Tips for Nurses: Continuity of Care

**What it is:** Continuity of care has three main parts:
1. The care provider knows and follows the care of a person, client or resident.
2. There is good exchange of relevant information between different care providers.
3. Different care providers cooperate so that care is connected care.

**Why it matters:** Continuity of care helps care providers to be aware of a person's preferences and care needs. It also helps with the smooth coordination of a person's care. It is particularly important for the care of a person who may be at the end of life. It also helps care providers to have the information they need so that the person's choices are respected.

**What I need to know:** Continuity of care can:
- avoid unnecessary hospitalisations
- ensure the older person receives uninterrupted care based on their needs
- make sure that important treatments continue when a person is moved to or from a care setting (home, hospital, residential aged care)
- make sure that a person's preferences and needs are considered.

**Actions**

- **Document** goals of care.
- **Refer** to a person's Advance Care Directive (ACD) when planning care and include plans for managing exacerbations of their health condition.
- **Make** certain that all care providers understand the goals of care for the older person.
- **If you identify** signs of imminent death communicate the person's end-of-life stage to the GP.
- **Ensure** that all appropriate documents accompany a person when transferred between care settings.

**Tools**

- Tools that may be useful include:
- **Continuity** of care can be supported by use of an end-of-life care pathway such as Residential Aged Care End of Life Care Pathway (RAC EoLCP).
**My reflections:**

What processes are in place in my organisation that assist continuity of care?

**My notes:**

See related palliAGED Practice Tip Sheets:
- Advance Care Planning
- End-of-Life Care Pathways
- Talking within the Aged Care Team