

## Shared Transfer of Care Policy (Page 1 of 3)

### Rationale

The transfer of care process plays an important role in enhancing health outcomes, reducing readmissions to hospital, improving efficiency and improving flow through health and community services.

Transfer of care between services is experienced by the majority of people at some stage of their lives. Older people with chronic and complex health needs are more likely to experience multiple transfers between sectors.

Where transfer of care planning is poorly prepared, people (particularly the elderly) are at a higher risk of experiencing events that will negatively impact on their experience, clinical outcomes, health and wellbeing, and importantly, their ability to proactively manage their chronic illness.

Effective shared transfer of care across services requires the process to be person-centred, i.e. working in partnership with the person and/or important significant others in their lives at all points of the transfer planning. As well as effective shared transfer of care, the system requires effective sharing of communication (both written and verbal), coordinated care and a shared accountability approach. The responsibility for the transfer of care is shared between providers and with the person, until sufficient information has been exchanged to ensure a quality and safe continuity of care.

This policy is supported by the Shared Transfer of Care Procedure and will use the Shared Transfer of Care Principles and SHARED concept as the framework, to ensure that at the point of transfer people will feel:

- safe and supported
- their goals and concerns are heard
- an agreed plan is developed and shared
- important relationships are identified and are included in the transfer plan (i.e. family/carers and/or other service providers)
- information that is easy to understand and consistent is provided to the person and other providers
- the transfer destination is identified, and appropriate arrangements made (i.e. transport, follow up appointments) and communicated to the person and referred provider in a manner/language that is clearly understood.

### Definitions

The term 'discharge' is referred to as 'transfer of care' throughout this policy. This is because a person's health care does not end when they leave a facility. 'Transfer of care' demonstrates that a person's care continues beyond that facility as they receive care from another service/facility/or in the community e.g. General Practitioner, community health providers, other organisation or the person and/or their carers.

This policy, as underpinned by the Guidelines for Shared Transfer of Care, is to put the person at the centre of their own care, and where possible, the traditional word 'patient' or 'client' has been replaced with 'person'.

### Quality

This policy aims to align with the values and mission statement of <organisation> and should be read in conjunction with the following Australia standards:

- Australian Aged Care Quality Agency, Accreditation Standards
- Australian Commission on Safety and Quality in Healthcare, National Safety and Quality Health Service Standards
- Australian Association of Social Workers, Practice Standards
- Australian Medical Association, Position Statement General Practice/Hospitals, Transfer of Care Arrangements 2013
- Community Care Common Standards
- National Mental Health Standards
- Occupational Therapy Board of Australia, Code of Conduct
- Pharmaceutical Society of Australia Professional Practice Standards
- Royal Australian College of General Practice, Standards for General Practice

Refer to Resources on the Shared Transfer of Care webpage at [www.primaryhealth.tas.com.au](http://www.primaryhealth.tas.com.au) for links to applicable standards

## Shared Transfer of Care Policy (Page 2 of 3)

### Scope

This policy applies to all staff members involved in transferring the care information of a person to another service provider or the family/carers or the person themselves.

All staff members involved in the care of a person within are responsible for shared transfer of care.

### Policy statement

<Facility / service name> will:

- › demonstrate a commitment to Shared Transfer of Care
- › develop a culture of person-centred care and engage people, families and their carers in the transfer of care process
- › establish, implement and monitor processes that ensure the safe and effective transfer of <persons> and information within its services and between other health and aged/residential care providers
- › acknowledge the role shared decision-making between the person and their families/carers and healthcare providers, to determine the goals and requirements of transferring care
- › work collaboratively with other providers to establish agreed standards, shared protocols and streamlined care pathways for the transfer of <persons> between services
- › meet the standards outlined in this policy.

### Principles

The Shared Transfer of Care Policy is based on the following principles:

- › Person and family-centred care: A respectful and collaborative partnership exists between the provider and the person. The person (and their families and/or carers) are involved in decision-making about care.
- › Integrated care approach, effective communication, and productive relationships within and between organisations to support and sustain an effective shared transfer of care process.
- › Standardised and documented transfer of care procedures and protocols promote consistency of practice and ensure a person's safe transfer.
- › Coordinated approach across all sectors including acute, sub-acute, primary health and aged services providers. This relies on effective and respectful communication between all providers of health and community services.

### Policy in Operation

This policy is to be implemented in accordance with the Shared Transfer of Care Procedures.

### Outcomes

People, their families and carers are actively involved in a planned and effective transfer of care process to improve their health and well-being and reduce the likelihood of poor health outcomes.

## Shared Transfer of Care Policy (Page 3 of 3)

### Responsibilities

As an executive or board member you should foster an organisational climate that supports the safe and effective transfer of people and information within and between health and community services which:

- › has clearly understood transfer of care arrangements
- › promotes a culture of person-centred care across the organisation
- › promotes a culture of teamwork based on mutual respect, and shared communication
- › supports staff mandatory training of *Guidelines for Shared Transfer of Care* through provision of resources and allocated time

### As a manager and clinical leader you should:

- › have clearly understood transfer of care arrangements
- › promote this policy within your areas of responsibility
- › develop and encourage a culture of person- or patient-centred care to engage the person, their families/ carers in transfers of care
- › support staff in the implementation of the policy, and if required, adapt to specific circumstances through the use of policies, procedures, mandatory training, and effective resources (including tools, time and education)
- › promote the importance of effective communication and teamwork in improving transfers of care
- › support the development of good communication and relationships between external providers, and understanding of the services provided along with capacity/capability
- › develop a resource of community-based providers to support staff in understanding service providers and the services/facilities they provide
- › ensure all new clinical staff read and understand the *Guidelines for Shared Transfer of Care* and the principles detailed in this document will be a fundamental part of the <facility / service name> orientation program
- › include the *Guidelines* as part of annual mandatory training/competency
- › undertake regular audit and evaluation of the transfer of care processes

### As a team member you should:

- › contribute to the positive implementation of the policy within your work area, through supporting effective communication and teamwork, both internally and externally
- › engage the person, their families and carers in transfers of care as early as possible in their journey
- › be responsible for attending to annual mandatory training for shared transfer of care (as per the organisations requirements)
- › develop the knowledge of the transfer of care tools, procedures and service provider information and capacity

### Related documents and useful resources

- › *Guidelines for Shared Transfer of Care*
- › *A Facilitator's Guide to Shared Transfer of Care*
- › *Shared Transfer of Care Procedure*
- › *Glossary*