

INFORMATION TRANSFER AT CARE TRANSITIONS PROJECT

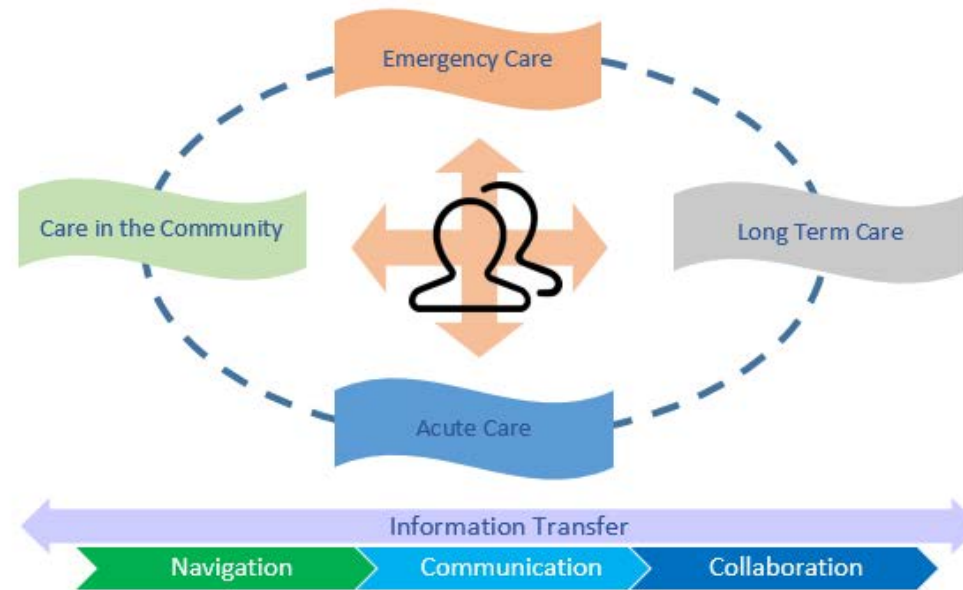
October 2018

GOALS

1. Enhance person-centered care through improved transfer of information at care transitions.
2. Ensure a standardized set of health information is collected to ensure client records are consistent across Continuing Care.
3. Ensure information relevant to the care of the client is communicated clearly and effectively during care transitions.

OBJECTIVES

1. Standardize practice in collecting, documenting, and sharing information at care transitions.
2. Modify existing and (as required) develop new tools and processes to ensure accurate, up to date and complete transfer of information during care transitions, including between zones.
3. Develop and integrate mechanisms into practice that engage clients and families to identify, collect, and share information relevant to their care.
4. Identify the conditions that will support success in implementing any recommended changes in practice for Continuing Care team members.
5. Inform the development of the Client Welcome Package as it pertains to supporting information transfer to clients and families.



OUTCOMES

1. Information relevant to the care of the client is communicated effectively during care transitions.
2. The need for clients and families to repeat health information and communicate information between providers is reduced.
3. Continuing Care staff know and fulfill their roles and responsibilities related to person-centered information transfer.
4. Clients and families know and understand what information is being collected, why it is important, who it will be shared with, and how it will be shared.
5. Clients and families have access to information about their care.
6. Continuing Care information transfer tools and processes are informed by clients and families.
7. The number of preventable adverse events relating to sharing of information at transitions of care is reduced.

WORKING GROUP LEADS

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Five working groups with 40 staff members!

