

health

# Transfer of care from acute inpatient services

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

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# 1. Purpose

The purpose of these guidelines are to:

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

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

## 2. Introduction

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

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

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

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

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

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

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

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<sup>1</sup> NSW Health 2012, *Transfer of care from mental health inpatient services*, NSW Government, Sydney.

<sup>2</sup> See <<https://ama.com.au/position-statement/general-practicehospitals-transfer-care-arrangements-2013>>.

## 3. Principles

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

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

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

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

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

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

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

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

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

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

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

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

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

## 4. Planning for transfer of care

### Key requirements

- Preparation for transfer of care is to begin prior to a planned admission and as soon as possible for emergency or unplanned patients.
- All patients are to undergo a thorough discharge risk assessment within 24 hours of admission.
- An estimated date of transfer of care should be established prior to, or as soon as possible after, an acute patient's admission and reviewed and updated to ensure accuracy and predictability.
- All patients are to have an individualised discharge plan or transfer of care plan.
- Responsibility for coordinating and implementing a patient's discharge or transfer of care plan is to be allocated to a specific individual or team.
- The individual or team responsible for coordinating the patient's discharge or transfer of care should engage with the patient and their carer to prepare them for discharge/transfer of care.

### Implementation guidelines

#### Conducting a discharge risk assessment

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

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

- Is the patient likely to have self-care problems?
- Does the patient live alone?
- Does the patient have caring responsibilities for others?
- Has the patient used community services before admission?
- Has the patient had unplanned admissions to hospital in the previous six months?
- Is the patient at risk of falls?
- Is the patient at risk of developing a pressure injury?
- Is the patient at risk of continuing functional decline?
- Does the patient usually take three or more medications, and have their medications changed in the last two weeks? Does the patient understand how to administer the medications and do they have the ability and willingness to do so?
- Is the patient taking large quantities of Schedule 8 medicines?

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

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

## **Estimating a date of transfer of care**

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

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

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

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

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

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

## **Developing an individualised transfer of care plan**

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

- be informed by, and include, relevant information from the patient's risk assessment, family and/or carer, GP and relevant community providers
- include the estimated date of transfer of care (or discharge) and strategies to ensure the estimated date of transfer of care is met (such as communication plans with community providers, families and/or carers)
- include information about referrals to hospital-based services and/or community services
- include information about the patient's transport arrangements from hospital to their transfer of care location
- include information about the patient's medications and how these will be transferred
- form an integral part of the patient's clinical notes while they are admitted
- be updated as required
- be provided to the patient and/or carer.

### **Allocating transfer of care responsibility to an individual or team**

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

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

# 5. Implementing the transfer of care plan

## Key requirements

- The transfer of care plan is to be developed and implemented in consultation with patients, their families and/or carers.
- All aspects of the transfer of care plan should be understood by the patient, their families and/or carers.
- A transfer of care summary should be commenced as soon as possible and developed throughout the patient's admission.
- A transfer of care checklist (or equivalent) should be completed for all patients prior to discharge or transfer of care.
- The transfer of patient information must comply with the privacy principles as defined in the *Information Privacy Act 2000* and the *Health Records Act 2001*.
- Patients at higher risk of readmission should be identified and strategies to minimise the risk of readmission implemented.
- The Victorian Quality Council's *Inter-hospital transfer patient transfer form*<sup>4</sup> should be used when transferring a patient from one hospital to another.
- Referrals to appropriate healthcare providers and/or community support services are to be made on completion of the risk assessment.
- Necessary community support services are to be engaged upon a patient's discharge home.
- Continuity of medication management should be maintained.
- An appropriate discharge or transfer of care destination should be confirmed.

## Implementation guidelines

### Communicating with the patient, their family and/or carer

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

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

### Completing a transfer of care checklist

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

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<sup>4</sup> See <[www.health.vic.gov.au/qualitycouncil](http://www.health.vic.gov.au/qualitycouncil)>.

## Identifying patients at higher risk of readmission

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

## Transferring the patient to another hospital

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

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

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

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

## Referring the patient to healthcare providers and community support services

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

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

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

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

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

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

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

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

## **Maintaining continuity of medication management**

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

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

## **Approving a patient's transfer of care**

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

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

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

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

## **Confirming an appropriate transfer of care destination**

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

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

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

## 6. Post transfer of care

### Key requirements

- A patient's discharge or transfer of care summary should be prepared ahead of the estimated date of transfer of care.
- A copy of the transfer of care summary should be sent to the patient's GP within 48 hours after the transfer of care (except for patients undergoing chemotherapy or dialysis where multiple treatments are required. In these circumstances, the summary should be sent to the GP after the patient's final treatment).
- The transfer of care summary should be given to the patient (or a family member and/or carer where appropriate) and sent to other relevant community providers.
- Patients who are deemed to be at higher risk of readmission should be contacted by telephone within 48 hours of discharge or transfer of care as a process for reviewing and identifying and resolving potential issues early.

### Implementation guidelines

#### Working with general practitioners and other primary care providers

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

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

#### Preparing and sending a transfer of care summary

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

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

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

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

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

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<sup>5</sup> See <[www.health.vic.gov.au/pch/gpp/working](http://www.health.vic.gov.au/pch/gpp/working)>.

<sup>6</sup> See <[www.nehta.gov.au](http://www.nehta.gov.au)>.

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

### **Contacting the patient after discharge**

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

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

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

## 7. Performance measures for transfer of care

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

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

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

### Key requirement

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

### Implementation guidelines

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

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

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

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

#### 1. Key performance indicators

##### a. Efficiency and patient flow

- Percentage of patients with a completed discharge risk assessment within 24 hours of admission
- Number of transfers of care within an episode
- Timeframe between admission (or the intention to admit) and preparing the transfer of care plan (prediction of a transfer of care date and destination)
- Proportion of patients assessed for transfer of care to subacute services within a clinically appropriate timeframe
- Proportion of patients assessed by ACAS within a clinically appropriate timeframe
- Timeliness of notification of community providers (appropriate number of days may vary depending on the service requested)

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

**b. Clinical outcomes and effectiveness**

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

**2. Demand and backlog measures**

**a. Demand**

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

**b. Backlog**

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

**3. Process measures**

**a. Key process times**

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

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

**b. Process quality**

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

**4. Check measures**

**Patient, staff and referral recipient experiences**

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

## Appendix: Suggested content for a transfer of care summary

### Patient demographic information

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

### Health service information

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

### Clinical information

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

### Post-acute follow-up

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