SA Community Care Identified Care Coordinator

Effective clinical handover is an essential team process and a critical component for the delivery of safe quality health care to the consumer across the whole spectrum of health care providers.

Prior to referral to SA Community Care, a care coordinator should be identified to take leadership in developing a comprehensive referral / care plan for the consumer, and for review of care as needed. The aim of this is to ensure there are clear lines of communication and role responsibilities in care delivery.

An Identified Care Coordinator (ICC) becomes the lead point for communication to be focused, and assists in:

- building confidence for hospital clinicians in referring their patients for out of hospital community care and ensures that their patient will not fall through service gaps;
- giving service providers (both in acute and community settings) someone to whom they can keep informed about the care that consumers have received;
- working closely with the Metropolitan Referral Unit (MRU) for changes in care in the community.

ICCs:

- undertake assessment, care planning and monitoring
- advocate and link patients/consumers with rehabilitation and support services
- address illness management and relapse prevention
- make clinical decisions with the care consumer
- facilitate effective clinical handover.

Depending where a person is in their health care journey, the ICC could be:

- a member of a specialist team or generalist health professional making a referral to the Metropolitan Referral Unit (MRU);
- the person's specialist or GP or Practice Nurse or community Nurse Practitioner (NP). Where a consumer does not have a usual GP, a GP Clinic may be approached (eg. in the hospital discharge process) to take on the ICC role.

Alternatively, if there is no ICC the MRU will undertake this role.

Government of South Australia
SA Health

The types of care offered under SA Community Care will be determined by the care referral plan which factor in the acuity of consumers, the rapidity of response required and the anticipated service length of stay. The types of services to be delivered will be consistent but the amount and frequency will be a decision made by an ICC (where there is one) in consultation with the MRU who will coordinate the service provider allocation. The MRU are the centralised single point of contact for referrals to SA Community Care services.

Decisions about additional service requests or changes to care required is the responsibility of the care coordinator, who will then refer to the MRU to enact care plan delivery. The clinical requirement of service providers is to deliver safe and effective care in line with the care plan and the National Safety and Quality Health Service Standards. Immediate notification by the service providers to the MRU is required if issues arise that prevent the provision of service delivery that would impact on care consumer outcomes.

Carers and family who feel respected will be more confident to speak up if they don't understand information, or if something just doesn't seem right, such as changes in a person's condition, unfamiliar medications, or some other abnormal event for their loved one.

For more information

SA Health
Operational Service Improvement and Demand Management
www.sahealth.sa.gov.au – Health @ Home

Confidentiality -I1-A1
© Department for Health and Ageing, Government of South Australia. All rights reserved.

www.ausgoal.gov.au/creative-commons

Government of South Australia
SA Health