Fostering Collaborative Practice in Continuing Care Facilities:
Role Clarity, Communication & Information Exchange

Scope of the Study
A collaborative practice model means that staff and residents work in partnership, sharing decisions about health and social issues (Canadian Interprofessional Health Collaborative, 2010). How facility managers organize and deploy regulated and unregulated health care providers (workforce utilization) affects this practice model. Looking at three continuing care settings, the study “Optimizing Workforce Utilization to Inform Care Delivery in Continuing Care Facilities” (Suter et al., 2013) identified three challenges influencing collaborative practice: role clarity, communication and information exchange with external providers.

Role Clarity
Role clarity issues were evident at two of the three facilities, especially within nursing. Contributing to these issues were the care delivery model and mix of providers:

- Care planning responsibilities were unclear between the Registered Nurse lead and the Care Coordinator which caused some tension among staff and confused residents.
- Care provision overlaps occurred between occupational therapists, physiotherapists and recreational therapists resulting in confusion with referrals.

Communication Issues
Concerns arose in the following areas:

- Manual charting was problematic as it was time consuming, duplicated in several locations and incomplete, or absent, altogether.
- Staff failure to read care plans resulted in poor follow-through on care directives, and subsequent gaps in care coordination among providers (on same shift or between shifts).
- Shift change reporting was difficult because most shifts did not overlap. (noted at the two long-term care facilities).
- Limited communication opportunities between care providers created role ambiguity and confusion (e.g., who should develop written care plans).

Information Exchange with External Providers
Coordinating services or exchanging information with external organizations was challenging due to:

- Inadequate information from hospitals or physicians about patients moving into supportive living or long-term care.

Either we don’t hear from the transition service nurse, or they [residents] are on the doorstep and we don’t know they’re back. Very few times is it a smooth transition.

- Lack of knowledge about available options for individuals and their families, when a family member transitions from home or acute care to supportive living or long-term care.

June 2014
Strategies
The following strategies, informed by the literature, may be helpful to address these issues.

**Society/policy level**
- Ensure health profession education includes communication skills as a key interprofessional competency.
- Consider carefully which information systems, such as Netcare, provide most effective information on residents in all facilities.

**Community level**
- Ensure continuing care placement coordinators use residents’ care needs to determine appropriate services/programs when transitioning residents into supportive living or long-term care.
- Develop timely and accurate information packages for both health care providers and residents/families explaining care options.

**Institution/organization level**
- Clarify job descriptions and expectations for each role.
- Review and restructure communication processes to support the different roles.
- Review communication processes (e.g., charting, shift reports) to identify gaps and duplication.
- Introduce electronic reporting and charting to improve communication flow and reduce time needed to complete documentation.

**Health care team level**
- Regularly discuss in staff meetings how to improve communication.
- Invite ideas for improved information sharing and mutual understanding.

Facilitating collaboration and care planning depends on providers having a clear understanding of their own role and the roles of other providers on the care team. Opportunities and clear processes for communication between care team members are essential. Smooth and effective communication will ease tensions between staff, positively affect collaborative practice, and enhance quality of care. Smoother transitions will occur if providers put more effort and time into documenting and communicating transfers.

Funding for this project was provided by Alberta Health

For more information, please contact:
**Esther Suter**, Workforce Research & Evaluation, Alberta Health Services; [esther.suter@albertahealthservices.ca](mailto:esther.suter@albertahealthservices.ca)

**Sandra Woodhead Lyons**, Institute for Continuing Care Education & Research; [scwl@iccer.ca](mailto:scwl@iccer.ca)

Full report and other fact sheets available at [http://www.albertahealthservices.ca/wre.asp](http://www.albertahealthservices.ca/wre.asp) or [www.iccer.ca](http://www.iccer.ca)

Other fact sheets available in this series are:
- Workforce utilization
- Resident/family-centred care
- Working to full potential
- Staff mix


Funding for this project was provided by Alberta Health Services.

For more information, please contact:
**Esther Suter**, Workforce Research & Evaluation, Alberta Health Services; [esther.suter@albertahealthservices.ca](mailto:esther.suter@albertahealthservices.ca)

**Sandra Woodhead Lyons**, Institute for Continuing Care Education & Research; [scwl@iccer.ca](mailto:scwl@iccer.ca)

Full report and other fact sheets available at [http://www.albertahealthservices.ca/wre.asp](http://www.albertahealthservices.ca/wre.asp) or [www.iccer.ca](http://www.iccer.ca)

Other fact sheets available in this series are:
- Workforce utilization
- Resident/family-centred care
- Working to full potential
- Staff mix


**Alberta Health Services**

June 2014