




Information Transfer at Care Transitions: Update & Engagement

2018 Fall Forums

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Wendy McVeigh, Director, Central Zone

WHY: Information Transfer at Care Transitions

- To comply with Accreditation Canada ROP and Case Management standards
- Aligns with the NSHA Quality Improvement, Safety, and Performance Framework and NSHA *Information Transfer at Care Transitions Policy* (approved, not yet in effect)
- Transitions in care are recognized as times when clients are at higher risk for adverse events; e.g. missed or delayed care, medication errors.
- Perceived poor communication between health team members contributes to caregiver distress and erodes client and caregiver trust in the health care system.



Clients and families should be involved and have input into their care but person-centered integrated care should not require clients and families to pass communications between healthcare providers. Having to do this repeatedly results in loss of trust in the system.

- Working Group Member

INFORMATION TRANSFER AT CARE TRANSITIONS PROJECT

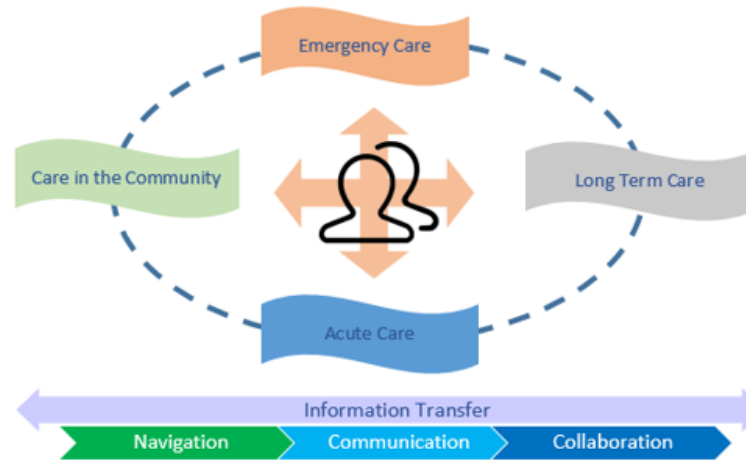
October 2018

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

Presenting Situation: **Jill Dollimount**, Team Lead, CZ Jill.Dollimount@nshealth.ca

Social History: **Marnie Oatway**, Behavioural Resource Consultant, WZ Marnie.Oatway@nshealth.ca

Documentation Standards: **Cat Young**, Education Coordinator Cathryn.Young@nshealth.ca

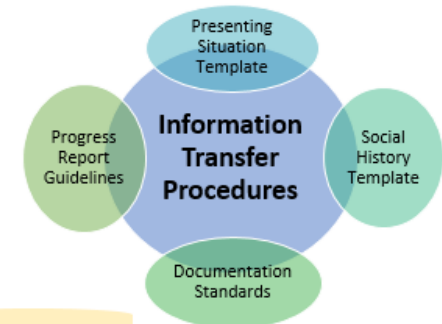
Progress Reports: contact David Mercer

Information Transfer Procedures: **David Mercer**, Senior Analyst David.Mercer@nshealth.ca

For more information on this project, contact David.Mercer@nshealth.ca



Five working groups with 40 staff members!



Project Status Update

Four groups have drafted tools and guidelines:

- Presenting Situation
- Social History **new!**
- Progress Report
- Documentation Standards



Project Status Update

Information Transfer Procedures working group:

- Started by mapping out care transitions across client journey and identifying partners
- Initial focus is on internal procedures for clinical handovers (e.g. zone to zone, hospital to community)
- Will make recommendation for external information sharing which will include working with our care partners in the next phase(s)



Project Next Steps

- Engagement underway, to be completed before year's end (2018), feedback incorporated
- Continuing Care Leadership approvals
- Incremental implementation in early 2019
- Define next phase(s)
 - working with care partners to improve information transfer at care transitions

Meanwhile, at today's meeting on feline healthcare...



Info Transfer Engagement Plan

Clients and Families

- Client/Family Advisors
- Interviews
- Caregivers NS, Alzheimer Society or other groups?

Internal (Continuing Care)

- Quality Teams & Council
- Specific Teams

External (Care Partners)

- Fall Forums
- Zone meetings as required
- Follow up sessions

Framing and decision realm

Input and feedback from engagement will be used to improve draft tools for information transfer and where applicable, process.

Beyond scope for change:

- Continuing Care's programs and services
- IT system interoperability, and access to network and system software
- Continuing Care's assessment tool
- PHIA legislation as custodians of personal health info

Discussion: Context

- One of our guiding principles in the context of information sharing and privacy is “*need to know, minimal amount*”.
- A key point of discussion has been about finding the right balance of information to ensure care partners have what they need to plan and deliver the care required.
- We recognize that sometimes too much information is shared and sometimes not enough. The key is to focus on the *right* information.
- There is a vital need to focus on reducing duplication and repetition for our clients. This comes down to how we *use* the information we gather and share.

Discussion: Questions

1. What client information do you need in order to plan and deliver care?
2. How can we use this information to reduce the amount of repetition for clients and families?
3. How can we use this info in our practice to improve care planning for better outcomes for clients?

Follow Up and Contact

Future Engagement Interest Form

- to provide input on specific tools
- to work with us on next phase

Contact:

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PHIA in relation to information sharing

Personal Health Information Act does two things:

1. Recognizes the right of individuals to protect their personal health information (PHI)
2. Recognizes the need of custodians to collect, use and disclose personal information to provide, support and manage health care by:
 1. Supporting collaboration between health providers
 2. Supporting consistency in collection, use, disclosure and management of PHI
 3. Mandates the development of information practices to better safeguard personal health information

And three others related to individuals accessing their own PHI, oversight and offenses.

[Personal Health Information Act | novascotia.ca](http://novascotia.ca)