Inter-Organizational Transfer of Accountability Guideline

Purpose:

The Inter-Organizational Transfer of Accountability (TOA) Guideline was developed to support safe patient care transitions across organizations and sectors.

Background and Approach:

The GTA Rehab Network convened two working groups to explore issues of information transfer during care transitions:

- Hospital working group (acute care to rehab/CCC transitions)
- Home and community care working group (hospital to home transitions).

Consultation with the working groups along with the literature review and key findings from data analyses were used to develop the guideline. The guideline was further updated through a consultation with a Patient Advisory Group and the review of the Health Quality Ontario's Draft Quality Standard Transitions from Hospital to Home: Care for People of All Ages.

GTA Rehab Network's Inter-organizational TOA guideline complements HQO's quality standard with two key differences:

- *Scope:* TOA guideline addresses transfer of information and follow-up care and not transition planning.
- *Focus:* TOA guideline incorporates a broader focus on transitions from hospital to hospital, hospital to home and community care or outpatient rehab.

Definition:

Inter-organizational TOA is an interactive process of transferring information and coordinating follow-up care between organizations and across sectors and care continuum to ensure continuity and patient safety.[1,2,3]

TOA Guideline Principles:

The guideline consists of **six** principles (not listed in order of importance). The principles support transfer of accountability across the patient lifespan and care continuum.

The principles include:

1. Ensure health service providers understand and have knowledge of legislation and policies that guide effective transitions
2. Communicate patient and caregiver preferences and goals to the next level of care
3. Establish one key contact at each transition point
4. Standardize processes for transition by the organization
5. Communicate effectively among health care providers to facilitate transition
6. Acknowledge dual responsibility of senders and receivers in transitions

Inter-Organizational Transfer of Accountability Guideline

1. Ensure health service providers understand and have knowledge of legislation and policies that guide effective transitions

- Understand what constitutes the Circle of Care[4] for sharing of personal health information
- Be aware of:
  - GTA Rehab Network's Repatriation Policy[5]
  - Organizational policies
    Examples include: service guidelines for Home and Community Care, hospitals' discharge policies
  - Accreditation Canada Standards[6]

2. Communicate patient and caregiver preferences and goals to the next level of care*

- Confirm patient short and long-term goals.
- Prepare patients and caregivers for the next level of care to establish a set of expectations.
- Use a multi-pronged approach in communicating with patients and caregivers to prepare them for transfer to the next level of care (written, verbal, face-to-face, over the telephone etc.).[7]
- Allow patients and caregivers time for questions about discharge timing, logistics, available resources and follow-up care.[7,8]
- Provide a documented care plan (e.g., Patient Oriented Discharge Summaries[10]) that includes safety concerns, signs or symptoms of declining health status, contact information for the team, care instructions and rehab goals.[6]
- Documented care plan should accompany patients and caregivers to the next level of care.[7,12]

**Next level of care includes hospital (acute care, inpatient/outpatient rehab, complex continuing care, day hospital, ambulatory care), home and community care, primary care, and other destinations as applicable.*

3. Establish one key contact at each transition point

- Identify one contact for patients and caregivers in the organization that assumes responsibility for coordinating transition (e.g., social worker, discharge planner, care coordinator, case manager, flow coordinator).[11,12]
- Have an open dialogue on patient status and plans for transition between the one key transition contact and the clinicians providing care to the patient.[13]

The guideline is continued on the next page

4. Standardize organizational processes for transition

- Use a structured standardized handover tool (e.g., referral form, discharge summary report, teaching materials, follow up instructions, care plan) to support quality and quantity of transferred information.[6,7,14,15]
- Implement a referral process that supports standardized, timely and comprehensive transfer of information.[16]
- Utilize IT systems for transferring and updating information.[6,8,17]
- Refer to the Discharge Information Checklist developed by the GTA Rehab Network outlining key information that should be provided at the time of transfer to the next level of care (to hospital or community).

5. Communicate effectively among health care providers to facilitate transition

- Keep reciprocal lines of communication open between sending and receiving teams to support a timely, accurate and interactive exchange of information (e.g., responding to additional information requests).[6,11,19,20]
- Provide opportunity for warm handover for patients with complex needs (e.g., huddles, rounds, pre-discharge case conferences).[13]
- Provide opportunity for discipline-to-discipline handover pre and post transition (use of SBAR* or a modified SBAR* tool is recommended).[6,8,13]

SBAR: Situation-Background-Assessment-Recommendation approach

6. Acknowledge dual responsibility of senders and receivers in transitions

- Recognize that both sending and receiving organizations must have a sense of ownership and accountability for safeguarding patient care beyond the time direct care is provided.[12,18,21,22]
- This includes understanding the different roles information givers, receivers and organizations have in coordinating transitions.[12,18,21,22]
  - Information givers need to focus on understanding the receivers' need in continuing to provide safe and effective patient care.[21]
  - Information receivers need to be actively engaged to ensure they are given necessary information to provide safe and effective care.[21]
  - Organizations need to have processes to support high quality patient transitions.[7]

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