

Health care of people with intellectual disability

Transitions of care

Transitions of care are points at which valuable information about safety, quality and continuity of care are transferred. For people with intellectual disability all transitions of care can be high risk and the successful transfer of this information is vital.

What are the risks in the transition of care for people with intellectual disability?

A key safety and quality risk is a lack of identification and communication about important supports someone needs to keep them safe in health care. This includes:

- Disability support needs
- Psychosocial history
- Communication and behavioural supports
- Other medical conditions or risk comorbidities
- Reasonable adjustments.

What should I do?

Identify when a transition of care will occur

- A transition of care is when all or part of a person's health care is transferred between care providers. This may involve transfer of responsibility for some aspects of a person's health care, or all their health care, on a temporary or permanent basis.

Plan for a safe admission

- Collect information ahead of the admission.
- If the person with intellectual disability cannot communicate their needs, identify a key contact, such as family member, guardian, or National Disability Insurance Scheme (NDIS) disability support worker who will be able to provide this information.

Be open to receiving and giving key disability information as part of the clinical handover

- Ensure that the person's intellectual disability, communication needs, and other reasonable adjustments are recorded.
- Use a peer review process to maintain continuity of knowledge about the person and check that all important information about the person is included in any transition.

Apply the principles of safe and high-quality transitions of care

- The Commission has published the [Principles to guide safe and high-quality transitions of care](#). Use the principles and enablers for clinical practice, standards, policy and guidance.

Involve the family, carers, disability service providers or guardian

- For adults, ask about the role of the family or NDIS service providers in the person's life e.g. managing medication, assisting with communication.
- For a child or young person decide how key health information will be shared with parents.
- Consider the best way to communicate with family, supporters, or guardians and allocate a consistent contact to provide regular updates.
- Include the person's family, supporters, or guardians in transitions of care meetings, and if that is not possible, ensure they are informed shortly afterwards. This is especially important for patients who do not use words to communicate.

Plan for a safer discharge

- Collaborate with the person, their family, supporters or guardians to plan the person's transition from hospital to home.
- Ensure that there are clear details about the environment /setting the person is being discharged to. Is it a disability residential accommodation, their own home or with family?
- Ensure the person, their family, supporters or guardian have a sound understanding of the person's health care needs, medication and follow up post discharge.
- Identify if clinical support can be provided by the hospital as part of recovery in home i.e. allied health or nursing supports as part of rehabilitation or Hospital in the Home programs.

Relevant actions in the National Safety and Quality Health Service Standards

[Action 2.10](#) The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care.

[Action 5.12](#): Clinicians document the findings of the screening and clinical assessment processes, including any relevant alerts, in the healthcare record.

[Action 5.13](#): Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan.

Action 5.13 (d) Commences discharge planning at the beginning of the episode of care.

[Action 5.27](#): A person's nutrition and hydration needs are identified and documented in their comprehensive care plan, making note of their eating, and drinking practices.

[Action 6.10](#) The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians.

For more information, please visit: safetyandquality.gov.au/intellectual-disability

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