



Jamie's Story

Jamie often creates a big disturbance when he is with new people and in unfamiliar situations. His hip replacement operation had the potential to cause disruption and anxiety to himself—and to others.

Can we do better?

Jamie had a positive outcome. Were all of the issues listed in the Guidelines for Shared Transfer of Care addressed? Can we use any of the good practices evidenced here in other situations involving health and community care for older Tasmanians?

Jamie is a fifty-year-old man with Down's syndrome who has lived in a supported group home since his mother died three years ago. Recently, Jamie was booked for a hip replacement. As was protocol for the hospital, Jamie attended the pre-admission clinic (PAC) with a carer from the group home. Jamie has several issues:

- He has poor communication skills.
- He becomes anxious easily, particularly around people he doesn't know. He becomes very loud and shouts out when distressed.
- He is unable to provide his own consent and has an appointed guardian.

The nurse in the pre-admission clinic took a proactive approach to ensure Jamie's admission was smooth:

- She arranged for Jamie to see the anaesthetist prior to admission (this is normally done in hospital on the morning of surgery).
- She ensured that the guardian would be present at admission to authorise consent with the surgeon.
- She advised his carers of his increased care needs upon discharge and arranged for equipment in his home.
- In collaboration with carers, a communication chart was devised with pictures so that Jamie would be able to communicate his needs (pain, toilet, showering, etc.). This was provided to the ward on Jamie's admission.
- Jamie and his carer had a consultation with the physiotherapist at PAC, who advised on exercises to be practised prior to admission.
- Prior to his admission, the ward and theatre were notified of Jamie's anxiety and difficulty in communicating. A private room was made available, with a carer available to support Jamie at critical times of the day (showering, exercises etc.).

Jamie was admitted, had his surgery, and was discharged on day six after an uncomplicated recovery. His preoperative procedures were smooth as most of the assessments and education had been done in PAC. The carer had explained the use of the communication chart with ward staff and was present at periods through the day to put Jamie at ease and assist the nursing staff in communicating with him. Where possible, Jamie had the same nurse care for him. As the nursing staff was well prepared for Jamie's needs, his periods of anxiety were well managed.

The discharge coordinator was able to meet with Jamie and his carer after the surgery to ensure that all discharge plans were in place. As his discharge needs had been anticipated, there was no delay when he was ready to go home. The carers knew his estimated length of stay and were ready with the increased resources that would be required during his recovery period.

Two weeks after his discharge, Jamie's carers sent an informal email to the discharge coordinator advising that Jamie was progressing well in his recovery and was slowly returning to his pre-surgery independence.



Joe's Story

The hospital has discharged Joe and told him to see his GP that day. The GP is unable to get any written records from the hospital—or even any details over the phone.

Can we do better?

A less diligent—or more overworked—practice nurse might not have checked that the community nurse had received the referral. How can we ensure that communication to health providers has been received?

How can we improve the sharing of hospital records with those who need this information?

Joe had made an appointment at a busy general practice on a Friday afternoon.

Joe had been admitted to hospital four days prior with a transient ischaemic attack (TIA), and though he had no residual effects, he had been put on twice daily (anticoagulant) clexane injections. He had been given a box of ten to take home and told to continue with them until he received notification of his outpatient appointment. He had been discharged from hospital in the morning and told to see his GP that day to ensure he was given his injections.

The GP saw Joe. There had been no notification of admission or discharge from the hospital. Luckily Joe had brought the box of clexane with him, and the GP was able to identify which "injections" Joe was referring to. The practice nurse contacted the hospital in order to obtain Joe's file notes and treatment plan. She was advised by the ward that these had been sent to medical records, yet medical records had no record of them. The acute care nurse (that the practice nurse spoke to) was unable to assist because she "had not looked after Joe during his stay".

The decision was made to ensure Joe received his twice-daily clexane and to follow up with more information on Monday. The GP realised that due to Joe's arthritic hands he would not be able to administer his own injections, and his partner was unwilling. The practice nurse was called and charged with the task of ensuring Joe was referred to community nursing. The referral documentation was completed and sent urgently and the practice nurse also followed up with a phone call that afternoon. The referral agency advised that they would send the referral to community nursing but couldn't guarantee service over the weekend due to the lateness of the referral.

The practice nurse, concerned about the importance of this treatment, contacted the community nursing service, who were not aware of the referral (it was found near the fax machine). The community nurse appreciated the urgency of the referral and assured the practice nurse that the clexane injections would be given over the weekend.

On Monday, after the morning rush, the practice nurse contacted the outpatient clinic on Joe's behalf to chase up his appointment and to find out how long he required the clexane injections. They advised that he had failed to turn up at an appointment that morning at 9 a.m. His file had been returned to medical records, and it would be up to Joe to make another appointment.

When the practice nurse rang Joe, neither he nor his partner knew about the appointment. No discharge summary had been received by the GP. Joe had to wait another week for an appointment and had to return to the GP for another script for clexane. The practice nurse had to call medical records and obtain the latest pathology results.

A discharge summary arrived later that week, stating that Joe had been admitted with TIA, and "discharged to his home residence". There was no mention of medications or the intention to follow up in the outpatient clinic.

Mavis' Story

Mavis has had a fall, but the consulting doctor in the emergency department won't supply a letter or x-ray report for her GP, telling her to just report the details herself. Mavis has Alzheimer's.

Can we do better?

Poor communication, accountability, and no follow-up documentation resulted in an unnecessary repeated x-ray and an unnecessary additional appointment with the GP.

How could these processes have been improved?

Mavis, seventy-six and suffering from Alzheimer's, normally resides in Ballarat, supported by her daughter. Her mobility is average, and she has a history of osteoporosis. She was visiting her son and his family in Tasmania. Her granddaughter had escorted her to help her deal with the flights, as she gets anxious easily.

During her visit she had a fall and broke her wrist. Though initially she said she was fine, the next day Mavis said that her wrist was a bit sore and swollen. With her family she went to the emergency department of the local hospital, where she was diagnosed with a hairline fracture of the radius. The family were advised to buy a wrist splint, as a plaster would be difficult for her to deal with and potentially upset her balance further.

As Mavis was due to fly back to Ballarat the next day, her daughter-in-law, who is a nurse, asked the consulting doctor for a letter and x-ray report for Mavis's GP. The doctor stated that this was unnecessary and that Mavis could tell her doctor what had happened. After being reminded that Mavis suffers from short-term memory loss due to Alzheimer's, the daughter tried again to ask for some documentation, at which time the doctor said to Mavis, "you will be able to talk to your doctor won't you?" Mavis responded, "Of course". It should be noted that Mavis is unable to remember the name or address of her GP.

On return to Ballarat, an appointment was made with the GP, and the daughter spoke to the receptionist at the clinic. A request was made for the x-ray report, and the daughter contacted the radiology department at the hospital in Tasmania, who promised to fax the report to the GP clinic once it had been typed later that day. The receptionist at the GP clinic was also given the phone number of the hospital's radiology department and said she would follow up if the report hadn't been received.

The next day at 5 p.m. Mavis turned up for her appointment, but her GP had not received the report. Neither the hospital's radiology department nor the GP clinic had followed up. By now Mavis was unsure of where the pain was, in her wrist or forearm. Without the hospital x-ray report, the GP had a duty of care to identify the cause of her pain, and justify his treatment regime. The result was that Mavis had to have another x-ray—which proved she had a hairline fracture of the radius—and return the next day for the result.



William's Story

William has dementia. After suffering a stroke, his memory loss and disorientation increase and he shows anxiety and aggression. He reacts badly to antipsychotics given in the hospital, so this medication is stopped. This information, however, is not communicated to his GP who prescribes William these same antipsychotics. William's condition rapidly deteriorates.

Can we do better?

How might we better communicate the rationale behind medication choices, medication history and any adverse reactions?

William was a seventy-four-year-old who was recovering from a stroke and had dementia. Prior to his stroke he had been living at home with his partner, Jill, and was physically able, though he had some memory loss due to the onset of dementia.

After the stroke, William had reduced mobility in his left side and his memory loss and disorientation worsened. The recovery period in hospital was long—sixteen weeks—and during this time his behavioural impairments were increasingly difficult to manage. He became aggressive and easily anxious and was restrained for several weeks while doctors regulated his medication. The agreed goal for his care was to enable him to manage and maintain appropriate social interaction, control impulsive behaviour, and improve anger management. The stroke had impaired William's insight into what was appropriate behaviour. He reacted to some medications, so there were many adjustments before the optimum combination of medications were achieved.

The rehabilitation he received focused on ensuring he could attain some independence in terms of feeding himself and taking care of some basic hygiene.

His family were supportive and were involved in the decision around his care, agreeing to transfer him into the dementia wing of a residential aged-care facility (RACF).

Basic information and existing medication sheets were exchanged between the hospital and the RACF. His GP had not been consulted at any time throughout the hospital stay or the transfer. No mention was made of the difficulty of achieving the correct medication doses.

The family were asked by nursing staff to provide basic information about William, and it was soon obvious that the information provided by the hospital was minimal, and really only provided a snapshot of William's condition at the time of transfer.

William was initially content with his new environment, interacting appropriately with staff, other residents and his family. He was able to feed himself and maintain his own hygiene with minimal assistance. However, once he realised he was not going home after the first week, he became highly agitated and aggressive, and started throwing things at staff.

His GP—who hadn't received the full history from the hospital—was contacted. He consulted with a colleague who had experience in aggressive behaviours in dementia patients, resulting in a change of medications from the successful combination that had been achieved over several weeks.

William had reacted badly to the anti-psychotics he had been given in hospital; they sedated him and further reduced his cognitive function. Unaware of this, the GP prescribed these same medications, and William declined quickly; he was drowsy—falling asleep whilst standing—and could no longer feed himself. He suffered two falls and became more withdrawn, finally becoming bed-bound.

William died five weeks after his transfer.



Charles' Story

It's Wednesday afternoon, and Charles—out of hospital for almost a week—is deciding if he's leaving his house today. His wound is red, tender and swollen, and he's feeling a little shaky.

Can we do better?

Charles had a raging wound infection which took ten days of intravenous antibiotics and many months to heal properly. He had a very poor experience and outcomes, and the health system had an unnecessary cost.

After being hospitalised for his infection, Charles was sent home with community nursing, domestic care support and frozen meals. He was extremely grateful—and frustrated. Why hadn't these been arranged first time around?

Charles is a fifty-seven-year-old man living in Hawley on the north-west coast of Tasmania. He lives alone, but has managed very well since his wife died five years ago. He is supported by his mates at the club that he visits four afternoons a week for a drink and a meal. He gets the rest of his meals himself, but at the moment he has very little food in his house. Since coming home from hospital six days ago, he hasn't felt like shopping. His friend who drove to Hobart to pick him up left him with some bread and milk, but that has run out.

Charles admits he has been hard on his body. He has been a smoker, enjoyed his food, and probably has had "a couple too many beers over the years". He has also worked long hours in a stressful job. He has had a heart attack, has type 2 diabetes and gets short of breath easily. His legs have been aching a lot lately. Six weeks ago he developed acute pain and was told the artery was blocked. After some tests in Launceston, the blockage cleared, but he was told he needed urgent surgery in Hobart and that he might lose his leg.

He was taken to Hobart by a mate. As a pensioner, Charles couldn't afford to pay for accommodation to come down the night before. Needing to be there at 7 a.m., they had a very early start.

He woke from the surgery incredibly relieved to still see his leg, but the surgery and the stress of the recent weeks had taken their toll. Charles was exhausted. He was surprised on day three to be asked, "How will you get home to Hawley?" and was eventually thanked by staff for not "abusing the system" when he was able to arrange another friend to drive down and collect him.

He was discharged from hospital but can't remember being given instructions on what to do with his wound, only that he was given an implement to "take out the staples". He admits that he was not "firing on all cylinders". "I don't think the nurses realised how much this had affected me."

Now back in Hawley for almost a week, Charles needs to decide if he is going out to the club for his main meal. It's Wednesday 3.30 p.m. and he's not feeling well.

He has been showering daily to "keep the wound clean" and removed the dressing when it was all wet. He has noticed over the last few days that the wound is starting to look red, feels quite tender, and is starting to "leak some fluid which was initially thin but is getting thicker and greyish in colour."

The skin is looking red and swollen where the staples are, so it occurs to him that the staples are irritating his skin. "Perhaps if I take them out it will feel better". He finds the staple removers and figures out how they worked.

As he removes the staples, the wound suddenly bursts open with "a lot of muck pouring out". Charles is feeling very unwell at this point and decides to call his mate, who rapidly drives Charles to the local regional hospital.

While they are asking Charles all the assessment questions, he becomes irritated and says, "You should know this from the other hospital. Call my GP. He will fill you in". The GP is contacted, but he is unaware that Charles has been to hospital.



In Tasmania





What is Person-centred Care?

Person-centred care is a way of working that puts people at the centre of their health care. In a person-centred approach, health and social care professionals work collaboratively with people who use services.

Person-centred care:

- enables people to develop the knowledge, skills and confidence they need to more effectively manage and make informed decisions about their own health and health care
- is coordinated and tailored to the needs of the individual
- ensures that people are always treated with dignity, compassion and respect.

The term 'person-centred care' is used to refer to many different principles and activities. There is no single agreed definition of the concept, as person-centred care is still an emerging and evolving area. What it looks like will depend on the needs, circumstances and preferences of the individual receiving care. What is important to one person in their health care may be unimportant, or even undesirable, to another. It may also change over time, as the individual's needs change.

Why do we need to practise person-centred care?

Many people want to play a more active role in their health care, and there is growing evidence that approaches to person-centred care such as shared decision-making and self-management support can improve a range of factors, including a person's experience, care quality and health outcomes.

What does person-centred care look like?

- It provides people dignity, compassion and respect.
- It offers coordinated care, support or treatment, that meets the identified goals of the person.
- It supports people to make informed decisions about their health and wellbeing.
- It supports people to recognise and develop their own strengths and abilities to enable them to live an independent and fulfilling life.

How do we put person-centred care into practice?

Some ideas include:

Collaborative care and support planning. A way of supporting people to work in partnership with health care providers to plan their care. The process involves exploring what matters to the person, identifying the best care, and supporting them to set goals and think about actions they can take to reach them.

Experience-based co-design. A method for improving people's experience of health care that involves gathering experiences of patients and staff and bringing them together to develop service improvements.

Self-management support. A whole-system approach to support people with chronic conditions to manage their health on a day-to-day basis. Every day, anyone living with a chronic condition will make decisions, take actions and manage a broad range of factors that contribute to their health. Self-management support acknowledges this, and enables people to develop the knowledge, skills and confidence they need.

Shared decision-making. A key element of person-centred care is shared decision-making, in which the consumer brings their lived experience, needs, values and care preferences, and combines this with a provider's professional expertise and experience. This is a collaborative process in which both parties' contributions are valued and acted upon.

Adapted from Person Centred Care Made Simple, The Health Foundation <http://www.health.org.uk/sites/default/files/PersonCentredCareMadeSimple.pdf>



ISOBAR SHARED Planning Checklist

It's OK
to ask



ISOBAR SHARED

SHARED
TRANSFER
OF
CARE
PLANNING
CHECKLIST

I	Identify Have you introduced yourself and do you know the person's name?	S	Safe Have you considered what support is required for the person to transfer safely?
S	Situation Have you identified the person's current health issue?	H	Heard Have you listened to the person's concerns?
O	Observations Have you identified the person's needs and risk factors?	A	Agreed Plan Does the plan reflect the person's goals and concerns?
B	Background Do you know the person's other relevant problems or issues?	R	Relationships Have the important people in the person's life been included?
A	Assessment Have you assessed the person's understanding of their condition and needs?	E	Easy Information Have you given the person information that is easy to understand?
R	Recommendation Is there an agreed plan for recommended ongoing care?	D	Destination Do you know where the person is going to next and have appropriate arrangements been made?





SHARED Planning Checklist

It's OK
to ask

SHARED
TRANSFER
OF
CARE

PLANNING CHECKLIST

S

Safe

Do you feel safe and supported?



H

Heard

Have you been heard and understood?



A

Agreed Plan

Does the plan reflect your goals and concerns?



R

Relationships

Have the important people in your life been included?



E

Easy Information

Have you received useful information that is easy to understand?



D

Destination

Do you know where you're going next and have the arrangements been made?



Elsie's Story

Elsie has a hard time remembering things, but every time that Elsie sees a clinician, she's expected to retell all the details of her medical history. Her family find it difficult to get information.

Can we do better?

What systems can we set up so that:

- Adequate information is provided to consumers after time in hospital?
- Clinicians can easily contact each other to share information?
- Shared assessment templates are made available to all care providers?
- Collaboration and coordination of care are improved?
- Family are informed about assessments?

Elsie, eighty-seven, was living independently in a unit complex attached to an aged-care facility.

Apart from some domestic assistance every two weeks, she was completely self-sufficient. She was socially connected to her local community and still driving her own car, but suffered from heart disease, short-term memory loss and severe osteoporosis. Because of the osteoporosis, she needed a total hip replacement.

After the operation, her cognitive impairment became more apparent, and she struggled with any instructions or new information. While still in the hospital—and with no family present—she was assessed for on-going home care. When her daughter visited, Elsie asked her to interpret the information left behind by the service provider. To Elsie, the three brochures the service provider had left were “meaningless” and “double Dutch”. Elsie described her hospital stay as like “being in another world”.

In the hospital, Elsie was taken off the heart medication (the white pill—as she described it) that she'd been taking for the last thirty years. She was told to see her GP about this. Her family arranged for Elsie to see her GP one week after discharge, but the practice had not received any information about her hospital stay, the medication changes or the care plan.

Unfortunately, this lack of communication continued. Over the next eight months, Elsie had twelve more interactions with health sector organisations, each one requiring a new assessment, with Elsie or her family having to repeat the same story over and over. When the family were not present, Elsie's declining cognitive function meant that the details she provided were often fragmented, with important snippets of information forgotten.

It was only toward the end of this period that health providers began to actively review previous assessments and consult with each other.

Elsie's family included medical professionals who were ready to support and advocate for her. But even though they had an understanding of the health system and the services available, they were not able to prevent Elsie's repeated assessments, being told that these were procedural requirements of the organisations.

All of the clinicians involved in Elsie's care had good intentions and supported her where they could, but all were bound within their organisational processes. In one incident, for example, Elsie had a fall while out in the community. The paramedics who attended were very supportive in picking her up and assessing her condition. They patched up some broken skin and drove her home when she said she did not want to go to hospital.

However, there were no established systems in place for them to alert other services or family members, and not having a full history, they were unaware of Elsie's declining cognitive functioning. Elsie's family only found out about the incident when they later discovered her unconscious on the floor, and took her to the hospital emergency department. Elsie was eventually admitted to an aged-care facility, where she resides today.

Draft Transfer of Care Plan* (Page 1 of 4)

IDENTIFICATION – PATIENT INFORMATION	
Family Name	Given Name
Preferred Name	UR
DOB	Gender
Home Address	Discharge Address (if different)
Contact phone numbers	Country of birth
Home	Preferred language
Mobile	Interpreter required
Work	Indigenous status
Email	
Living Arrangements	Lives with
Next of Kin	Emergency Contact
Address	Address
Home	Home
Work	Work
Mobile	Mobile
Relationship to Person	Relationship to Person
General Practitioner	Employment Status
Practice Name	Government benefits/pension type
Address	Card number
Phone	Health care card status
Fax	Card number
Admitting Doctor	Medicare care number
Private Health Insurance	DVA entitlements
Fund	Card type
Card number	Card number
Consumer Agrees to referrals	
Signature	

*Provided with kind permission of Calvary Health Care Launceston. This template is currently under development, review and trial as a Shared Transfer of Care plan to be given to consumers, general practitioners, and community service providers.



Draft Transfer of Care Plan* (Page 2 of 4)

IDENTIFICATION – REFERRER INFORMATION	
Hospital	
Ward	Phone
Name	Position
Signature	Date
Date of First Visit	
Written/Phone Feedback to Calvary Health Care Launceston required Yes/No	
Identification – Consumer Goals of Care	
What are the person's identified goals of care, needs and their understanding of their condition?	
IDENTIFICATION – REASON FOR REFERRAL	

SITUATION – WHAT IS CURRENTLY GOING ON?	
Admission date	Reason for admission
Discharge date	
Procedure performed	Discharge diagnosis
Significant events during admission	
Home in the care of	
Other information	
BACKGROUND	
Clinical and social history, and if relevant advanced care directives and care plans:	

Draft Transfer of Care Plan* (Page 3 of 4)

ASSESSMENTS – CURRENT NEEDS			
Risks, Allergies & Alerts (including falls)			
Functional Status (mobility, aids required, cognitive status, ability to perform regular activities)			
Clinical Assessments			
Current treatment received			
Radiology/pathology results (including pending results)			
RECOMMENDATIONS – FOR CARE OR ACTION, AGREED PLAN REFLECTING GOALS OF CARE			
Activity limitations and instructions:			
Management plan for medications			
<input type="checkbox"/> Medication Profile given to person / caregiver			
<input type="checkbox"/> Medication chart (if required)			
<input type="checkbox"/> Medications supplied			
<input type="checkbox"/> Webster Pack			
Medication recommendations & information			
Pharmacist (name and contact)			
Follow up			
Care of wounds/sutures			
Interventions required			
Other Information			
Follow up appointments			
With	Date	Time	
With	Date	Time	
With	Date	Time	
With	Date	Time	



Draft Transfer of Care Plan* (Page 4 of 4)

Health Care Providers currently involved in person's care (i.e. Community Nursing, Community Aged Services)				
Name	Contact	Services Provided	Referral Sent / Ongoing Service	Acknowledged
Emergency Contact Number				
Crisis Contact Number				
Ward Contact Number				
Transfer plan discussed with person/caregiver and checked for understanding.				
Consent given for sending to follow up providers, General Practitioner and health services (if required) Yes / No				
Name			Signature	
Staff Name			Signature & Designation	

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How can we improve Shared Transfer of Care?

How can we, individually and together, improve Shared Transfer of Care?

Finding opportunities for change often begins by noticing what could be improved.

Sometimes it is expressed as wishes; "I really wish we could..."

Sometimes it is expressed as a complaint; "It annoys me that we're not..."

Either starting point is fine.

Flip these statements into possible challenges.

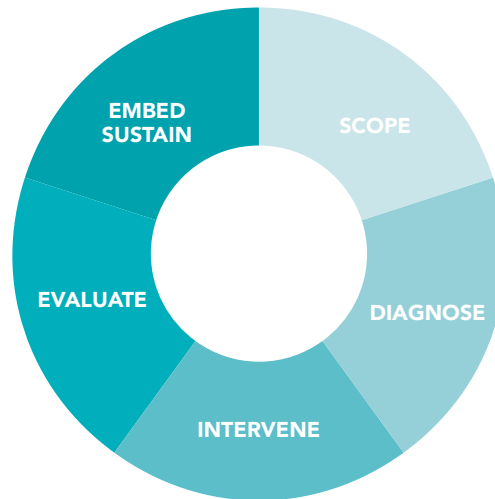
Beginning your question with "How might we...?" changes the problems into opportunities!

List your ideas below.

In a group setting, these ideas could be collectively prioritised to decide what changes to implement.

THINGS THAT COULD BE BETTER	HOW MIGHT WE...?
THINGS I WISH WOULD FOR	HOW MIGHT WE...?

The Theory of Constraints



The Theory of Constraints

System and process redesign is more likely to be successful when done systematically.

A flexible, phased example of redesign is called the Theory of Constraints, which states that in any complex system there are only a few factors (constraints) that limit performance.

The theory explores the factors or constraints that limit performance or change. It seeks to identify and strengthen the constraints of people, policies or equipment. Five focusing phases are worked through as part of exploring and implementing solutions (see figure below).

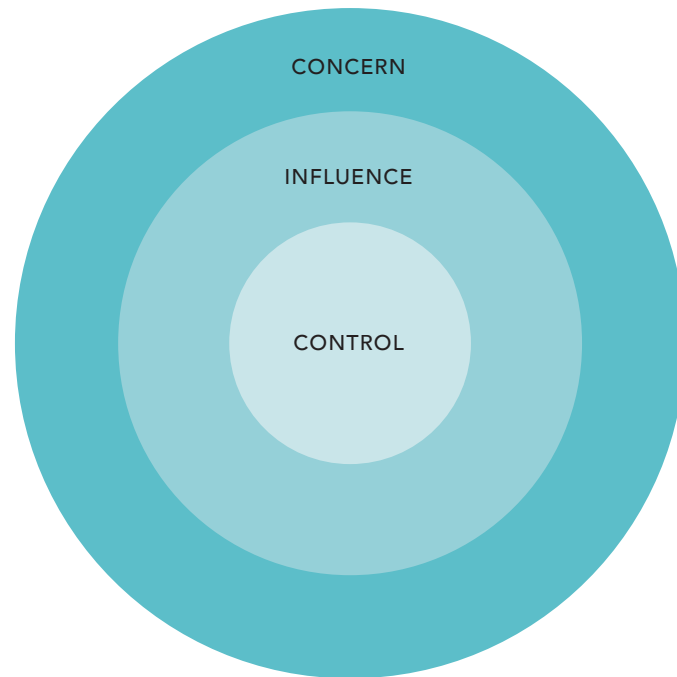
The phases include:

- defining the scope of work
- diagnosing the issues
- developing appropriate interventions
- evaluating the outcomes
- sustaining the improvement.

Sustainability is the end-product of good improvement design.

This information is adapted from the document 'Redesigning Hospital Care Program: An introduction to process redesign' from the Victorian Department of Health. Please see the Resource List on the Shared Transfer of Care web page at www.primaryhealthtas.com.au to download the full publication.

The Circle of Influence



Circle of Control

This is what we have the ability to control, and may be responsible for.

Circle of Influence

We may have some influence over certain outcomes and can invest some energy in this area.

Circle of Concern

Here lie areas of work that are out of our control, but we are aware of their relative importance.

Understanding and focussing on what we can control and influence, rather than what concerns us (but over which we may have no influence) can help us prioritise.

Potential benefits of people-centred and integrated services

Achieving people-centred and integrated care would have a dramatic effect upon peoples' experience of services. It would also offer broad societal benefits by reorienting service delivery to a model that emphasises the co-production of care by individuals, communities and workers. The range of potential benefits are outlined below*.

To individuals and their families	To health professionals and community workers
<ul style="list-style-type: none"> ➤ 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. 	<ul style="list-style-type: none"> ➤ 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
<ul style="list-style-type: none"> ➤ 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. 	<ul style="list-style-type: none"> ➤ 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.

The provision of health services must go beyond an emphasis on the hospital sector and specialist services towards a more coordinated approach that embraces primary and community care-led strategies and has the potential to be a more cost-effective way of delivering care.

To make the needed service delivery reforms, it will be necessary to contest current patterns of power, compel changes in provider attitudes and question strongly held beliefs about the types of health services that are most valuable. This strategy proposes reforms to reorient health services, shifting away from fragmented provider-centred models, towards health services that put people and their families at their centre, and surrounds them with responsive services that are coordinated both within and beyond the health sector.

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



Shared Transfer of Care Training (Page 1 of 2)

Thank you for your participation in this training session. To help us improve the session, please complete the brief survey below by circling the most appropriate answer.

1. The training helped me to identify how I could use my learnings in the workplace/organisation.

Strongly disagree	Disagree	No opinion or uncertain	Agree	Strongly agree	Very Important
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2. I have been equipped with skills, knowledge and tools to transfer my learning into my workplace/organisation.

Strongly disagree	Disagree	No opinion or uncertain	Agree	Strongly agree	Very Important
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3. I have been equipped with resources to transfer my learning into my workplace/organisation.

Strongly disagree	Disagree	No opinion or uncertain	Agree	Strongly agree	Very Important
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4. How important is it to you that your consumers with long-term conditions are able to determine when they need to go to a medical professional for care, and when they can manage the problem on their own?

Strongly disagree	Disagree	No opinion or uncertain	Agree	Strongly agree	Very Important
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5. My expectations of Shared Transfer of Care facilitator training were met.

Yes	No
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Why or why not?

6. How do you think Shared Transfer of Care facilitator training could be improved?



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7. What other resources do you need to support you to facilitate the Shared Transfer of Care training in your organisation?

8. Do you need further training to support your participation in Shared Transfer of Care?

Yes	No
If yes, please specify your additional training needs:	

Thank you for completing this survey. It will help us improve the program.



Shared Transfer of Care Principles (Page 1 of 2)

Before the workshop: Answer Question 1 and Part A of Questions 2-7

After the workshop: Answer Question 8 and Part B of Questions 2-7

1. In your experience, what do you consider to be important considerations for transfer of care?

a.

b.

c.

d.

e.

2. Rate your knowledge of what needs to change in your workplace to improve transfers of care.

	No knowledge	Minimal knowledge	Some knowledge	Extensive knowledge
A Before the training				
B After the training				

3. Rate your knowledge of how to implement these proposed changes in your workplace.

	No knowledge	Minimal knowledge	Some knowledge	Extensive knowledge
A Before the training				
B After the training				

4. How important is it to you that your consumers with long-term conditions are able to determine when they need to go to a medical professional for care, and when they can manage the problem on their own?

	Not important	Slightly important	Neutral	Moderately Important	Very Important
A Before the training					
B After the training					

5. How important is it to you that your consumers with long-term conditions knows what each of their prescribed medications does?

	Not important	Slightly important	Neutral	Moderately Important	Very Important
A Before the training					
B After the training					



Shared Transfer of Care Principles (Page 2 of 2)

6. How important is it to you that the provider initiating the transfer of care provides complete information about the consumer to the receiving provider?

	Not important	Slightly important	Neutral	Moderately Important	Very Important
A Before the training					
B After the training					

7. How important is it to you that the provider initiating the transfer of care involved the consumer in their transfer planning?

	Not important	Slightly important	Neutral	Moderately Important	Very Important
A Before the training					
B After the training					

To be completed **after** the session.

8. What are five key steps for best-practice transfer of care?

1.
2.
3.
4.
5.

Thank you for your participation.