Best Practice Checklist (Page 1 of 3)

Please rate the following questions on a scale of 1-3:
(1) not achieved **(2)** in progress **(3)** achieved

RATE	SHARING WITH PEOPLE	EVIDENCE
	Consumer and Community Engagement	
	People are informed of timeframes before the transfer occurs (and their carers)	
	People are provided with access to their own information	
	People are asked to nominate their general practice home	
	Professional and Provider Interaction	
	Organisational staff discuss transfer of care timeframes with people and their families	
	Organisational staff provide people with access to their own information	
	Organisational staff ask people for their General Practitioner's contact details if not already provided	
	System Integration	
	Systems are in place to ensure that people and their carers are fully informed of the transfer of care timeframes before the transfer occurs	
	Systems are in place to provide people with access to their own information, including but not limited to their personal health record, a copy of the transfer summary and ongoing management plan	
	Systems are in place to prompt people and their carers to identify their general practice home	
RATE	**SHARING ACCOUNTABILITY**	**EVIDENCE**
	Consumer and Community Engagement	
	People are aware of who is responsible for their care at any given time during the transfer of care, who they should contact and how to contact them	
	People understand the information provided to them and can follow instructions about their care	
	People are supported to self-manage their health conditions	
	Professional and Provider Interaction	
	Organisational staff initiate the transfer of care, coordinate follow-up care, resources and appointments to another provider	
	Organisational staff utilise techniques to ensure information is understood by people and their carers; and make sure that people understand the information provided to them	
	Organisational staff educate people about strategies to support their self-management	

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RATE	SHARING ACCOUNTABILITY (continued)	EVIDENCE
	System Integration	
	Systems are in place to prompt providers to coordinate follow-up care, resources and appointments before transferring the person	
	Systems are in place to ensure the organisation is health literate (refer to Health Literacy surveys)	
	Systems are in place to use resources to educate people about how to self- manage their condition	
RATE	**SHARING COMMUNICATION**	**EVIDENCE**
	Consumer and Community Engagement	
	Information (including the transfer plan) is provided to the person in a format that respects a person's health literacy	
	Appropriate and timely information is shared between providers	
	Consumers are provider with a contact number back into the organisation to address questions/concerns about their treatment	
	Professional and Provider Interaction	
	General practitioner is encouraged to be involved in the transfer of care plan (where appropriate)	
	Staff ensure referrals are standardised, timely, complete and acknowledged	
	System Integration	
	Systems are in place to facilitate communication with GPs	
	Systems are in place to use standardised referral templates	
	Systems are in place to support the timely communication of referrals	
	Systems are in place to acknowledge receipt of referrals	
	Systems are in place to audit referrals for quality and timeliness	
RATE	**SHARING DOCUMENTATION**	**EVIDENCE**
	Consumer and Community Engagement	
	People receive a clearly documented transfer plan	
	People are not subjected to multiple assessments unnecessarily	
	People receive a copy of their medication list	
	Professional and Provider Interaction	
	Organisational staff give written communication that is person-centred, appropriate and timely	

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RATE	SHARING DOCUMENTATION (continued)	EVIDENCE
	Organisational staff give written communication that is legible, free of acronyms and based on a clearly articulated plan	
	Organisational staff give written communication that provides a contact back into the organisation should further information be required	
	System Integration	
	Systems are in place for a shared single assessment and transfer template in a secure, private and accessible format	
	Systems are in place for patients to receive a current and legible medication list	
	Systems are in place for the medication list to be provided to the general practice home and/or to the receiving provider	
	Systems are in place to flag people taking ≥ 3 medications or high-risk medications for medication counselling	
RATE	**SHARING COORDINATION**	**EVIDENCE**
	Consumer and Community Engagement	
	People experience coordinated transfers of care	
	People are aware of referred services, who, why and when they are attending	
	People are aware of future appointments	
	Professional and Provider Interaction	
	Organisational staff understand the scope of their role during the transfer process	
	Organisational staff follow protocols for the communication feedback loop	
	Organisational staff participate in the evaluation of their transfers of care	
	System Integration	
	Best practice clinical guidelines are being used	
	Policies and procedures clearly outline transfer processes, and role delineation	
	A communication feedback loop exists (referring organisation → receiving organisation → referring organisation)	
	There is a multidisciplinary approach to a person's care	
	There are protocols to evaluate transfer of care process and experience	
	There are processes for consumer complaints, compliments and incident management that enable collaborative learning opportunities	