

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).

Name:

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

References used to develop this sheet are available at
www.palliaged.com.au