Improving Care for Aboriginal and Torres Strait Islander Patients (ICAP)

Best Practice Information Package
Discharge planning for Aboriginal and Torres Strait Islander patients

A component of the ICAP on-line resource kit

November 2007
Contents

Acknowledgements ........................................................................................................................................................................... 2
Background & Introduction ........................................................................................................................................................................ 3
What is 'Best Practice'? ............................................................................................................................................................................ 4
Best Practice Principles and ICAP Key Result Area 3 ......................................................................................................................... 5
Principles arising from the Best Practice Workshop .......................................................................................................................... 5
Table of Principles in relation to the Australian Council on Healthcare Standards (ACHS) EQuIP - 4 Functions, Standards and Criteria .......... 6
Suggestions for the publication and adoption of principles across organisations ................................................................................ 9
Conclusion ........................................................................................................................................................................................................ 10
APPENDICES

A. St. Vincent’s Discharge Plan for Aboriginal and Torres Strait Islander Patients (3 pages) .......................................................... 11
B. Royal Children’s Hospital Discharge Plan for Aboriginal and Torres Strait Islander Patients ...................................................... 14
C. South West Health Discharge Plan for Aboriginal and Torres Strait Islander Patients (3 pages) ..................................................... 15
D. Bairnsdale Regional Health Service Discharge Plan for Aboriginal and Torres Strait Islander Patients (2 pages) ......................... 18
E. Workshop 14th August 2007 attendance list ................................................................................................................................. 20
F. Table of ACHS EQuIP 4 Functions, Standards and Criteria .................................................................................................................. 21
G. Mildura Base Hospital Discharge Plan for Aboriginal and Torres Strait Islander Patients (20 pages) .................................................. 22

Acknowledgments

We wish to acknowledge the contributions of members of the Discharge Planning for Aboriginal and Torres Strait Islander Working party for their insightful contributions:
Michelle Winters
Shawana Andrews
Juliet Gavens

All the participants of the workshop held on the 14th August 2007, health services that have shared their discharge plans and the ICAP team:
Leanne Andrews
Andrew Morrison
John Willis
Annette Forbes
Background

We wish to acknowledge the traditional owners of the land in Victoria and pay respect to their Elders both past and present.

Please note that where the term ‘Aboriginal’ occurs in this document it encompasses all Australian Aboriginal and Torres Strait Islander people.

Culture and identity are inextricably linked with the emotional, social and physical health and wellbeing of Aboriginal people and are central to the Aboriginal perception of health. The consideration of culture and identity in determining appropriate health care has been limited in the formulation of general health policies and practices in Victoria.

This information package is about improving the ‘visibility’ of Aboriginal patient’s needs within routine hospital processes and as a result, presenting hospitals more positively as places where appropriate health care can be accessed. This in turn will reduce the ‘fear factor’ often associated with hospitalisation by Aboriginal patients, and decrease the number of readmissions to wards and repetitive attendances at emergency departments. It will also facilitate collaborative practices with local Aboriginal Community Controlled Health Organisations (ACCHO) and general practitioners; and offer a culturally comfortable structure for the continuance of high quality health care after hospitalisation.

Recognition of the vital role that culture plays in relation to health, and respect for Aboriginal and Torres Strait Islander identity, are both central to good outcomes for Aboriginal patients because they are the defining elements that determine when and why a service is accessed and whether treatment is accepted or rejected. This relates to discharge planning too. How culture and identity are considered by a health service provider during the discharge process necessarily impacts on the successful implementation of the plan and subsequent health outcomes of patients; as well as the ongoing relationship between the community and the service.

Introduction

The ICAP program supports health services to provide culturally sensitive care and appropriate referral for Indigenous patients, and recognizes that ‘...high quality and culturally sensitive health care for Aboriginal and Torres Strait Islander patients is a whole of health service quality issue, not just the responsibility of designated Aboriginal staff.’ (DHS Information for health services, 2005). A further ICAP aim, to promote partnerships between health services and Aboriginal Community Controlled Health Organisations, informed the context in which principles for culturally sensitive discharge planning were discussed and developed. The work was carried out by ICAP project officers based in rural and metropolitan areas (one at the Department of Human Services (DHS), Grampian Regional Office Ballarat, and the other at St Vincent’s), who engaged local and regional Aboriginal Hospital Liaison Officers (AHLO’s), along with mainstream staff, in the development of a set of principles. This work occurred in two main phases; the first consisted of a well attended workshop where participants from prominent metropolitan hospitals and rural health services delegated 5 participants to form a working party; and the second was the meeting of the working party and compilation of their deliberations into Best Practice principles as set out below.
**What is ‘Best Practice’?** (Presentation given at the Best Practice in Discharge Planning workshop held on 12/9/2007 at St.Vincent’s)

Best Practice is a concept which asserts that there is a technique, method, process or activity that is more effective at delivering a particular outcome than any other. The idea is that with proper processes, checks and testing, a desired outcome can be delivered with fewer problems and unforeseen complications. Best practice can also be defined as the most efficient (least amount of effort) and effective (best results) way of accomplishing a task, based on repeatable procedures that prove themselves evidentially over time, for large numbers of people.

Best practice continually evolves and does not commit people or organisations to one inflexible, unchanging activity. Instead, ‘Best Practice’ is a philosophical approach based around continuous learning and continual improvement. It does not impose one template or format that everyone must follow without question. On the contrary, in the context of good management, ‘Best Practice’ means that an effective process is planned and followed in any situation, and outcomes are continually monitored, documented and evaluated so that necessary changes can be made. The American Productivity and Quality Centre (APQC) suggest that the following conditions need to exist for a successful transition to ‘best’ practice to take place:

- Meaningful relationships precede the transfer of best practices
- Best practice stems from a personal and organizational willingness to learn and change
- Best Practice is an interactive, ongoing, and dynamic process

Best Practice planning and design includes these steps:

1. Revisit the organisational purpose of the practice
2. Form a strategic management team(working party)
3. Create a vision and define a strategy (or strategies) to achieve it
4. Design a core plan that embeds its own support mechanisms eg executive driven activity, staff cultural education programs, GP contact lists, community controlled organisational networks

The first three steps have already been undertaken by the project team in preparation for the distribution of this document. Core plans will necessarily be contextual and their design will depend on local issues like geography, demographics, service resources, agency protocols and patient need.

Best Practice planning also includes the following process to facilitate the implementation of principles into practice:

1. Communicate and educate
2. Roll-out the plan and encourage its use
3. Maintain momentum by monitoring, documenting and reporting outcomes
4. Evaluate results to plan for the future
Best Practice Principles and ICAP Key Result Area 3

The following principles meet and mirror the aim of Key Result Area 3 in the ICAP program which reads:

*Set up and maintain service planning and evaluation processes that ensure the cultural needs of Aboriginal people are addressed when referrals and service needs are being considered, particularly in regard to discharge planning.*

There are 3 demonstration of achievement exemplars highlighted in the ICAP Guidelines and they are;

- Involvement of Aboriginal staff in the development, review and refinement of post-acute care and discharge planning arrangements
- Views of Aboriginal organisations and Aboriginal service users have been sought
- Aboriginal – specific post acute planning policies, procedures and protocols are in place

Principles arising from ideas expressed in the Best Practice workshop

These principles meet the mandatory criteria identified in the Australian Council on Healthcare Standards (ACHS) EQuIP 4 table for clinical, support and corporate standards (see appendix G), and are to be used only as a procedural aid in discharge planning for Aboriginal patients and their subsequent follow up in the community.

1. Discharge planning commences at admission with accurate identification of the patient
2. AHLO involvement is essential to the success of the discharge process
3. Medical discharge information alone is not adequate - Specialist Aboriginal input must be actively sought
4. An Aboriginal cultural awareness program is included in staff professional development schedule
5. The patient who requires a discharge plan must have given informed consent to its implementation
6. A case management model is best utilised for discharge planning, especially for those patients deemed medically and socially complex
7. All relevant departments are notified of the discharge
8. Patient follow up should not be the sole responsibility of the AHLO

**Note:** In the event that a health service does not employ an Aboriginal Hospital Liaison Officer (AHLO) the basic principles still apply and efforts should be made to involve the patient’s family, carer and local Aboriginal community organisation in the discharge process; and to look at opportunities to recruit Aboriginal staff to the service.
Table of Principles in relation to the ACHS EQuIP - 4 Functions, Standards and Criteria

The following table has been designed to display best practice ideas in relation to each principle as it reflects the ACHS EQuIP – 4 Functions, Standards and Criteria. The first principle has been completed as an example of how each could be implemented, monitored and evaluated with the understanding that strategies would depend on local health service needs, resources and protocols.

<table>
<thead>
<tr>
<th>Principle</th>
<th>Relevant ACHS EQuIP 4 Functions, Standards and Criteria</th>
<th>Best practice ideas</th>
<th>Who could be responsible for implementation?</th>
<th>How may this practice be implemented and monitored across the organisation?</th>
<th>What evidence could be required for evaluation?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Discharge planning commences at admission</td>
<td>Clinical: 1.1.2; 1.1.6; 1.2.2 1.3.1; 1.4.1 1.5.6; 1.6.3 Support 2.2.2; 2.2.3 2.2.4; 2.3.3 Corporate 3.1.1.</td>
<td>• Ensure accurate identification of Aboriginal patients by regular training of front line staff in asking the question. • Include the rationale for asking patients; “Are you Aboriginal or Torres Strait Islander?” in cultural awareness programs for all staff</td>
<td>Health Information Services manager (or equivalent) Human Resources manager (or equivalent)</td>
<td>AHLO to encourage staff to ask the question about identity and advise on training for frontline staff AHLO &amp; Supervisor to include Aboriginal cultural awareness sessions in staff orientation programs</td>
<td>Internal audit of patient records shows increase in identified patients Periodic survey of staff awareness of the cultural issues</td>
</tr>
<tr>
<td>2. AHLO involvement is essential to the discharge process</td>
<td>Clinical: 1.1.1; 1.6.3 Support: 2.2.2; 2.2.5; 2.3.4 Corporate: 3.1.2</td>
<td>• Recruit Aboriginal people to professional roles in the service. • Value Aboriginal staff by offering them relevant training • Introduce &amp; clarify</td>
<td>Human Resources manager (or equivalent)</td>
<td></td>
<td>Appropriateness and success of Recruitment &amp; Training processes for Aboriginal staff into professional roles</td>
</tr>
</tbody>
</table>
| 3. Specialist Aboriginal input must be sought | AHLO role in staff orientation programs: 
- Notify AHLO as early as possible of patients presence in hospital or impending discharge | Health Information Services manager (or equivalent) | Use of supportive technology where available eg email/computer printout |
|----------------------------------|-------------------------------------------------------------|-------------------------------------------------|----------------------------------------------------------|
| Clinical: 1.1.1; 1.1.2; 1.3.1; 1.6.1; 1.6.3  
Support: 2.3.1; 2.3.2; 2.3.4  
Corporate: 3.1.4 | - Include AHLO in the discharge process  
- Involve family and carers in planning  
- Liaise closely with local Aboriginal Community Controlled Organisations (ACCHO’s)  
- Establish alliances with Indigenous-friendly GP's | | |
| 4. An Aboriginal cultural awareness program is included in the staff professional development schedule | Clinical: 1.3.1  
Support: 2.2.1; 2.2.2  
Corporate: 3.1.3 | | | |
| - Work with local Indigenous community members to develop a program  
- Bring in an external Aboriginal consultant to run the program | | | |
| 5. The patient who requires a discharge plan must have given informed consent to its implementation | Clinical: 1.1.3; 1.6.2  
Support: 2.3.3  
Corporate: 3.1.2; 3.1.5 | - Involve the AHLO in gaining informed consent to the plan – (see appendices for examples) | |
6. Use case management models to plan the discharge, especially for those patients deemed medically and socially complex

| Clinical: | Discharge plans are individually tailored to patient circumstances eg use of the Patient Assistance Transport Scheme (PATS) |
| Support: | Socially complex patients are the responsibility of the whole team, not just the AHLO |
| Corporate: | Ensure that all stakeholders including the ACCHO’s are informed of their role in the plan |

- Use of supportive technology where available eg e-health/e-referral processes/tele-conferencing

- Correlate improvement measures of patient experience with planned service/business outcomes

7. All relevant departments are to be notified of the discharge

| Clinical: | Discharge plans are filed in patient’s notes and highlighted with an Aboriginal marker eg flag, to assist with continuity of care |
| Support: | Discharge notification is distributed as soon as possible, to Outpatient Dept, GP and local ACCHO; and through the internal care team network eg HARP programs |

- Use of supportive technology where available eg e-health/e-referral processes/tele-conferencing

- Correlate improvement measures of patient experience with planned service/business outcomes
| 8. Patient follow up is not the sole responsibility of the AHLO | Clinical: 1.1.6 Support:2.2.5 Corporate: 3.2.1 | • Implement a systematic patient appointment reminder procedure that involves the whole staff team  
• Designate responsible team members to support the AHLO where necessary | Set up a central liaison point within the team for ACCHO's to contact as necessary | Utilise multiple measurements of performance eg patient experience surveys, complaint process, patient and family advisory groups |

**Suggestions for the publication and adoption of principles across organisations**

- Set up a local working party (including members of relevant external service agencies and Aboriginal Community Controlled organisations) to discuss, devise and implement a district or region-specific plan. ◊The plan may include a recruitment and training process for Aboriginal staff where none are currently employed in the health service.
- Integrate best practice ideas into staff professional development sessions
- Table best practice ideas at care network meetings
- Circulate best practice ideas among clinical leadership teams for comment/endorsement
- Encourage clinical leadership teams to model the best practice ideas in consultation with the AHLO
- Include the best practice ideas in on-line training packages
- Promote the best practice ideas on the service website
- Promote the best practice ideas in departmental Newsletters
- Place the best practice principles document in wards and relevant departments
Conclusion

The aim of these principles is to make discharge planning for Aboriginal patients part of core business in a quality health service. This will happen if the principles are supported at executive level by their inclusion in the policies and protocols of the organisation. The development of an explicit set of policies, procedures and review mechanisms can ensure that ‘best’ practices are institutionalised and that opportunities for improved practice are regularly identified. They will also help identify where responsibility for best practice is ill defined and needs to be clarified.

The absence of a framework such as an explicit policy for the discharge of Aboriginal patients does not mean that high quality work is not occurring. It does mean that it is difficult to determine if this is the case, and how widespread efficient and effective practices are in the organisation. There may be many useful discharge practices across departments and responsibility is often ‘assumed’ for activities that maintain the quality of services. However, the maintenance of these practices depends on the initiative and commitment of particular individuals and in the case of Aboriginal patients, this often means a single AHLO if one is employed.

In this context these principles are designed to provide information that supports the documentation of existing good practice; to establish mechanisms that ensure good practices are monitored and improved where possible; and to enhance the potential for reduction in both the under-use and over-use of health services. To this end, an essential element of Best Practice as presented here is the employment of the AHLO and where this is not currently the case, the active recruitment of Aboriginal people to the health staff. The eventual reduction in rates of re-admission to hospital and a positive change in the Aboriginal perception of the purpose and outcome of hospitalisation will not only result in an improvement in health outcomes for Aboriginal patients but in the overall relationship between health services and their local Aboriginal community.
ATSI Communication Project

Identify ATSI Client

(Focus on EOU, MAPU, Gen medical Units, Cottage, ED (Seen by ALERT for Care coordination) EMU)

On Assessment ensure up to date details are taken on:
  - Service Providers
  - Family members/contacts
  - GP & Surgery

Gain Verbal/ written consent to develop and send a “Communication Letter” to those identified above. (If no consent process can stop here).

Complete Communication Plan and send.
Appendix A – St. Vincent’s Discharge Plan for Aboriginal and Torres Strait Islander Patients

Date

Community Controlled Organization Address

Dear Program Manager and Nurse Unit Manager etc.

Re: Patient and DOB

Patient (Name) presented to the St Vincent’s Emergency Department/ was discharged from St Vincent’s on Date.

The following is a plan, which has been developed by Patient’s Name, and KHLO Name and Social Worker Name to ensure clear communication between St Vincent’s Health and community service providers, patients and carers.

<table>
<thead>
<tr>
<th>Issue</th>
<th>Action</th>
<th>Timeline / Dates</th>
<th>Agency/ contact &amp; Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow up out patient appointments at St Vincent’s Health – Orthopaedics etc.</td>
<td>Transport needed</td>
<td>14/9/06 Out patients for XRay 3.00 pm</td>
<td>VAHS Transport Section 9419 3000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>19/9/06 Day of surgery - scheduled for 10am</td>
<td></td>
</tr>
<tr>
<td>Surgery at St Vincent’s</td>
<td>Orthopaedic surgery for fractured surgical neck of left humerus</td>
<td>19/9/06 10am</td>
<td>St Vincent’s Victoria Parade Fitzroy 9288 2211</td>
</tr>
<tr>
<td>Assistance during hospital inpatient stay at St Vincent’s</td>
<td>Practical support and counselling and care coordination</td>
<td>20/9/06 until discharged 1/10/06</td>
<td>KHLO Name 9288 3436 Social Worker Name 9288 3336</td>
</tr>
<tr>
<td>Respite required for approximately 2 to 3 months after surgery.</td>
<td>Short term respite whilst convalescing</td>
<td>1/10/06 until approximately 15/12/06</td>
<td>ACES Ph: 9383 4244 Fax: 93843011</td>
</tr>
<tr>
<td>Funding of Respite (partial)</td>
<td>Referral to Inner Melbourne Post Acute Care for $200 towards respite.</td>
<td>28/9/06</td>
<td>Social Worker Name 9288 3436</td>
</tr>
<tr>
<td>Exploration of Long term accommodation options</td>
<td>Discussion with patient regarding hostel or other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
and assessment for CACPS case management.  
long term accommodation.

<table>
<thead>
<tr>
<th>Updated patient information to be supplied to patient’s GP and psychiatrist</th>
<th>Medical discharge summary</th>
<th>At discharge</th>
<th>SVH and VAHS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>D + A counselling/linkage</strong></td>
<td>Pt requesting ongoing drug and alcohol support.</td>
<td>Within 24 hrs of discharge</td>
<td>St Vincent’s D + A Liaison Nurse 9288 2211 Worker name VAHS 9403 3300</td>
</tr>
<tr>
<td><strong>Family counselling and support</strong></td>
<td>Pt requesting family counselling.</td>
<td>During admission On discharge and ongoing</td>
<td>VAHS Family Counselling Service.</td>
</tr>
<tr>
<td><strong>Mental Health support, medication management and counselling</strong></td>
<td>Pt requires review of current medications, medication management, mental health support and long term psychological support</td>
<td>On Discharge On Discharge and Ongoing</td>
<td>St Vincent's Mental Health Team Worker name 9288 2211 pager VAHS GP &amp; Family Counselling Service to follow up.</td>
</tr>
</tbody>
</table>

**RECOMMENDATIONS**

St Vincent’s KHLO recommends that all key organisations be involved in providing services and care to patient and to develop a care plan to ensure that patient receives her surgery and after care without delay. If any problems or issues arise please feel free to contact KHLO or Social Work Dept to schedule a case planning meeting time to discuss.

Additional information as relevant will be provided to patient and GP, including a medical discharge summary, medication information and outpatient appointments.

Please contact KHLO name on telephone 9288 3436 Or 9288 2211 pager 980 or Social Worker Name 9288 3385 pager X if you would like to discuss this information further

Yours Sincerely,

Signed

---

_The Communication Plan initiative supported by the St.Vincent’s Aboriginal Health Advisory Committee in consultation with key community agencies as part of St.Vincent’s Improving Care for Aboriginal and Torres Strait Islander Patients initiative (ICAP)._
Appendix B – Royal Children’s Hospital Discharge Plan for Aboriginal and Torres Strait Islander patients

RCH Policy and Procedure Manual

Full HTML version  RCH > Executive > Policy and Procedure Manual

Discharge and Community Support of Aboriginal Patients

1. Policy statement

To outline the RCH policy and procedures for discharge and community support of Aboriginal patients

Policy number  RCH0311
Historical  9P-06-1-001
Policy number  ?
Category  Continuum of Care
Sub category  Separation
Policy type  Policy
Revision  2 (view history)
Approved  18-Dec-2001
Approved by  Executive Director Clinical Support Services
Next review  16-Nov-2008

Author  * Jane Miller
Social Work Department
Please remember to read the disclaimer.

2. Persons Affected

Aboriginal Family Support Unit staff, Medical Nursing and Allied Health staff, Health Information Services Staff.

3. Definition of terms

Discharge planning should begin at the time of admission. (See policy re Services To Aboriginal Families). It is acknowledged that as Aboriginal society is communally based and many families are rural, the Aboriginal discharge planning process will necessitate appropriate Aboriginal community consultation.

4. Responsibility

Discharge planning should begin at the time of admission. (See policy re Services To Aboriginal Families). It is acknowledged that as Aboriginal society is communally based and many families are rural, the Aboriginal discharge planning process will necessitate appropriate Aboriginal community consultation.

5. Criteria

All Aboriginal children and their families should be offered the support of the staff of the Aboriginal Family Support Unit at the time of admission. All families attending the hospital must be asked the mandatory question “Are you of Aboriginal or Torres Strait Islander descent?” If “yes”, this should be indicated on the Bradmar label.

The Aboriginal Family Support Unit will be automatically notified of the admission via daily printouts from Health Information Services. Unit staff will meet with every patient identifying as Aboriginal.

The Aboriginal Support Unit will receive early notification of and will then link into what ever discharge process is in place for that child to ensure culturally appropriate planning is undertaken and culturally acceptable support services are in place prior to discharge. The above will allow this policy to link with whatever hospital wide discharge policy/practices are developed in the future.

After discharge the Aboriginal family support unit staff will monitor the more complex situations to ensure that plans put in place were implemented and that follow up appointments are attended.

Medical Record Documentation

In addition to the normal medical record documentation, where a child has been identified as Of Aboriginal or Torres Straight Islander background, the Aboriginal Family Support Unit will indicate their involvement by the placing of Aboriginal Flag sticker, and their own name and pager number in the progress notes.


13/08/2007
Appendix C – South West Health Discharge Plan for Aboriginal and Torres Strait Islander patients

**OBJECTIVE:** Form to be completed for all Aboriginal or Torres Strait Islanders presenting to Emergency Department Reception and the SWH Admissions Office.

**IMPORTANT POINTS:**

- An Aboriginal Liaison Officer has been appointed to South West Healthcare. As part of the South West Healthcare Aboriginal Liaison Officer Program, follow up care is available to patients after discharge from hospital.

- Further information is available by contacting the South West Healthcare Aboriginal Liaison Officer.

**GUIDELINES / PROCEDURE:** The following steps are to be followed in order to correctly process ALOP Follow Up Care Referrals.

<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The question “Are You Aboriginal or Torres Strait Islander?” should always be asked as a routine enquiry at Admissions Office and ED Reception.</td>
</tr>
<tr>
<td>2</td>
<td>The relevant section of Vital/TrakCare should be completed to reflect their answer.</td>
</tr>
<tr>
<td>3</td>
<td>If the patient’s answer is “NO” to the above question, complete the Admission as required.</td>
</tr>
</tbody>
</table>
| 4    | If the patient’s answer is “YES” to the above question, the HIS Staff Member should provide the ALOP FOLLOW UP CARE REFERRAL MR 36 form from the manila folder and provide an overview:  
  - Follow up care is available to Aboriginal or Torres Strait Islander patients after discharge from hospital;  
  - The SWH Aboriginal Liaison Officer will contact the Aboriginal or Torres Strait Islander organisation of choice and a preferred worker if known. |

**CONTROLLED DOCUMENT**
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Ask if the patient would like follow up care after discharge.</td>
</tr>
</tbody>
</table>
| 6 | If the Answer is NO, the patient Ticks NO and crosses out "give permission" in the consent sentence and signs at the bottom of the form.  
   The HIS Staff Member witnesses and designates the form.  
   The form is then set aside and the patient's details are later recorded either by hand or by attaching a patient ID label in the space provided in the top right hand corner.  
   The original should be filed in the Medical Record. It is not necessary to make a copy and leave for the SWH Aboriginal Liaison Officer. |
| 7 | If the Answer is YES, the patient Ticks YES and completes the form noting one preference and indicating a preferred worker [if known] from the organisations listed below:  
   1. Gunditjmara Aboriginal Co-operative – Health  
      • Home And Community Care [HACC]  
      • Chronic Illness Worker  
   2. Kirrae Health Service Framlingham  
   3. Other Aboriginal Organisation |
| 8 | The patient crosses out "do not give permission" in the consent sentence and completes the relevant contact details and signs at the bottom of the form. |
| 9 | The HIS Staff Member witnesses and designates the form.  
   The patient's details should be recorded either by hand or by attaching a patient ID label in the space provided in the top right-hand corner. |
| 10 | The completed and signed form should then be photocopied.  
   The original should be filed in the Medical Record.  
   The copy should be placed in the blue manila folder located on the storage cupboard adjacent to the Admissions Desk for the SWH ALO to collect. |
| **PLEASE NOTE** | **If an eligible patient is not able to complete the form at the time, the ALOP form should be left at the Admissions Desk With Patient ID labels attached and the Aboriginal Liaison Officer will follow up later.** |
| **OUTCOME STATEMENT** | The ALOP Follow Up Care Referral Form is completed correctly and the information forwarded in a timely manner to the ALO. |
### Appendix C – South West Health Discharge Plan for Aboriginal and Torres Strait Islander patients

**SOUTH WEST HEALTHCARE**

**ABORIGINAL LIAISON OFFICERS PROGRAM**

**FOLLOW UP CARE REFERRAL**

As part of the Aboriginal Liaison Program, follow up care is available to patients after discharge from South West Healthcare.

If you would like follow up care, the Aboriginal Liaison Worker will contact the organisation of your choice and your preferred worker.

Would you like follow up care after discharge?  

- [ ] YES  
- [ ] NO  

*Please sign below*

If yes, please tick one preference and indicate a preferred worker (if known) from the organisations listed below:

<table>
<thead>
<tr>
<th>PLEASE TICK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gunditjmara Aboriginal Co-operative – Health</td>
</tr>
<tr>
<td>Preferred worker: [ ]</td>
</tr>
<tr>
<td>Home And Community Care [HACC]</td>
</tr>
<tr>
<td>Preferred worker: [ ]</td>
</tr>
<tr>
<td>Chronic Illness Worker</td>
</tr>
<tr>
<td>Preferred worker: [ ]</td>
</tr>
<tr>
<td>Kirrae Health Service Framlingham</td>
</tr>
<tr>
<td>Preferred worker: [ ]</td>
</tr>
<tr>
<td>Other Aboriginal Organisation</td>
</tr>
<tr>
<td>Organisation Name: [ ]</td>
</tr>
<tr>
<td>Preferred worker: [ ]</td>
</tr>
</tbody>
</table>

I give permission/do not give permission to the Aboriginal Liaison Worker to contact the organisation and preferred worker noted above.

Patient Signature: [ ]

Contact Telephone Number: [ ]

Witness: [ ]

Designation: [ ]

Date: [ ] / [ ] / [ ]

**TRIAL**

**A LOP FOLLOW UP CARE REFERRAL MR 36**

**OFFICE USE ONLY**
Appendix D – Bairnsdale Regional Health Service Discharge Plan for Aboriginal and Torres Strait Islander patients

DISCHARGE PLAN: ABORIGINAL AND TORRES STRAIT ISLANDER PATIENTS

BAIRNSDALE REGIONAL HEALTH SERVICE (BRHS)

BRHS holds that the continuum of care is everyone’s responsibility so we in the Koorie Health Liaison Office (KHLO) like to be, and are encouraged to be, involved in discharge planning for all Aboriginal and Torres Strait Islander patients.

There are times when clients are discharged and we are not in the hospital so then it is up to the Nurse Unit Managers (NUMS) to make sure that discharge planning is done to meet the client’s individual needs. The process starts from when the client is first admitted to hospital.

Our planning procedure begins with our office being heavily involved in discharge planning meetings and playing the role of advocate as we voice opinions on the client’s needs. Hospital staff may not know the client’s history, kinship system and why certain discharge plans may not work. We encourage staff to try different avenues through the local Koori Aboriginal Medical Centre.

Our Hospital has a responsibility to train all staff in cross-cultural awareness and at all meetings, even when Koori clients are not admitted to hospital, input from our office is essential; the better they know you, the better the staff will understand Koori ways.

To facilitate this we get on to the Hospital Orientation Program to let staff know about our service within the hospital and we speak to registrars and new nursing staff about the KHLO role. It helps when all staff know what we expect from them while dealing with Aboriginal clients. For instance we will contact the relevant doctor if the client does not understand what is happening to them and we get medical staff to explain the issues to them in layman’s terms.

It is also essential that our participation in discharge planning is ongoing so that the discharge of clients is correctly done, and we follow up clients to see if the plan itself is working, and review it regularly in case a change may be necessary.

We have the Aboriginal Health Workers from the Gippsland and East Gippsland Aboriginal Corporation (GEGAC) coming to the hospital every morning to do the rounds with the KHLO to meet the clients who have agreed to see them. We have not had a refusal yet.

The Maternal and Child Health Worker at GEGAC is called the ‘Boori’ Worker and the KHLO office will also contact them if client wants that, and the Boori Worker will visit as well.

This system works very well as the Health Workers can also follow up clients when they leave the hospital. They can also have input into their discharge plan as it rolls out so we liaise with the Aboriginal Health Workers on an ongoing bases.

It is advisable for KHLO’s to spend time with each allied health discipline to know what their services provide and to look at ways to refer to them; and to learn what sort of details are needed to make an appropriate referral. As outpatients appointments can also be made before the client goes home, the KHLO can find out if follow up is going to be needed; and transport can also be arranged at this time.

The KHLO also promotes outpatient services within the hospital to clients, for example specialties like Pulmonary Rehabilitation, Occupational Therapy, Dietician, Physiotherapy, Podiatry etc. We have also been invited to sit through sessions with clients until they feel comfortable going to these departments on their own.
An important aspect of KHLO work is to build up a network of useful contacts not just in the Koori community but in the mainstream. This is so we can let the client know about various healthcare agencies and consequently, they are better resourced to make informed decisions. We write up a list of Aboriginal services in the local area so that staff know that services are available and when and where to go to access them. This list is laminated and put on all wards.

Visibility is very important for the KHLO and we are seen on wards daily if possible so the staff know we are there and what we do. It is up to Hospital Staff to let the KHLO know where clients are and they do this by phone, email or pager. We write in the client’s file after every visit to keep everyone up to date with what is happening. This is crucial because things can change several times and very quickly. At BHRS the KHLO places a coloured sticker with KHLO written on it in the client’s file when we write our notes.

The KHLO is also involved in the e-Referrals system here at BRHS. The e-Referrals system is a form of communication technology where the hospital can let Home and Community Care (HACC) and the Aboriginal Medical Centre know that their clients are in and can also let them know about discharge so that case managers can have a say in discharge planning.

A lot of our clients don’t know if their on a HACC, CO-CARE, CAPS (Care of the Aged Packages) or EACH package etc and this is where the e-Referrals system can be very helpful. It assists the hospital in getting to know what services the clients may be having within their own homes (as a lot of relatives also do home help up our way), and e-Referrals to a variety of regional and metropolitan Medical Centres also let doctors know that their clients are in hospital or that they may have been sent off to other hospitals. This stops the confusion that often arises particularly in relation to medications being changed (as some clients enter Accident and Emergency and are flown out to Melbourne hospitals without their doctors even knowing.)

This is the work that the KHLO is responsible for at BRHS. We hope that you have found it interesting and informative.

Bonnie O’Shanassy
Rob Hudson

Koorie Health Liaison Officers
Bairnsdale Regional Health Service
Appendix E – Workshop 14\textsuperscript{th} August 2007 attendees

**DISCHARGE PLANNING FOR ABORIGINAL AND TORRES STRAIT ISLANDER PATIENTS**

Workshop 10am – 1pm – 14\textsuperscript{th} August 2007

<table>
<thead>
<tr>
<th>NAME</th>
<th>ORGANISATION</th>
<th>TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michele Stankovic</td>
<td>Latrobe Regional</td>
<td>AHLO</td>
</tr>
<tr>
<td>Andrew Morrison</td>
<td>VACCHO</td>
<td>ICAP Project Officer</td>
</tr>
<tr>
<td>Leanne Andrews</td>
<td>DHS</td>
<td>Rural ICAP Policy Advisor</td>
</tr>
<tr>
<td>Cathy Brunton</td>
<td>RVEEH</td>
<td>Patient Systems Co-ordinator</td>
</tr>
<tr>
<td>Kate McBride</td>
<td>RVEEH</td>
<td>MSW</td>
</tr>
<tr>
<td>Elizabeth Wilson</td>
<td>RVEEH</td>
<td>Nurse Unit Manager</td>
</tr>
<tr>
<td>Alison Hocking</td>
<td>Peter Mac</td>
<td>MSW</td>
</tr>
<tr>
<td>Elizabeth Ballinger</td>
<td>Peter Mac</td>
<td>Head MSW</td>
</tr>
<tr>
<td>Penelope Vye</td>
<td>Maroondah</td>
<td>Manager Social Work</td>
</tr>
<tr>
<td>Juliet Gavens</td>
<td>SVHM</td>
<td>GP Liaison Coordinator</td>
</tr>
<tr>
<td>Sonia Posinelli</td>
<td>SVHM</td>
<td>MSW - Aboriginal Projects</td>
</tr>
<tr>
<td>Sharyn Young</td>
<td>SVHM</td>
<td>Care Coordinator ALERT</td>
</tr>
<tr>
<td>John Worters</td>
<td>Gippsland Regional</td>
<td></td>
</tr>
<tr>
<td>Shirley Firebrace</td>
<td>Austin</td>
<td>Aboriginal patient support officer</td>
</tr>
<tr>
<td>Lori Hobbs</td>
<td>RMH</td>
<td>MSW</td>
</tr>
<tr>
<td>Marika Kalargyros</td>
<td>RWH</td>
<td>Senior Aboriginal support officer</td>
</tr>
<tr>
<td>Terrori Hareko-Samnios</td>
<td>RWH</td>
<td>Aboriginal patient support officer</td>
</tr>
<tr>
<td>Sharon Bolger</td>
<td>Alfred</td>
<td>AHLO</td>
</tr>
<tr>
<td>Nicola Watt</td>
<td>RCH</td>
<td>MSW</td>
</tr>
</tbody>
</table>

**PRESENTERS**
Karen Atkinson
Michele Winters
Danielle Moss
Shawana Andrews (RCH)

**FACILITATORS**
John Willis & Annette Forbes
### Appendix F – Table of EQUiP 4 Functions, Standards and Criteria

#### Table of EQUiP 4 Functions, Standards and Criteria

**Mandatory criteria**

<table>
<thead>
<tr>
<th>1. CLINICAL</th>
<th>2. SUPPORT</th>
<th>3. CORPORATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Consumers / patients are provided with high-quality care throughout the care delivery process.</td>
<td>2.1 The governing body, in its strategic direction, ensures, through policy and the required functions, that the organisation has in place the necessary processes to achieve the desired outcomes.</td>
<td>3.1 The governing body, in its strategic direction, ensures the Provision of quality, safe and effective care services.</td>
</tr>
<tr>
<td>1.1.1 The discharge plan ensures current and ongoing needs of the consumer / patient are identified.</td>
<td>2.1.1 The organisation’s discharge planning function demonstrates its commitment to ensuring the outcomes of care and service delivery, in addition to the desired outcomes.</td>
<td>3.1.1 The organisation provides quality, safe and effective care services through an integrated, inclusive, organisation-wide discharge management policy and system.</td>
</tr>
<tr>
<td>1.1.2 Care is planned and delivered in partnership with the consumer / patient and the necessary care is delivered.</td>
<td>2.1.2 The discharge plan integrates and complements other management tools and processes to ensure that the organisation’s discharge management system is effective.</td>
<td>3.1.2 Governance is assisted by formal structures and delegation practices within the organisation.</td>
</tr>
<tr>
<td>1.1.3 Consumers / patients are informed of their rights and responsibilities.</td>
<td>2.1.3 Health care facilities, consumers and families are managed to ensure appropriate access to the system of care.</td>
<td>3.1.3 Processes are established and defined to identify and resolve any areas of concern.</td>
</tr>
<tr>
<td>1.1.4 Plans for discharge / transfer are consistent with the service needs of the consumer / patient and are clearly documented.</td>
<td>2.2 Human resource management supports quality health care, a competent workforce and a satisfying workplace environment for staff.</td>
<td>3.1.4 External service providers are managed to ensure quality care and service delivery.</td>
</tr>
<tr>
<td>1.1.5 Services for ongoing care of the consumer / patient are identified and offered.</td>
<td>2.2.1 Human resource management plans, supports and funds the organisation’s current and future ability to address needs.</td>
<td>3.1.4.1 (e) Documented clinical and customer policies avoid the organisation’s failure to provide quality care</td>
</tr>
<tr>
<td>1.1.6 Systems for ongoing care of the consumer / patient are identified and effective.</td>
<td>2.2.2 The recruitment, selection and appointment system ensures that the skill mix and competence of staff, and roles of volunteers, meet the needs of the organisation.</td>
<td>3.2 The organisation maintains a safe environment for employees, consumers / patients and visitors.</td>
</tr>
<tr>
<td>1.1.7 Systems that ensure that the care of dying and deceased consumers / patients is managed with dignity and respect.</td>
<td>2.2.3 The continuing-education and performance development system ensures the competence of staff and volunteers.</td>
<td>3.2.1 Safety management systems ensure safety and wellbeing for consumers / patients, staff, visitors and contractors.</td>
</tr>
<tr>
<td>1.2 Consumer / patients / communities have access to health services and care appropriate to their needs.</td>
<td>2.2.4 The learning and development system ensures the skill and competence of staff and volunteers.</td>
<td>3.2.2 Buildings, signage, offices, equipment, supplies, utilities and consumables are managed safely and used efficiently and effectively.</td>
</tr>
<tr>
<td>1.2.1 The community has information on, and access to, health services and care appropriate to its needs.</td>
<td>2.3 Information management systems enable the organisation’s goals to be met.</td>
<td>3.2.4 Emergency and disaster management supports safe practice and a safe environment.</td>
</tr>
<tr>
<td>1.2.2 Access and admission to the system of care is prioritised according to clinical need.</td>
<td>2.3.1 Records management systems support the collection and dissemination of information throughout the organisation.</td>
<td>3.2.5 Security management supports safe practice and a safe environment.</td>
</tr>
<tr>
<td>1.3 Appropriate care and services are provided to consumers / patients.</td>
<td>2.3.2 Information and data management and collection systems are used to assist in meeting the strategic and operational needs of the organisation.</td>
<td>3.2.5.1</td>
</tr>
</tbody>
</table>
Appendix G – Mildura Base Hospital Discharge Plan for Aboriginal and Torres Strait Islander patients *(available on request, as a separate pdf document)*