

# Tips for Nurses: Continuity of Care



**What it is:** Continuity, coordination and transition of care are part of providing quality care to older adults at the end of life. Continuity refers to the exchange of knowledge between carers, the person and health professionals so that care is not interrupted or compromised.

Continuity of care has three main parts:

1. The care provider knows and follows the care of the older person.
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
- regular meetings between team members and with the family helps to maintain a good level of communication.
- transition between acute care and home/ residential aged care (RAC) should include early discharge planning with advice for self-care, medications, and community support as appropriate.

## Actions

**Document** the person's goals of care and regularly review these as a person's care needs change.

**Prepare** plans for managing exacerbations of their health condition. Also review the person's advance care directive (ACD).

**Clarify** your role in the palliative care team and how you will stay 'in the loop' with care planning.

**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

**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).

**iSoBAR** is a structured mnemonic tool that provides a framework for communicating the minimum information needed at handovers.

**Name:**

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## 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

For references and the latest version of all the Tip Sheets visit

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CareSearch is funded by the Australian Government Department of Health and Aged Care