Shared Transfer of Care Procedure

Background

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 aged services.

A person-centred care approach respects the needs, preferences and values of the person, supporting them to make informed decisions, and promotes the active participation by people in their own health care.

This procedure aligns with the principles in the Transfer of Care Policy, and should be considered in line with the Guidelines for Shared Transfer of Care

Aims

Transfer planning

All people experience a well-coordinated, safe and timely transfer out of *<facility / service name>* with an agreed, well-communicated and smooth transfer to the referred organisation or to their own, or family, care.

All people and their carers/family are involved in the transfer planning, with a supported shared decision process acknowledging their treatment goals.

Each person is encouraged and supported to take an active role in the management of their health, and is supported to achieve the highest possible level of independence.

There is effective and timely communication (written and/or verbal) of relevant information to healthcare providers.

The person and their family/carers are provided with a transfer plan, with all appropriate information, and follow-up contact numbers. This needs to be in a format that takes into consideration the patient's ability to understand and absorb information (i.e. their health literacy).

The focus of this procedure 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'.

Definitions

The term 'discharge' is referred to as 'transfer of care' throughout this procedure. 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 (GP), community health providers, other organisation or the person and/or their carers.

Scope

All staff involved in a person's care during their admission to *<facility / service name>* have a responsibility to contribute towards the transfer-of-care plan.

The nurse responsible for the person on the person's last day of care day at *<facility / service name>* has final responsibility to ensure the:

- person has a copy of their transfer plan and can verbalise understanding of arranged treatment/services and appointments
- service providers have correct information, including contact information, required to accept accountability for the transfer of care
- transfer plan documentation is shared amongst appropriate providers, including the person's general practitioner.

Procedure

The Transfer of Care Procedure aligns with the Shared Transfer of Care Method.

Related documents and useful resources

- Transfer of Care Risk Assessment
- Shared Transfer of Care Policy
- Shared Transfer of Care Method

Shared Transfer of Care Procedure (Page 2 of 3)

PREPARE	**Planning is to commence as soon as possible after admission to <facility/service name> or for elective planned admissions through a pre-admission process (either attendance at a clinic, phone call or completion and review of patient admission questionnaires).**
Consult	Once referral or admission pack has been received – if appropriate contact referrer or person to clarify information
Gather	Gather as much information as possible including: › If other providers have been involved › If previous assessments have been completed › Obtain any relevant written letters or test results
Organise	› Make sense of the information › Discover the story
ENGAGE	**Involve the <person/patient> throughout their stay at <facility/organisation>**
Connect	› Connect with the <person/patient> › Discover the person's story › Identify the important relationships – who do they want involved in their transfer plan? Clarify the information received › Build upon the assessment (if required) › Complete a Transfer of Care Risk Assessment
Goals	› Listen to the <person's/patient's> goals and concerns › Identify the person's strengths and the strengths of people around them › What goals are achievable for the person, with the support around them?
Agreement	› With all the gathered information, provide the person with treatment/care options › Use a shared decision-making process to create an agreed plan › Commence the Shared Transfer of Care Checklist › Allow time for the person to consider the plan, discuss with their family/carer and ask further questions › Using a Teach-Back technique, ensure the person understands the plan

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TRANSFER	Collaborative shared transfer process supported by appropriate information shared between health providers and the person themselves
Plan	› Generate the plan – gather relevant information and complete appropriate referrals › Document the plan – should include contact details of all service providers involved in person's care Check the plan with the person – to ensure it meets their agreed goals and addresses their concerns › Revisit the plan and adapt as a person's needs or goals change
Share / Consult	› Email/fax referral to appropriate provider of platform (i.e. General Practitioner and My Aged Care Gateway) › Follow up referral with phone call to clarify any questions › Give a copy of the written plan to the person, and use a Teach-Back technique to ensure they understand › Provide a copy to the person's nominated General Practitioner › Complete Transfer of Care checklist to ensure appropriate sharing of communication has occurred
Follow up	› Ensure the plan contains contact details for the person and providers to call back if issues arise › Contact provider to check on progress › Contact person within 48 hours to check progress (see post transfer check)