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**TOOLS**

**Organisational Self-Assessment** (Page 1 of 3)

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**Shared Transfer of Care**

**RATE**

**SHARING POINT**

**EVIDENCE**

**SHARING WITH PEOPLE**

**Consumer and Community Engagement – People:**

[ are informed of timeframes before the transfer occurs (and their carers)

[ are provided with access to their own information

[ are asked to nominate their general practice home

**Professional and Provider Interaction – Organisational staff:**

[ discuss transfer of care timeframes with people and their families

[ provide people with access to their own information

[ 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

[ 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

[ to prompt people and their carers to identify their general practice home

**SHARING ACCOUNTABILITY**

**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

[ understand the information provided to them and can follow instructions about their care

[ 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

[ utilise techniques to ensure information is understood by people and their carers and make sure that people understand the information provided to them

[ educate people about strategies to support their self- management

**System Integration – Systems are in place:**

[ to prompt providers to coordinate follow-up care, resources and appointments before transferring the person

[ to ensure the organisation is health literate (refer to the Health

Literacy Survey)

[ to use resources to educate people about how to self-manage their condition

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**Shared Transfer of Care**

**RATE**

**SHARING POINT**

**EVIDENCE**

**SHARING COMMUNICATION**

**Consumer and Community Engagement – People:**

[ 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 provided with a contact number of the organisation to address questions/concerns about their treatment

**Professional and Provider Interaction – Organisational staff:**

[ 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

**System Integration – Systems are in place:**

[ to facilitate communication with General Practitioners

[ to use standardised referral templates

[ to support the timely communication of referrals

[ to acknowledge receipt of referrals

[ to audit referrals for quality and timeliness

**SHARING DOCUMENTATION**

**Consumer and Community Engagement – People:**

[ receive a clearly documented transfer plan

[ are not subjected to multiple assessments unnecessarily

[ receive a copy of their medication list

**Professional and Provider Interaction – Organisational staff:**

[ is person-centred, appropriate and timely

[ is legible, free of acronyms and based on a clearly articulated plan

[ provides a contact number of 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

[ for patients to receive a current and legible medication list

[ for the medication list to be provided to the general practice home and/or to the receiving provider

[ to flag people taking more than 3 medications or high-risk

medications for medication counselling

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**TOOLS**

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**Shared Transfer of Care**

**RATE**

**SHARING POINT**

**EVIDENCE**

**SHARING COORDINATION**

**Consumer and Community Engagement – People:**

[ experience coordinated transfers of care

[ are aware of referred services, who, why and when they are attending

[ are aware of future appointments

**Professional and Provider Interaction – Organisational staff:**

[ understand the scope of their role during the transfer process

[ follow protocols for the communication feedback loop

[ participate in the evaluation of their transfers of care

**System Integration – Systems are in place:**

[ 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 processes and experience

[ there are processes for consumer complaints, compliments and incident management that enable collaborative learning opportunities