

## section 4.2.4: discharge to rural and remote regions

### specific considerations for the patient and family:

Economic and physical barriers such as distance, lack of accommodation, lack of transport and the need to travel in order to access centralised services have been identified as problematic for rural and remote families.<sup>1</sup> Detailed planning and timely transfer of information is critical in providing a smooth transition of care as individuals move between health care settings in the city and country regions.

### practical considerations for this patient group include:

#### Transport arrangements

- which mode of transport will ensure the patient's safety and comfort and takes into account their current needs and condition? – can the patient manage a lengthy road trip without adverse effects?
- does the person require assistance to manage likely symptoms during the journey home – this may include such symptoms as pain, nausea, shortness of breath and anxiety

#### Discussions with the patient and family

- what do the patient and their family understand about the patient's diagnosis, disease status, prognosis and future appointments?
- do the patient and family have ready access to contact telephone numbers for their General Practitioner, local hospital and palliative care service?
- what are the patient's wishes regarding their preferred site of care?

#### Involvement of key staff at the acute hospital

- Discharge Planner/Case manager
- Rural Liaison Nurse
- Specialist Palliative Care Liaison Nurse
- Social Worker

**Providing current up to date clinical information** about the patient's condition to the GP and local palliative care service is critical. This will include the current status treatment plan, management and future follow-up:

- **medical discharge summaries** – names and contact details of all medical specialists participating in the patient's care, including the metropolitan specialist service, if one has been involved
- **nursing discharge summary** or relevant community nursing referral – copies of progress notes sent home as part of discharge or referral paperwork are often not helpful as they do not provide relevant, succinct information which highlights the relevant issues for the particular patient quickly and efficiently
- other **allied health letters** as appropriate
- a phone conversation with the GP is essential if there have been significant changes to the patient's treatment plan and specifically changes to medications

- all private scans and x-rays are to be returned to the patient after completion of therapy, eg radiotherapy

The faxing or electronic distribution of the above information via Oasis is normally preferred, if this facility is available.

### **Medications**

- are medications prescribed by the metropolitan hospital readily available in the community where the patient lives and are they the most affordable option? (i.e. PBS listed where possible)?
- have medications been prescribed that will require some time for the local pharmacy to access?

### **Important geographic and social information**

- details of the patient's actual residential address (not just a postal address) are necessary to allow local services to plan and schedule initial contact visits, if these are required – include a simple sketched map if instructions are complicated
- identification of the primary caregiver/family involved with care
  - what is the patient's living situation?
  - is isolation and therefore access to medical and nursing care a significant issue and what plans are in place to deal with this?
  - if a primary caregiver is not able to be identified, is home care a realistic option?

### **Follow-up plans**

- **plan for follow-up management and appointments**
  - is the person able and medically fit to travel from the country region for follow-up appointments?
  - have outpatient appointments been arranged on a day and at a time that takes distance and travel into account?
- **clarify the follow-up required from the local palliative care service and/or community based services**
  - what is the *priority* of the follow-up required, particularly if the patient is not already known to the local palliative care service?
  - what *type* of follow-up is required? eg Community Nursing/OT/Social Work
  - are there any *immediate needs*? (eg wound management) – community services may not be available over weekends or after hours, therefore for urgent needs or follow-up the local hospital may be the most suitable facility to provide assistance
- **identify a key contact person at the acute facility discharging the patient** should questions or difficulties arise with patient management on their return to the rural region

## related resources and information

### **Accommodation located near the major hospitals**

Contact your local Patient Assistance Transport Scheme (PATS) – eligibility criteria exist. Contact your regional office or the **Health Consumer Support office** – freecall **1800 188 115**

**Alternatives to Hospital Care information** can be found at

<http://www.southernhealth.sa.gov.au/aboutus/pages/commhealth/6822/>.

**Community Passenger Transport network services and routes** details are available on <http://www.bussa.com.au/cpn.html>.

**Guide for country patients attending RAH** – is now available via the website. The link is <http://www.rah.sa.gov.au/country/counpath.php>.

**Patient Assisted Transport Scheme** – partial reimbursement of travel and accommodation costs for people who must travel more than 100kms for treatment by a medical specialist – visit:

<http://www.countryhealthsa.sa.gov.au/pats.asp> or freecall 1800 188 115.

### **People from out of Town Information Booklet**

[http://www.wch.sa.gov.au/patients/facilities\\_support/outoftown/documents/OutoftownInformationBooklet](http://www.wch.sa.gov.au/patients/facilities_support/outoftown/documents/OutoftownInformationBooklet) link will take you to the Children, Youth and Women's Health Service.

**Planning a trip Brochure – *From Bush Tracks to Big Smoke* produced by Country Health SA** amended brochure can be viewed at

<http://www.erhs.sa.gov.au/5services/pats.php>.

**Supports for patients with cancer** – see [www.cancersa.org.au](http://www.cancersa.org.au)

Accommodation for country patients accessing treatment for cancer in Adelaide and regional cancer support groups.

## references

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<sup>1</sup> Curtiss C (1993) Trends and issues for cancer care in rural communities. *Nursing Clinics of North America*; 28(1): 241-251.