SD – Transition of Care

Purpose

Transitions of care refer to participants' movement between places or services providing care, such as people moving between disability support services and hospitals. There is a risk of harm to participants. In Australia, the transition of care problem has been associated with risks of harm to people who have a disability. The safe transition of care requires clear communication about participant care between providers, health care staff, participants, and their support network.

Scope

Staff are required to support participants in the transition process under the guidance of management and this policy.

Policy

Transitions of care are priority areas for improving medication safety and reducing avoidable harm. During transitions to and from different healthcare settings, a lack of clear communication about a participant's healthcare needs and current treatments can increase the risk of harm.

Safe transitions of care require clear communication and coordination between the participants, their carers, health care and our service. Our organisation will ensure that the communication and coordination between our organisation and the participant's support network about the participant's health needs, potential risks and current health care are not lost during care transitions, including:

- going to hospital from home or supported accommodation
- leaving the hospital to return home or to supported accommodation

Staff must follow the NDIS Code of Conduct and ensure that they:

- provide supports and services safely and competently with care and skill
- promptly take steps to raise and act on concerns about matters that might impact the quality and safety of supports provided.

Under the NDIS Practice Standards, our obligations are related to delivering safe, quality supports and services and managing risks associated with the supports you provide to NDIS participants. This policy is

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linked to the NDIS Practice Standards, including:

- **Risk management**: Risks to participants are identified and managed.
- **Quality management:** Participants benefit from a quality management system where we continuously use information and feedback to improve support delivery.
- **Information management:** Management of each participant's information ensures it is identifiable, accurately recorded, current and confidential. Each participant's information is easily accessible to the participant and appropriately utilised by relevant workers.
- **Incident management:** Participants are safeguarded by the provider's incident management system, ensuring that incidents are acknowledged, responded to, well-managed and used as part of our continuous improvement
- **Management of medication:** Participants requiring medication are confident that we administer, store and monitor the effects of their medication and work to prevent errors or incidents.

Procedure

Headway Gippsland will undertake the following (where applicable):

- Support participants in preparing for hospital admission by coordinating a pre-admission meeting with hospital staff and the participant's support network.
- Plan transitions out of the hospital as early as possible based on professional medical advice to ensure that any changes in care are considered.
- Work with hospital staff and the participant's support network to ensure you can provide any additional health-related support the participant may require after leaving the hospital.

Supporting the participant

Headway Gippsland, where applicable, will prepare for possible transitions of care by:

- communicating with other services during transitions of care
- helping participants understand and communicate information about their health.

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Prepare for a planned hospital admission

To support participants in preparing for planned hospital admissions, the Support Coordination team may arrange a pre-admission meeting with hospital staff to:

- coordinate the transition of care with the participant, relevant hospital staff, our staff, and, if possible, the participant's support people such as family or friends
- inform hospital staff about the participant's communication requirements, mobility and physical support needs, nutrition and mealtime management, and behaviour support strategies.

Information to provide to hospital staff

Providing information to hospital staff requires Headway Gippsland to have consent from participants, guardians or carers to share information; if possible, Headway Gippsland will make the following available to hospital staff on admission:

- My Health Record (if used by the participant)
- Hospital Support Plan– based on the participant's specific needs and requirements
- List of current medications
- Webster packs and other required medications
- Health Care Card
- Medicare Card
- Behaviour Support Plan
- Communication plan/profiles and any related communication aids/tools.

For an emergency visit to the hospital, you may need to arrange for a disability support worker familiar to the participant to stay with them during the admission.

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Support when the participant leaves the hospital

Plan for discharge from the hospital

Plan for the participant's hospital discharge in consultation with health professionals as early as possible, including:

- estimated date of transfer
- destination of transfer
- transportation
- referral services
- home assessments for equipment, modifications
- re-assessing support risks (e.g. wound management, tube feeding).

Understand the participant's ongoing support needs and assess your capacity to meet them

Work with hospital staff to understand the participant's ongoing needs after they leave the hospital, including obtaining the following and assessing if they have the funds in their NDIS to cater for their release:

- Transfer of Care summary:
  - summary of the medical care the participant received in the hospital.
- Care plan:
  - follow-up appointments with medical specialists,
  - care recommendations for the participant's regular health care providers, such as their GP, and
  - any other required health or social requirements.
- Medications summary:
  - list of current medications, including information about any new or changed medications.
- Risk Assessment review
  - Review Individual Risk Profile and completely new document, as required
  - Adjust support plan, as required
  - Train staff, as required

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The Relevant Managers or their delegate must ask about and understand any changes to the participant's ongoing care needs during their hospital stay and assess whether you can provide for these (for example, if the participant now requires specifically trained staff or equipment). If our organisation cannot provide these new care requirements, we must communicate this to hospital staff as soon as The Relevant Manager or their delegate must undertake early and ongoing communication with hospital staff, the participant, and support people such as carers (and, if required, the participant's NDIS plan manager) to prevent delays in leaving the hospital and reduce risk to participants after their discharge.

References

- NDIS Practice Alert Transitions of care between disability services and hospitals (November 2020)
- NDIS Code of Conduct Rules 2018
- NDIS Practice Standards and Quality Indicators 2021