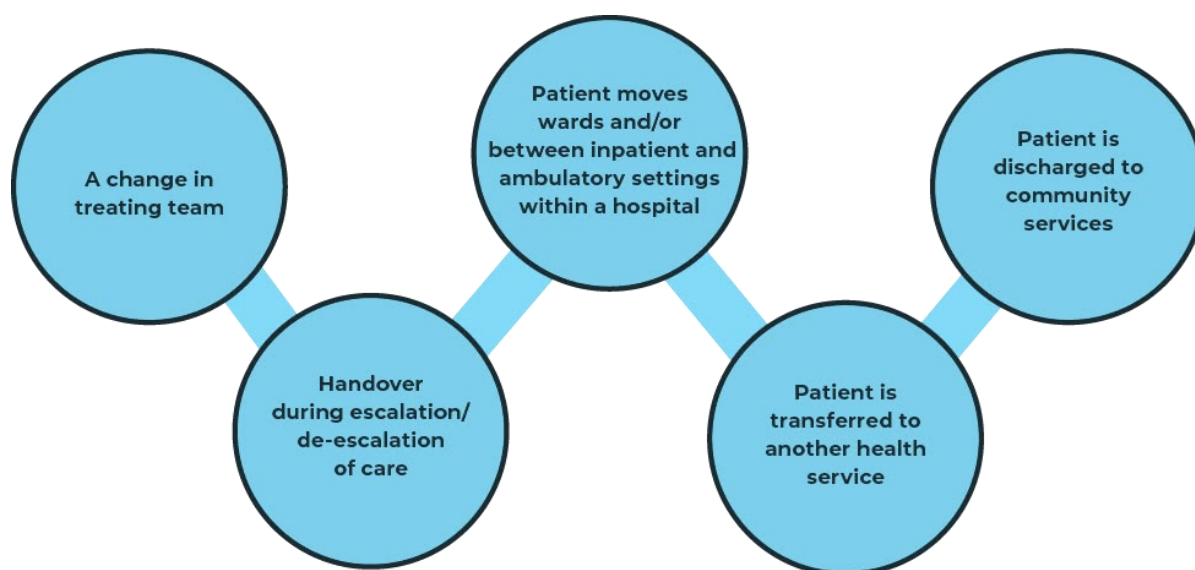


# HOW TO ENSURE EFFECTIVE TRANSITIONS OF CARE?

## What are transitions of care?

Transitions of care are time-points when care is transferred between care providers. Transitions of care may occur within and between healthcare locations, settings, care delivery types, levels of care and involve a range of health care providers. For example:



## How to ensure safe and high-quality transitions of care?



### Person-centered

- Transitions of care should be based on shared decision making and informed consent.
- Communication with the patient and/or their family should be open, honest and respectful, and provide opportunity for clarification and feedback.



### Plan for transitions of care early

- Discuss the plan for ongoing care with the patient and/or their family from day one of admission and/or change of setting, treatment and/or clinical situation.
- Ensure there is multidisciplinary collaboration to support transitions of care.



### Documentation

- Ensure malnutrition and/or sarcopenia diagnosis is included in all relevant documentation in the medical history and handover documents, including medical discharge summary.
- Include current and future goals/management plans in handover documents.



### Communication

- In effective patient-clinician communication, information is exchanged between the patient and their healthcare provider and includes communication with the family or carer.
- At transitions of care, communication should be timely and handover should be both verbal and written.
- Ensure comprehensive documentation about the patients' previous and ongoing care:
  - The ISBAR format should be used to aid communication.
  - Using ISBAR ensures a minimum dataset of information is discussed and improves efficiency and effectiveness of handover.
- Consider the use of handheld records for the patient
  - Macmillan Cancer Support – [My records](#)
  - AHCP Template - [After Hospital Care Plan](#)



### Understand referral pathways

- Understand local cancer services available in primary and community care to ensure continuity of care post discharge or at the completion of treatment.
- Articulate escalation pathways back into the treating cancer service if specialist care/monitoring is required.



### Cross-sector collaboration

- Ensure coordination and continuity of care by outlining responsibility and accountability between the treating and receiving service.
- Consider utilising telehealth or other digital solutions to support transitions of care.
- Shared care models can be used to support transition to/from metropolitan and regional health services or to/from acute and primary care health services.

## Key information to include at handover

- The ISBAR framework represents a standardised approach to communication which can be used for any transition of care.
- ISBAR stands for Identity, Situation, Background, Assessment, Recommendation.

<b>Identity</b>	<ul style="list-style-type: none"><li>▪ Patient name</li><li>▪ URN (or address if no URN)</li><li>▪ Date of birth</li></ul>
<b>Situation</b>	<ul style="list-style-type: none"><li>▪ Diagnosis or presentation</li><li>▪ Reason for referral</li><li>▪ Treatment history</li></ul>
<b>Background</b>	<ul style="list-style-type: none"><li>▪ Relevant past medical history</li><li>▪ Social history</li><li>▪ Patient goals and preferences</li></ul>
<b>Assessment</b>	<ul style="list-style-type: none"><li>▪ Your assessment of the current situation</li><li>▪ Include relevant clinical information (anthropometry; assessment of weight, muscle mass, muscle strength, muscle function; relevant biochemistry; symptoms)</li><li>▪ Diagnosis of malnutrition and/or sarcopenia (with documentation of severity and duration)</li><li>▪ Current management plan</li></ul>
<b>Recommendations</b>	<ul style="list-style-type: none"><li>▪ Follow up and actions required by receiving service (explain what you want the staff member to do)</li><li>▪ Future goals/management plan (i.e., survivorship)</li></ul>

### References:

- Australian Commission on Safety and Quality in Health Care:
- [Transitions of Care](#)
  - [Principles of safe and high-quality transitions of care](#)
  - [Communicating for safety at transitions of care](#)