

Principles for safe, high-quality transitions of care

A transition of care (TOC) is when all or part of a person's health care is transferred between care providers. This may involve transfer of responsibility for some aspects of a person's health care, or all of their health care, on a temporary or permanent basis.

A set of principles has been developed to guide safe, high-quality transitions of care. These should be applied consistently wherever health care is received including primary, community, acute, subacute, aged care and disability care.

The principles for safe, high-quality transitions of care

Transitions of care are person-centred

- The person is supported to be an active partner in their own care
- TOC are based on shared decision-making, informed consent and goals of care
- Clinicians work in partnership with the person to deliver person-centred TOC
- Models of care and communication support person-centred TOC

There is multidisciplinary collaboration to support the transition of care

- The clinicians and broader teams relevant to the transition process are identified and communicated with, prior to commencement of the transition process
- There are established systems and technology for communication amongst the multidisciplinary team
- The person is encouraged to have a regular general practitioner as part of the multidisciplinary team, to support them in the coordination of their care
- Relevant care providers know the general practice primarily responsible for the person's care

There is an enduring, comprehensive and secure record system to document and access information about the person's current and ongoing care

- Clinicians use an electronic record management system to document shared decisions, diagnoses, comprehensive care plans, and other key information needed by the person, their treating team, and any other clinicians responsible for ongoing care
- The Discharge/Transfer Summary or handover information is provided to the person, and the clinician responsible for ongoing care at the time of transition
- Transition of care documentation has sufficient information for the intended audience
- The health information communicated is contemporaneous, complete, accurate, timely, appropriate, precise and evidence based
- The person and clinicians responsible for ongoing care have access to this information

There is ongoing continuity of care

- There is effective coordination and continuity of care, that relies on responsibility and accountability between the treating team, the person, and the receiving service
- There is an agreed framework for communication such as ISBAR*, that includes the purpose of care, a provisional or differential diagnosis, the person's preferences, care provider responsible and recommendations for ongoing care
- Timing of follow up contact with the person and/or the clinician responsible for ongoing care, should reflect the clinical need and inform TOC planning processes

* Introduction, Situation, Background, Assessment, Recommendation

Enablers to support safe, high-quality transitions of care

When implementing the principles for safe, high-quality transitions of care, consideration should be given to the range of enablers that support the effective application of these principles. These include:

Recognising the central role of primary care

The person receiving care is encouraged to work with their general practice to coordinate their care. People without a regular general practitioner risk fragmentation and poor transitions of care.

Acknowledging and addressing system complexity

Care needs, treatment pathways and the healthcare system can be complex and lead to poor transitions. This complexity needs to be acknowledged and addressed in care planning, focusing on a person-centred approach.

Supporting implementation of digitally enabled care

Standardisation and high-level of interoperability of digital systems (including electronic medical records) supports transitions of care. Linked data sets enable 'whole of system' health information, integration and improvement.

Providing education and training to clinicians

Skills and training that are specific to transitions of care, need to be evidence based. Structured communication tools such as ISBAR*, and the use of standardised digital health information templates, facilitate transfer of accurate and important information.

Alignment of funding models

Alignment between models of care and funding models needs to support safe, high-quality transitions of care.

For more information

Please visit: safetyandquality.gov.au/principles-TOC

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