SHARED TRANSFER OF CARE

Facilitator's Guide to Shared Transfer of Care

primary health TASMANIA

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An Australian Government Initiative

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FOREWORD

Shared Transfer of Care is professional, integrated and supportive care. It places the person, their family and carers at the centre of the transfer plan. If implemented well, it allows everyone in our health system to move safely through the different levels of care, regardless of their changing needs or conditions.

'Transfers of care' refer to the movement of people between service locations, providers or different levels of care within the same location as their condition and care needs change. In Tasmania, these movements (transfers) are touch points in the system that can either support or negatively impact on health outcomes. The consequences of poor-quality transfers of care have a significant negative impact on patients, families and their carers, and place added stress on the Tasmanian health system.

Primary Health Tasmania's Shared Transfer of Care project was designed to:

- improve transfers of care between acute, primary and community services sectors for people living with chronic complex needs
- focus on capacity-building and system redesign to improve transfers of care and reduce avoidable hospital readmissions
- improve or 'streamline' existing practices and processes within the health system.

Improving transfers of care is a shared responsibility. It will take the collaboration of the primary, sub-acute and community services sectors to overcome the factors which contribute to poor transfers of care, negative health outcomes for individuals, and added costs for our healthcare system.

The *Guidelines for Shared Transfer of Care (Guidelines)* were developed to improve the quality of journeys in health and community care. They were produced following an extensive literature review, consultation and trial process with service providers and consumers, and were further validated by the Australian Primary Health Care Research Institute, Australian National University, through their 2014 research report *Sub-acute Care in Tasmania*.

The *Guidelines* promote a different way of working; putting people at the centre of their care, involving them in a shared decision-making process, and encouraging health providers to collaborate; sharing communication, and accountability for the transfer of care.

People, their families and carers, and the professionals who serve them want a system that supports better health outcomes for all. Shared transfer of care is a goal we can all have ownership over. Through implementing the principles contained in the *Guidelines*, we can work together to achieve this goal.

SHARED TRANSFER OF CARE

CONTENTS

INTRODUCTION

Purpose of the Guide

The *Facilitator's Guide to Shared Transfer of Care* is designed to assist in the preparation and delivery of group professional training on improving Shared Transfer of Care. The guide contains four learning modules, each supporting implementation of the *Guidelines for Shared Transfer of Care*.

The aim of a training session is to :

- work with participants' expertise and knowledge
- adopt a strengths-based approach
- use the collective wisdom of the group
- explore opportunities to improve shared transfer of care for consumers and communities.

Shared Transfer of Care workshops are designed for both clinical and non-clinical staff working in the health and community service sectors. The content of this *Facilitator's Guide* can be adapted to fit the context of different organisations. The delivery may depend on available time for training, number of staff attending and prior knowledge of Shared Transfer of Care.

The activities provided will reinforce the learnings, engage participants and are optional. It is not intended that participants complete them all; rather the facilitator selects the appropriate activities.

Suggested timing of this guide has been intentionally omitted, as this can be flexible based on the time available, audience and organisational focus.

Organisations are encouraged to review their transfer of care processes and outcomes through audits; review of compliments/complaints, and staff, consumer and external provider satisfaction surveys or focus groups. This will highlight areas of focus, especially for Module 3 and 4.

The modules may be run separately depending on time and staff availability. Where the scenarios are used, and depending on the discussions, extra time may need to be allocated.

Facilitators should adapt the session to their organisational need.

How to use this Guide

Resources to support the *Facilitator's Guide to Shared Transfer of Care* are available for download from the Shared Transfer of Care web page at **www.primaryhealthtas.com.au**.

The *Facilitator's Guide to Shared Transfer of Care* is set out in four practical modules of learning. Each module has supporting resources for the trainer and the participant, including handouts, tools and additional reading.

The following icons appear throughout the text, and highlight links to topic-specific resources.

	**VIDEO**
	**RESOURCE / ADDITIONAL READING**
	**TOOLS**
	**STORY OR CASE STUDY**
	**REFLECTION**
	**ACTIVITY**
	**TRAINING TIP**
	**MATERIALS**

Printed resources included with this Guide

Facilitator's Guide to Shared Transfer of Care (this document)

Handouts for each module in the *Facilitator's Guide*

Guidelines for Shared Transfer of Care

Passport to better health

Electronic resources available for download

Shared Transfer of Care PowerPoint slides

Training videos for each module

Table of tools, resources, and additional reading material, including the description of each resource and relevant hyperlinks

Example consumer stories

Glossary of Terms used in the Shared Transfer of Care suite of documents

Evaluation forms for this course

ORGANISATION OF WORKSHOP

Proposed agenda

The following outline provides a suggested agenda for a Shared Transfer of Care professional development / education workshop. The workshop can be facilitated in its entirety or presented as individual modules.

The Time column has been intentionally left blank so the facilitator can adapt the agenda to meet the needs of the participants, and be flexible with time available. The choice of activities will influence the length of each module.

TIME	TOPIC	CONTENT
	Welcome Introduction and session overview	› Acknowledge experience in room and invite participation › The 4MAT Model of Learning
	Module 1 **WHY** is Shared Transfer of Care important?	› Use of a story to engage participants › What does the research tell us? › Shared Transfer of Care and Australian Safety and Quality Standards
	Module 2 **WHAT** is Shared Transfer of Care?	› Transfer of care in an organisational context › Core Principles for Shared Transfer of Care › Key Elements of Shared Transfer of Care
	Module 3 **HOW** do we deliver quality Shared Transfer of Care?	› Putting Shared Transfer of Care into practice › Key strategies
	Module 4 **IF** we use Shared Transfer of Care, what are the benefits?	› Potential benefits of Shared Transfer of Care › What can we do to improve transfers of care?
	Conclusion	› Review of session › Evaluation

Introduction and session overview

Before moving to Module 1, cover the following topics:

- welcome and participant Introductions, including expectations of participants
- the aim of the session (see introduction)
- the 4MAT Model of Learning used as a guide
- a brief explanation of handouts included to support successful implementation of Shared Transfer of Care.

It is important to remember that every participant brings their experience, both professional and lived, to the training session. Participants will relate to a poor shared transfer of care experience, and should be encouraged to reflect on their own experiences whilst participating and to share these experiences with the group, if appropriate and managed. Consider this as a coaching session, where participants can share experience, learn from each other and collectively identify potential solutions to issues.

The 4MAT Model

The Shared Transfer of Care facilitator training is designed around the **4MAT Model of Learning.**[1] This model appeals to diverse learning styles and encourages active and reflective sessions.

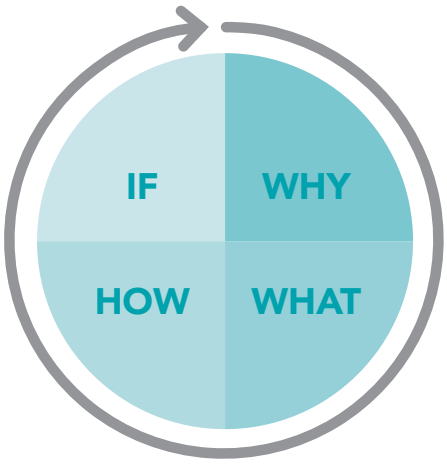
The basic premise of 4MAT is that people go through four major steps/questions when learning (Figure 1). It begins with the creation of personal meaning of the content for participants, proceeds to conceptual understanding and application, and finishes with integration. Successful learning combines all four of these components.

People's different learning styles result in varying levels of learner comfort as they move through the cycle. Participants experience their most comfortable place while being stretched to learn in ways that are more challenging for them.

The four sections of the 4MAT cycle correspond to the four modules in this guide.

Working through the 4MAT model's questions (on a whiteboard or with butcher's paper) will help define the aim of each module.

Revisiting the 4MAT after each module will reinforce and summarise learning.



WHY is it important?
WHAT is it?
HOW do we deliver it?
IF we use it, what are the benefits?

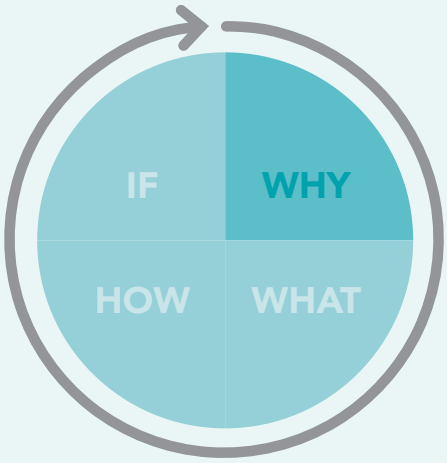
Figure 1.

THE 4MAT MODEL OF LEARNING

Notes

SHARED TRANSFER OF CARE

MODULE 1
WHY is Shared Transfer of Care important?



1 **WHY is it important?**
2 WHAT is it?
3 HOW do we deliver it?
4 IF we use it, what are the benefits?

Figure 2.

WHY IS SHARED TRANSFER OF CARE IMPORTANT?

MODULE 1
WHY is Shared Transfer of Care important?

OBJECTIVES

This module aims to:

- engage participants through the use of stories and evidence to help them understand, and relate to the shared transfer of care concept?
- support participants to identify if and where change needs to occur.

PREPARATION/MATERIALS

- Module 1 PowerPoint Slides
- Whiteboard or butcher's paper
- Markers
- Sticky notes

PARTICIPANT HANDOUTS

- 1.1 Jamie's story
- 1.2 Joe's story
- 1.3 Mavis' story
- 1.4 William's story
- 1.5 Charles' story
- 1.6 In Tasmania

Use a story to share a consumer's experience

Start with a story that will set context and engage your participants. You may wish to:

- use your own story (de-identify the people or organisations involved)
- use one the example stories provided as Handouts
- show a video.

The story should set the scene by describing the situation and people involved, outline what happened, explain the impact on those involved (feelings, outcome, adverse event, readmission, etc.) and finally make the point (celebrate the good or acknowledge the bad process).

Handout 1.5
Charles' story

Summarise your story using the following format as an example based on *Handout 1.5 Charles' story.*

> *"The reason I'm telling you this story is because Charles had a poor experience. He was readmitted for 10 days' of antibiotics which could have been prevented if he had known who to see to get his sutures removed, if someone had checked in with him to see if he understood his wound care instructions prior to him going home, or if he had a contact number to speak to someone if he had concerns. It was an unnecessary inconvenience for him, and an avoidable cost to the health system."*

Training Tip
Stress to participants that, whilst stories are used to demonstrate the issue, they are not used to apportion blame. Stories help people to recognise inadequate processes and identify solutions.

Stories can be negative or positive. A negative story tends to elicit an emotive response such as, "How can this occur?", or people relate to it, e.g., "Yes, that happens" or "I have a similar story." A positive story is useful with participants who may be experiencing a negative workplace culture, as it illustrates the benefits of care that is collaborative.

Acknowledge that many transfers of care go smoothly with no adverse events. We need to learn equally from these positive examples and ask "why did it go well?" and "how can we replicate these processes to ensure all of our consumers have good outcomes?" Discuss that "although this is not always the case, the positive outcome is what we aspire to."

Invite participants to consider an experience they've had or a story they have heard. Participants should **reflect** on these throughout the modules and consider what made the transfer work well, or what could have been done at an individual or organisational level to influence or improve the experience.

In Tasmania

The following infographic (Figure 3) illustrates the vast majority of a person's care occurs in the community.

As Tasmanians, we have:

- higher rates of most common chronic diseases than other Australians
- a population that is ageing faster and living more in regional and rural areas
- more health risk factors (smoking, alcohol consumption, poor diet and insufficient exercise)
- lower levels of health literacy (the ability to understand and use health information)
- the highest poverty rate of all states and territories with the lowest individual income
- a high reliance on government income support and the highest proportion of the population living in the most disadvantaged areas.[2]

People affected by one or more of these factors will access health and community services more often and move with greater frequency between the different health and community services. In Tasmania, these movements (transfers) are touch points in the system that can either support or negatively impact on health outcomes.

We face significant challenges to improve transfers of care.

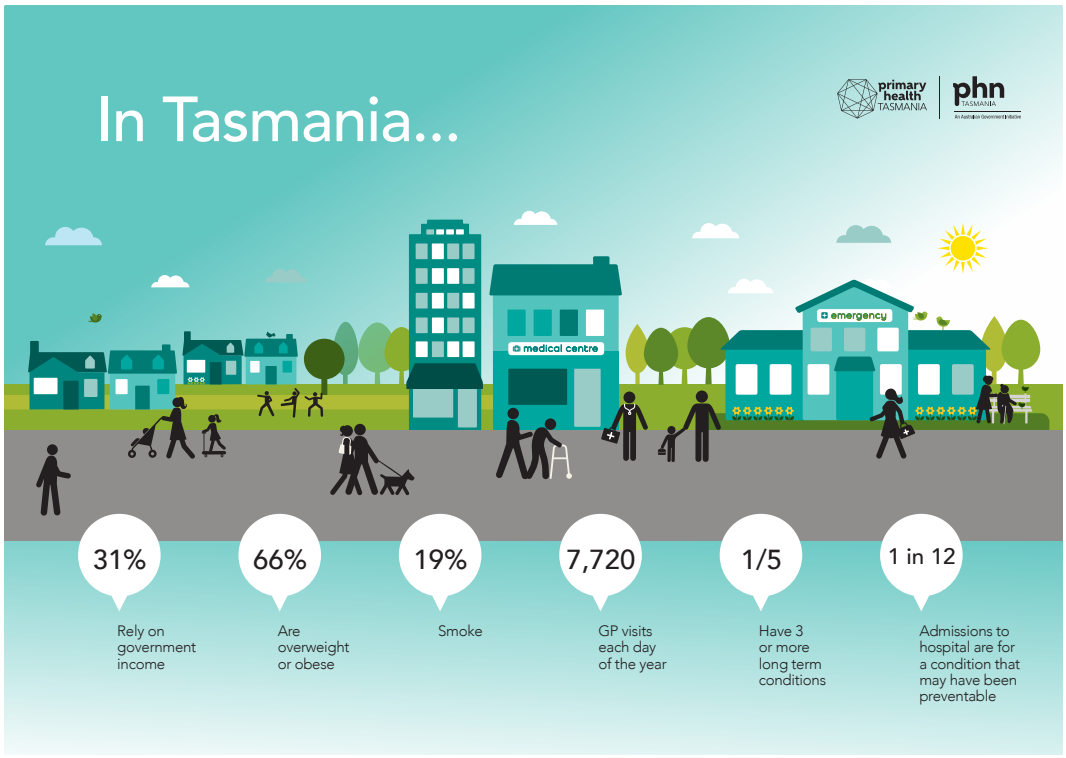


Figure 3.

INFOGRAPHIC—IN TASMANIA

What does the research tell us?

Transfer of care within and between different sectors of the health and community service systems are associated with an increased likelihood of adverse events and disruptions in the continuity of care.

The impacts of problems identified at the acute and primary care interface(s) in the literature are:

- increase in deaths and morbidity
- increase in adverse events
- delays to appropriate treatment and community supports
- additional primary healthcare (PHC) or emergency department (ED) visits
- additional or duplicated tests
- preventable readmissions to hospital
- additional costs to consumer, family, health system and community
- emotional and physical pain and suffering for consumers, carers and families
- high level of consumer and provider dissatisfaction with coordination of care across community and acute interface.[3]

This data is reflected by the experiences of consumers and health and community providers involved in transfers.

What we hear from providers	What we hear from consumers
▸ Service professionals are not speaking to one another ▸ Service professionals work in silos… "it's hard to find the right door to get help" ▸ "There are so many different referral pathways" ▸ "There is not enough coordination across services" ▸ Frustration experienced by providers who forward information which either "gets lost" or "is not read"	▸ People feel 'lost' in the system ▸ They have to repeat their stories over and over ▸ Few people complain about the intent of the people giving the care, but rather about the processes; e.g. "the staff were so busy, it wasn't their fault." ▸ People lose trust in the system

Do these comments sound familiar?

Shared Transfer of Care and Australian Safety and Quality Standards

Quality improvements in the Shared Transfer of Care program link directly to a number of Australian national health and community standards.

Ensuring alignment with Shared Transfer of Care will support organisational accreditation processes. These standards include:

- National Safety & Quality Health Service (NSQHS) Standards
- The Royal Australian College of General Practitioners (RACGP) – Standards for General Practices
- Australian Aged Care Quality Agency – Accreditation Standards
- Pharmaceutical Society of Australia – Professional Practice Standards
- Community Care Common Standards
- National standards for mental health services
- Occupational Therapy Board of Australia – Code of Conduct
- Australian Association of Social Workers – Practice Standards.

A summary of the national standards that promote quality shared transfer of care processes is available from **Resources** on the Shared Transfer of Care web page.

Activity options

Small group activity

Consider data from your own organisation (if available) to generate discussion. This data might be gained from organisational audits (e.g. consumer satisfaction, stakeholder feedback, compliments/complaints, record audits), focus groups, review of adverse events, or feedback from an accreditation review. To be engaging, the data needs to be relevant, and presented in a meaningful way.

Consider the following questions and write responses on a whiteboard or butcher's paper:

- How well do you think your organisation transfers the care of consumers?
- What does the evidence show?
- Are there any gaps and if there are what improvements are needed?

Reflect on these answers as you complete the other modules.

Whole group activity

Think of your own practice when you transfer the care of a consumer, either receiving the transfer of care or implementing the transfer of care to another organisation, then consider:

- What does a successful transfer of care mean to you?
- What supports or hinders transfer of care for the consumers in your organisation?
- When the outcomes are not optimal, what do you think happened?

Small group activity

Consider the following statements:

- Consumers may want to be involved in their transfer of care, but they don't know how.
- Consumers expect service providers to share information.
- A person's journey through the service system is everyone's business.

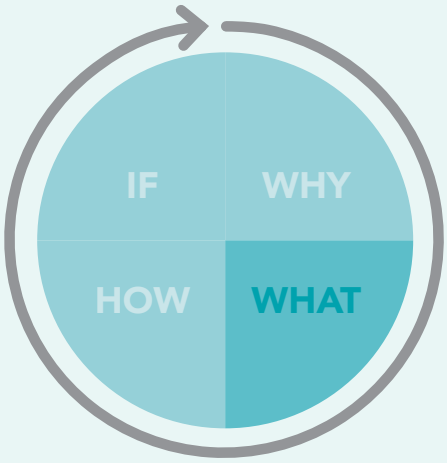
Discuss these statements in a small group. What are your initial thoughts?

Review of Module 1
Reflect on the learning objective, "Why is shared transfer of care important?"

Notes

SHARED TRANSFER OF CARE

MODULE 2
WHAT is Shared Transfer of Care?



1 WHY is it important?
2 **WHAT is it?**
3 HOW do we deliver it?
4 IF we use it, what are the benefits?

Figure 3.
WHAT IS SHARED TRANSFER OF CARE?

Training Tip
Download and save videos to USB prior to the session to avoid issues with internet connectivity.

MODULE 2
WHAT is Shared Transfer of Care?

OBJECTIVES

This session aims to:

- encourage participants to look at their own practice and behaviour within their organisation when transferring the care of a person
- provide an understanding of the five important elements of Shared Transfer of Care
- provide a way of working that supports a quality Shared Transfer of Care approach.

PREPARATION/MATERIALS

	Module 2 PowerPoint Slides
	Training videos
	"Finding the Why" http://youtu.be/hZN1CyEiFNM
1.9	Pharmacist and general practitioner
2.6	Registered nurse and Madge
1.5	Mary and locum general practitioner
2.2	Podiatrist and locum general practitioner
2.5	Paramedic and registered nurse
1.3	Hospital registrar and general practitioner
1.7	Aged care registered nurse and physiotherapist
2.3	Community nurse and Bill
2.9	General practitioner and Bill
1.3	Hospital registrar and general practitioner
1.4	Physiotherapist, community nurse and Mary
	Whiteboard or butcher's paper
	Sticky notes
	Markers

PARTICIPANT HANDOUTS

- 2.1 Person-centred care
- 2.2 ISOBAR SHARED Planning Checklist
- 2.3 SHARED Planning Checklist
- 2.4 Elsie's story
- 2.5 Example Transfer Form

Training Tip
A valuable activity might be to establish, through discussion, a shared vision or statement that everyone in the organisation will adopt.

Guidelines for Shared Transfer of Care

The *Guidelines for Shared Transfer of Care* have been developed following a wide review of the literature and extensive stakeholder consultation. These learnings are applied to consumer care according to core principles and major elements that are adaptable to local context.

The concepts within the *Guidelines* are not new, but they do reflect a way of working and behaviour that—although often well-intended—is not always implemented.

Reflect on your own transfer of care practice and behaviour as each of the principles and elements are discussed. Are there areas where you or your organisation could improve?

Principles

The following core **principles** underpin the *Guidelines*, and are essential for shifting from a service-driven model to a person-centred model of transfer of care:

- **Person- and family-centred care**
- **Evidence-based, quality services**
- **Equity in access to care**
- **A strengths-based approach**
- **Strong linkages and coordination across sectors**
- **Interdisciplinary approach**

Person- and family-centred care: Putting the person back in the patient

A person and their family or carers collaborate with service providers to receive services that place the person at the centre of their own care.

The concept of person-centred care is an important one and certainly worth exploring as providers have different views on what this is. Person-centred care will be discussed further in the next section at 'Sharing with People'.

Evidence-based, quality services

Professionals and people work together using the best available evidence and their individual expertise, to make shared decisions.

The Appendix describes how the *Guidelines for Shared Transfer of Care* were developed following a review of literature and broad stakeholder consultation.

Equity in access to care based on need: right care, right place, right time

There is access to services and support that meet the needs of a person.

Equity means 'fairness' and this translates to providing additional support to some communities to achieve the same outcomes as others.

Health systems need to be flexible, consider innovative approaches, and utilise the strengths and resources within communities.

Training Tip
Emphasise that all initiatives are supported by evidence. Audit results, focus groups and real-life scenarios can be used to obtain and strengthen staff engagement.

A strengths-based approach

Engage with the person to identify their capabilities and strengths so they can achieve their goals.

A strengths-based approach in Shared Transfer of Care acknowledges that each person has their own experience, knowledge and support network. This approach allows the clinician to support and empower a person to harness these strengths and collaboratively develop a transfer plan.

Strong linkages and coordination across sectors

Providers work together using a coordinated and integrated approach to service delivery, using respectful communication as the key.

Coordination of care is a concept that involves activities at the person level, the service level and the system level. It helps provide high-quality services that minimise duplication and address service gaps.

Interdisciplinary approach

A person receives support that involves the different services they need for holistic care.

Elements

The key **elements** are presented as five 'Sharing Points'. These Sharing Points provide the framework for quality Shared Transfer of Care and further support care that is person-centred.

Each element is followed by suggestions and recommendations to achieve best-practice.

1 Sharing with People

2 Sharing Accountability

3 Sharing Communication

4 Sharing Documentation

5 Sharing Coordination

SHARING POINTS

1 Sharing with People

A person, their family and carers are involved in the transfer plan. The plan takes into account the person's physical, social, psychological, spiritual and cultural needs.

People want to be listened to, receive adequate explanations from health professionals, have their questions answered, to share in decisions about their health and to be treated with dignity, compassion and respect[4]. A lack of seamless transfer of care across health sectors is often described by people as 'falling through the gaps', 'being forgotten about', or 'having to explain yourself to every professional or service you encounter'.[5]

Activity options

Group activity

Use the whiteboard or sticky notes to define participants' definition of a person-centred approach to care with people.

- What would a person-centred approach look like at a whole-of-organisation level?
- What are the facilitators and barriers to a person-centred approach in organisations and in practice?
- In your practice what strategies do you use to involve people in their own care, and what might support or hinder this?

Handout 2.1
Person-Centred Care
provides further information on how to put person-centred care into practice.

Training video

Starrett Lodge Uniting Care in NSW has adopted a person-centred approach to caring for the people with dementia in their facility. They developed a short video of their experience entitled "Finding the Why". The video is 16 minutes in length so you may want to look at a short section only.

Alternatively, consider this statement by Colin McDonnell, Care Manager at Starrett Lodge (from the video).

> *"Person-centred care is about building relationships—how much you know about a person so that you can do things that assist and enable that person to still be a person. Rather than take over and tell, and control and manage their health, I am there to be an advocate for that person. That means you are around if they need it, to support but not tell them what to do. People need to be participants rather than recipients. It's person-centred care between staff, between residents and between families."*

- In your organisation, what does it mean to deliver person-centred care?
- How does a person-centred approach to care impact on your role?
- What does it mean for people to be participants rather than recipients in their care?
- Discuss the enablers and barriers to providing a person-centred approach to care in your organisation.

2 Sharing Accountability

Shared accountability between service providers and including the person enables a person-centred approach to care.

Improvement of outcomes related to transfers of care can be achieved through service integration, during the planning of services, across disciplines and across acute and community service boundaries.[6]

Sharing Accountability means that professionals and consumers share information, responsibility and decision-making.

In a shared decision-making approach, the consumer brings their lived experience, circumstances, needs, value base and care preferences and the provider brings their professional knowledge and expertise. This is a collaborative conversation, in which both parties' contributions are recognised, acted upon and valued.

When people have this increased participation in their care, they gain a greater understanding of their condition. They know why treatments are required, have a better understanding of risk, are more comfortable about decisions about their care and can identify where they wish or are able to manage their own care.

Shared Decision Making—it's a different type of conversation.

Activity options

Group activity

What are the key facilitators and barriers to shared accountability in your role? Whiteboard and discuss:

- provider to provider
- provider with consumer
- consumer's role.

Training video

View one or both of the following videos and use the questions to prompt discussion.

- 1.9 Pharmacist and general practitioner
  What are some of the practical ways in which the practitioners showed Shared Accountability?
- 2.6 Registered nurse and Madge
  How do you think Madge, as a carer, felt after her interaction with the nurse? What could have happened differently to promote shared decision-making?

3 Sharing Communication

Timely, appropriate, routine and non-routine communication between providers and with the person.

Sharing Communication between providers and including the person is important to ensure safe transfer of care. Where there is a breakdown or inadequate communication between providers there is a greater risk of adverse events.

Sharing communication in action includes:

- a person being supported to manage their wellbeing in their daily life
- a person being aware of transfer timeframes, key contacts and actions to take as required.
- a person receiving information and documentation related to their care in a format they can understand with providers checking for understanding.

Successful communication sounds easy, but listening and drilling down to the important pieces of information to be shared, while in a busy work environment, can be one of the hardest things to do. The evidence tells us that the outcomes at transfer points are improved if we are able to understand the 'person' perspective. This is achieved through communicating and sharing more than the health context.

Health Literacy at the individual level is the knowledge, motivation and competencies of a person to access, understand, appraise and apply health information to make effective decisions and take appropriate action for their health and health care."[7]

The health literacy environment includes the infrastructure, policies, processes and relationships that exist within the health system. These factors can make it easier or more difficult for consumers to navigate, understand and use health information and services to make effective decisions and take appropriate action about health and health care.[8]

Handout 2.2
ISOBAR SHARED Planning Checklist

ISOBAR is a widely adopted communication framework supported by the Australian Commission of Safety and Quality in Health Care. It provides a snapshot of the clinical information to ensure a good transfer of care. Where this is the clinical tool, an additional person-centred tool called SHARED has been developed as a resource to ensure that communication remains person-centred. See Handouts 2.2 and 2.3 to view this framework.

Activity options

Group activity

Whiteboard the following question:

- What are some of the considerations when involving people and their carers in the transfer process?

Use the SHARED Planning Checklist as a demonstration of the SHARED concept for a person-centred approach to communication.

- What are the barriers to shared communication between the consumer and the service provider?
- What are the barriers to shared communication between service providers?

Consider the methods of communication you use in your practice.

- What works well? What can be improved?
- How do you ensure that the person/consumer understands the information you have provided?
- How could you incorporate the SHARED concept to consider the person when communicating with other providers?

Handout 2.3
SHARED Planning Checklist

Training videos

View one or more of the following videos and use the questions to prompt discussion.

- 1.5 Mary and locum general practitioner
  What factors influenced the quality of Shared Communication in this scenario?
- 2.2 Podiatrist and locum general practitioner
  What are some appropriate and inappropriate examples of times and places to Share Communication? How could they be improved?
- 2.5 Paramedic and registered nurse
  In terms of Sharing Communication, what works well in this scenario? Could anything be improved?

A link to *Helping People Share Decision-Making* by The Health Foundation is available in the Resources & Additional Reading list on the Shared Transfer of Care web page.

4 Sharing Documentation

Sharing of high-quality documentation between providers that includes the person, regardless of setting.

Sharing Documentation includes:

- the person being transferred having a clearly documented care plan
- shared assessment and referral templates being clear, person-centred and free of jargon
- information between providers is confidential, secure and accessible to the person.

Transfer of care [discharge] summaries often lack important information, including test results, treatment information, medications and patient or family/carer follow-up plans.[9]

Shared single assessment and referral templates are ideal.

Activity options

Story – Elsie

Elsie's story highlights a poor transfer of care related to poor coordination and sharing of information.

Handout 2.4
Elsie's story

Two core pieces of documentation that can communicate shared information are referrals and care plans. Reflect on Elsie's story and consider the following questions:

- Why would we share documentation and what can we do to ensure that happens?
- What is the essential information to include?
- What is the key information needed to communicate in an interdisciplinary care plan across services and organisations?
- Can we capture all the information needed on a single template and use it for different audiences, including consumer and service providers?

Handout – Transfer Form

Handout 2.5
Example Transfer Form

This form was developed by Calvary Health Care Launceston to provide a single template for sharing information with their consumers and relevant stakeholders. The aim is for a consistent sharing of information.

- How many templates are used in your organisation?
- Is it viable to consider consolidating these?

Training videos

View one or more of the following videos and use the questions to prompt discussion.

- 1.3 Hospital registrar and general practitioner
  How does this scenario demonstrate poor Sharing Documentation and Communication?
- 1.7 Aged care registered nurse and physiotherapist
  What happens in this scenario to demonstrate Sharing Documentation? How does the physiotherapist follow-up on the transfer of information?
- 2.3 Community nurse and Bill
  What does the community nurse say and do in this scenario that positively demonstrates Sharing Documentation? How does Bill feel? How does technology facilitate a good outcome?
- 2.9 General practitioner and Bill
  In what way is the Passport a person-centred document? How does it benefit the GP as well as Bill?

Discussion

Reflect on the documentation used in your workplace.

- What might a high-quality process look like?
- Identify the core documentation and processes used in your workplace to support shared transfer of care. What is working well and what are the limitations?

5 Sharing Coordination

Coordinated, evidence-based, person-centred care across sectors.

Sharing Coordination can include:

- best practice guidelines and protocols across all sectors
- where transfers of care are inter- or multi-disciplinary, is a collaborative approach across sectors with a focus on respectful communication
- evaluation of coordination processes, including consumer feedback, is built into quality improvement processes.

Care that is coordinated is centred around and involves the person, information between providers is communicated and shared, and the accountability of care is shared between providers and the person/consumer.

Activity options

Small group activity

Review one of the stories supplied, or use one from your own experience. Discuss the following:

- How is coordination of care organised in your workplace?
- What process, skills and resources are needed?
- What can we do collectively to improve coordination of care?
- How would the story have been different if the care was coordinated?

Handouts 1.1-1.4
Consumer stories

Training videos

View one or both of the following videos and use the questions to prompt discussion.

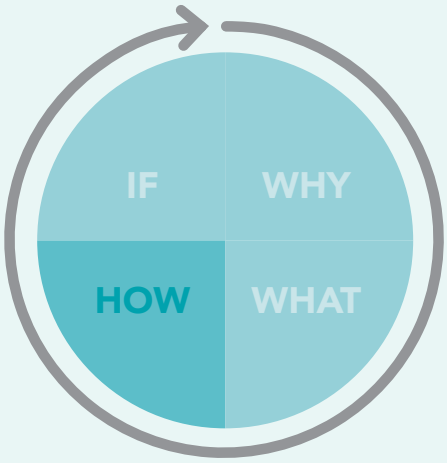
- 1.3 Hospital registrar and general practitioner
  What are the ways this scenario demonstrates poor sharing of coordination? What are the challenges when coordination of care occurs across different settings e.g. hospital, community, residential care?
- 1.4 Physiotherapist, community nurse and Mary
  How do the physiotherapist and community nurse coordinate Mary's care in this scenario? In what ways do they show person-centred care?

Review of Module 2
Summarise the five evidence-based elements that support Shared Transfer of Care.

Notes

SHARED TRANSFER OF CARE

MODULE 3
HOW do we deliver quality Shared Transfer of Care?



1 WHY is it important?
2 WHAT is it?
3 HOW do we deliver it?
4 IF we use it, what are the benefits?

Figure 5.
HOW DO WE DELIVER SHARED TRANSFER OF CARE?

Training Tip
Download and save videos to USB prior to the session to avoid issues with internet connectivity.

MODULE 3
HOW do we deliver quality Shared Transfer of Care?

OBJECTIVES

This module aims to:

- identify areas where Shared Transfer of Care are provided well in your organisation and where there could be improvements
- provide access to tools to implement the Guidelines for Shared Transfer of Care
- discuss strategies to create change.

PREPARATION/MATERIALS

	Module 1 PowerPoint Slides
	Training videos
1.10	Aged care registered nurse and Mary's daughter
2.6	Registered nurse and Madge
1.6	Registered nurse and general practitioner
1.7	Aged care registered nurse and physiotherapist
2.9	General practitioner and Bill
	Whiteboard or butcher's paper
	Markers
	Sticky notes

PARTICIPANT HANDOUTS

	3.1 How can we, individually and together, improve Shared Transfer of Care?
	3.2 The Theory of Constraints
	3.3 The Circle of Influence
	Transfer Plan Checklist – Consumer
	Assess the health literacy environment of your workplace

Putting Shared Transfer of Care into practice

All staff must be involved in identifying existing issues and developing solutions to successfully implement new strategies to improve transfers of care.

Handouts 1.1 to 1.4
Consumer stories

Handout 3.1 poses the question "How can we, individually and together, improve shared transfer of care?" This question acknowledges that all staff bring expertise, ideas and solutions, and their contribution is valued.

Training Tip
Ask participants to consider this question as they progress through the module.

Key strategies

There is no single solution to improving transfers of care; however, the following three strategies will enable adoption of the Shared Transfer of Care.

1	**Introduce ways to support Shared Transfer of Care at a system and service level**
2	**Engage the person, their families and carers in transfers of care**
3	**Communication and teamwork—integration**

STRATEGY 1
Introduce ways to support Shared Transfer of Care at a system and service level

The following actions by organisations and individuals will influence the success of initiatives to implement Shared Transfer of Care:

- establish a positive organisational environment
- lead and resource transfer-of-care initiatives
- create individual staff awareness and positive behaviours
- engage staff in improving transfers of care
- establish productive partnerships
- determine the intended outcomes of implementing shared transfer of care
- develop effective policies, guidelines, tools and resources.

Activity options

Small group activity

Ask each participant to complete the handout, reflecting on their workplace and role. This can be done individually or in small groups.

Whiteboard some of the responses to each section of the worksheet. Ask participants *"how do we, as individuals, have the greatest ability to improve the shared transfer of care for people?"* (E.g. we can change ourselves—our behaviour, our language, and the way we work.)

Handout 3.1
How can we work, individually and together, to improve Shared Transfer of Care?

Small group activity

In small groups, discuss the steps you could take to ensure delivery and maintenance of *Shared Transfer of Care* in practice, both at the individual and organisational levels.

Handout 3.2
The Theory of Constraints

Handout 3.3
The Circle of Influence

The following tools introduce ways to support Shared Transfer of Care at a system and service level. These tools are available for download on the Shared Transfer of Care web page.

- Shared Transfer of Care Method
- Shared Transfer of Care Policy
- Shared Transfer of Care Procedure
- Shared Information Record

STRATEGY 2
Engage the person, their families and carers in transfers of care

Organisations could undertake work in the following areas to promote the engagement of the person, their families and carers in transfers of care:

- promoting a person-centred approach to care
- improving the health literacy environment
- supporting people to self-manage.

Activity options

Group activity

Discuss how the *Passport to better health* supports person-centred care and self-management.

Training videos

View one or more of the following videos and use the questions to prompt discussion.

- 1.10 Aged care registered nurse and Mary's daughter
  Is this scenario a good example of engaging with a person's family member? If you were the nurse, what would you take away from this meeting? How would Mary's daughter feel after the discussion?
- 2.6 Registered nurse and Madge
  Does Madge feel engaged in this scene? How could the nurse have shown person-centred care in both her verbal and non-verbal communication?

The following are useful for engaging with the person, their families and carers in transfer of care. These can be downloaded at **Resources** on the Shared Transfer of Care web page.
- Evaluation of Consumer Care
- Transfer Plan Checklist Consumer

Assess the health literacy environment of your workplace is a resource that can help organisations strengthen health literacy. See **Resources** on the Shared Transfer of Care web page.

STRATEGY 3
Communication and teamwork—coordination and integration

It is recommended that organisations undertake work in the following areas to enhance Shared Transfer of Care:

- promoting communication and teamwork
- coordinating care
- integrating care.

Promoting communication and teamwork

Poor communication and poor teamwork are key contributing factors to adverse events, while effective communication and teamwork are cited as critical for achieving a culture of safety to support quality care.[10,11]

Effective communication, productive relationships and teamwork are necessary to support and sustain effective Shared Transfer of Care processes. Organisations will need to assess the requirement to improve communication and teamwork as part of introducing Shared Transfer of Care initiatives.

Coordination of care

Coordination of care refers to the deliberate organisation of care activities between two or more participants involved in a person's care to facilitate the appropriate delivery of services. Organising care involves the marshalling of personnel and other resources needed to carry out all required person care activities, and is often managed by the exchange of information among participants responsible for different aspects of care.[12]

Effective coordination of care results in better consumer outcomes, reduced complications associated with care and an enhanced consumer and carer experience of care.

Integration

Integration is a coherent and coordinated set of services which are planned, managed and delivered to individual service users across a range of organisations and by a range of cooperating professionals and informal carers.[13]

Activity options

Small group activity

Ask participants to discuss the steps they can take to improve the integration of care across services and sectors.

Small group activity

Ask participants to review Handout 3.3, The Circle of Influence. and consider—in their respective organisations—what aspects of communication, relationships and team work are within their influence and what are outside of their control.

Handout 3.3
The Circle of Influence

Training videos

View one or more of the following videos and use the questions to prompt discussion.

- 1.6 Community nurse and general practitioner
  What do the nurse and GP do and say that exemplifies good teamwork here? How does it benefit them as well as Mary?
- 1.7 Aged care registered nurse and physiotherapist
  What does this scenario suggest about the quality of the teamwork here?
- 2.9 General practitioner and Bill
  Describe the relationship between Bill and his GP. How would you characterise their communication?

The following **Tools** will help build communication and teamwork to promote Shared Transfer of Care and are available at Shared Transfer of Care web page.

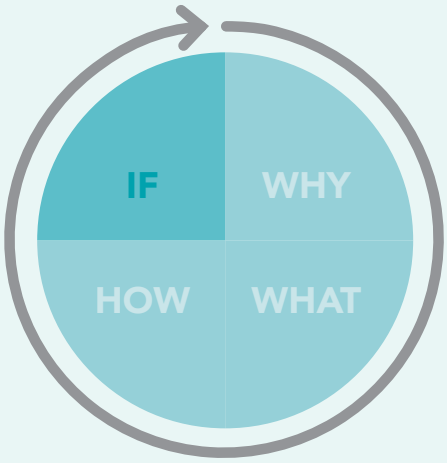
- Teamwork Evaluation
- Self-assessment of person-centred care

Review of Module 3
Summarise the strategies that can be used to deliver shared transfer of care.

Notes

SHARED TRANSFER OF CARE

MODULE 4
IF we use Shared Transfer of Care, what are the benefits?



1 WHY is it important?
2 WHAT is it?
3 HOW do we deliver it?
4 IF we use it, what are the benefits?

Figure 6.

IF WE USE SHARED TRANSFER OF CARE, WHAT ARE THE BENEFITS?

MODULE 4
If we use Shared Transfer of Care, what are the benefits?

OBJECTIVES

This module aims to:

- enable participants to articulate the benefits of Shared Transfer of Care
- encourage participants to consider actions to sustain change.

PREPARATION/MATERIALS

Module 1 PowerPoint Slides

Training videos

Vignettes of health professionals answering questions about quality Shared Transfer of Care practices

PARTICIPANT HANDOUTS

4.1 The potential benefits of people-centred and integrated services

Training Tip
Download and save videos to USB prior to the session to avoid issues with internet connectivity.

The potential benefits of Shared Transfer of Care

To implement change, it is important to consider who benefits and what the benefits are. The box below describes the potential benefits of implementing Shared Transfer of Care for consumers, communities, providers and systems. This table is also provided as a handout.

To individuals and their families	To health professionals and community workers
› increased satisfaction with care and better relationships with care providers › improved access and timeliness of care › improved health literacy and decision-making skills that promote independence › shared decision-making with professionals with increased involvement in care planning › increased ability to self-manage and control long-term health conditions › better coordination of care across different care settings.	› improved job satisfaction › improved workloads and reduced burnout › role enhancement that expands workforce skills so they can assume a wider range of responsibilities › education and training opportunities to learn new skills, such as working in team-based health care environments.
To communities	**To systems**
› improved access to care, particular for marginalized groups › improved health outcomes and healthier communities, including greater levels of health-seeking behaviour › better ability for communities to manage and control infectious disease and respond to crises › greater influence and better relationships with care providers that build community awareness and trust in care services › greater engagement and participatory representation in decision-making about the use of health resources › clarification on the rights and responsibilities of citizens to health care › care that is more responsive to community needs.	› enables a shift in the balance of care so that resources are allocated closer to needs › improved equity and enhanced access to care for all › improved patient safety through reduced medical errors and adverse events › increased uptake of screening and preventive programmes › improved diagnostic accuracy and appropriateness and timeliness of referrals › reduced hospitalisations and lengths of stay through stronger primary and community care services and the better management and coordination of care › reduced unnecessary use of health care facilities and waiting times for care › reduced duplication of health investments and services › reduced overall costs of care per capita › reduced mortality and morbidity from both infectious and non-communicable diseases.

Modifed from *WHO Global Strategy on people-centred and integrated health services - Interim report.* World Health Organization. Geneva, Switzerland. 2015. 48 p

Activity options

Group activity

Discuss the benefits of improved Shared Transfer of Care processes for:

- individuals and their families
- communities
- professionals
- the broader service system.

Training videos

View one or more of the following vignettes where health professionals discuss the benefits of improved shared transfer of care:

- What is good person-centred care?
- What is good shared accountability?
- What is good shared documentation?
- What is good coordination of care?
- What is good shared communication?
- Transfer of care—key messages.

Reflect on the topic of each vignette and name one thing you can change to improve transfers of care.

Handout 4.1
The potential benefits of people-centred and integrated services can be downloaded at **Resources** on the Shared Transfer of Care web page.

Review of Module 4
Reflect on the learning objective—What are the benefits of improved transfers of care?

Notes

CONCLUSION

Creating solutions together is ideal; we all want what's best for the providers and the people receiving care. Some ideas to instill change are:

- Small things can make a difference, such as changing our language, applying person-centred care in our behaviour and being positive.
- We can each promote a person-centred approach to care in our organisations but more importantly in our own practice.
- Celebrate success—provide positive feedback when transfer processes are done well.
- Finally after each contact with a person, ask yourself the questions on the SHARED Planning Checklist (provided in Module 2). Reflect on whether the plan clearly meets the person's needs and goals, and whether you have allowed time to go back and check for understanding.

Activity
Ask each participant to share one thing that they can do immediately to adopt a Shared Transfer of Care approach within their practice.

Where to from here?

The following resources have been developed to assist providers implement successful Shared Transfer of Care:

- *Guidelines for Shared Transfer of Care*
- Shared Transfer of Care tools and templates that can be adapted and modified by organisations to suit their needs
- an online eLearning course entitled Shared Transfer of Care, developed in collaboration with the University of Tasmania
- this *Facilitator Guide* and it's supporting handouts and video resources

Feedback to refine and improve resources is always welcome. See the Shared Transfer of Care web page for contact details.

Thank you

Thank you to the many services and organisations—public, private and non-government—who have participated in the development of the Guidelines and this Facilitator's Guide. These collaborative efforts have ensured their relevance and applicability to support the building of a coordinated, integrated, effective primary care system

Thank you to those who participated in this session to introduce Shared Transfer of Care.

Evaluation Handout
Evaluation of Shared Transfer of Care Training

Session evaluation

Ask participants to complete the session evaluation. Note that evaluations and participant feedback will be used to continuously improve and revise the course.

Evaluation Handout
Evaluation of Shared Transfer of Care Principles

GLOSSARY OF TERMS

Admission	The processes, tools and techniques by which an episode of care is formally commenced by a health professional or health provider organisation involving their acceptance of responsibility for a person and/or their treatment and care.[1]
Barriers	Obstacles that may potentially prevent a quality transfer of care can be a person, a system or a process
Best practice	Practices, behaviours, systems and processes that are based on research and evidence to provide quality shared transfer of care outcomes for the consumer
Boundaries of care	The interface between care services.
Care coordination	The facilitation of appropriate service delivery for a person following assessment, goal-setting and care planning. It involves linkages with other service providers, efficient use of resources and regular review.
Carer	*The Carers (Recognition) Act* 2008 identifies a carer as an individual who provides, in a non-contractual and unpaid capacity, ongoing care or assistance to another person who, because of disability, frailty, chronic illness or pain, requires assistance with everyday tasks.[2]
Clinical handover	The transfer of professional responsibility and accountability for some or all aspects of care for a person, or group of people, to another person or professional group on a temporary or permanent basis.
Collaborative approach to shared transfer of care	A collaborative approach to shared transfer of care includes effective communication, productive relationships and teamwork within and between organisations.
Community Service	The broad understanding of the nature of community services is that they include activities that support individual and family functioning.[3]
Community Service Provider	An individual who provides community services to a person or group of people.
Consumers	Any actual or potential recipient of health care, such as a patient in a hospital, a client in a community mental health center, or a member of a prepaid health maintenance organisation.[4]
Coordination of care	A concept that involves activities at the person level, service level and system level. It helps provide high-quality care services that minimise duplication and addresses service gaps.

Discharge	The processes, tools and techniques by which an episode of treatment and/or care to a patient is formally concluded by a health professional, health provider organisation or individual.
Discharge summary	The written account of a person's episode of care within a facility. Referred to as Transfer Summary in the corresponding documents.
Enabler	People, systems or processes that support quality shared transfer of care.
Equity in access to care	Access to services and support that meet the needs of a person.
Evidence-based, quality practice	Professionals and people work together using the best available evidence and their individual expertise to make shared decisions.[5]
Family carer	A person who is providing or who has provided unpaid support and care to a family member or friend who is living with a disability, mental illness, chronic condition or terminal illness or who is frail or aged.
Guidelines	Systematically developed statements to assist practitioners and people to make appropriate decisions about health care for specific circumstances.
Health literacy	Individual health literacy is the knowledge, motivation and competencies of a person to access, understand, appraise and apply health information to make effective decisions and take appropriate action for their health and health care.[6] The health literacy environment includes "the infrastructure, policies, processes and relationships that exist within the health system. These factors can make it easier or more difficult for consumers to navigate, understand and use health information and services to make effective decisions and take appropriate action about health and health care."[7] A person's level of health literacy and the health literacy environment are significant factors which influence their capacity to actively participate in shared transfer of care
Health service	An organisation that is responsible for the clinical governance, administration and financial management of a service providing health care.
Health service provider	An individual who provides health services to a person or group of people.

Integrated care	Integrated care is a coherent and coordinated set of services which are planned, managed and delivered to individual service users across a range of organisations and by a range of cooperating professionals and informal carers.[8]
Interdisciplinary approach	A person receives support that involves the different services they need for holistic care.
ISOBAR	Effective communication at the transfer of care is important for improving patient safety and reducing adverse outcomes. ISOBAR is a clinical communication tool used widely in the health and community sector, prompting minimum information requirements to improve a person's safety, and reduce adverse events at the point of transfer. The acronym ISOBAR (identify–situation–observations–background–assessment–recommendation) summarises the components of a checklist adapted to promote effective communication.
ISOBAR SHARED	The addition of SHARED (safe-heard-agreed plan-relationships-easy information-destination) provides a person-centred approach to the ISOBAR (see above) clinical communication framework.
Medical home	The medical home refers to a model of primary care that is person-centred, comprehensive, team-based, coordinated, accessible, and focused on quality and safety.[9]
My Health Record	A secure online summary of a person's health information. The individual supported by the primary care team controls the information entered and accessed. This enables doctors, hospitals and other health care providers to view and contribute to the record, to facilitate easy access to the person's health care information.[10]
Person-centred	A person-centred approach to transfer of care is respectful of, and responsive to, the preferences, needs and values of consumers. It includes the respect, emotional support, physical comfort, information and communication, continuity of transfer, coordination of care, and involvement of family.
Person- and family-centred care	A person and their family and/or carers collaborate with service providers to receive services that place the person at the centre of their health and wellbeing.

Primary health care	The first level of contact that a person, families and communities have with the health care system. It involves health promotion and prevention. The underpinning interconnecting principles of equity, access, empowerment, and community self-determination and collaboration across sectors are implicit. It encompasses an understanding of the determinants of health.[11]
Principle	A fundamental truth or proposition that serves as the foundation for a system of belief or behaviour.
Protocol	An established set of rules used for the completion of tasks or a set of tasks.
Referral	The processes, tools and techniques by which a person (and the provision of all or part of their care) is transferred between health professionals and health provider organisations to facilitate access to services and/or advice that the referring source is unable or unwilling to provide.
Self-management	Self-management is the active participation of people in managing their own health and wellbeing. It puts the person in the 'driver's seat' and enables them to choose how they want to live with their condition/s. Self-management varies between a person being the lead manager of their own care to those who are able to be involved in managing their own care with the support of resources and other people.
Shared transfer of care	Shared transfer of care has the person, their family and carers at the centre of the transfer plan—assessment and planning is based on the principles of person-centred care.
Strengths-based	A strengths-based approach focuses on engaging with the person to identify their capabilities and so achieve their goals.
Strong linkages and coordination across sectors	Providers work together using a coordinated and integrated approach to service delivery, using respectful communication as the key.
Sub-acute care	Continuing care delivered after an acute care episode. This might be rehabilitation, palliative, psychogeriatric, geriatric, management or maintenance care and may be provided in facilities or in the community. In Tasmania this care may also be provided in hospital (prior to discharge) due to the absence of needed sub-acute care services.

Talking Points / Sharing Points	Five elements of the *Guidelines for Shared Transfer of Care* which designed to improve the quality of shared transfer of care for people living with chronic complex needs. 1. Sharing with People 2. Sharing accountability 3. Sharing Communication 4. Sharing Documentation 5. Sharing Coordination
Tasmanian health care system	A complex system in which both public and private providers, through a variety of funding mechanisms, work to provide access for all community members to a range of health care services ranging from primary to acute health care, in hospital and community settings.
Transfer of care	Transfer of care refers to the movement of a person's care between locations and providers
Transition of care	The movement of patients between health care locations, providers or different levels of care within the same location as their conditions and care needs change.[12]

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APPENDIX

Linking Evidence to Practice

The *Guidelines to Shared Transfer of Care* are the conduit from research to clinical practice. They apply research learnings to consumer care according to broad principles that are adaptable for a local context.

In developing the *Guidelines*, a wide review of the literature was conducted and key stakeholder consultations were held. At the same time that the Guidelines were being produced, the Australian Primary Health Care Research Institute (APHCRI) was federally commissioned to report on subacute care in Tasmania. The resulting APHCRI report,[27] produced in collaboration with KP Health and the Menzies Research Institute of Tasmania, added powerful validation to the principles contained in the Guidelines, and formed the basis of collaboration to:

- analyse existing sub-acute pathways in Tasmania
- establish an evidence base across the post-hospital patient pathways
- identify gaps and inefficiencies that impact post-hospital care.

In summary, the *Guidelines for Shared Transfer of Care* were validated by evidence that showed that their implementation would improve patient outcomes and reduce health service utilisation. This link between the evidence, the Guidelines and improved health outcomes provides the overarching foundation and justification for the Shared Transfer of Care program (Figure 7).

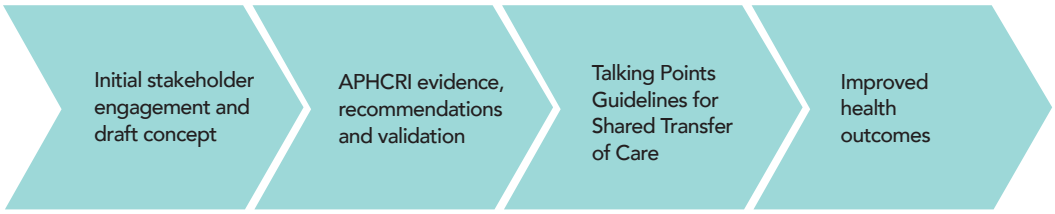

Figure 7.

EVIDENCE TO OUTCOMES

It is important to note that the *Guidelines for Shared Transfer of Care* foster a new way of working, rather than documenting prescriptive instructions for how transfers of care should be conducted. This approach ensures the *Guidelines* have applicability to the system as a whole. Organisations and professionals can implement the *Guidelines* according to their specific needs and incorporate them into existing work practices. Operationalising the *Guidelines* in this manner engenders ownership of new systems and processes at a local level and is a key tenet of sustainable change.

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