Transition of Care Standard

Quality statement: Effective Transition of Care from Paediatric to Adult Services

Quality statement
There will be effective transition of patients' care from paediatric to adult allergy healthcare services, ensuring continuity, safety, quality and effectiveness in care delivery, with the adolescent being central to the process.

Intent of the Statement
The development of standard is to guide the transition of care for adolescents with allergies in Australia from paediatric to adult services.

Patient/carer outcome
I can expect my allergy health care providers to work with and help me transition from paediatric to adult services to maintain access to the provision of safe, high-quality and comprehensive allergy care.

Criteria	
1.1	Services will develop and utilise clear criteria and methods for assessing transition readiness and prioritisation, with consideration of the adolescent's medical history, health status, severity, co-morbidities, and psychosocial factors. Where possible, services should align the timing and frequency of appointments with the adolescent with the transition process.
1.2	Services will establish clear referral pathways which enable the adolescent to identify suitable adult clinicians and healthcare teams and understand when and how to access them. Ongoing communication with the adolescent's GP prior to transition is important to ensure that adolescents who are no longer accessing a paediatric allergy service continue care in an adult setting.
1.3	Services will identify and inform the adolescent of channels and methods of communication between teams, specifying responsible parties and critical information to be shared along with communication frequency.
1.4	Services will ensure accurate, confidential and comprehensive documentation, including patient information such as medical history, medications, treatment plans, and preferences is provided to the adolescent and to the receiving healthcare team, including their general practitioner.
1.5	Services will work in partnership with the adolescent to coordinate the adolescent's care during transition and assign responsibilities and tasks to appropriate staff or individuals themselves. There will be clear guidance about which service has clinical accountability, at which point in the process.
1.6	Services will commence transfer of care planning with sufficient time and provide the adolescent with a timeline for the transition process and task completion, including escalation pathways should timelines or clinical condition change [a roles and responsibilities of each service will be defined in the model of care].
1.7	Services will review processes about their transition processes from feedback and evaluation received from the adolescent patients' experiences to ensure ongoing improvement and adherence to protocols.
1.8	Services will use the transfer process as a cue to promote optimal self-management of the adolescent in their allergic condition.