain the consent of clients to engage with their general practitioner (<i>refer to guideline 1.1.4 Client consent</i>).
All	<p>With the client's consent:</p> <ul style="list-style-type: none"> once a referral has been accepted notify the client's general practitioner of their enrolment, care coordinator contact details and information regarding the referral, ideally within one working day request any relevant care plans, medical history and medication list provide the client's general practitioner with documentation of the care plan, services initiated, tests and follow-up appointments provide regular information to the general practitioner of the client's progress in the program and discharge planning arrangements within a minimum of five working days of the client's discharge from the health independence program, notify their general practitioner and provide a copy of the discharge summary.
All	Encourage and accept input from the general practitioner regarding the care plan.
All	Provide verbal information via phone to the general practitioner or practice nurse for urgent issues.
All	Provide written information by secure electronic transfer, fax or mail for non-urgent issues, including notice of enrolment and the care plan. Ensure the general practitioner can accept electronic information transfer securely.
All	Communicate with general practitioners in a concise and timely manner, ideally through the care coordinator.

Related program	
All	Work with existing general practitioner liaison units and the relevant Divisions of General Practice to develop appropriate communication channels between health independence programs and general practitioners.
All	Encourage and work with general practitioners to use the chronic disease management Medicare items for care planning and review.
All	Document processes for engaging with general practitioners.

Resources

Human services directory: <http://humanservicesdirectory.vic.gov.au>

Chronic disease management Medicare items: www.health.gov.au/epc

Working with general practice Department of Human Services position statement:
www.health.vic.gov.au/communityhealth/downloads/gpc_dhs_positionstatement_jan08.pdf

1.3 Person-centred care

Person-centred care is treatment and care that places the client at the centre of their own care and considers the needs of the client's carers.

Person-centred care is based on a collaborative and respectful partnership between the service provider and client, which includes involving clients and carers in goal setting and decision making. Involving clients helps health services to better recognise and deal with issues that are central to the client's recovery, promoting health independence.

Person-centred care respects the wishes and needs of the client and carer. Health services have a responsibility to provide care that takes each individual's needs and preferences into account, including preferences based on religious beliefs, language or cultural background.

Guidelines in this section:

- Accessing external services
- Flexible service provision
- Human rights and responsibility
- Working with people from cultural and linguistically diverse background
- Working with Aboriginal and Torres Strait Islander peoples
- Working with people with a disability
- Paediatrics
- Transition to adult services
- Psychosocial issues
- Medication management
- Advance care planning and palliative care

Resources

The Department of Human Services is developing a functional decline resource toolkit. This is due for limited draft release in September 2008, and will include information and tools on person-centred care.

References

Department of Human Services 2005, *Improving care for older people. A summary of policy for Health Services*. State of Victoria, Department of Human Services, Melbourne.

National Ageing Research Institute: commissioned by the Department of Human Services 2006, *What is person-centred health care? A literature review*, Melbourne. See the Metropolitan Health and Aged Care Services Division website at: www.health.vic.gov.au/acute-agedcare.

1.3.1 Accessing external services

Program guideline

Facilitate access to external services to meet client needs.

Context

Clients of health independence programs often require access to other services to ensure optimal outcomes. Facilitating access to other services ensures that clients will receive expert care to address their needs. Clinicians should use evidence-based practice where guidelines indicate use of another practitioner.

External services may include:

- specialist physicians (such as cardiologists, respiratory physicians, geriatricians, psychiatrists)
- medical investigations
- pharmacists, medication education and review services
- case management services (such as Linkages, Community Aged Care Packages)
- paediatric services
- home nursing services (such as wound management, continence management, stoma care)
- carer support services (such as respite)
- mental health services
- drug and alcohol services
- palliative care
- specialist nurse practitioners and educators (such as stoma nurse)
- Aged Care Assessment Service
- secondary consultations for psychosocial issues
- Aboriginal and Torres Strait Islander liaison officers
- specialist services for culturally and linguistically diverse clients
- housing services.

Information about services can be accessed through the *Human services directory*.

Minimum requirements

Related program	
All	Link with community services, where required and available.
All	Facilitate referral to external services during the episode of care or on discharge as needed and in consultation with the client's general practitioner.
All	Include and document referrals to external services on the care plan.
All	Maintain up-to-date information on local service providers and their referral processes.
All	Establish and adhere to an agreed process for sharing client information between health services, general practitioners and community-based providers (with consent). Involve existing general practice liaison units in this process (<i>refer to guideline 1.2.9 Engagement with general practitioners</i>).
All	Encourage and work with general practitioners to use the chronic disease management Medicare items, where appropriate.

Resources

Human services directory: <http://humanservicesdirectory.vic.gov.au>

1.3.2 Flexible service provision

Program guideline

Provide access to a wide range of services to meet clients' needs and choices.

Context

Flexible service provision is a key principle of person-centred care and is required to meet the individual needs of clients. Each client will present with a different, and frequently complex, health profile that requires service provision to be flexible and tailored to meet the goals of the client.

It is likely that health independence programs will not include all the necessary services to meet clients' needs. Additional services may be purchased to provide rapid response to required services that will facilitate discharge from hospital or prevent avoidable hospital admission. Service gaps can also prevent the provision of adequate support to clients, and may lead to deterioration in their health or an admission to hospital. However, flexible funding is utilised only when all other services have been investigated.

It may be appropriate for health independence programs to consider directly employing staff rather than purchasing external services, where cost savings are clearly demonstrated (such as PAC utilising SACS staff to provide the PAC allied health service). This will allow for improved continuity of care for clients between health independence programs.

Health independence programs are accountable for ensuring continuity and quality of care for clients who have external services provided. Managing the client's care plan remains the responsibility of the health independence program.

Although the majority of SACS settings do not historically have access to flexible funding, the Department of Human Services will be reviewing this in the future. SACS clients should be supported by PAC, within existing program guidelines, to access flexible funding. Health independence programs within an organisation or geographical area should move towards a single flexible funding arrangement across all health independence programs.

Minimum requirements

Related program	
All	Refer to services to meet a client's needs and choices.
All	Link with community services (for example, HACC), where available, prior to utilising flexible funding.
All	Flexible funding is utilised within program scope and only when all other services have been investigated.
All	Review the client's care plan before arranging purchased services and include purchased services in the care plan.
All	Ensure the care coordinator is notified of any purchased service where they are not directly involved in purchasing services.
All	Communicate regularly with purchased service providers to plan, coordinate and monitor a client's care.

Related program	
All	Notify the client's general practitioner when services are purchased via inclusion in the care plan.
All	Maintain up-to-date information on local service providers and their referral processes.
All	Establish and adhere to an agreed process for sharing client information between health services, general practitioners and community-based providers (with consent). Involve existing general practice liaison units in this process.
All	When using purchased services, use providers with a demonstrated record of quality service. Use the same external provider, where possible, so that the client can establish an ongoing relationship with them, and to enhance continuity of care.
All	Manage organisational risk by ensuring appropriate agreements are in place to ensure safety for clients, that services are provided by accredited, qualified staff and that they are insured appropriately. Managing risk also includes sharing appropriate information (especially risk assessments) with purchased services.
All	Ensure up-to-date service agreements are in place with services purchased that cover: <ul style="list-style-type: none"> • service responsiveness • service standards • occupational health and safety standards • mechanisms for review • risk management processes for clients and service providers.
All	Consider directly employing staff, including allied health and nursing, if this is an efficient option.

Resources

Victorian Aids and Equipment Program: www.dhs.vic.gov.au/disability/supports_for_people/living_in_my_home/aids_and_equipment_program

1.3.3 Human rights and responsibility

Program guideline

Public hospitals and other public authorities are bound by the *Victorian Charter of Human Rights and Responsibilities* (the charter) to comply with the charter.

Context

The charter protects and promotes the human rights of all people in Victoria. It does this by imposing obligations on parliament, courts, tribunals, government departments and public authorities which must act in a way that is compatible with charter rights when they interpret laws, set policies, make decisions and provide services.

The charter was enacted in 2006 and came into full operation on 1 January 2008. Public health services are considered public authorities under the charter and therefore must comply with it.

In relation to contracting out services by a public hospital, it should be noted that even if an organisation is not ordinarily a public authority, it may be bound by the charter to the extent that it is carrying out services of a public nature when it is exercising those services on behalf of a public hospital. To this extent, that organisation would be bound by the charter.

The charter:

- sets out the human rights protected
- provides guidance for balancing rights and responsibilities
- requires public authorities to act compatibly with human rights
- gives the Victorian Ombudsman power to investigate whether administrative actions by a public authority are incompatible with the rights of the charter
- enables individuals to raise possible breaches of charter rights before a court or tribunal where they have an existing case founded on another legal claim.

Minimum requirements

Related program	
All	Public hospital and other public authorities bound by the charter comply with the charter.
All	Consider the charter in developing and carrying out policies and procedures.
All	Ensure staff are informed about the charter.

Resources

Human rights charter: www.humanrightscommission.vic.gov.au/human%20rights/the%20victorian%20charter%20of%20human%20rights%20and%20responsibilities

1.3.4 Working with people from culturally and linguistically diverse backgrounds

Program guideline

Clients from culturally and linguistically diverse (CALD) backgrounds have access to services that meet their needs and appropriate resources to facilitate care.

Context

Providing person-centred care involves respecting clients' cultural and religious beliefs and delivering culturally appropriate services.

Government policy states that all Victorians are entitled to equal access to services. However, policy also recognises that health services face particular challenges in ensuring Victorians who are from CALD backgrounds have the same entitlement to access high-quality services as other members of the community.

People from CALD backgrounds can have difficulty accessing health services and following care plans. This may be due to factors such as:

- unfamiliarity of the complex Australian health service system
- differing cultural norms and beliefs regarding health care
- communication difficulties and language differences.

Minimum requirements

Related program	
All	Consider the cultural context of clients throughout the client journey.
All	Document cultural requirements for each client in the assessment and care plan.
All	Provide access to qualified interpreter services either in person or via telephone, where necessary.
All	Provide clients with education and information material in multiple languages where possible.
All	Provide staff with information of the cultural diversity of clients in the community to assist staff engage with these groups and provide culturally appropriate care
All	Provide staff with cultural awareness training.
All	Develop partnerships with multicultural and ethno-specific agencies relevant to local CALD community groups. Link clients with these services, where appropriate.

Resources

Cultural diversity guide: offers advice on how to improve services for CALD communities. The guide can be found at: www.dhs.vic.gov.au/multicultural/cultdivguide.htm.

Health Service cultural diversity committee and annual health service cultural diversity plan: all health services are required to convene a committee and develop a plan to respond to their local culturally and linguistically diverse communities through a strategic coordination and planning process. Your health service's plan will be an important local resource.

Language services policy: outlines the necessary requirements to enable people who cannot speak English, or who speak limited English, to access professional interpreting and translating services when making significant life decisions and where essential information is being communicated. The policy can be found at: www.dhs.vic.gov.au/multicultural/langservpolicy.htm.

1.3.5 Working with Aboriginal and Torres Strait Islander peoples

Program guideline

Aboriginal and Torres Strait Islander (ATSI) peoples have access to services that meet their needs and appropriate resources to facilitate care.

Context

Providing person-centred care involves respecting clients' cultural beliefs and delivering culturally appropriate service provision.

Government policy states that all Victorians are entitled to equal access to services. However, policy also recognises that health services face particular challenges in ensuring ATSI peoples have the same entitlement to access services as other members of the community.

Aboriginal and Torres Strait Islander peoples can have difficulty accessing health services and following care plans. This may be due to factors such as:

- unfamiliarity of the complex mainstream health service system
- differing cultural norms and beliefs regarding health care.

Statistics show that ATSI people have significantly poorer health and lower life expectancy than non-Aboriginal Australians. Poor health outcomes for ATSI peoples are the result of a complex set of interacting factors. Social factors such as income, education and employment combine with health risk factors such as poor living arrangements, poor nutrition, excessive alcohol consumption, smoking and lack of physical activity. Health services that are equipped to provide culturally appropriate services to ATSI peoples are one of the key factors that will contribute to improved health outcomes (*The cultural respect framework for Aboriginal and Torres Strait Islander health, 2004–09*).

Minimum requirements

Related program	
All	Consider the cultural context of clients throughout the client journey.
All	Document cultural requirements for each client in the assessment and care plan.
All	Provide staff with information of the cultural diversity of clients in the community to assist staff engage these groups and provide culturally appropriate care
All	Facilitate access to ATSI liaison officers and services as required.
All	Provide staff with cultural awareness training.

Resources

Improving care for Aboriginal and Torres Strait Islander patients: aims to improve the access of ATSI people in Victoria to mainstream health services. See the website at: www.health.vic.gov.au/koori/icap/index.htm.

The cultural respect framework for Aboriginal and Torres Strait Islander health: aims to influence the corporate health governance, organisational management and delivery of the Australian health care system to adjust policies and practices to be culturally respectful and thereby contribute to improved health outcomes for ATSI peoples. See the website at: www.health.vic.gov.au/koori/cultural-respect-framework.pdf.

1.3.6 Working with people with a disability

Program guideline

People with a disability have access to services that meet their needs and appropriate resources to facilitate care.

Context

There are many different types of disability including:

- intellectual disability
- physical disability
- sensory disability
- acquired brain injury
- neurological impairment
- mental health issues.

Disability varies in severity from person to person. In general, people with a disability are more likely to experience health, social and economic disadvantage than the general population.

People with a disability are eligible for health independence programs on the same basis as all other Victorians. Despite this, some face barriers to accessing health services, including communication difficulties, cognitive impairment, difficulties with physical access, transport issues, inability to provide informed consent and lack of a person legally responsible to provide consent.

People with a disability may live at home alone, with family, at home with paid support or in supported accommodation. Generally, disability support staff who provide care to people with a disability are not qualified as medical or health workers. They provide the type of support that a family member would normally provide and require training for any new procedures. Organisational policies specify what health procedures disability support staff can and cannot perform. Occasionally people with a disability will be supported by staff employed as a qualified nurse. This information needs to be considered when developing the care plan and discharge plan.

Minimum requirements

Related program	
All	Written information outlining the service is legible for all, including layman language and font size, so that people with mild cognitive impairment and visual impairment can understand.
All	Initial needs identification processes take into account the disadvantages experienced by people with a disability.
All	Policy and procedures are developed to ensure that a person is not excluded if they cannot provide informed consent and there is no authorised representative who can provide consent for them (<i>refer to guideline 1.1.4 Client consent</i>).
All	Provide support that optimises the client's ability to participate in health independence programs, such as providing additional time for appointments or attendance of someone they know well to support them with communication.

Related program	
All	Assess a client's home environment prior to care planning to establish the level of support available.
All	Determine if a client with a disability requires health or medical support on discharge, regardless of where they live or whether they receive paid support.
SACS	Provide time-limited, goal-centred intervention to address specific need, and refer to or link with disability services for longer term support.

Resources

Disability Services: www.dhs.vic.gov.au/disability/disabilityserviceshome

1.3.7 Paediatrics

Program guideline

Services delivered to children and adolescents are appropriate to their developmental stage. The family situation and involvement with other services is also considered.

Context

While all the guidelines are relevant for paediatrics, there are a number of factors to be considered in any program with a paediatric component.

Developmental stages

As children grow, they progress through a number of developmental stages. The developmental level of a child must be considered when deciding appropriate management. This includes cognitive, emotional, social and physical abilities, activities of daily living, speech and language skills.

Chronic disease, psychosocial issues, trauma or disability may impact on the progression of a child through the developmental stages. As a child reaches significant developmental milestones they may require re-entry into, or further involvement from, a service.

Family unit

Understanding the family unit is critical when working with a child. Working within the context of the whole family and recognition of the dynamic interplay between the family situation and the child's health is required.

The family unit may consist of parents, siblings, extended family members, carers or foster carers. Where appropriate, the primary carer should be involved in making decisions regarding the child.

Consent

As children become older they are generally able to and should actively participate in decisions regarding their own health care. At times this can make the consent process complicated.

There is no strict age limit for treating an adolescent patient as an adult or determining when they can provide their own consent to treatment. An assessment of their age and maturity at the relevant time by the treating clinician should be administered and documented.

Workforce

Paediatrics is a specialised area of health care that involves a knowledge and understanding of the ages and stages of child development and their implications on health.

Service linkages

A child may be linked with a variety of services. These may include the education system, child care services, child disability services, maternal and child health, acute health services, paediatricians and general practitioners. Effective communication with these services and clarity of respective professional roles will be important.

Paediatrician

Paediatricians are often the main medical professional involved in coordinating the medical, social and psychological needs of children with functional impairment. Where a general practitioner is mentioned in these guidelines, consider the paediatrician if appropriate. Children with less complex needs may not require the involvement of a paediatrician. In these cases, the client's general practitioner will be responsible for their care. *Refer to guideline 1.2.9 Engagement with general practitioners.*

Minimum requirements

Related program	
All	Assessment, management and discharge planning is in accordance with the client's developmental stage. Reviews are conducted as the client progresses in age and developmental stage.
All	Processes are in place for timely re-entry into the program as required.
All	Link with child services in care planning and management, particularly to avoid duplication of services.
All	The environment should be safe and age appropriate (for example, child friendly), where possible.
All	Developmentally appropriate resources are used (for example, assessment tools, education materials and equipment such as toys).
All	Consider the most appropriate setting for intervention. This may include home, school, hospital, community centre or another setting.
All	Intervention is family focused and includes the child, primary carers and other family members, as appropriate.
All	Consider the culture, capacity, intellectual ability and parenting skills of the client's family when planning intervention for the child.
All	Determine who provides consent. Note that it may be a shared decision making process between the child or adolescent and their caregivers (<i>refer to guideline 1.1.4 Client consent</i>).
All	It is desirable that paediatric services are staffed by paediatric-skilled practitioners.
All	Access to clinical support, advice, mentoring or training from staff with paediatric skills is available to staff without these skills, where possible. This may need to be provided by staff outside their organisation.
All	Clinicians undertake professional development relevant to paediatric care, as appropriate.
All	Clinicians comply with child-safe practices, including mandatory reporting guidelines.

Resources

Children, Youth and Families Act, 2005:

www.office-for-children.vic.gov.au/policy-planning-funding/legislation

Child Wellbeing and Safety Act, 2005:

www.office-for-children.vic.gov.au/policy-planning-funding/legislation

Working with Children Act, 2005: www.justice.vic.gov.au/workingwithchildren

1.3.8 Transition to adult services

Program guideline

The transition process from child to adult services is planned and coordinated, and includes effective communication to ensure seamless service provision.

Context

As children move through the developmental stages of early years, middle years and adolescence, there is a need for a planned transition from child- and family-centred paediatric services to adult services, which can be more complex to navigate.

Transition involves a change in services, roles and expectations and is a time of heightened anxiety for adolescents and family members. This can pose an increased risk for the client and can be further exacerbated by normal adolescent risk-taking behaviour.

Minimum requirements

Related program	
All	A plan for transition into the adult service system is included in the client's care plan.
All	Involve the client's general practitioner in the transition care plan.
All	Transition occurs at the appropriate time in relation to the client's age and individual needs.
All	Establish an agreement between service providers regarding who has responsibility for coordinating the transition process.
All	Transition planning may need to address adult health issues such as housing, access to vocational services, women's health and other issues.

Resources

The Royal Children's Hospital transition to adult health care website:
www.rch.org.au/transition/index.cfm?doc_id=8143

1.3.9 Psychosocial issues

Program guideline

Consider the psychosocial needs of clients.

Provide or facilitate interventions that address a client's psychosocial needs where they significantly impact on the client's health, quality of life or ability to self-manage and function.

For clients who are acutely psychiatrically unwell, treatment or admission to the area mental health service is the most appropriate response.

Context

Health status is affected by biological, physical, psychological, social and environmental conditions. Psychosocial issues involve the psychological, social and environmental circumstances that adversely impact clients' health, quality of life or functioning. Clients may have multiple, often overlapping, needs across a number of areas. Complexity is associated with high need, crisis-driven behaviour and poor intrinsic and extrinsic supports.

Psychosocial issues, either one or in combination, can impact on how a person copes with their health and treatment and their level of engagement with health services. If psychosocial issues exist and are not addressed, treatment is unlikely to succeed. Clinical judgement will determine whether a client's psychosocial issues need to be addressed, as in many cases a client's psychosocial issues will not have a clinically significant or negative impact on their functioning or capacity to self-manage.

Psychosocial complexity can include:

- impaired cognition
- altered mood state (for example, anxiety and depression)
- grief and loss associated with chronic disease
- self-harm
- unsafe or poor living arrangements, including poor access and environmental hazards
- homelessness or risk of homelessness
- limited availability of social and emotional support
- carer burden
- domestic violence or abuse, including physical, psychological and financial
- financial insecurity
- drug and alcohol abuse.

People with mental health issues, disability and culturally diverse backgrounds, or living in remote areas, may be more susceptible to psychosocial issues that impact on their health.

Frequent hospital presentations or admissions may be the result of unresolved psychosocial issues. Psychosocial issues can either be the primary reason for frequent presentation to hospital or can be a compounding factor for an individual with chronic health care needs. HARP will consider psychosocial issues as a reason for frequent hospital presentations/admissions.

Minimum requirements

Related program	
All	Initial needs identification includes screening for psychosocial issues.
All	Assessment addresses psychosocial issues.
All	Care plans address psychosocial issues that have been assessed as having a significant impact on a client's functioning or ability to self-manage.
All	Link with area mental health services for clients who are acutely psychiatrically unwell.
All	Link clients into appropriate community-based services, including specialised services such as drug and alcohol, mental health, housing, forensic, social recreation support services, employment, chronic pain management, personal care services, pharmacological management, outreach programs and organisations that support the homeless.
HARP	Provide assertive outreach ² and intensive care coordination as required.
HARP	Provide interventions for psychosocial issues that have been assessed as having a significant impact on a person's functioning or ability to self-manage and as a reason for frequent presentation to hospital across all HARP streams of care.
HARP	Provide access to, or employ, psychologists, psychiatrists and clinicians with mental health training.

2. Assertive outreach is providing intensive support for people with complex psychosocial needs and psychiatric illness who may require repetitive contact in the community to engage them in the proactive management of their condition.

1.3.10 Medication management

Program guideline

Review a client's medications and how they are managed.

Context

Medication errors may occur at any part of the medication management pathway. Available data suggests that between two and three per cent of all hospital admissions are related to problems with medicines that may originate within the community or within the hospital (ACSQHC, 2002). It has been reported that up to 43 per cent of adverse drug events are preventable (Leach, 2006).

Evidence shows that significant patient harm and sub-optimal use of medicines frequently result from the discontinuity that occurs when consumers move between different health care settings and providers. To assist clients in moving safely among health care providers and settings, the quality use of medicines³ must be realised across the health care continuum. The key to safe and appropriate management of medicines is a coordinated approach that supports and encourages continuity in all areas of the community and health care sector.

By ensuring health independence program services have access to clinical expertise in medication management, the skills of other staff around medication issues can be developed. This will ensure that medication management is a central component of care for people with chronic and complex needs and may lead to a reduction in avoidable hospital presentations.

Minimum requirements

Related program	
All	Assess every client's ability to manage their medication (including complementary, alternative and over-the-counter medicines) as part of the common, comprehensive or specialist assessment.
All	Document a client's medication history and medication list as part of assessment.
All	Provide access to medication management training and clinical experts, such as a pharmacist or clinical nurse expert, for clinicians.
All	Communicate the identified medication issues to general practitioners and other relevant community services in a timely manner.
All	Provide comprehensive, complete and accurate information when transferring a client to another episode of care, to ensure the client's medication management is continued in accordance with their medication action plan.
All	Provide education, information and devices to clients and carers to assist with managing medication and promote compliance.
All	Encourage general-practitioner-initiated home medicine reviews.
HARP	Ensure access to specialist pharmacist advice is available, as required, from pharmacy departments, community pharmacies or an employed pharmacist. Establish protocols and processes for engagement with pharmacists.

3. Quality use of medicines (QUM) means selecting management options wisely, choosing suitable medicines if a medicine is considered necessary and using medicines safely and effectively.

Resources

Assessment requirements: APAC's *Guiding principles to achieve continuity in medication management* provides information on assessing medicines to ensure quality use of medicines and a list of minimum requirements for an assessment interview. See Principles 4 and 5, pages 27–33.

The guiding principles have been developed to achieve the continuity of quality use of medicines in medication management as consumers move from one episode of health care to another. The guiding principles apply across all health care settings and to all health care providers. The publication includes an implementation guide, which provides specific strategies for their implementation. See: www.health.gov.au/internet/wcms/publishing.nsf/Content/nmp-guiding.

The Australian Commission for Safety and Quality in Health Care has produced the *Second national report on patient safety – improving medication safety*. The report is available at: [www.health.gov.au/internet/safety/publishing.nsf/Content/F0FD7442D1F2F8DDCA2571C6000894FF/\\$File/med_saf_rept.pdf](http://www.health.gov.au/internet/safety/publishing.nsf/Content/F0FD7442D1F2F8DDCA2571C6000894FF/$File/med_saf_rept.pdf).

The Victorian Medicines Advisory Committee (VMAC) leads the strategic direction and policy development for quality use of medicines (QUM) in Victoria. The VMAC leads the application of the *National medicines policy* and the *National strategy for QUM* in Victorian hospitals and at the interface with primary care settings. Their website has links to a number of tools to assist in medication management; see: www.health.vic.gov.au/vmac/.

The Victorian Quality Use of Medicines Network is a moderated email discussion group for health professionals with an interest in quality use of medicines. See the following website to sign up to the network: www.health.vic.gov.au/vmac/register.htm.

The National Prescribing Service is a member-based organisation providing accurate, balanced, evidence-based information and services to health professionals and the community on quality use of medicines. Its website provides a range of information and resources for health professionals and consumers, including a number of consumer resources that health independence programs could use to provide clients with education and information to assist with managing medication and promote compliance. The website is: www.nps.org.au.

Consumer resources

Medimate: helps consumers to find, understand and use information about medicines.

Medimate also includes a special medicines list in which consumers can list their medicines and keep notes. Available free in English, Chinese, Greek, Italian and Vietnamese.

See: www.nps.org.au/site.php?content=/resources/content/cons_medimate.html.

MedicinesTalk: a free quarterly newsletter that gives consumers reliable, accurate information and useful hints on managing medicines. Available at:

www.nps.org.au/site.php?page=2&content=/resources%2Fcontent%2Fcons_medtalk.html.

Get to know your medicines: Assists consumers with managing their medicines by using the free materials, searching the Consumer Medicine Information service, or phoning the Medicines Line groups. Go to the NPS website at: www.nps.org.au, then click on the 'Consumers' link.

National Prescribing Service free medicines information catalogue: material and information for consumers that can be ordered or downloaded free. Go to the NPS website, click on the 'Consumers' link, then click on 'Catalogue' link.

References

Australian Commission for Safety and Quality in Health Care (ACSQHC) 2002, *Second national report on patient safety – improving medication safety*. Accessed January 2008 at: [www.health.gov.au/internet/safety/publishing.nsf/Content/F0FD7442D1F2F8DDCA2571C6000894FF/\\$File/med_saf_rept.pdf](http://www.health.gov.au/internet/safety/publishing.nsf/Content/F0FD7442D1F2F8DDCA2571C6000894FF/$File/med_saf_rept.pdf).

Leach, H 2006, Editorials. *Journal of Pharmacy Practice and Research*, 36, pp. 1–2.

1.3.11 Advance care planning and palliative care

Program guideline

Initiate advance care planning discussion with clients when appropriate. Link clients with palliative care services when necessary.

Context

Advance care planning is a process that enables a person to plan for their future medical treatment and other care, particularly for a time when they are not competent to make, or communicate, decisions for themselves. It is often about end of life, but not always. It aims to improve quality of care and is based on the principles of human rights, including self-determination, dignity and the avoidance of suffering and unwanted treatment.

Advance care planning addresses a person's values, wishes and goals for treatment and encourages people to:

- discuss their values and wishes about their own life and death
- talk about their concerns about the dying process, seek information to help them make decisions about their future care, and to review possible scenarios related to their own situation
- talk to their families and/or friends about these matters
- determine whether a proxy decision-maker has been appointed
- identify the person responsible for decision making as per the *Guardianship and Administration Act Victoria 1986*
- address other matters to do with their death, such as organ donation, wills and funerals.

Palliative care services address specific issues such as the management of pain and other symptoms for people living with a terminal illness, and provide psychological, social and spiritual support where required.

Minimum requirements

Related program	
All	Engage with the client's general practitioner as appropriate (<i>refer to guideline 1.2.9 Engagement with general practitioners</i>).
All	Introduce clients to the advance care planning process and support clients who wish to engage in the process.
All	Consider engaging in advance care planning with clients as part of care plan as appropriate.
All	Provide access to training for staff in facilitating effective advance care planning.
All	Establish close links with palliative care services and refer when appropriate.

Resources

Advance care planning policy: the department will deliver a policy on advance care planning for health professionals in 2009. Information will be available on the department's website at: www.health.vic.gov.au.

Respecting patient choices: provides information on advance care planning, and advance care plan template, guide, booklet and leaflet. See: www.respectingpatientchoices.org.au.

Victoria's Palliative Care Program website: provides a list of contacts and contact information for palliative care referral and enquiries. The website can be accessed at: www.health.vic.gov.au/palliativecare/contacts.htm.

Clinical practice guidelines for communicating prognosis and end-of-life issues: provide guidance for health professionals in communicating prognostic and end-of-life issues to patients with progressive life-limiting illnesses, and their families. Available in the Medical Journal of Australia at: www.mja.com.au/public/issues/186_12_180607/cla11246_fm.html.

Medical Treatment Act (Vic) 1988: www.health.vic.gov.au/mta/

Guardianship and Administration Act (Vic) 1986: www.legislation.vic.gov.au

Office of Public Advocate: www.publicadvocate.vic.gov.au

2. Program management

Improving performance and ensuring corporate and clinical risk are effectively managed is essential to providing high-quality services.

Guidelines in this section:

- Recruitment
- Performance appraisal
- Learning and development
- Client record management
- Data management
- Research and evaluation
- Quality improvement
- Compliment, incident and complaint management

2.1.1 Recruitment

Program guideline

Staff recruitment supports an optimal skills mix in the health independence program and facilitates quality client care.

Context

Clients enrolled in health independence programs require clinicians with specific skill sets and experience, and require an optimal skills mix within the team. Staff are recruited and managed in a manner that supports quality and safe care.

Defining the scope of practice for a clinician is the outcome of matching their qualifications, skills, experience and competence with the required role and need of the organisation.

The health independence program workforce needs to be flexible, multi-skilled and able to deliver care in a variety of settings including centre-based and home-based settings.

Minimum requirements

Related program	
All	Recruit staff with relevant experience, knowledge, skills and qualifications.
All	Staff are registered or are eligible for registration with their professional association.
All	Develop and adhere to a process for establishing and reviewing staff credentials, experience and competencies.
All	Adhere to organisational policy for credentialing and defining the scope of clinical practice.
All	Check that staff qualifications are current at all times.
All	Recruitment adheres to the organisation's human resources policies and procedures.
All	Staff have a documented position description that is kept current and defines responsibilities, accountabilities and activities. The performance appraisal process is documented.
All	Develop competencies or key performance indicators relevant to standards of practice.
All	Staff participate in a comprehensive orientation program.
All	Volunteers are recruited in accordance with organisational policy and procedures.
All	Relevant police checks are completed.

2.1.2 Performance appraisal

Program guideline

Staff performance is formally reviewed on a regular basis.

Context

The performance appraisal (or performance management) provides an opportunity to establish a shared understanding about what is to be achieved within an individual's position, and to manage and develop people in a way that increases the probability of achieving the objectives of the position.

The purpose of identifying, evaluating and developing the work performance of staff assists in more effectively achieving the organisational goals and objectives. Performance management also benefits staff in terms of recognition, receiving feedback, catering for work needs and offering career guidance. Reviewing staff career progress helps staff to develop to their full potential.

The performance review system involves assessing the staff member's performance, taking into account both the work-related requirements of the job and individual interests. Aligning individual goals with the goals of the health independence program service ensures that the contributions of individuals help to accomplish the goals of the program.

As health independence programs are often interdisciplinary teams, links with relevant discipline departments will need to be maintained by staff for access to professional development and mentoring where appropriate. Clinicians will report operationally to the health independence program manager; however, as part of their professional development they should also receive discipline-specific supervision.

Minimal requirements

Related program	
All	Staff performance appraisals are conducted in accordance with organisational policies and procedures.
All	Clear goals and expectations are set for staff.
All	Ensure staff act within their respective professional code of conduct.
All	Clear reporting lines for operational and clinical supervision are set.
All	Accountability processes are established, transparent and clearly documented.
All	Review staff members' scope of clinical practice at regular intervals using defined core competencies that are in line with national standards and guidelines.
All	Staff link with relevant discipline departments for access to professional development and mentoring where appropriate.
All	Incorporate a rotation program for junior staff through health independence program services where possible.

2.1.3 Learning and development

Program guideline

Health independence programs have a structured, planned and comprehensive learning and development system. Encourage staff participation in professional development.

Context

Professional development assists staff to achieve the skills, knowledge, behaviour and performance to provide excellence in service delivery. Professional development is an essential component of quality improvement.

Minimum requirements

Related program	
All	Staff have access to, and are involved in, a professional development program that includes: <ul style="list-style-type: none"> • a documented learning and development plan • internal and external education opportunities • compulsory training sessions, (for example, evacuation, infection control, risk management, cardiopulmonary resuscitation and occupational health and safety) • participation in continuing education programs relevant to their work, interdisciplinary team and discipline.
All	Individual learning and development plans reflect the skills required for the relevant role.
All	Link with other health independence programs and health services to access appropriate professional development, when necessary. Utilise teleconferencing and videoconferencing for staff education where appropriate.
All	Where there are workforce shortages, link with other services to build staff capacity through joint education, mentoring and skills sharing.
All	Individual staff members are also responsible for maintaining their skills.

2.1.4 Client record management

Program guideline

Ensure relevant client information is accurately and clearly documented within a client record.⁴

Context

The client record provides the health independence programs team with relevant client information and the plan of care that is required for consistency and continuity of care.

Health independence programs are responsible for timely documentation and maintenance of client records, while respecting client privacy in accordance with privacy laws.

A single client record enables services to be informed about other services' involvement with the client and access to the most current information. This may reduce duplication of service activities such as client assessment, referrals and investigations.

Minimum requirements

Related program	
All	Policies and procedures articulate how client records are managed, including transferring information across organisations.
All	Staff are orientated to record management and documentation processes.
All	Client record management is consistent with the organisation's policies and procedures.
All	Documentation is legible and well articulated, including use of abbreviations.
All	Client consent is obtained for sharing information between services.
All	Client information is exchanged in a secure form between services.
All	Client records contain relevant and current information.
All	Client records are kept in a safe and secure environment consistent with organisational policy.

4. In practice the client record may also be described as the health information record or medical record. For the purpose of these guidelines 'client record' is the term used to describe these records.

2.1.5 Data management

Program guideline

Collect and report program activity data and patient-level information through the Victorian Integrated Non-Admitted Health Minimum Data Set (VINAH MDS) to the department.

Note: The VINAH MDS will replace the Agency Information Management System (AIMS) reporting. AIMS reporting for health independence programs will continue until a letter from the department has been sent to the health service chief executive officer advising of the discontinuation of AIMS reporting, and move to VINAH MDS reporting. This is to enable the VINAH MDS data to be reviewed against that submitted to AIMS.

Context

The VINAH MDS is a client-level electronic reporting system suitable for reporting a wide range of non-admitted activity. This data collection will be used to provide clinical, demographic and resource utilisation essential for service planning and coordination, and to meet the department's reporting obligations.

The monitoring and analysis of data allows programs to evaluate the quality of the service and, thereby, facilitate quality improvement. Accurate data enables the department to monitor performance and provides accountability for program funding. Program data examines activity, growth and capacity and, therefore, assists in program planning and determining future requirements.

Minimum requirements

Related program	
All	Collect and report data for VINAH MDS. Data is reported as per the specifications listed on the Health Data Standards and Systems website at: www.health.vic.gov.au/hdss/index.htm .
All	Meet reporting requirements and be able to articulate data collection, accountability and reporting processes.
All	Regularly monitor and evaluate your program and provide results to the governing body, health professionals and partner agencies.
All	Use an integrated information and data management system.
All	Report monthly aggregate data as per the AIMS S2_305 form until instructed otherwise by the department.
All	Where services are purchased, formal service agreements are developed regarding data collection.
All	Meet the specified key performance indicators.

Resources

Health Data Standards and Systems website: www.health.vic.gov.au/hdss/index.htm

AIMS website: www.health.vic.gov.au/aims

2.1.6 Research and evaluation

Program guideline

Participation in clinical or health service research is encouraged.

Context

Research activities include direct involvement in conducting research or participation in research undertaken by another service or organisation.

Research has a role in improving the quality of services and providing evidence for best practice. Staff involvement in research, including evaluation of client management, encourages the provision of quality care and developing best practice management.

Minimum requirements

Related program	
All	Encourage research and evaluation within the program, where appropriate.
All	Encourage staff participation in research conducted externally, where appropriate.
All	Research undertaken is of high quality and makes a valuable contribution to the body of knowledge in that area.
All	Research undertaken is administered in accordance with acceptable health service guidelines and standards. Clinical research and policy is consistent with the following National Health and Medical Research Council (NHMRC) publications: <ul style="list-style-type: none"> • <i>National statement on ethical conduct in human research</i> • <i>NHMRC and Australian Vice Chancellors' Committee (AVCC) Statement and guidelines on research practice</i> • <i>Values and ethics: Guidelines for ethical conduct in Aboriginal and Torres Strait Islanders.</i>

References

NHMRC 2007, *National statement on ethical conduct in human research*. Accessed December 2007 at: www.nhmrc.gov.au/publications/synopses/e72syn.htm.

NHMRC and AVCC 1997, *Statement and guidelines on research practice*. Accessed December 2007 at: www.nhmrc.gov.au/funding/policy/researchprac.htm.

NHMRC 2003, *Values and ethics: Guidelines for ethical conduct in Aboriginal and Torres Strait Islanders health research*. Accessed December 2007 at: www.nhmrc.gov.au/publications/synopses/e52syn.htm.

2.1.7 Quality improvement

Program guideline

Annual quality improvement plans are developed in line with the organisation's quality improvement process.

Context

Quality improvement optimises client care by providing evidence of outcomes and identification of areas for enhancement. It is essential to delivering a safe and quality service and promotes program development and best practice.

Clinical governance is where managers and clinicians share responsibility and are held accountable for client care, minimising risks, and for continuously monitoring and improving the quality of care. An effective quality program requires a planned approach and the Victorian Quality Council's *Safety and quality framework* outlines a strategic overview of the key principles and practices necessary for effectively monitoring, managing and improving health services.

Minimum requirements

Related program	
All	A framework for continuous quality improvement is developed and implemented.
All	Staff are informed of the continuous quality improvement system and participate in the ongoing monitoring and analysis in everyday practice.
All	Analysis of the outcomes of client care is consistent over time to allow evaluation of specific indicators and improvement.
All	Promote a quality improvement culture that involves recognising leaders in quality improvement across the services.
All	Conduct ongoing evaluation of the services including client, staff and stakeholder satisfaction surveys.
All	Quality improvement plans are in line with the organisation's overall quality plan.
All	Evaluate the effectiveness of continuous improvement activities regularly.
All	Facilitate staff development and provide professional development opportunities.

Resources

Better quality, better health care: A safety and quality improvement framework for Victorian health services is a strategic overview of the key principles and practices necessary for the effective monitoring, managing and improving of health services. Available at: www.health.vic.gov.au/qualitycouncil/pub/improve/framework.htm.

The Australian Council on HealthCare Standards: www.achs.org.au

2.1.8 Compliment, incident and complaint management

Program guideline

Processes are defined, documented and adhered to for managing compliments, incidents and complaints and reflect the organisation's policy.

Context

Many clients are satisfied with their health care and provide compliments to the services they receive. It is important that staff know when clients have been impressed or pleased with the service they have received. Compliments can be used to share good practice among staff and compliments can also help boost morale and encourage staff to provide high-quality care.

Dealing promptly and effectively with complaints has considerable benefits for health organisations including better quality health care, better risk management, better quality assurance by providing feedback on service delivery, reduced likelihood of litigation and substantial savings in the direct and indirect costs arising from adverse incidents, complaints and claims. Dealing with complaints quickly and effectively also reduces stress on staff and often results in more satisfied consumers. Also, analysing complaints and other comments from consumers can be a valuable learning tool.

Efficiently and effectively managing adverse events improves the quality and safety of services and client care.

Comprehensive incident and complaint management involves identifying, notifying, classifying, investigating and analysing the incident. Subsequent action to resolve the issue and prevent recurrence follows. Evaluating the outcome and documentation completes the process.

A formalised process for incident and complaint management allows for transparency and supports the quality improvement process.

Minimum requirements

Related program	
All	Compliments, incidents and complaints are dealt with in a timely manner and in accordance with the organisation's incident reporting policy.
All	Processes are defined for identification, notification, classification, investigation and analysis of the incident/complaint, follow-up action, evaluation of the outcome and documentation. Processes are in accordance with organisational policy.
All	Processes are defined for notifying compliments and complaints.
All	Processes for communicating with clients following an adverse event are defined, documented and adhered to.
All	Encourage a culture of incident reporting.
All	Inform clients and the community of the process to make a compliment or complaint.
All	An escalation policy ⁵ for external providers is in place.
All	Complaints from referrers are actioned on the same business day.

5. The purpose of an escalation policy is to deal with complaints directly and quickly by the service provider at the point where the problem arises. However a policy should be in place for the management of serious matters or complaints with broader implications.

Resources

Guide to complaint handling in health care services: designed to assist health service providers to develop and implement effective complaint handling practices. Available at: www.health.vic.gov.au/hsc/downloads/complaints_handling.pdf.

Koori health rights bulletin: newsletter produced by the Health Services Commissioner's Office. This edition focuses on what our health rights are and touches on the privacy legislation in Victoria. Could be used as a resource to inform Koori clients about complaints procedures. Available at: www.health.vic.gov.au/hsc/downloads/koori-bulletin1.pdf.

Office of the Health Services Commissioner: the Health Services Commissioner is an independent and impartial body set up to conciliate health complaints when they arise. It also seeks to improve the quality of health services through education and promotional activities. The website has information and resources that health services can use, accessible at: www.health.vic.gov.au/hsc/index.htm.

3. Corporate services

Consistent corporate and clinical policies and procedures across health independence programs will assist with providing quality, safe services.

Guidelines in this section:

- Corporate governance
- Risk management
- Private specialist ambulatory care services in public hospitals
- Transport
- Infection control
- Emergency and disaster management

3.1.1 Corporate governance

Program guideline

Health services are responsible for ensuring appropriate governance structures are in place for health independence programs.

Context

Corporate governance is the process by which the organisation is directed, controlled and held to account. It encompasses authority, accountability, stewardship, leadership, direction and control exercises within the organisation.

The department contracts with one agency to be the fundholder for each of the health independence programs. Governance responsibilities for the fundholder in relation to the department include financial accountability and accountability for implementing service delivery models in line with these guidelines. A clear line of communication should exist between the fundholder and the department.

It may be beneficial for a combined health independence program services' governance structure within an organisation/geographical area.

It is encouraged that partnerships exist with community agencies in the area to ensure the appropriate program monitoring and planning occur within a region. Partnerships could include formal funding and service agreements, advisory committees, involvement in the relevant primary care partnership and joint projects.

Minimum requirements

Related program	
All	Organisations articulate and put in place governance agreements and processes.
All	Terms of reference for the governing body are established.
All	The governing body meets regularly to oversee and evaluate the program's function.
All	The governing body verifies that the program complies with the guidelines and funding agreement.
All	The membership of partnership arrangements will be inclusive of all key stakeholders. For example, include representation from hospital and community providers, the local PCP, division of general practice, community health service, local government, and consumers.
PAC	Organisations document, publish and disseminate to key stakeholders annual financial reports

3.1.2 Risk management

Refer also to guideline 1.2.8 Client and staff safety.

Program guideline

Identify and manage risks to achieve program deliverables and objectives, minimise adverse events and optimise the safety of clients and staff.

Context

Risk management is essential for good governance and the provision of safe care. It complements business planning, performance reporting, quality assurance and internal and external audit to support good stewardship and control.

A risk can be anything that impacts on the ability to deliver services or meet objectives. Risk management is a systematic and deliberate process to identify, evaluate, manage and monitor risks.

Identifying risks enables the implementation of strategies to avoid or minimise adverse events, and optimise client and staff safety.

Implementing a risk management process formalises reporting on risks and enables risks to be compared and monitored at a global level.

Minimum requirements

Related program	
All	Define policy and procedures for risk management, ensuring risk identification and analysis is ongoing.
All	Identify risks and determine their severity.
All	Develop strategies to avoid the identified risks, such as supervision, audit programs and preventative maintenance.
All	A risk management plan is in place and linked to the organisation's risk management plan.
All	Risk management process is in line with AS4360 risk management standard (Australian standard) and WorkSafe Victoria.

Related program	
All	Ensure orientation programs, staff education and policy manuals include relevant procedures for minimising risk, which address the following items (if applicable): <ul style="list-style-type: none"> • traveling in cars • home visit guidelines • working in isolation • critical incident management • manual lifting and handling • infection control • handling hazardous materials • bush fires • smoking • infection control and waste disposal • dangerous goods • radiation • clinical emergency procedures.
All (excluding paediatric services)	Utilise the resource <i>Improving the environment for older people in health services: an audit tool</i> when developing risk management strategies.

Resources

Improving the environment for older people in health services: an audit tool:

www.health.vic.gov.au/older/pubs

WorkSafe Victoria: www.workcover.vic.gov.au/wps/wcm/connect/WorkSafe

WorkSafe Victoria 2006, *Working safely in visiting health services*: www.worksafe.vic.gov.au/wps/wcm/resources/file/ebc8ea435b4c5e4/healthcare_working_safely.pdf

References

Department of Human Services 2007, *What is risk management?* Accessed 5 December 2007 at: <http://knowledgenet:8080/knowledgenet/Knowledg.nsf/allDocs/RWPA326E082A50BB6C8CA25708300000C3D?OpenDocument>.

Department of Human Services 2006, *Your role in managing risk*. Accessed 5 December 2007 at: [http://knowledgenet:8080/knowledgenet/rwpgslib.nsf/graphic+files/riskmgt/\\$file/your_role.pdf](http://knowledgenet:8080/knowledgenet/rwpgslib.nsf/graphic+files/riskmgt/$file/your_role.pdf).

3.1.3 Private specialist ambulatory care services in public hospitals

Program guideline

Private specialist ambulatory care services provided at hospital premises meet the various obligations including the Australian Health Care Agreement obligations and the Medicare requirements.

Context

Private specialist ambulatory services should be considered as an adjunct to health independence programs and in particular to HARP and SACS. Often medical consultation is required and having these services as private specialist ambulatory services may be an option.

For the purpose of this guideline, private specialist ambulatory care services include:

- services that are direct billed (commonly referred to as bulk billed) under the Medicare Benefits Schedule (MBS) with no additional charge to the client
- services that are not bulk billed, with a co-payment payable by the client.

For the purposes of this guideline, private specialist ambulatory care services do not include:

- non-admitted services provided by general practitioners in public hospitals
- non-admitted services provided on an emergency (unplanned) basis in either a public hospital emergency department or some other setting in a public hospital, provided by a medical practitioner with right of private practice.

Minimum requirements

Related program	
All	Meet the Australian Health Care Agreement obligations.
All	Meet the Medicare requirements.
All	Public hospitals seek legal, financial and industrial advice on the impact of particular remuneration models and consider their ability to recruit and retain a skilled specialist medical workforce. Within this context, the preferred model is based on medical practitioners being remunerated under the 100 per cent donation model.
All	Ensure double reporting does not occur. Where clients are seen under the MBS, there should not be a client service event recorded under a health independence program.

Resources

Australian Health Care Agreement between Victoria and the Australian Government:

www.health.vic.gov.au/agreement/index.htm

Specialist clinics in public hospitals: A resource kit for MBS-billed services:

www.health.vic.gov.au/outpatients/specialist-clinics0608.pdf

3.1.4 Transport

Program guideline

Organise transport for clients who have difficulty accessing transport to the service. A co-payment may be charged if the health independence program provides transport.

Context

Delivering a person-centred care approach means providing a holistic approach to service delivery, ensuring services are delivered in the most appropriate setting determined by clinical need rather than transport issues. Health independence programs should work with clients to overcome any identified transport issues.

Health independence programs are not required to provide free transport for clients. Where possible, clients should provide their own transport. However, inability to access the service due to transport difficulties should not be a barrier to a client receiving a service. For clients who have difficulty accessing the service, assistance in organising transport is appropriate.

For example, if centred-based rehabilitation is most appropriate for a client, a client should not be seen at home purely due to transport issues. This is not person centred or cost effective for the service.

Minimum requirements

Related program	
All	Encourage clients to provide their own transport, or use public transport where safe to do so.
All	Link in with volunteer driver programs where available.
All	Consider the client's financial situation when determining the most appropriate form of transport.
All	When transport is provided for a client, arrange for the client to make a contribution to the cost of transport; however, avoid placing financial burden on the client. If a client is unable to make the contribution they should not be precluded from having the transport made available to them.

3.1.5 Infection control

Program guideline

Adhere to safe practice around infection control.

Context

Infection control is essential to providing safe and effective practice for both staff and clients.

Minimum requirements

Related program	
All	Adhere to infection control policy.
All	Provide staff with adequate resources to provide a safe service in organisational settings and in clients' homes.

Resources

Sure protection against infection: the department has adopted a systematic and strategic approach to prevent and manage the spread of infectious diseases in the workplace. Originally published for Department of Human Services staff, the document has been made publicly available due to overwhelming requests. The resources is available at: www.health.vic.gov.au/ideas/regulations/sure.

Guidelines & regulations for infectious diseases: website that includes guidelines, standards and legislation for the investigation, control and prevention of infectious diseases in a range of settings. The website is accessible at: www.health.vic.gov.au/ideas.

3.1.6 Emergency and disaster management

Program guideline

Policies and procedures to respond to an emergency or disaster are in place.

Context

Health independence programs require systems, policies and procedures to identify and manage potential emergency situations that may arise either internally or externally.

Minimum requirements

Related program	
All	Adhere to the organisation's policy for emergency and disaster management and WorkSafe practices, and EQulP 4 guidelines if relevant.
All	Disaster management plans remain current.
All	Policies include information on both internal and external emergencies.
All	Procedure for managing the event of a fire and evacuation that covers all people and all areas of the organisation is documented.
All	Appoint and train personnel to manage an event or disaster, for example, wardens.
All	Staff are orientated to emergency and disaster management plans.
All	Staff education includes cardiopulmonary resuscitation and emergency evacuation.
All	Tailor emergency and disaster management information to the home environment if staff are conducting home visits.
All	Policies include a financial risk strategy.

Resources

WorkSafe Victoria: www.workcover.vic.gov.au/wps/wcm/connect/WorkSafe

EQulP 4: www.achs.org.au/Home

Glossary

Glossary

Adolescence

The period between the onset of puberty and adulthood = 11–18 years

Agency Information Management System (AIMS)

The AIMS is an online entry system and reporting facility primarily used to collect summary level statistical and financial information from Victorian health services for the Department of Human Services.

Assertive outreach

Provides intensive support for people with complex psychosocial needs and psychiatric illness who may require repetitive contact in the community to engage them in proactively managing their condition.

ATSI

Aboriginal and Torres Strait Islander

Avoid duplication

Where a service exists it is the intent to build the capacity of the provider (including assessment and care planning) rather than establishing another service that will provide a similar service.

CALD

Culturally and linguistically diverse

Care coordination

The decision to use one generic term has been made to create consistency across health independence programs and in recognition of the fluctuating and diverse needs of clients. For the purpose of this document the term ‘care coordination’ has been used as the generic term for the multitude of coordinating roles in existence for people accessing health independence programs. This includes case management, care management, service coordination and key worker roles. The intensity of care coordination will vary depending on the client’s needs. In some instances clients may need significant input from the care coordinator while others may need more emphasis on referral to appropriate services.

Care planning

A process to outline how the issues identified in an assessment or review of the client’s needs and goals are to be best managed. This may involve linking into a range of existing services, how self-management and education are to be provided and involves setting up communication between the general practitioner and other people involved in providing care to the client. Care planning involves balancing competing needs and assisting consumers to come to decisions that are appropriate to their needs, wishes, values and circumstances.

Carer

A person who provides unpaid care and support to family members or friends who have a chronic or acute condition, mental illness, disability or who are frail aged.

Case conference

The group discussion of a client's complex care needs. A case conference normally entails a client's goal or problem that requires a team approach to establish a resolution. This discussion occurs with the patient or guardians consent and commonly involves the general practitioner, care providers, family or next of kin in discussion with the client.

Case management

For the purpose of this document 'case management' refers to programs such as linkages, Community Aged Care Packages (CACPs) and Extended Aged Care at Home (EACH) packages. Health independence programs may refer clients to existing case management services as required.

Case review

The care plan is reviewed using an interdisciplinary approach. Often a case review is conducted by the health independence program multidisciplinary team; team members from different disciplines collectively review the assessment, client's goals and care plan.

Children

Refers to people aged 0–18 years.

Chronic condition

A condition of at least six months' duration that can have a significant impact on a person's life and requires ongoing supervision by a health professional. Chronic conditions that are among Australia's national health priorities and are our greatest burdens of disease include asthma, cancer, cardiovascular disease, chronic respiratory, dementia, diabetes mellitus, mental health conditions, arthritis and musculoskeletal conditions.

Chronic disease management (CDM) Medicare item

CDM Medicare Benefits Schedule (CDM MBS) items are incentive payments for general practitioners to undertake, participate in or review general practice management plans, team care arrangements and care planning activities for people with chronic disease and complex care needs.

See: www.health.vic.gov.au/communityhealth/gps/mbs_gp/care_planning.htm.

Chronic heart disease

Diseases of the coronary arteries around the heart that frequently lead to heart attacks (includes CHF).

Chronic heart failure

Often previously referred to as congestive heart failure. While congestion with fluid retention is commonly present, in some patients congestion is absent so that the term 'congestive HF' has been replaced by the broader term 'chronic HF'.

Chronic respiratory disease

Includes chronic obstructive pulmonary disease (COPD) and asthma.

Collocated

Services located on one campus.

Community health services

Agencies in receipt of community health program funding that also deliver a wide range of other primary health and support services to meet local community needs. This definition includes gazetted community health centres (with independent boards of management as defined in the Health Services Act), primary health units and divisions of rural and metropolitan health services.

Community service providers

Agencies located in the community whose core business is to provide services to clients living in the community (including but not limited to local government agencies, Royal District Nursing Service, community health services, general practitioners and non-government agencies).

Complex care needs

People with complex care needs have multiple health, functional and/or social issues and are at risk of functional decline and/or hospital admission. The complexity of the individual's care needs are compounded by the presence of one or more of the following: an unstable or deteriorating condition; increasing frailty and/or dependence; development of complications; comorbidities; significant change in social circumstances; or two or more hospital admissions in the past 12 months.

Comprehensive assessment

Comprehensive assessment involves the most intense level of inquiry and incorporates an advanced dimension of history taking, examination, observation and measurement/testing about medical, physical, social, cultural and psychological dimensions of need.

COPD

Chronic obstructive pulmonary disease (COPD) is the collective term for a number of lung diseases that prevent the lungs from working properly. Two of the most common types of COPD are emphysema and chronic bronchitis.

Credentialing

Credentialing is the formal process of verifying the qualifications, experience, professional standing and other relevant professionals attributes of health professionals for the purpose of forming a view about their competence and suitability to provide safe, high-quality health care services within specific organisational environments.

Developmental stages

Developmental progress related to age and determined by standardised measurements of body size and dimensions, by social and psychologic functioning, by observation of motor skills and by assessment of mental and aptitude tests.

Diabetes

Includes type 1 and type 2 diabetes.

Discharge

Discharge refers to the transition and exit of a client from a program or service after a review.

Disease management

‘...a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant’ (Disease Management Association of America).

Early intervention in chronic disease in community health services (EliCDiCHS)

The target population for the EliCDiCHS initiative includes people with newly diagnosed chronic disease/s (for example, diabetes, chronic heart failure, chronic respiratory disease), and/or older people with complex needs at level 3 of figure 3 of the chronic disease hierarchy.

Enhanced primary care (EPC)

See: Chronic disease management (CDM) Medicare items.

Enrolled patient population

Those clients who have been assessed as eligible and are currently receiving services from/or coordinated by health independence programs.

Escalation policy

Most complaints should be dealt with directly and quickly by the service provider at the point where the problem arises. However a policy should be in place for the management of serious matters or complaints with broader implications.

Evaluation and Quality Improvement Program (EQuIP)

The EQuIP framework used by the Australian Council on Healthcare Standards (ACHS).

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 available evidence from a variety of sources; critically appraise the 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.

Family unit

The family unit may include, but is not limited to, parents, carers, siblings and extended family members.

Flexible funding

Funds specifically allocated for purchasing services or packages of care for clients enrolled in PAC, SACS and HARP. May include, but is not limited to, interpreter costs, private nursing, allied health, food services, short-term private home care, purchase of equipment and transport escort services.

General practitioner

A general practitioner is a registered medical practitioner who is qualified and competent for general practice in Australia. A general practitioner has the skills and experience to provide holistic, comprehensive, coordinated and continuing medical care and maintains professional competence for general practice.

Governance

There are two main aspects of governance in health care:

Corporate governance:

The process by which the organisation is directed, controlled and held to account. It encompasses authority, accountability, stewardship, leadership, direction and control exercises in the organisation.

Clinical governance:

A systematic approach to maintaining and improving the quality of patient care. It encompasses education and training, clinical quality and safety, clinical effectiveness, research and development, openness, risk management, credentialing and scope of practice.

Successfully implementing clinical governance requires developing strong and effective partnerships with clinicians and managers for providing safe and effective health care. A key component of clinical governance is recognition by managers and clinicians that they share the responsibility for the quality of care delivered by the service.

Health independence programs

Comprises post-acute care services (PAC), sub-acute ambulatory care services (SACS) and Hospital Admission Risk Program (HARP) services.

Health service

The acute and sub-acute campuses of a health service, as well as the additional programs that a health service provides in the community. The term does not include general health care and ongoing community support services delivered by various other providers in the community.

HealthSMART

Victoria's whole-of-health information and communication strategy. HealthSMART aims to improve patient care, reduce the administrative burden on health care professionals and ease the costs associated with updating technical infrastructure within the public health care system by adopting a more standardised approach to information systems.

Hospital Admission Risk Program (HARP)

Government initiative established to address sustained increases in demand on the hospital system.

Initial contact

Initial contact is the first point of contact with the service system and will most commonly include providing accurate service information, health promotion literature and/or direct access to services via initial needs identification.

Initial needs identification

Initial needs identification is an initial assessment process where the underlying issues as well as presenting issues are uncovered to the extent possible. It is not a diagnostic process but is a determination of the consumer's risk, eligibility and priority for service and a balancing of the service capacity and the consumer's needs.

Integrated care

Care provided to a client that is coordinated and connected across the continuum of services and among providers in all sectors and levels.

Interdisciplinary approach

The approach is characterised by the participation and involvement of two or more health disciplines. The different disciplines within a team pool their expertise to make team-based treatment decisions based on the identified client needs. An interdisciplinary approach adopts a client-centred approach in that the focus shifts from a discipline-specific approach to treatment and towards the different disciplines within a team.

Interdisciplinary team

Interdisciplinary teams are defined by their approach to care in which team members from different disciplines collectively set goals and share resources and responsibilities. Interdisciplinary teams differ from multidisciplinary teams from which they evolved. Multidisciplinary teams create discipline-specific care plans and implement these simultaneously without explicit regard to their interaction. Interdisciplinary teams also differ from transdisciplinary teams in which each team member must be so familiar with the roles and responsibilities of other members that tasks and functions become, to some extent, interchangeable.

Medication management

The functional management of medications in the home for clients discharged with chronic and or complex care needs.

Older person

For the purpose of health independence program services, an older person is either a person aged 65 years and over, an ATSI person aged 45 years or over, or a person with an age-related illness.

Outreach services

Providing health care in a setting away from where the clinician normally practices in order to deliver services that are more easily accessible for the client.

Paediatric skilled practitioner

A practitioner who has particular skills in paediatrics through training and/or experience.

Parties

Includes the client, health independence program interdisciplinary team, general practitioner and carer and family and any other relevant community services involved in providing care.

Person-centred care

Delivering health care configured around the needs of the person.

Post-acute care (PAC)

Government program that assists people of all ages to be safely discharged from Victorian public hospitals by purchasing and coordinating the delivery of services they need to assist with recuperation at home.

Prevention

There are three types of prevention: primary, secondary and tertiary prevention. Primary prevention relates to interventions before diagnosis whether they are population wide or targeted to high-risk individuals and groups. Secondary prevention relates to early detection and prompt intervention to control impact and disability arising from the disease. Tertiary prevention is aimed at softening the impact of long-term disease and disability and can include rehabilitation.

Primary Care Partnership (PCP)

A PCP is a voluntary alliance of service providers that work together to improve health and wellbeing in their local communities as part of the Victorian Government's Primary Care Partnerships strategy. In Victoria, more than 800 services have voluntarily come together in 31 PCPs (catchments) across the state to progress reforms.

Private specialist ambulatory care services

Services that are provided to a person who has been referred to a medical specialist exercising a right of private practice at a public hospital, resulting in the cost of these services being billable against the Medicare Benefits Schedule (MBS).

Specialist:

Refers to services that are provided by a medical specialist, again with rights of private practice at a public hospital.

Ambulatory care services:

Planned or scheduled non-admitted health care services provided at a public hospital.

Progressive neurological disorders

Conditions involving a progressive neurological deterioration causing an alteration in function, and are often likely to affect the individual for life. Disorders among others can include: Alzheimer's disease, multiple sclerosis, motor neurone disease and Parkinson's disease. Some of the neurological disorders may progress more rapidly than others. Some neurological disorders are unpredictable and typically have periods of relapse and periods of remission.

Psychosocial issues

Includes psychosocial conditions that have a profound effect on a person's ability to function and their emotional well-being and can include psychotic diseases, drug and alcohol issues, homelessness and clinical depression and anxiety.

Quality use of medicines (QUM)

Selecting management options wisely, choosing suitable medicines if a medicine is considered necessary and using medicines safely and effectively.

Rehabilitation

Rehabilitation is the combined and coordinated use of medical, social, educational and vocational measures for training or retraining the individual to their highest possible level of function. It utilises functional and social models rather than a predominantly disease-based model of care.

Self-management

‘Involves [the person with the chronic disease] engaging in activities that protect and promote health, monitoring and managing symptoms and signs of illness, managing the impacts of illness on functioning, emotions and interpersonal relationships and adhering to treatment regimes’ (Flinders Human Behaviour and Health Research Unit).

Service coordination tool templates (SCTT)

The SCTT are a suite of tools that have been developed by the Department of Human Services in consultation with the funded sector. They support service coordination practice by assisting with identifying the initial needs of clients and providing a vehicle to collect and share core client information in a consistent way across diverse programs and agencies. These tools are not assessment tools nor do they replace agency processes.

Specialist assessment

A specialist assessment builds upon a common assessment and is appropriate where a potential health issue such as dementia, continence, pain or mobility has been identified. It is often required to reach a diagnosis, develop a care plan, undertakes intervention and facilitates referral as necessary.

Stakeholder

A stakeholder is any person, group or organisation that can lay claim on an organisation’s attention, resources or output, or is affected by that output.

Sub-acute ambulatory care services (SACS)

Government program that provides person-centred, interdisciplinary care support via flexible service delivery in a range of settings. It is directed at improving and maintaining a person’s functional capacity and maximising their independence.

The department (or department)

Department of Human Services

Transition care program

Provides short-term support and active management for older people at the interface of the acute/ sub-acute and residential aged care sectors. It is goal-oriented, time-limited and targets older people at the conclusion of a hospital episode who require more time and support in a non-hospital environment to complete their restorative process, optimise their functional capacity and finalise and access their longer term care arrangements.

VAED

Victorian Admitted Episode Dataset

VEMD

Victorian Emergency Minimum Dataset

VINAH MDS

Victorian Integrated Non-Admitted Health Minimum Dataset

Resources

Resources

This section contains all resources and references referred to in the guidelines. This section also offers a list of resources provided by the sector that may be of assistance to health independence programs staff, but is by no means an exhaustive list of all relevant resources.

Aboriginal and Torres Strait Islanders (ATSI)

Improving care for ATSI patients: www.health.vic.gov.au/koori/icap/index.htm

The cultural respect framework for ATSI health:

www.health.vic.gov.au/koori/cultural-respect-framework.pdf

Acts and charters

Children, Youth and Families Act 2005:

www.office-for-children.vic.gov.au/policy-planning-funding/legislation

Child Wellbeing and Safety Act 2005:

www.office-for-children.vic.gov.au/policy-planning-funding/legislation

Guardianship and Administration Act 1986: www.legislation.vic.gov.au

Health Records Act 2001: www.health.vic.gov.au/healthrecords

Health Services Act 1988: www.austlii.edu.au/au/legis/vic/consol_act/hsa1988161/

Mental Health Act 1986: www.austlii.edu.au/au/legis/vic/consol_act/mha1986128/

Public hospital patient charter: www.health.vic.gov.au/patientcharter

Working with Children Check: www.justice.vic.gov.au/workingwithchildren

Advance care planning and palliative care

Advance care planning policy: the department will deliver a policy on advance care planning for health professionals in 2009. Information will be available on the department's website:

www.health.vic.gov.au

Respecting patient choices: www.respectingpatientchoices.org.au

Victoria's Palliative Care Program website: www.health.vic.gov.au/palliativecare/contacts.htm

Clinical practice guidelines for communicating prognosis and end-of-life issues:

www.mja.com.au/public/issues/186_12_180607/cla11246_fm.htm

Office of Public Advocate: www.publicadvocate.vic.gov.au

Agency Information Management System (AIMS)

AIMS helpdesk: email helpdesk@healthcollect.vic.gov.au or phone 9096 8595

AIMS website: www.health.vic.gov.au/aims

Allergy and immunology

Australasian Society of Clinical Immunology and Allergy: www.allergy.org.au

Alzheimer's Australia

Alzheimer's Australia: www.alzheimers.org.au

Ambulatory and continuing care section

Department of Human Services Ambulatory and continuing care section:

www.dhs.vic.gov.au/ahs/concare.htm

Assessment

Centre for Applied Gerontology Bundoora Extended Care Northern Health; commissioned by Australian Health Ministers' Advisory Council (AHMAC) by the AHMAC Care of Older Australian Working Group 2004, *A guide for assessing older people in hospitals*. Australian Health Ministers' Advisory Council's Care of Older Australian Working Group, Melbourne. Metropolitan Health and Aged Care Services Division. www.health.vic.gov.au/acute-agedcare

Asthma

Asthma Foundation: www.asthma.org.au

Australian Health Care Agreement

www.health.vic.gov.au/agreement/index.htm

Care in your community

www.health.vic.gov.au/ambulatorycare/careinyourcommunity/index.htm

Carers Victoria

www.carersvic.org.au or 1800 242 636

Chronic disease management (CDM) Medicare items:

www.health.gov.au/internet/main/publishing.nsf/Content/pcd-programs-epc-chronicdisease

Compliment, incident and complaint management

Officer of the Health Commissioner – *Guide to complaint handling in health care services*:

www.health.vic.gov.au/hsc/downloads/complaints_handling.pdf

Complex psychosocial

Department of Human Services – adult mental health services:

www.health.vic.gov.au/mentalhealth/services/adult/index.htm

Department of Human Services – aged persons mental health services:

www.health.vic.gov.au/mentalhealth/services/aged/index.htm

Consent

Consent information brochure in different languages can be found at:

www.health.vic.gov.au/pcps/publications/languages_privacy.htm

Consumer involvement

Consumer participation: www.participateinhealth.org.au

Doing it with us not for us participation policy (2006–09): www.health.vic.gov.au/consumer

Continence

Continence Foundation of Australia website: www.continence.org.au

Victorian Continence Resource Centre website: www.continencevictoria.org.au

COPD

American Thoracic Society, *Guidelines for COPD management*: www.thoracic.org/sections/copd

Australian Lung Foundation 2003, *The COPDX plan: The Australian and New Zealand guidelines for the management of COPD*: www.lungnet.org.au

British Thoracic Society 2004. *Chronic Obstructive Pulmonary Disease. National clinical guideline on management of chronic obstructive pulmonary disease in adults in primary and secondary care 2*: www.brit-thoracic.org.uk

Global Initiative for Chronic Obstructive Lung Disease 2004, *Pocket guide to COPD diagnosis, management and prevention*: www.goldcopd.com

National Institute for Research Excellence (NICE UK) *Management of COPD in adults in primary and secondary care*: www.nice.org.uk/Guidance/CG12

Cultural and linguistically diverse

Department of Human Services – *Cultural diversity guide*: www.dhs.vic.gov.au/multicultural/

Department of Human Services – *Language services policy*: www.dhs.vic.gov.au/multicultural/downloads/language_service_policy.pdf

Cultural diversity

Centre for Cultural Diversity in Ageing: www.culturaldiversity.com.au

Victorian Transcultural Psychiatry Unit: www.vtput.org.au

Dementia

Dementia Collaborative Research Centres: www.dementia.unsw.edu.au

Department of Human Services policies and resources

Ambulatory care policy and planning framework: www.health.vic.gov.au/ambulatorycare

Care in your community: A planning framework for integrated ambulatory health care (2006): www.health.vic.gov.au/ambulatorycare/downloads/care_in_your_community.pdf

Continuous improvement framework: www.health.vic.gov.au/pcps/publications

Directions for your health system: Metropolitan Health Strategy (2003): www.health.vic.gov.au/metrohealthstrategy/index.htm

HealthSMART: www.dhs.vic.gov.au/ahs/healthit.htm

Good practice guide for practitioners: www.health.vic.gov.au/pcps/publications

Improving care for older people: a policy for health services (2003): www.health.vic.gov.au/older

Improving care: Hospital Admission Risk Program public report (2006): www.health.vic.gov.au/harp-cdm

Rural directions for a better state of health (2005): www.health.vic.gov.au/ruralhealth

Improving patient transition from hospital to the community: A good practice guide for hospitals (2003): www.health.vic.gov.au/discharge/patrans.htm

Victorian services coordination practice manual (2007): www.health.vic.gov.au/pcps/publications

Depression and anxiety

Australian Beyond Blue resources: www.beyondblue.org.au

Department of Human Services – mental health services:
www.health.vic.gov.au/mentalhealth/illnesses/depression.htm

Diabetes

Diabetes Australia: www.diabetesaustralia.com.au

Diabetes Australia, kids and teens website: www.diabeteskidsandteens.com.au

Diabetes information for children, young people and families: www.rch.org.au/diabetes

Department of Human Services *Diabetes self management program guidelines*:
www.health.vic.gov.au/communityhealth/cdm/diabetes.htm

Disability services

Department of Human Services – Disability Services website:
www.dhs.vic.gov.au/disability/disabilityserviceshome

Early intervention in chronic disease (EliCD)

EliCD guidelines: www.health.vic.gov.au/communityhealth/cdm_guidelines.htm

Education resources

Australian Lung Foundation: www.lungnet.org.au

Heart Support Australia: www.heartnet.org.au

Cardiomyopathy Association of Australia: www.cmaa.org.au

Stanford/Lorig Programs are conducted through Arthritis Victoria (phone: 8531 8008)

Education tool

Partners in health scale, cue and response interview, problems and goals assessment tools by the Human Behaviours and Health Research Unit at Flinders University for assessment and client goal setting: <http://som.flinders.edu.au/FUSA/CCTU/Home.htm>

Environmental audit tool

Improving the environments for older people in health services: an audit tool:
www.health.vic.gov.au/older/pubs.htm

Evaluation and quality improvement program (EQulP)

EQulP of the Australian Council on Healthcare Standards is available online at: www.achs.org.au

General practitioners

Working with general practice – Department of Human Services position statement:

www.health.vic.gov.au/communityhealth/downloads/gpc_dhs_positionstatement_jan08.pdf

Health promotion

‘Go for your life’: www.goforyourlife.vic.gov.au

Department of Human Services – health promotion website: www.health.vic.gov.au/healthpromotion

Heart failure

Australian Heart Foundation. *Guidelines on the contemporary management of CHF:*

www.new.heartfoundation.com.au/downloads/cont.management.pdf

National Institute for Research Excellence (NICE UK) *NICE guidelines on the management of CHF in primary and secondary care:* www.rcplondon.ac.uk/pubs/books/CHF/heartfailure.pdf

American College of Cardiology/American Heart Association. *ACC/AHA guidelines for the evaluation and management of chronic heart failure in the adult:*

www.acc.org/clinical/guidelines/failure/hf_index.htm

Hospital Admission Risk Program (HARP)

Department of Human Services – HARP website: www.health.vic.gov.au/harp-cdm

Human Services Directory

Human services directory: <http://humanservicesdirectory.vic.gov.au>

Infection control

Department of Human Services – *Sure protection against infection guidelines:*

www.health.vic.gov.au/ideas/regulations/sure

Department of Human Services – *Infectious diseases epidemiology and surveillance website:*

www.health.vic.gov.au/ideas

Medication management

APAC’s *Guiding principles to achieve continuity in medication management* provides information on assessing medicines to ensure quality use of medicines and a list of minimum requirements for an assessment interview. See Principles 4 and 5, pages 27–33.

See: www.health.gov.au/internet/wcms/publishing.nsf/Content/nmp-guiding

The Australian Commission for Safety and Quality in Health Care has produced the *Second national report on patient safety – improving medication safety*. The report is available at:

[www.health.gov.au/internet/safety/publishing.nsf/Content/F0FD7442D1F2F8DDCA2571C6000894FF/\\$File/med_saf_rept.pdf](http://www.health.gov.au/internet/safety/publishing.nsf/Content/F0FD7442D1F2F8DDCA2571C6000894FF/$File/med_saf_rept.pdf)

The Victorian Medicines Advisory Committee (VMAC) leads the strategic direction and policy development for quality use of medicines (QUM) in Victoria. The VMAC leads the application of the *National medicines policy* and the *National strategy for QUM* in Victorian hospitals and at the interface with primary care settings. Their website has links to a number of tools to assist in medication management; see: www.health.vic.gov.au/vmac

Victorian Quality Use of Medicines Network email discussion group for health professionals: www.health.vic.gov.au/vmac/register.htm

National Prescribing Service: www.nps.org.au

Medimate: helps consumers to find, understand and use information about medicines.

See: www.nps.org.au/site.php?content=/resources/content/cons_medimate.htm

MedicinesTalk: a free quarterly newsletter that gives consumers reliable, accurate information and useful hints on managing medicines. Available at:

www.nps.org.au/site.php?page=2&content=/resources%2Fcontent%2Fcons_medtalk.htm

Get to know your medicines: Assists consumers with managing their medicines. Go to the NPS website at: www.nps.org.au, then click on the 'Consumers' link.

National Prescribing Service free medicines information catalogue: Go to the NPS website, click on the 'Consumers' link, then click on 'Catalogue' link.

National Health and Medical Research Council (NHMRC) resources

National statement on ethical conduct in human research (2007):

www.nhmrc.gov.au/publications/synopses/e72syn.htm

NHMRC & AVCC Statement and guidelines on research practice (1997):

www.nhmrc.gov.au/funding/policy/researchprac.htm

Values and ethics – Guidelines for ethical conduct in Aboriginal and Torres Strait Islanders health research: www.nhmrc.gov.au/publications/synopses/e52syn.htm

Quality improvement

Better quality, better health care: a safety and quality improvement framework for Victorian health services: www.health.vic.gov.au/qualitycouncil/pub/improve/framework.htm

Paediatrics

Paediatric mental health: www.health.vic.gov.au/mentalhealth/services/child/index

General practitioners with a paediatric/adolescent interest – The Health for Kids Network:

www.healthforkids.net.au

Victorian Paediatric Rehabilitation Service model of care:

www.health.vic.gov.au/subacute/paed_rehab_model.htm

Person-centred care

Improving care for older people. *What is person-centred health care? A literature review.*

www.health.vic.gov.au/older/pubs.htm.

Post-acute care services (PAC)

Department of Human Services – PAC website: www.health.vic.gov.au/pac

Private specialist ambulatory care services in public hospitals

Specialist clinics in public hospitals: A resource kit for MBS-billed services:

www.health.vic.gov.au/outpatients/specialist-clinics0608.odf

Service coordination tool templates (SCTT)

The SCTT is a statewide service coordination template developed by the Department of Human Services that facilitates the sharing of information and assessments among all services including community and acute sectors. See: www.health.vic.gov.au/pcps/coordination

Sub-acute ambulatory care services (SACS)

Department of Human Services SACS website: www.health.vic.gov.au/subacute

Transition to adult health care

The Royal Children’s Hospital transition to adult health care website:

www.rch.org.au/transition/index.cfm?doc_id=8143

Victorian Aids and Equipment Program (VAEP)

www.dhs.vic.gov.au/disability/supports_for_people/living_in_my_home/aids_and_equipment_program

Victorian Integrated Non-Admitted Health Minimum Data Set (VINAH)

Health Data Standards Systems helpdesk: email HDSS.Helpdesk@dhs.vic.gov.au
or phone 9096 8141

Health Data Standards Systems website: www.dhs.vic.gov.au/hdss/vinah/index.htm

Victorian public hospital patient charter

www.health.vic.gov.au/patientcharter/index.htm

WorkSafe Victoria

www.workcover.vic.gov.au/wps/wcm/connect/WorkSafe

