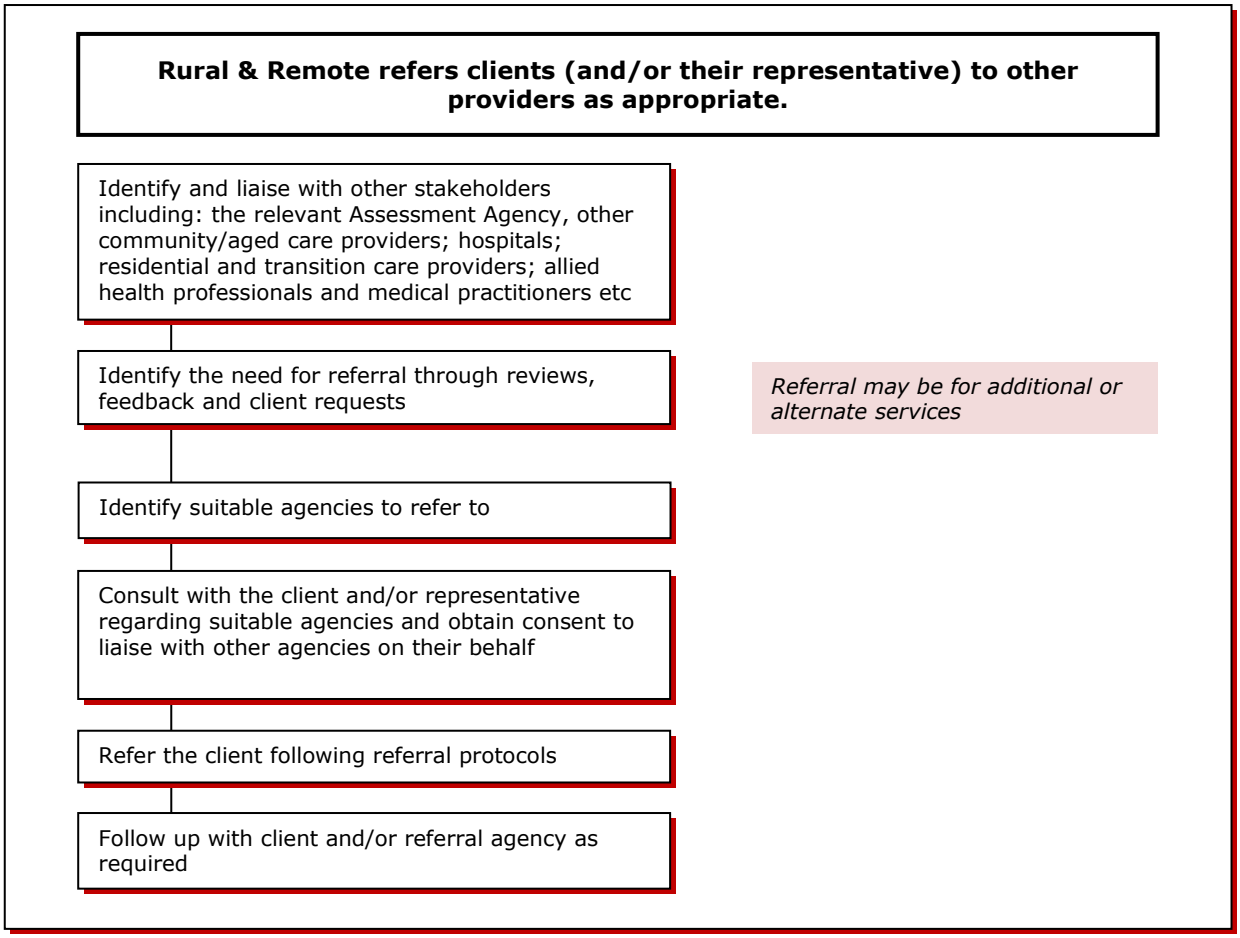
CLIENT REFERRAL



FORMS AND RECORDS

Community Resources Brochures	Office
Referral to another Agency Form	Client records
Client Progress Notes	Client records and Information Management System

13.1 Networking and Liaison with Other Providers

13.1.1 NETWORKING AND COORDINATION WITH OTHER AGENCIES

R&R is aware of services provided by other local organisations and ensures open communication is maintained with them regarding service type and capacity.
The Program Manager and other R&R senior staff network and liaise with other relevant stakeholders including Assessment Teams , other community care and package level providers, hospitals, allied health professionals, medical practitioners and other NGO's/community services within the broader service system.

Networking and coordination of other services is promoted through forums, network meetings and telephone discussions; this is further described in 4.4 Program Planning and Community Involvement.

R&R also maintains a contact list and range of brochures that outline other relevant community services and supports to assist in the client referral process (see 4.6 Community Resources Information).

13.2 Referral

All service level documentation is completed in partnership with the client/carer or nominated representative, has a wellness focus and incorporates the following considerations in regard to the client referral process, in particular those outlined in the following **Standards 1.5, 1.6, 2.1 – 2.5, 3.5, 3.6 and 4.5 of the Aged Care Quality Standards:**

- ***Information provided to each client is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise real choice***
- ***Each client's privacy is respected and personal information kept confidential – unless signed consent to share information is received from the client/carer***
- ***Assessment and planning, including consideration of risks to the consumer's health and wellbeing, informs the delivery of safe and effective care and services***
- ***Assessment and planning identifies and addresses the client's current needs, goals and preferences, including advance care planning and end of life planning if the client wishes***
- ***Assessment, planning and review is based on an ongoing partnership with the client and others that the client wishes to involve, and includes other organisations and individuals/providers of other care and services that are involved in the care of the client***
- ***The outcomes of assessment and planning (including any identified risks and mitigation strategies) are effectively communicated to the client and documented in a care/support plan that is readily available to the client, and***
- ***Care and services are reviewed regularly for effectiveness, when circumstances change or when incidents impact on the needs, goals or preferences of the client.***
- ***Information about the client's condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared***
- ***Timely and appropriate referrals to individuals, other organisations and providers of other care and services***

The need for other referrals is often identified at the initial assessment, and post service delivery commencement by R&R, through regular reviews and staff or client feedback.

13.2.1 IDENTIFYING THE NEED FOR REFERRAL

A referral to another service provider may be required in the following circumstances:

- A new contact is ineligible for In-Home services

- R&R does not have the capacity to provide the required services due to a lack of appropriately skilled staff or funding
- The needs of the client change significantly warranting a higher/more complex type of care, or
- The client requires specific assistance from another health/allied health/community or aged care provider e.g. referral for STRC (Short Term Restorative Care) following hospitalisation.

13.2.2 REFERRAL PROCESS FOR INELIGIBLE SERVICE CONTACT

Ineligible service contacts are provided with contact details of agencies that may be able to meet their stated needs.

If appropriate, R&R staff may contact the agency to confirm eligibility and to make an appointment for the person.

13.2.3 REFERRAL PROCESS FOR EXISTING CLIENTS

The referral process generally includes the following steps. The RnR Team Leader/Cluster Team Leader:

- Liaises with the client and/or their representative and identifies the need for services from another agency
- Explains the need for a referral to another agency including the reasons for being unable to provide the required or requested services
- Identifies referral options and discusses these with the client/carer
- Continues to provide services currently in place (as applicable)
- Obtains consent to liaise with other providers on behalf of the client
- Contacts other service providers that may be able to provide services to discuss the service needs of the client
- Refers them to another provider and completes documentation to make the referral.
- Follows up with the client & Agency regarding the outcome
- Provides any further information to the other provider as required
- Documents any relevant information in the client records
- Advises the Program Manager of any new agencies that should be included in the community resources information held by R&R or of changes to current information on agencies.

13.3 Monitoring Client Referral Processes

Client referral processes and systems are regularly audited as part of the audit program and staff, client and other stakeholders are encouraged to provide ongoing feedback on issues and areas where improvements can be made (see Corporate Calendar and Section 5: Continuous Improvement).