Hip fracture care clinical care standard indicators: 7a-Evidence of local arrangements for the development of an individualised care plan for hip fracture patients prior to the patient's separation from hospital

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Identifying and definitional attributes

Metadata item type:	Indicator
Indicator type:	Indicator
Short name:	Indicator 7a-Evidence of local arrangements for the development of an individualised care plan for hip fracture patients prior to the patient's separation from hospital
METEOR identifier:	696450
Registration status:	Health, Standard 12/09/2016
Description:	Evidence of local arrangements for the development of an individualised care plan for **hip fracture** patients prior to the patient's separation from hospital.
Rationale:	A range of interventions has been shown to improve outcomes for hip fracture patients. These include medication review, secondary fracture prevention, treatment/management of co-morbidities, addressing mental health/ cognitive needs (prevention/ management of delirium in particular), environmental modifications, and linkage into cultural services, primary care, community support services and carer support services (ACSQHC 2009). Involvement of patients and carers in the development of the individualised care plan aligns with the principles of consumer-centred care (ACSQHC 2012).
Indicator set:	Clinical care standard indicators: hip fracture 2018 Australian Commission on Safety and Quality in Health Care, Standard 15/05/2018
Outcome area:	Transition from hospital care Health, Standard 12/09/2016

Collection and usage attributes

Computation description:	Documented local arrangements for patients with a hip fracture to have an individualised care plan developed prior to the patient's separation from hospital, and provisions to make this available to them (and/or their carer), and to their general practitioner and other ongoing clinical care provider within 48 hours of the patient leaving hospital. The care plan should describe the care received by the patient during their hospital stay and ongoing care and goals of care. The plan must include a summary of any changes to medicines, any new medicines, and equipment and contact details for rehabilitation services they may require. It should also describe mobilisation activities, wound care and function post surgery, and include information and recommendations for secondary fracture prevention.
Computation:	Yes/No

Representational attributes

Representation class:	Count
Data type:	Real
Unit of measure:	Service event

Format: Yes/No

Source and reference attributes

Submitting organisation: Australian Commission on Safety and Quality in Health Care

Reference documents: ACSQHC (Australian Commission on Safety and Quality in Health Care) 2009. Preventing falls and harm from falls in older people: best practice guidelines for Australian hospitals. Sydney: ACSQHC. Viewed 5 May 2016, www.safetyandquality.gov.au/wp-content/uploads/2012/01/Guidelines-HOSP1.pdf.

ACSQHC (Australian Commission on Safety and Quality in Health Care) 2012. Safety and quality improvement guide standard 2: partnering with consumers. Sydney. ACSQHC.

Relational attributes

Related metadata references: Has been superseded by Hip Fracture Clinical Care Standard: 7a-Evidence of local arrangements for the development of an individualised care plan for hip fracture patients prior to separation from hospital
Australian Commission on Safety and Quality in Health Care, Standard 10/09/2023