COMMUNICATION AND TEAMWORK

[Your organisation's name / logo]

2 PAGES

SHARED TRANSFER OF CARE

Guide to Role Delineation

Background

Shared transfer of care requires a coordinated approach to ensure that people can access the care they need as determined by the transfer plan. Transfer planning should be strengths-based; i.e. should identify the strengths of the person, their family and the support around them, as well as determining the most appropriate and achievable outcomes for the person. Transfer planning is **shared,** with assessments, accountability and information shared openly between the person and all relevant providers. To be person-centred, transfer planning must commence prior to or on admission, and is a continuing process throughout the person's stay at **<service/facility>.**

Role delineation will assist team members to understand what part of the shared transfer of care process they are accountable for. Every organisation will be different; some will employ specific staff to support those people who require complex transfer-of-care planning. However, every clinician has a responsibility in developing, reviewing and updating the transfer plan **in consultation** with the person, family/carers and/or other health providers who are a part of that person's healthcare team.

Example of what some of these roles may involve are provided below, but we acknowledge that other staff may be involved in the Transfer of care process.

Nurse Unit Managers

- Develop a strong and positive culture of person or patient centred care in order to engage the person, their family/significant others/carers in all aspects of the transfer of care.
- Support staff to implement the policy and if required adapt it to specific departmental /unit/organisational circumstances, through the use of policies, procedures, mandatory training, and effective resources (both tools, time and education).
- Promote the importance of effective and timely communication relevant to individual health literacy standards.
- Promote the importance of teamwork in improving transfers of care.
- Support the development of appropriate communication and meaningful relationships between external providers, and understand the services each provide including capacity/capability.
- Develop a resource of these external community based providers in order to support staff in understanding each provider and the services they offer.
- Undertake regular audit and evaluation of the transfer of care processes and involve people (including staff) to gauge their experience/s.

Ward/Residential Care Facility Nurses

- Contribute to and support the implementation of the policy within your work area.
- Engage the person, their family/significant other and carers in transfers of care.
- Support effective, timely and appropriate communication according to the health literacy standard of the person.
- Support and encourage collaborative teamwork within your department/ward area, between external providers.
- Be responsible for attending (or completing online) mandatory training for shared transfer of care.
- Develop the knowledge of the transfer of care tools, procedures and service provider information and capacity/capability.
- Become a Champion for shared transfer of care within your department/ward area.

Visiting Medical Officers (VMO)

- VMO contributes to and supports the implementation of the Shared Transfer of Care policy between all providers regardless of the setting.
- Communicates with the person and their family/ significant other/carer to provide clinical advice on requirements and appropriate timing of transfer planning.

- Ensure an accurate understanding of the health literacy of the person/family/significant other/carer (engage interpreter service if necessary for language barriers).
- VMO will support a shared decision-making process, providing the person, family/carers with the information required to assist them to make responsible decisions for their ongoing health care.
- Keeps person and ward/organisational staff informed re anticipated date of transfer away from <service/facility>, giving as much notice as is possible to ensure a safe, timely and smooth transition/transfer.
- Communicates where appropriate, with the person's general practitioner or practice as soon as practical after admission. Communication remains open during the episode of care.
- Communicates with other specialist medical teams/allied health professionals when and where appropriate.

General Practice (GP/Practice Nurse)

- Where possible the person's general practitioner should be identified early in the person's admission.
- Communication regarding the admission/transfer of care should be generated/forwarded to the GP.
- The GP should be invited to have input into the transfer plan, including being invited to case conferences where appropriate.
- The GP should be sent a copy of the transfer plan as soon as possible after the person is transferred from the organisation, noting in particular why the person was admitted, the treatment they received, changes in their care, (particularly medications), and all follow up plans/appointments/referrals.
- A Practice Nurse is often aware of social and family situations, have a broad understanding of the person's medical background, and can also be a conduit to liaise with a GP.

Transfer of Care Coordinators

- Some organisations employ specific 'discharge planners/coordinators'. Their role is to specifically assist those people with complex transfer planning needs. These staff could be case managers, nurses, social workers, occupational therapists or other allied health staff. Where these staff are specifically employed there can sometimes be a lack of accountability from other clinical staff, who do not see transfer of care planning as part of their role. Often these services are only available during business hours, and people/patients/consumers entering a health organisation after hours can be disadvantaged, as clinical staff are not aware of appropriate services or referral pathways.
- Transfer of Care Coordinators or teams, should endeavour to act as a support to general clinical staff, educating them about services available, appropriate referral pathways and instilling the importance and value of good transfer planning. They should only be involved where the planning is very complex.

Community Nurses

- Community Nurses are a valuable resource during the transfer of care planning.
- Where they have previously been involved in a person's care, they are aware of social and family situations that may impact on a person's transfer of care plan.
- CN are highly skilled and able to provide a range of services in the home, but these may vary depending on the team size and capacity as well as geographical location/s.
- CN should be contacted early in a person's tertiary care stay, to provide input into what is available and realistic care/goals that can be provided/attained in their community.
- Referrals from GP to community nursing is also available as a means to avoid unnecessary hospitalisation.

Allied Health Professionals

- May include (but not limited to) Occupational Therapist, Social Worker, Pharmacists, Podiatry, Speech Therapist, and Physiotherapist.
- Each may have a varied role in the transfer process, often to ensure the person feels safe, supported and have the resources necessary to transfer out of an organisation/ward/unit.

Community Service Providers

- Access to community provider is usually through the My Aged Care Gateway.
- However, where a community provider is already engaged to support a person to be safe and supported in their home environment.
- they should be identified and notified early on in the admission.
- requested to provide any relevant information around current services.
- have input into the transfer planning.