Interim care

Best practice guide

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Disclaimer

Purpose

The purpose of this document is to provide guidance to Hospital and Health Services (HHS) on best practice principles relating to the:

- health service management of interim care, including governance, monitoring, reporting, evaluation, and funding of interim care
- care delivery within interim care, with a focus on safe, effective, and person-centred practice.

This guide should be used in conjunction with Delayed discharge – best practice guide in HHSs where patients in interim care are experiencing delayed discharge.

Scope

This best practice guide is relevant to all interim care models funded by Queensland Health, as described below.

Background

Definition

Interim care is short-term, transitional support provided to patients while awaiting transition to a more appropriate long-term living or care arrangement.

Patient cohorts

Patient cohorts may include (but are not limited to) those who:

- are able to return home but are awaiting commencement of necessary supports, such as home modifications, formal care services, or community-based programs
- are unable to return to their pre-admission residence and require ongoing support while longer-term living arrangements are finalised.

Aim of interim care

For patients, the aims of interim care are to:

- deliver high-quality, short-term care that is responsive to the individual needs and goals of the patient

- maximise functional capacity through ongoing assessment and the provision of person-centred, restorative and maintenance care
- actively support patients to return home safely or, when required, transition to appropriate long-term care outside the hospital setting.

For health services, the aim of interim care is to:

- support timely and effective patient flow across the health system.

Models

A range of interim care models funded by Queensland Health operate across the state. HHSs determine how interim care is delivered, including through publicly operated services or commissioned arrangements.

Current models include care:

- delivered within Queensland Health hospital facilities
- provided within residential aged care homes (RACHs)
- delivered by contracted service providers (e.g. private hospitals)
- delivered in the patient's home (e.g. Interim Care – Hospital in the Home)
- models where clinical governance is retained by Queensland Health or delegated to an external medical provider, such as a general practitioner (GP)
- provided under admitted or non-admitted care models.

Duration of interim care

The typical duration of interim care is between 2 and 6 weeks, with flexibility to accommodate individual patient needs. In exceptional circumstances, this may be extended up to a maximum of 12 weeks (3 months).

Guiding principles

As per the *Hospital and Health Boards Act 2011*, the best interests of users of public sector health services should be the main consideration in all decisions and actions.

HHSs must ensure that interim care models meet the principles outlined in the Queensland Health Patient access to care Health Service Directive, including:

- access – optimise patient flow and access across the patient journey from pre-hospital arrival, through to admission and discharge
- integration – whole-of-system approach to equitable patient flow and access
- safety – optimise patient safety, quality of clinical care and outcomes
- effectiveness – achieve effective outcomes with efficient use of resources
- collaboration – support collaboration and interface between HHSs the Queensland Ambulance Service (QAS), and other partners in health service delivery.[1]

HHSs are responsible for ensuring the safety and quality of patient care, including providing:

- care that is aligned with relevant Queensland Health directives, standards, protocols, and guidelines
- care that is flexible and responsive, designed to optimise the patient's functional capacity while holistically meeting their social, cognitive, psychosocial, and cultural care needs.[1]

Best practices

Health services management of interim care

1. Establish clear corporate governance and accountability.

- All interim care arrangements should comply with the Department of Health Corporate Governance Framework[2].
- In particular, HHSs should:
    - nominate a senior responsible reporting officer and seek a responsible reporting officer from providers of interim care, through contractual arrangements if applicable.
    - develop clearly defined governance structures between the HHS and the interim care provider, which include pathways for escalation of issues and risks to patient care and patient flow.
- If choosing to outsource interim care, HHSs should ensure all contracting and purchasing arrangements align with Queensland Health requirements, policies and guidelines for contracts.[3]
- HHS might consider incentives or disincentives if patients are not transferred to longer-term living arrangements in a timely manner.
- HHSs are responsible for building and maintaining strong relationships with providers of interim care, residential aged care homes and community supports, including GPs, primary health networks and community-based organisations, for the purposes of facilitating safe and timely patient discharge, as well as enabling the co-design of innovative, locally responsive solutions to ongoing systemic challenges.
- HHSs should develop and maintain clear documentation of the interim care model, including eligibility criteria, care settings, service scope, and intended outcomes, to avoid inappropriate use of interim care. The documented model should be accessible to staff and interim care providers and supported by local procedures or workflows to promote consistent application.

2. Monitor performance and evaluate outcomes.

- HHSs should establish a mechanism for regular monitoring, reporting, and evaluation of interim care services that aligns with Queensland Health reporting requirements and relevant evaluation.[4]
- Monitoring should include:
    - patient outcomes to ensure the interim care model delivers high-quality, safe, and appropriate care
    - patient throughput and length of stay, to ensure the model is operating efficiently and effectively in supporting timely patient flow across the health system
    - external, systemic issues that impact patient movement to longer-term living arrangements, such as a lack of available community supports.

3. Ensure sustainable and responsive funding of interim care models.

- Funding arrangements should support the delivery of safe, high-quality health care that meets patient needs, complexity, and model requirements.
- Where patients have higher or more complex care needs, HHSs should consider supporting providers through additional funding or resourcing (e.g. provide additional HHS support/staffing).

Patient care

4. Enable safe and coordinated transfer to interim care.

- All patients must have an Acute Resuscitation Plan (ARP) clearly documented in their medical record and formally handed over at the time of transfer to the interim care facility.
- There is no requirement for patients to have an Advance Health Directive (AHD) completed prior to admission to interim care, unless an AHD is required to meet specific legal or decision-making requirements.
- For patients who may be for aged care services pathway:
    - While patients must provide informed consent to the aged care pathway, the absence of completed consent – including where formal Queensland Civil and Administrative Tribunal (QCAT) processes are underway – should not prevent a patient's transfer to interim care.
    - Ideally, patients should have an aged care assessment completed and approval for aged care prior to referral; however, referral may proceed without this where delays of more than 48 hours in obtaining an aged care assessment are anticipated.

- Treating medical and multidisciplinary teams should provide comprehensive handover of clinical and psychosocial information to receiving clinicians at the point of patient transfer to interim care, to support continuity of care and patient safety.

5. Define medical governance and clinical responsibility.

- The HHS must ensure patient care is supported by appropriate medical governance, either through Queensland Health or via formal transfer to an external medical provider, such as a GP.
- Service models or provider agreements should clearly define the circumstances and escalation criteria under which a patient is required to be transferred back to an acute care setting.

6. Ensure safe medication management and continuity.

- Clear accountability for medication management should be established during transitions of care. This includes defining prescribing responsibility, ensuring continuity of medication supply, and confirming who is responsible for ongoing monitoring and review. Medication information should be accurately communicated at handover, including recent changes made during admission.

7. Provide access to coordinated multidisciplinary team (MDT) care.

- Interim care models should incorporate a coordinated multidisciplinary approach involving relevant medical, nursing, and allied health professionals, to ensure patient needs are comprehensively assessed and addressed during interim care and to inform and support transition to an appropriate longer-term living arrangement.
    - The composition of the multidisciplinary team should be flexible and tailored to the patient's individual needs and goals
- Interim care models should ensure each patient is assigned a dedicated care coordinator or case manager who coordinates multidisciplinary care, facilitates access to required services and supports, and maintains an ongoing understanding of the patient's goals, preferences, and wishes (via substitute decision-maker, if necessary).
- Cultural supports and providers should be involved in case reviews and discharge planning where appropriate, to promote culturally safe care as patients transition from hospital to interim care and subsequently to longer-term living arrangements. Where possible, this should include engagement with the First Nations health workforce and Multicultural Health Liaison Officers.

8. Partner with patients (or their families/carers/substitute decision-makers) in shared decision-making and respect and support their dignity of risk

- Within 24 hours of transfer to interim care, and no later than 72 hours, the patient should have a comprehensive multidisciplinary case review and documented care plan in place.

- Clinicians should work collaboratively with patients in shared decision-making, honouring their autonomy and supporting informed choices, including those that involve an agreed and understood level of risk, in line with the principle of dignity of risk.
- Patients (and their families/carers/substitute decision-makers) should be informed of their right to reconsider and withdraw from pursuing aged care placement or services if they choose. Shared decision-making and respecting and supporting patient dignity of risk are crucial to facilitating this. Patients (and their families/carers/substitute decision-makers) should be advised of all available discharge options, with multidisciplinary supports provided to enable transition planning directly from interim care, without the need for a return to an acute hospital bed for discharge planning. Where admission to other appropriate services, such as Geriatric Evaluation and Management – Hospital in the Home (GEM-HITH) or rehabilitation, is indicated, these referrals should be facilitated directly with the relevant service, avoiding unnecessary admission to an acute hospital setting.
- Patients (and their families/carers/substitute decision-makers) should be kept informed at all stages of a patient's journey.

9. Proactively manage care through case reviews and/or MDT meetings.

- Multidisciplinary case reviews should be conducted jointly by the HHS and the interim care provider at least weekly, or more frequently where possible, recognising the short-term nature of interim care.
- The purpose of case reviews is to identify, as early as possible, the barriers and enablers to a patient's safe and timely transition to a longer-term care or living arrangement. Case reviews should result in clear actions, with the case coordinator responsible for progressing and following up on these actions.

10. Ensure timely and effective clinical handover and information sharing.

- Comprehensive, multidisciplinary clinical handovers should be provided at key transition points, including at the time of hospital discharge, entry to interim care, and discharge to longer-term living arrangements.
- Interim care models should, where possible, incorporate shared digital health records and care plans between the responsible HHS and the interim care provider or facility. Where appropriate, access should also extend to providers supporting the patient's longer-term living arrangement, such as the GP, Primary Health Network, and community-based support providers.
    - Where shared digital records are not available, interim care models should define clear processes for the secure sharing, updating, and handover of records, including care plans, clinical handover information, and relevant medical documentation, between all involved parties.

11. Coordinate safe discharge from interim care.

- Once a patient transitions from interim care to a longer-term living or care arrangement, at least one post-discharge meeting should be held with all relevant parties involved in their ongoing care, including the patient and their carers or supports, to promote a smooth transition and reduce the risk of re-admission.

12. Manage length of stay and escalate delays.

- HHSs should have a documented escalation pathway for patients who are unable to transition to a longer-term living arrangement within 6 weeks of admission to interim care. Patients remaining in interim care at 6 weeks should undergo a mandated comprehensive case review, in addition to routine case management reviews, to clearly document the reasons for the delay and identify additional actions, supports, and timeframes required to facilitate transition.
- Where all local HHS discharge options have been exhausted, the Long-Stay Policy and Program (LSPP) Unit should be engaged to support escalation. The LSPP Unit works in partnership with health services, relevant state departments, and the Commonwealth to facilitate operational solutions and appropriate escalation pathways for patients experiencing delayed discharge.

13. Provide clear information and ensure financial transparency.

- Clear, transparent information about potential fees should be provided to patients and their families/carers/substitute decision makers about any potential fees associated with a hospital stay, in accordance with the Queensland Health Fees and Charges Register v2.[5] This includes when a patient remains in hospital for more than 35 days without an Acute Care Certificate in place. Any discussion regarding fees, including informed financial consent, should be appropriately documented.

References

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