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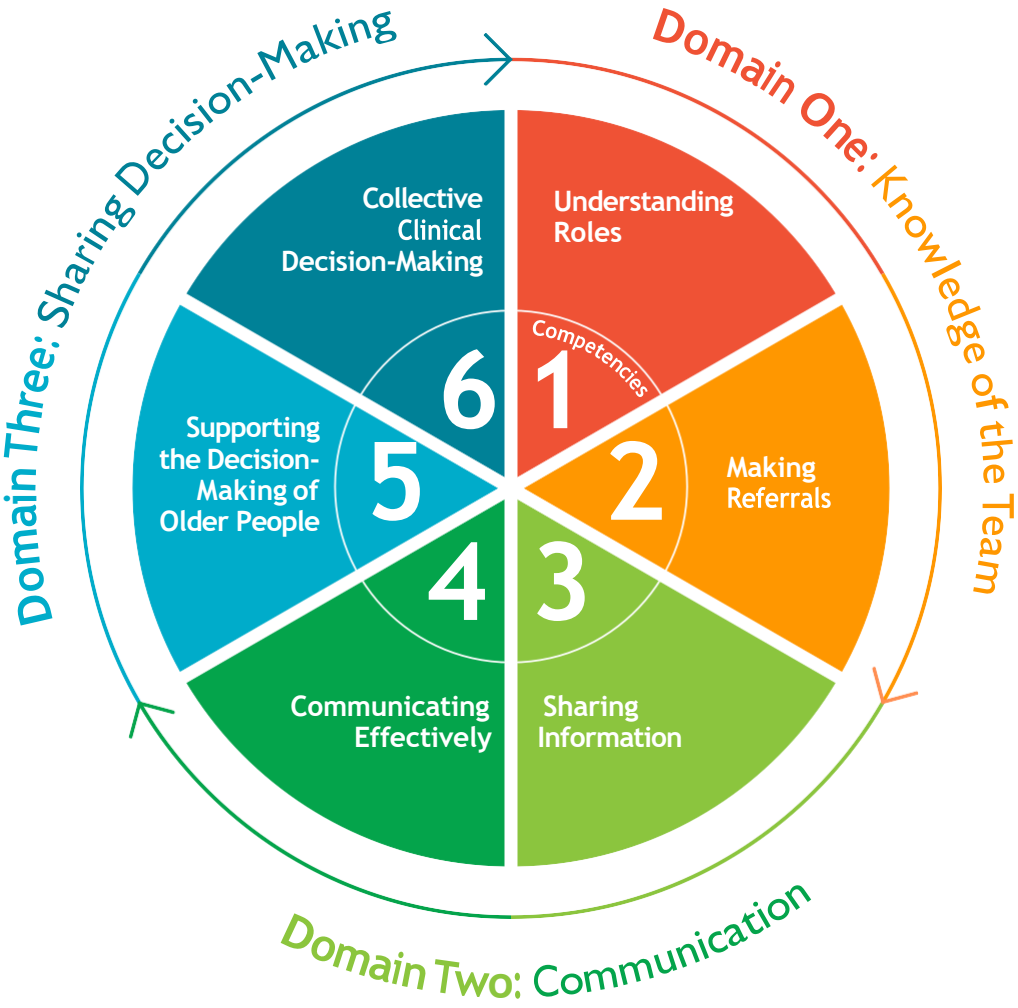

Getting Started in Developing Core Competences for Interprofessional Collaboration in Integrated Care for Older People: A Step-by-Step Guide

A Framework for the National Integrated Care Programme for Older Persons (NICPOP)

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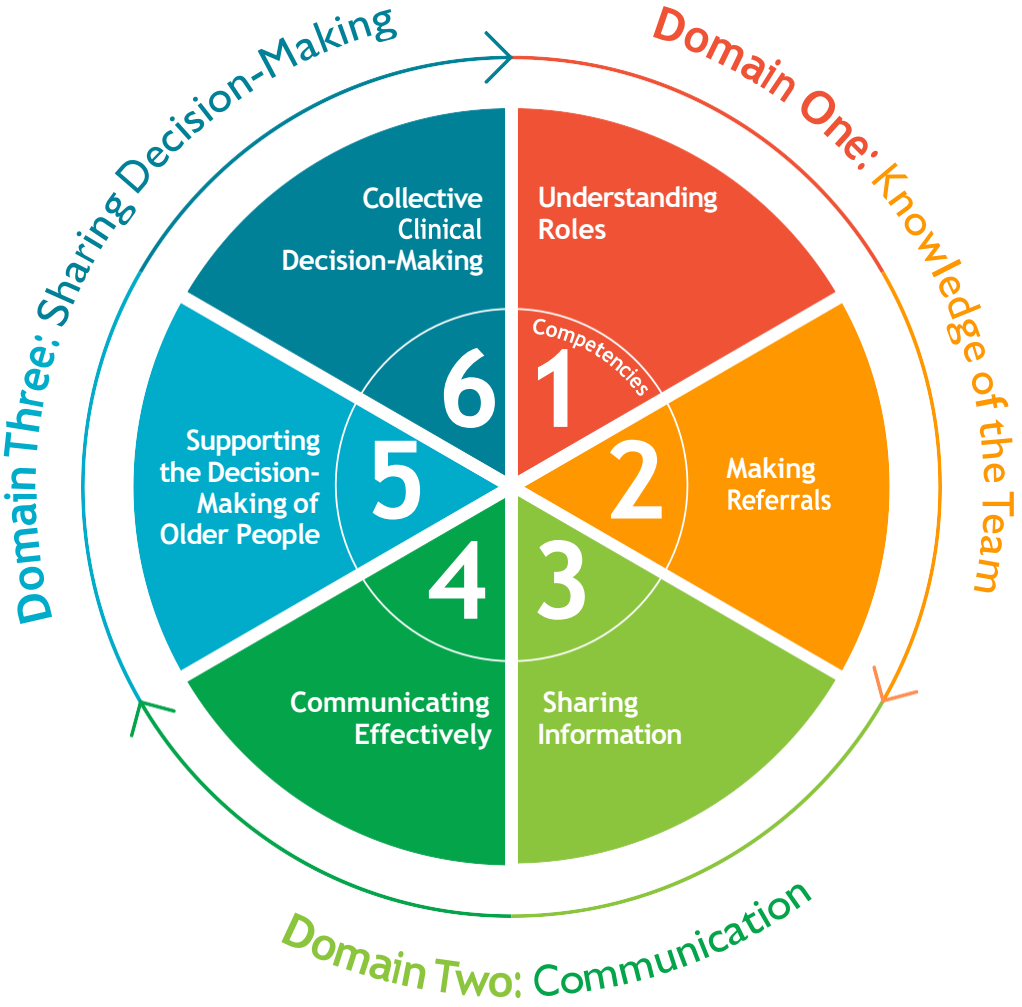
Contents



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Glossary of Abbreviations

ADM(C) Act 2015
Assisted Decision-Making (Capacity) Act 2015

CGA
Comprehensive Geriatric Assessment

ECLECTIC
Embedding Collective Leadership to Foster Collaborative Interprofessional Working in the Care of Older People

GDPR
General Data Protection Regulation

HCPs
Health Care Professionals. This refers to all disciplines involved with interdisciplinary care teams for older people. This includes all those represented by the Irish Regulatory Authority for Health and Social Care Professions (www.coru.ie) as well as physicians, nurses and pharmacists.

HSE
Health Service Executive

HSE NCAGL for Older Persons
Health Service Executive National Clinical Advisor and Group Lead for Older Persons

IC
Integrated Care

ICT
Information and Communication Technology

MDT
Multi-disciplinary Team

NICPOP
National Integrated Care Programme for Older Persons

PPR
Public Patient Representative

SOP
Standard Operating Procedure

Background

This framework provides a step-by-step guide for getting started in building competences for interprofessional collaboration within interdisciplinary teams for older people.

It is intended that this framework be used as a practical guide for interdisciplinary teams working with older people across practice settings and sectors to build their competences for interprofessional collaboration. It is the result of the first phase of a programme of research that aims to foster a culture of strong interprofessional collaboration and collective leadership in interdisciplinary teams delivering integrated care with older people (ECLECTIC).

This programme of research is mapped over three iterative phases:

1. Co-design a model of core competences for interprofessional collaboration in interdisciplinary teams caring for older people across settings and create a guide to support these teams to develop the relevant knowledge, skills and behaviours.
2. Prospective implementation and realist process evaluation of the competences for interprofessional collaboration within interdisciplinary teams integrating the care of older people.
3. Embedding the competences into core interdisciplinary professional educational curricula.

This document presents the framework resulting from phase one of the study: "Getting Started in Developing Core Competences for Interprofessional Collaboration in Integrated Care for Older People: A Step-by-Step Guide."

Integrated Care for Older People

Integrated Care (IC) has been adopted in Irish health and social care policy as a strategy for improving the coordination of health and social services through comprehensive care pathways that are organised around patient needs (Government of Ireland, 2021). Internationally, there is little consensus on a single definition or understanding of concepts related to IC (Armitage et al., 2009). In their review of international evidence for integrated systems, Curry and Ham (2010, p. 3) noted that "integration is concerned with *processes* of bringing organisations and professionals together, with the aim of improving *outcomes* for patients and service users through the delivery of integrated care". Within Ireland, IC has been envisaged as requiring both 'horizontal' coordination, spanning disciplinary, professional and departmental boundaries as well as 'vertical' coordination along a continuum from primary to secondary and tertiary sectors (Committee on the Future of Healthcare, 2017). The central aim of this understanding of IC is to avoid unplanned, episodic care in the acute setting. Rather care should be delivered and managed 'at the lowest level of complexity' or at home where possible (Committee on the Future of Healthcare, 2017, p. 73).

Research evidence indicates that models of IC may enhance patient satisfaction, increase the perceived quality of care and, importantly in the context of growing demand, enable improved access to services (Baxter et al., 2018). Models of IC, which focus on older people, have been shown to decrease hospital inpatient and nursing home use, slow down functional decline, increase access to home and community-based services and in some cases, there is evidence of a reduction in caregiver burden (Curry & Ham, 2010).

The National Integrated Care Programme for Older Persons (NICPOP) aims to support older people to live well in their homes by developing primary and secondary care services for older people, especially those with complex needs. It involves changing how health and social care is planned and delivered while ultimately focusing on patient experience, outcomes and quality of care (HSE, 2017). The programme develops integrated intermediate care which traverses both hospital and community settings through interdisciplinary and interagency teams. The development of integrated care pathways through the implementation of interdisciplinary hubs for coordination of older people's care is a key element of the Irish Government's health reform programme outlined in the Sláintecare Implementation Strategy and Action Plan 2021-2023 (Government of Ireland, 2021). This team-based approach to the integration of health services is a relatively novel innovation in Irish health service delivery and will require, over time, a shift in cultures of care to allow for the development of competences for interprofessional collaboration across the care continuum.

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In their reflective review on the role of multidisciplinary teams (MDTs) on practice within geriatric medicine, Ellis and Sevdalis (2019) identify three types of MDTs distinguishable from each other by their degree of 'integration' starting with multidisciplinary (least integration) to interdisciplinary to transdisciplinary teams (most integration). For this study, we adopted their definition of interdisciplinary teams as the model of interdisciplinary teams that are being implemented as part of the NICPOP in Ireland:

> *"Members come together as a whole to discuss their individual assessments and develop a joint service plan for the patient. Practitioners may blur some disciplinary boundaries but still maintain a discipline-specific base (for instance, aspects of functional assessments may be shared across disciplines). Teams integrate closer to complete a shared goal (Ellis & Sevdalis, 2019, p. 500)."*

We have developed a working description of Interdisciplinary Care Teams from the European Core Competency Framework for Health and Social Care Professionals working with Older People (Dijkman et al., 2016). This framework defines health and social care professionals as those "who provide systematically direct and indirect professional care and support to individuals or communities of 65 and older and their families" and, in this context, includes physicians, nurses and pharmacists, as well as members of the health and social care professions who are known collectively as, HCPs (2016, p. 5).

For this report, interdisciplinary care teams may include health care professionals and social care professionals from a wide range of disciplines. This includes all those disciplines represented by the Irish regulatory body for Health and Social Care Professionals (www.coru.ie) as well as nursing, pharmacy and medicine.

In the Irish context where formal integration of services is in the early stages of development and implementation, these interdisciplinary care teams may also intersect with multiple existing teams and settings. These intersecting teams may include *inter alia* Frailty Intervention Therapy Teams, Rehabilitation Teams, Community Health Organisations, Public Health and Primary Care Teams, Safeguarding and Protection Teams, Enhanced Community Care Teams and Mental Health Teams working in acute, rehabilitation and community settings.

For this framework, we have used the term 'HCPs' to refer to all health care professionals who work as part of an interdisciplinary care team in the coordination and delivery of health and social care for older people across integrated care settings. This includes all those professions represented by the Irish regulatory body for Health and Social Care Professionals (www.coru.ie) as well as physicians, nurses and pharmacists.

We have made reference throughout this framework to family carers who may be important to some older people in supporting them with care planning and decision-making. With reference to the Assisted Decision Making (Capacity) Act (2015) we use the term 'family carer' to refer to any person nominated by the older person to support their health and social care decision-making and care planning. This relationship may be formalised under the 2015 ADM(C) Act as a legally authorised decision-supporter or may be a more informal arrangement between the older person and their nominated decision-supporter. This may be a member of the older person's family, a friend or neighbour. They may play a role in providing instrumental care and support for an older person and/or provide assistance with care planning and coordination.

Interprofessional Collaboration

Effective teamwork is pertinent to interprofessional collaboration, especially for integrated care. The European Competency Framework for Health and Social Care Professionals working with Older People (Dijkman et al., 2016) describes the outcomes that interdisciplinary care teams providing care to older persons are expected to achieve and demonstrate in their different roles (seven roles in total). The framework describes a minimum set of competences (18 in total) that constitute a common baseline for these teams working with older people and their families within their local communities. However, there is limited guidance in the literature regarding how interprofessional collaboration could be fostered and sustained in this context. Internationally, the literature points to a knowledge gap concerning how different HCPs can foster new ways of collaborative working that are foundational to implementing integrated care cultures (Ahmed et al., 2015; Cameron et al., 2014). This requires consideration of how leadership is conceptualised in relation to the roles of team members as well as the processes for sharing decision-making.

Collective and shared approaches to leadership and decision-making have been found to enhance team effectiveness and team performance outcomes (D'Innocenzo et al., 2016; Wang et al., 2014). There is now considerable evidence for the effectiveness of collective leadership interventions in healthcare settings on staff engagement, quality improvement, team-working and patient satisfaction (De Brún et al., 2019). Collective and shared approaches to team working may well provide appropriate models and mechanisms by which interdisciplinary healthcare teams working with older people can cultivate interprofessional collaboration.

Phase One: Project Aims

The aim of phase one of the ECLECTIC programme of research was to co-design with key stakeholders core competences for interprofessional collaborative working in interdisciplinary care teams providing care to older people. A further aim was to develop a practical guide for developing and evaluating these competences within interdisciplinary care teams for older people.

To realise these aims, the following objectives were identified:

- describe the appropriate knowledge, skills and behaviours for demonstrating competence in interprofessional team working
- identify mechanisms for achieving and monitoring proficiency for each competence
- align the competences to collective and shared approaches to leadership and decision-making in healthcare

ECLECTIC Team

The ECLECTIC programme of research involves a partnership between academic health systems researchers and the members of the Interprofessional Interest Group, a sub-committee of the NICPOP. This interest group was established to inform the strategic development of improved collaborative interprofessional working across all settings of health and social care with older people. For this first phase of the programme of research, we collaborated with knowledge users and experts which included public and patient representatives as well as HCPs.

Research Design

The research design for phase one of the ECLECTIC programme of research was developed in collaboration with the Interprofessional Interest Group, a subcommittee of the NICPOP. It is mapped over three consecutive work packages (Figure 1) combining a multi-method approach including co-design workshops, outcome measurement development, prospective qualitative data collection, scoping review of evidence and validation of the emerging model of core competences.

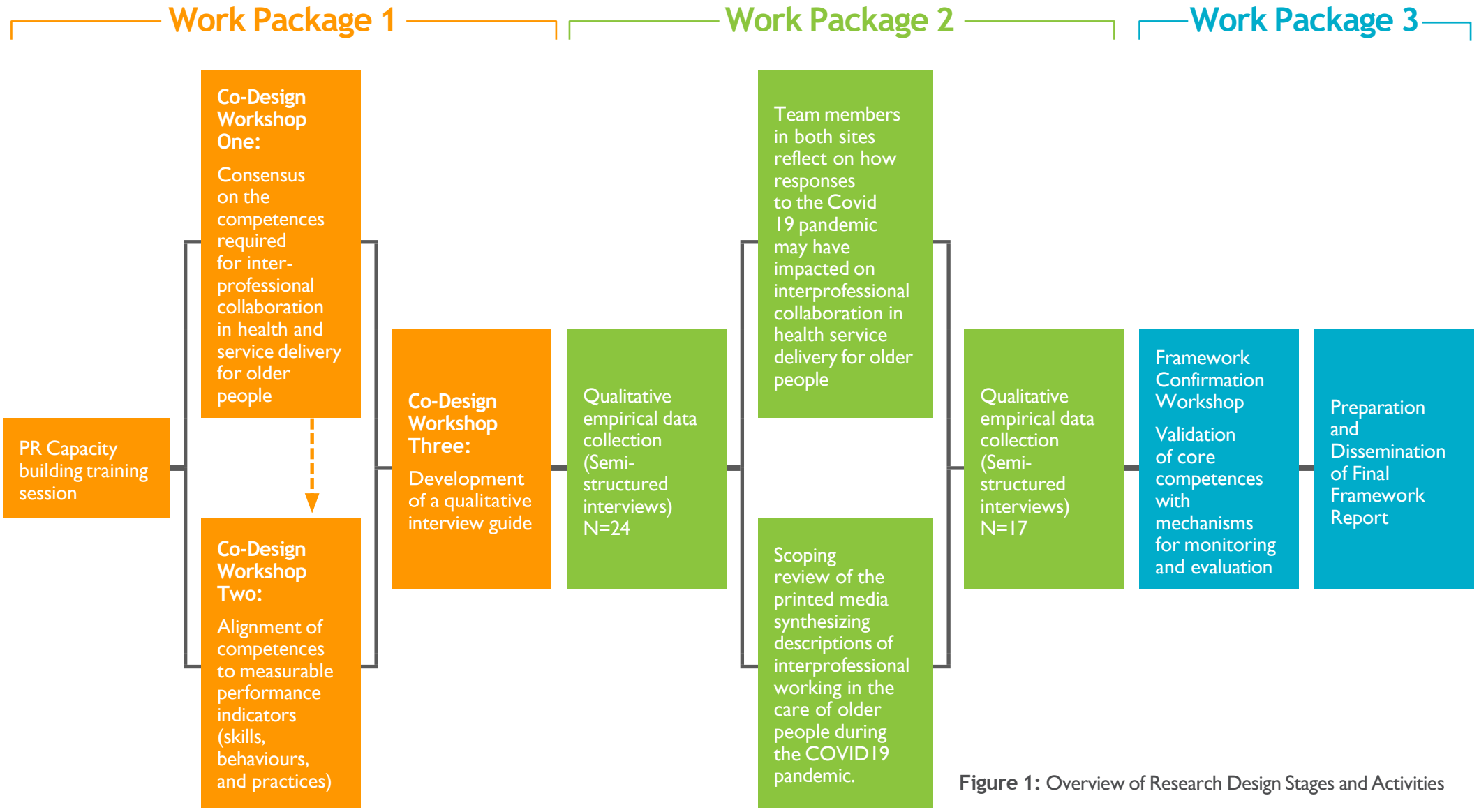
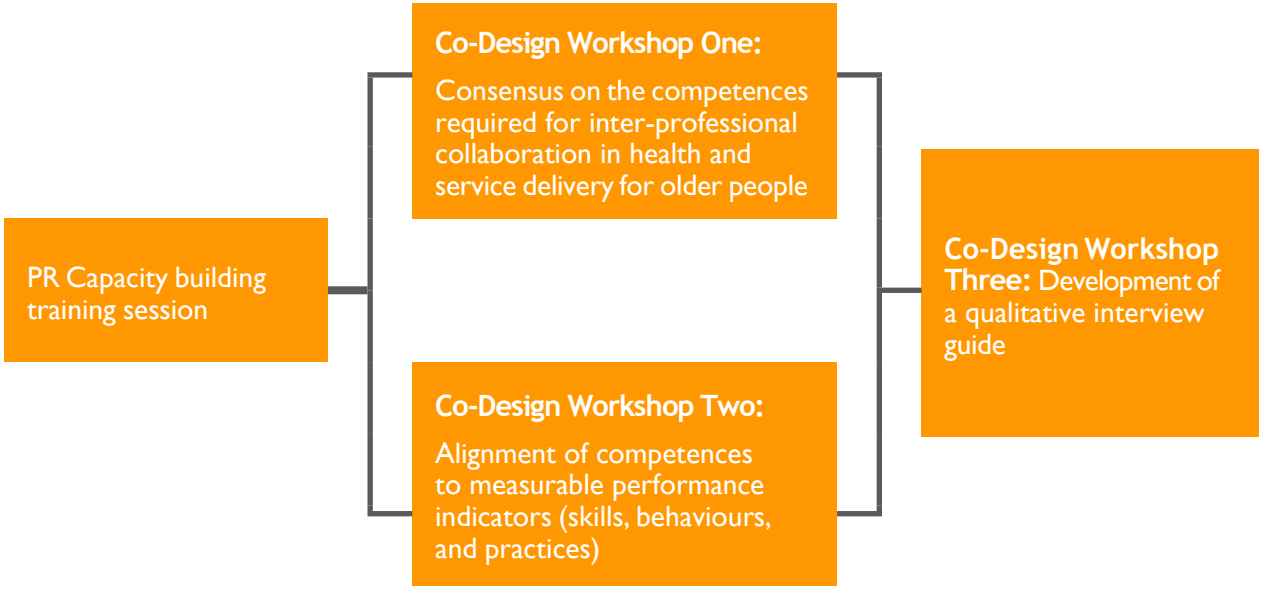


Figure 1: Overview of Research Design Stages and Activities

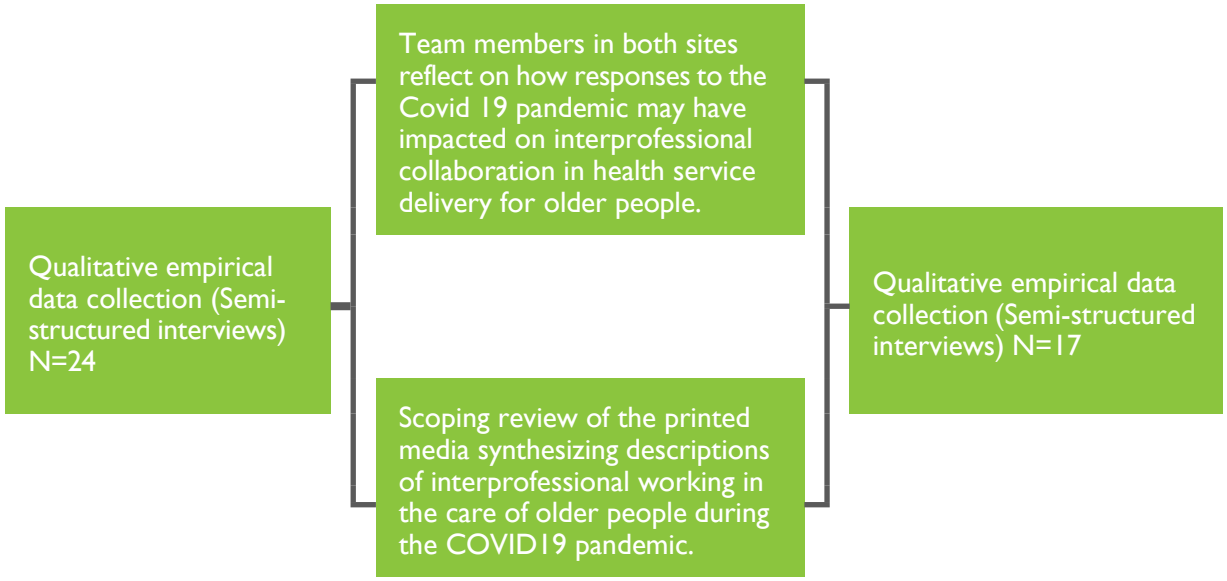


Work Package One: **Co-Design Workshops**

Co-design is a values-based methodology. Within healthcare, the process includes bringing together service users, clinical and non-clinical staff and, at times, relevant support and advocacy groups to work together to improve or refine elements of the care systems, services or processes (Palmer et al., 2019). It is focused on the reality of healthcare contexts and of healthcare staff work environments (Ward et al., 2018). At its core is open reciprocal democratic dialogue where all participants contribute equally (O'Donnell et al., 2019). This approach moves from consulting to enabling the involvement of all from the outset. It ensures and supports all relevant partners to be involved in defining the problem, designing the solution and monitoring and championing the implementation.

The project co-design activities commenced with a capacity building training workshop for five public and patient representatives (PPRs) two of whom were nominated by Age Friendly Ireland; a member of the project steering committee. The remaining three PPRs were recruited from the UCD OPEN Network which aims to promote the involvement of older people in academic health and social care research. Capacity building for PPRs engaging with academic research supports meaningful and democratic participation through a receptive research environment as well as clarifying roles and expectations regarding participation (O'Donnell et al., 2019). The training was delivered by a designated coordinator for the public and patient involvement in the project (ÉNS). The training involved an orientation to the project objectives and governance as well as an overview of the policy and service context for integrated care for older people in Ireland. This included an explanation of key terms, an outline of key policy documents and a description of the health care professionals involved in the co-design workshops.

After the capacity training, three co-design workshops were facilitated by members of the project research team (DOD, MOS, ÉNS) running consecutively for five months. The co-design team (see page 2) was composed of public and patient representatives and HCPs with experience of interprofessional collaboration in the integrated care for older people across health care settings. The co-design workshops built incrementally towards the development of consensus on core competences for interprofessional working in the care of older people. This included descriptions of core competences, as well as the identification of mechanisms for monitoring competences within teams. The final workshop also involved the co-design of data collection materials for a qualitative exploration of team-working within two case study multi-disciplinary teams.



Work Package Two:
Qualitative exploration of interprofessional collaboration

The second work package involved prospective qualitative exploration of interprofessional collaboration within two interdisciplinary care teams integrating care for older people in two case study sites (one rural, one urban). The first case study site selected for this work package involved the Frailty Intervention Therapy (FIT) Team, based in the Emergency Department of Beaumont Hospital and the Integrated Care Team for older people attached to Beaumont Hospital, Dublin North City and County Community Healthcare Organisation (CHO9) and Dublin North Integrated Care Team for Older Persons. This is one of the pioneer early adopter integrated care sites, established under the NICPOP. The second case study was the interdisciplinary care team attached to the Regional Hospital in Mullingar and the Midlands Community Healthcare Organisation (CHO8).

This team is not formally part of the NICPOP, but are operating across the boundaries of acute and community care for older people. Each of the case study teams was multi-disciplinary in their composition and were working to integrate care for older people across acute as well as community care settings. The selection of a pioneer early adopted Integrated Care Team (CASE STUDY ONE) and a pre-existing interdisciplinary care team (CASE STUDY TWO) not formally part of the NICPOP was strategic. It facilitated the application of the competency framework emerging from this project within different types of care teams. Therefore, this framework supports the plans of NICPOP for developing further interdisciplinary integrated care teams in its scale-up of integrated care for older people in the next phase of programme implementation.

The prospective qualitative data collection ran for 17 months (February 2020-July 2021). An exploratory qualitative investigation was deemed appropriate for this work package as little is known about how individual team members interpret and understand interprofessional collaboration in relation to their own disciplinary competency and the integration of patient-centred care. Semi-structured qualitative interviews were conducted with team members from both case study sites in two prospective waves (See Tables 1 and 2). The first wave of interviews (N=23) were conducted between February 2020 and March 2020. The second wave of interviews (N=16) were conducted from September 2020 to July 2021.

Table 1: Overview of participants interviewed in the first wave of data collection (Feb-March 2020)

Discipline	Case Study		Total
	One	Two	
Nursing	1	5	6
Nutrition and Dietetics	1	0	1
Occupational Therapy	2	2	4
Pharmacy	1	1	2
Physiotherapy	1	4	5
Social Work	2	0	2
Speech and Language Therapy	1	2	3
Total	**9**	**14**	**23**

Table 2: Overview of participants interviewed in the second wave of data collection (Sept 2020-July 2021)

Discipline	Case Study		Total
	One	Two	
Medicine (Consultant Physician)	1	1	2
Nursing	0	0	0
Nutrition and Dietetics	0	1	1
Occupational Therapy	3	0	3
Pharmacy	1	0	1
Physiotherapy	2	2	4
Social Work	1	0	1
Speech and Language Therapy	2	2	4
Total	**10**	**6**	**16**

Analysis of the qualitative data generated from the interviews focused on identifying contextual information about how competences for interprofessional collaboration were conceptualised and demonstrated within the two teams.

The prospective lens facilitated the capture of qualitative data over time and during the first and second waves of the COVID-19 pandemic in Ireland. This allowed the participants to reflect upon the changes to team dynamics and working that may have resulted from their response to the COVID-19 crisis. The analysis of this data was supported by a scoping review of the emerging evidence of '*new ways of working*' in the care of older people among health and social care teams across Europe. This evidence was systematically retrieved and synthesised by research team members in June 2020 from online social media as well as print media accounts of team-working during the first wave of the pandemic (Ní Shé et al., 2020). This scoping review identified four clusters of '*new ways of working*' in the health and social care of older people during the first wave of the pandemic: role expansion and compensation, online training and enablement, innovation in communication and environmental restructuring (See Figure 2).

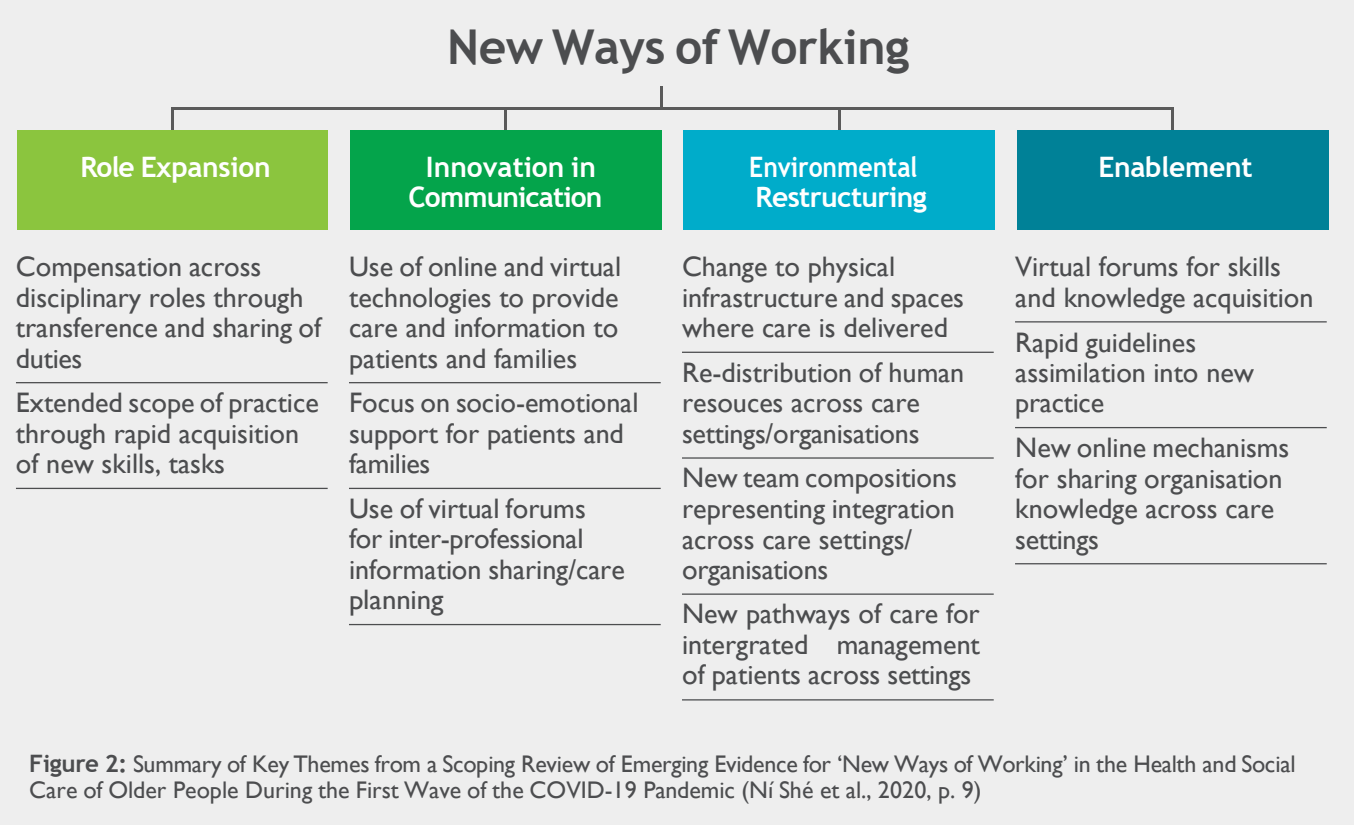
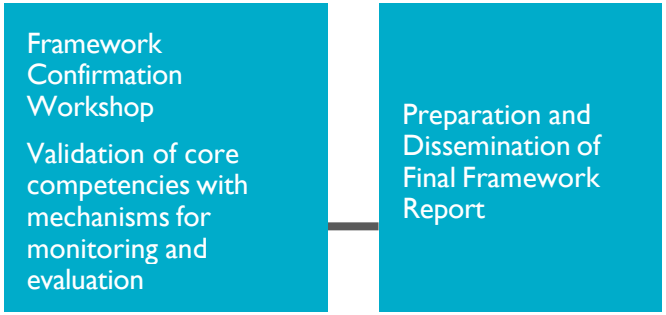


Figure 2: Summary of Key Themes from a Scoping Review of Emerging Evidence for 'New Ways of Working' in the Health and Social Care of Older People During the First Wave of the COVID-19 Pandemic (Ní Shé et al., 2020, p. 9)

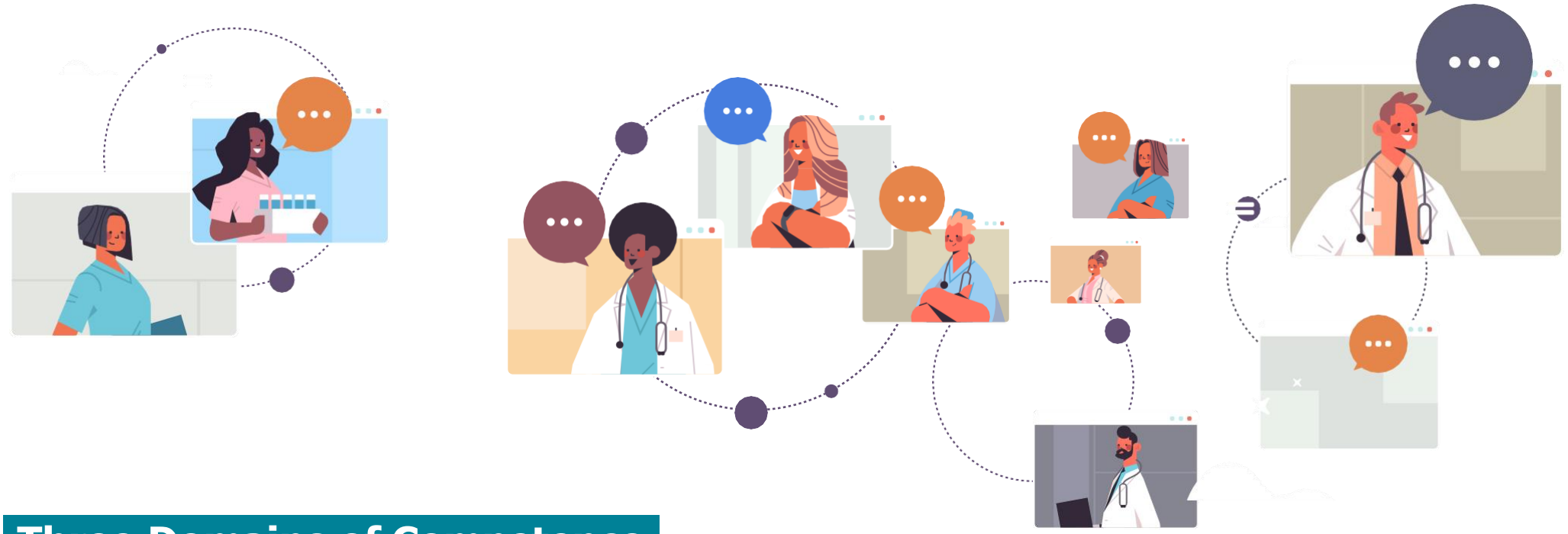
These themes describing 'new ways of working' were echoed in the accounts of the interview participants, who reflected upon the impact of the pandemic upon their roles as well as their collaboration within, and across, teams. Our analysis of the qualitative data facilitated refining of the core competences identified through the co-design workshops in work package one.

Furthermore, the experiences and reflections of our participants provided context and nuance to our understanding of interprofessional collaboration and of the knowledge, skills and behaviours required for effective team working in the health and social care of older people.



Work Package Three: Framework Development

The final work package involved developing a model for the core domains describing six competences for interprofessional collaboration. An online workshop was held in March 2021 with all of the co-design team members in which the qualitative data analysis was presented and the core competences discussed and validated. The model was further consolidated through a consultation meeting with the public and patient representatives as well as a primary care physician with expertise in the care of older people.



Three Domains of Competence

Three domains describing six competences were identified through the co-design meetings as well as consultations with two case study sites (one rural, one urban). The three domains are: knowledge of the team, communication and shared decision-making (see Figure 3). Each of the three domains consists of two competences that support proficiency in that area of interprofessional collaboration.

The domains are mutually exclusive, but collectively they are exhaustive in their description of the competences required for effective interprofessional collaboration in the care of older people. The six competences are reciprocal, whereby proficiency in one supports proficiency in the next. For example, when interdisciplinary team members demonstrate an understanding of team roles, they are supported in making effective and appropriate referrals, which in turn supports sharing of information and so forth. This reciprocity is illustrated through the use of cyclical arrows in Figure 3. The three domains are grouped by colour.

The model describes three domains of competency that are common to all health and social care professionals involved in interdisciplinary care teams for older people. This includes all those disciplines recognised by the Irish regulatory authority for Health and Social Care Professionals (www.coru.ie) as well as medicine, nursing and pharmacy (see pages 5 and 6 and 6).

The three domains are relevant to all levels or settings in which care is provided. It is understood that individual team members will have different levels of competency in each domain from basic to more advanced proficiency. Therefore, it is suggested that monitoring of each of the six competences should be at the level of the team rather than the individual. This means that proficiency should be demonstrated for each competency within the team, rather than by each team member.

The six core competences are defined by a statement of the knowledge required to demonstrate proficiency, as well as a summary of the key behaviours or attitudes associated with the competency. This is followed by a description of four key steps for getting started in building competence within an interdisciplinary care team for older people. Finally, a list of mechanisms for the evaluation of competence at the team level is provided. These mechanisms are aligned with the broader evidence which supports the efficacy for interventions that foster collective and shared approaches to leadership and decision-making in healthcare. The six competences are also supported with qualitative extracts from the consultations conducted with members of the two interdisciplinary case study teams.

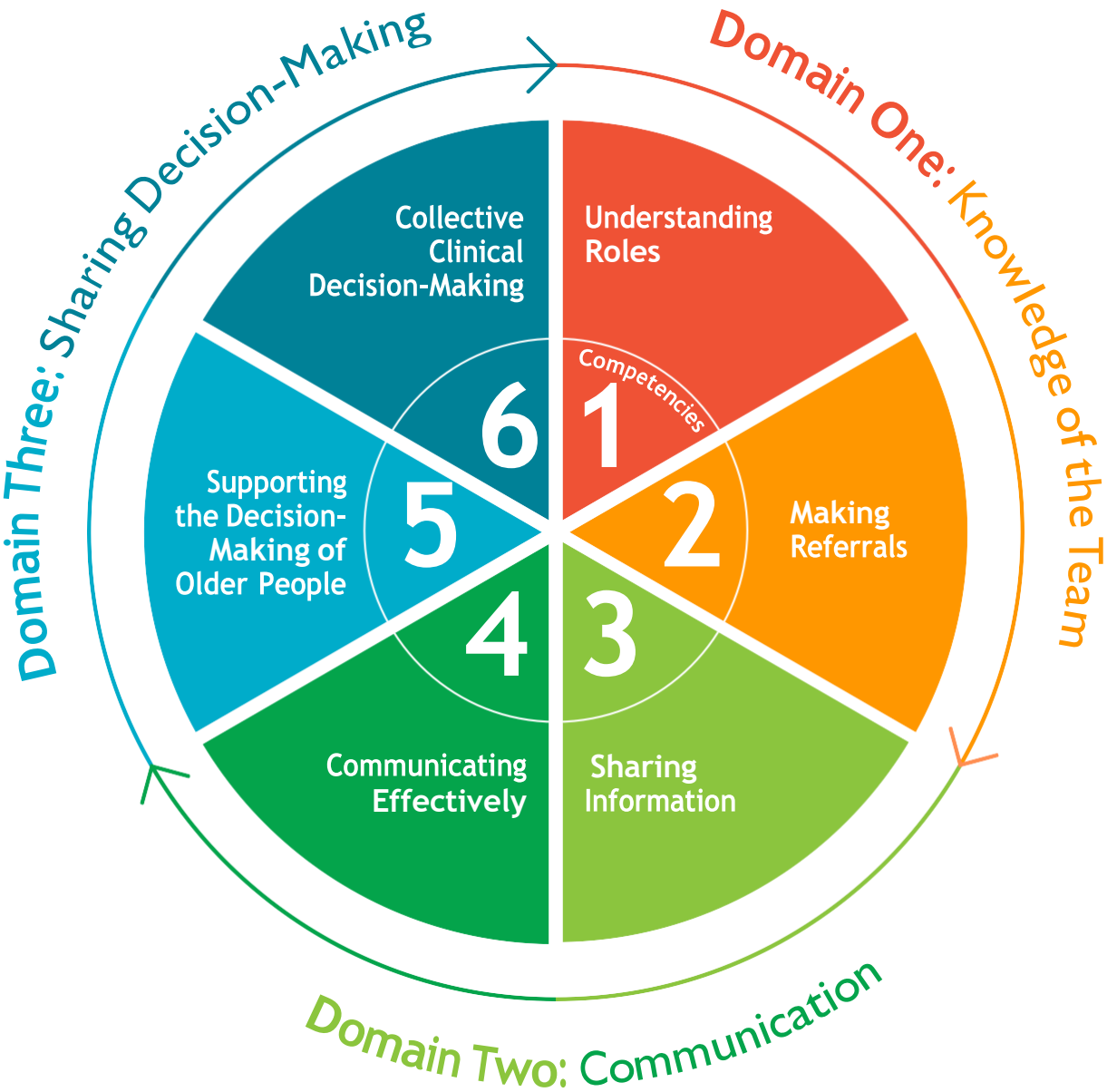


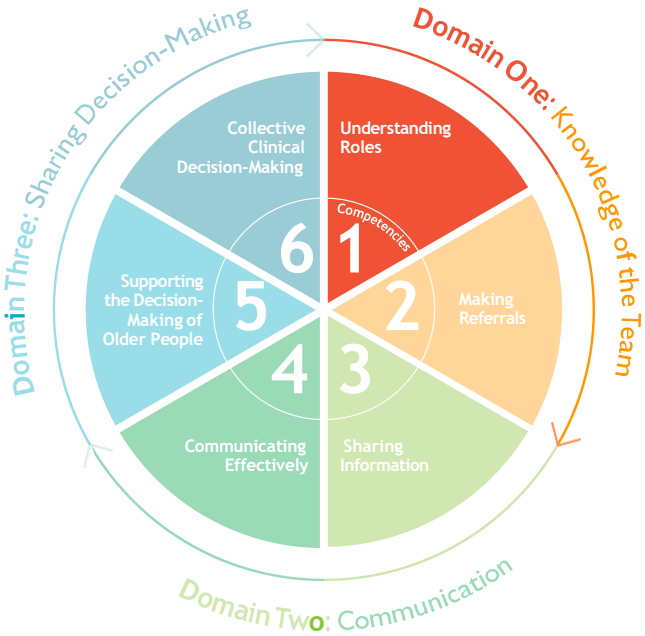
Figure 3: Three Domains describing Six Competences for Proficiency in Interprofessional Collaboration within Integrated Care of Older People

Domain One:
Knowledge of the Team

The first competency domain describes the knowledge, skills and behaviours required for interdisciplinary care teams working with older people to demonstrate a knowledge and understanding of their team. This domain includes an understanding of the roles of individual team members and the goals of the overall team.

Furthermore, the domain includes proficiency in making referrals within the team as well as with different service providers and any healthcare professional outside of the team, including those from medicine, nursing and pharmacy.

Domain One:
Knowledge of the Team



Central to this competency is an understanding and articulation of one's role and the role of other team members in service delivery. This understanding should also be aligned to the shared vision and mission of the overall team. While always adhering to the professional scope of practice, roles should be flexible and fluid to guarantee seamless service delivery.

Competency One:
Understanding Roles

How to do it: Getting started

Key Steps for building competency in **'Understanding Roles'** within Interdisciplinary Care Teams working with Older People

1 Establish team values, vision and mission

- Complete this Co-Lead module to collectively develop your team vision for integrated care and set a series of goals to achieve interprofessional working. Estimated time to complete is one hour: **www.ucd.ie/collectiveleadership/resourcehub/toolkit/teamvaluesvisionandmission**
- Co-design and document the team values, vision and mission on an accessible and shared file

2 Establish role clarity for all team members

- Avail of clinical supervision, professional development and/or mentoring to gain clarity on individual scope of practice. Consider how one's own discipline specific skills can be combined with the skills of others to create optimum and safe outcomes for older people.
- Complete this module to establish role clarity for successful interprofessional working. Estimated Time is One Hour: **www.ucd.ie/collectiveleadership/resourcehub/toolkit/roleclarity**
- Create a shared and accessible file with professional role descriptors for each team member

3 Build and measure trust in the team

- Complete this Co-Lead module to identify the strong areas of your teams and build mechanisms of mutual support and foster a climate of trust. Estimated time to complete is one hour: **www.ucd.ie/collectiveleadership/resourcehub/toolkit/buildingtrust**
- The instrument developed by Costa and Anderson (2011) is suggested here for measuring Trust within interdisciplinary healthcare teams. See Appendix Three for description of the tool
- Agree with the team what are the processes for addressing any breach of trust within the team.

4 Schedule regular team meetings

- The meetings can be online and/or in person as required.
- The meetings should encourage discussion of roles and encourage a degree of role flexibility to deliver continuity of service and collective responsibility

How to conduct oneself

The behaviours or attitudes of team members which will facilitate or assist in the development of role understanding include:

- respectful communication
- engaging in team meetings and care planning conversations
- reflecting on one's role and a willingness to negotiate roles
- open-mindedness
- recognition of the value and contribution of every team member.

Mechanisms for Self-Evaluation

The following are suggested mechanisms that could be used to monitor or measure competency in this domain:

- Professional role descriptors are available for each team member.
- Knowledge of each team members' disciplinary expertise and competences
- Knowledge of team vision and values
- Attendance at team meetings
- Regular measurement of trust with a team approach to resolution should a breach of trust be identified. (See **Appendix Three**)
- Professional development plans are utilised to address identified areas for improvement necessary for aligning individual professional scope of practice with the interdisciplinary team working.

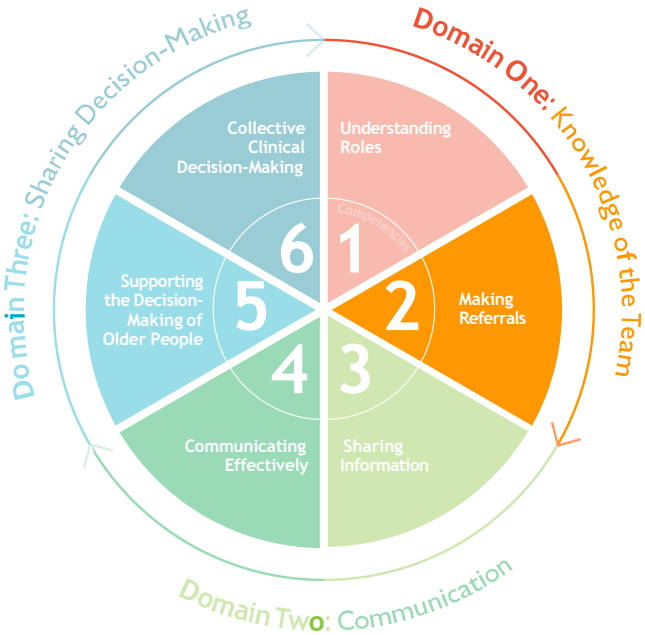
Qualitative extracts

> *I think there needs to be a **mutual understanding** and a **mutual respect** of everybody's roles. […] So, I think to **get everybody around the table** and actually discuss each other's roles in depth so that we all understand what everybody does. I suppose a lot of ice breakers and **team-building exercises** will probably be needed, not necessarily clinical team-building exercises, but just to get an idea of each other's personalities and how everybody works."*

> *I think what's enabled it is probably an element of allowing each team member, allowing each other to **take on pieces of work** that might traditionally be let's say a social work or nursing thing or a physiotherapy thing, an occupational therapy thing, you know."*

> *So, it's not just about one profession doing one thing. It's about **us all kind of doing similar things.** Each profession has maybe a speciality or has specific skills, but **it's knowing when they need to be used** and contacting their colleagues too for them to utilise them."*

Domain One:
Knowledge of the Team



Central to this competency is making the right referral to the right person at the right time. This includes referral within the interdisciplinary team as well as from the team to external services/disciplines. In both types of referral, it is necessary to ensure that the referral is received and acted upon by the person to whom the referral is being made promptly. Competency in this domain involves a single triage point within the interdisciplinary team which will ascertain the primary disciplines relevant for the case. It also involves up-to-date knowledge of the available services across different sectors and signposting older people to these available services (community, departmental, out-patient, etc).

Competency Two
Making Referrals

How to do it: Getting started

Key Steps for building competency in **'Making Referrals'** within Interdisciplinary Care Teams working with Older People

1 Gather information from the older person

- Discuss with the older person (or family carer where appropriate) their preferences and values regarding referrals for example: social activities or home care
- Where there is an option, discuss with the older person (or family carer where appropriate) their preferences and values regarding the setting in which they may wish to receive an assessment/intervention (domiciliary, primary, acute or tertiary setting)
- Obtain consent from the older person (or from those who have legal authority to act for the older person where appropriate) for any referral

2 Compile a list of services available for referral

- The list should include all internal and external agencies that provide services for older people in the relevant area as well as all health and social care services available for older people in the relevant area
- The list should be accessible to all team members as a shared document
- Responsibility should be assigned to a team member to regularly review and update the document

3 Develop a Standard Operating Procedure (SOP) for making referrals which is accessible as a shared file

- Discuss and document how referrals are to be prioritised for each discipline represented on the team.
- Create an agreed referral document for the team which provides a single triage point for referrals into the team. This document will record the information required to receive and prioritise a referral for each discipline on the team
- The SOP should acknowledge the importance of direct informal or verbal communication between team members that might support a referral where clarification or discussion may be required
- The SOP should document an agreed pathway for the timely management of urgent referrals
- Create a standardised mechanism by which receipt of a referral can be acknowledged for the person who has made the referral. This could be a standardised email or notification template.

4 Agree a standardised mechanism for communicating the referral to the older person (or family carer as appropriate)

- This mechanism should include documentation of which services the older person has consented to be referred to, why they have been referred and what will happen at that referral.

How to conduct oneself

The behaviours or attitudes of team members which enable or facilitate appropriate referrals include:

- respect for the will and preferences of the older person
- respect for capacity and workloads of other team members
- honesty and reflection from team members as to the suitability and the urgency of referral
- clear communication with the older person regarding why they are being referred, what they are being referred to, ensuring they consent to same, and what the referral will entail for them.

Mechanisms for Self-Evaluation:

The following are suggested mechanisms that could be used to monitor or measure competency in this domain:

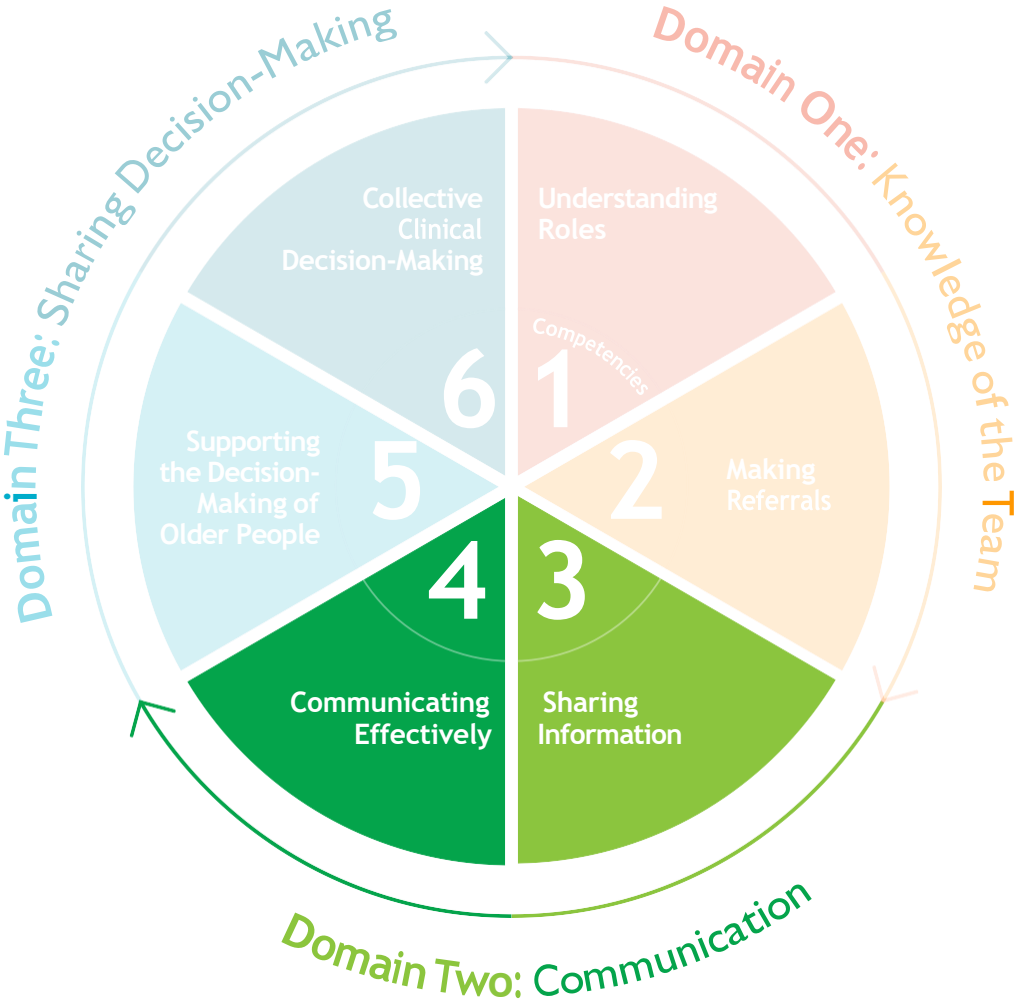
- A Standard Operating Procedure for making referrals has been agreed upon and developed by the team and is being adhered to. (See **Appendix Two**)
- Informed consent has been obtained from the older person (or from those who have legal authority to act for the older person, where relevant) for each referral
- The older person (or family carer where appropriate) has a document that details which services they have been referred to, why they have been referred and what they can expect from that referral
- A service directory (listing the services available in the area) is accessible to all team members and is regularly updated
- Appropriate referrals (right person, right info). When receiving a referral, each team member receives accurate information relevant to their function
- Duplicate, declined, and/or missed opportunities for referrals as identified from case review
- Episodes of missed, poor quality or unsafe care. Any identified episodes of poor quality or unsafe care should be followed up, if required, in line with the relevant HSE procedures for example incident management and safeguarding policy

Qualitative extracts

> *At the moment, I would say that I'm still kind of getting to **know the services that are there.** And like, even knowing what's there. And then the next step after that would **be having ways to contact people directly** […] I know forms are important and the passing on of information, but they can be quite anonymous and sometimes it doesn't **capture the kind of specifics of the case** and that information that you want to convey. So, when I think of good interprofessional collaboration, I think of kind of some kind of face to face or phone interaction where I actually am dealing directly rather than through "can you send on that referral? Can you send on that piece of paper?"*

> *Any time I wasn't sure. I came back and said, "I'm not sure about this person" and we discussed it, and they'd say, "no you're right to refer". So, it **was just trusting t**hat I would **use their information correctly**, but not overstep the mark and then refer on."*

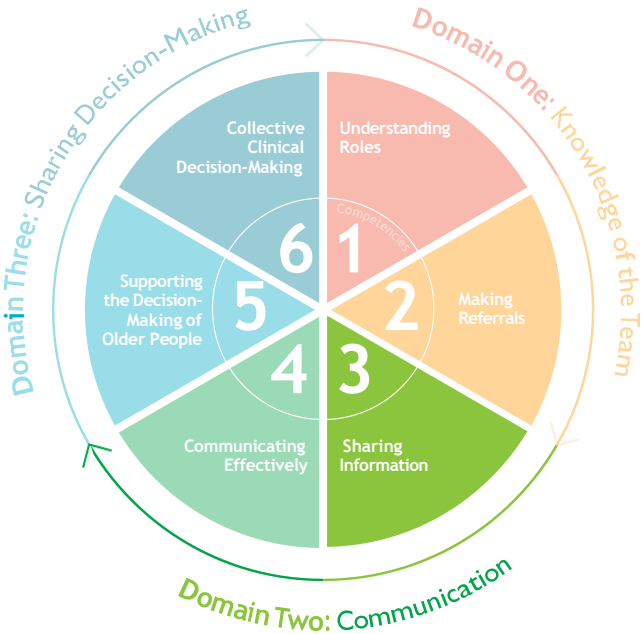
> *Like I would say, it's one of the strengths of it, it is they do accept our referrals. And there is a kind of a trust built up there in terms of the appropriateness of patients that were referring. It's very rare that we do get rejected - referrals into them."*



Domain Two:
Communication

The second competency domain describes the knowledge, skills and behaviours associated with communication which are core to interprofessional collaboration. This domain includes competency in sharing information as well as effective communication skills and behaviours.

Domain Two:
Communication



Central to this competency is the ability to apply professional judgement as to the information that should be shared and obtain relevant informed consent to share. Furthermore, it involves applying the most appropriate method of storing and sharing information which may involve having knowledge of and skills in the relevant Information and Communications Technology System.

Competency Three:
Sharing Information

How to do it: Getting started

Key Steps for building competency in **'Sharing Information'** within Interdisciplinary Care Teams working with Older People

1 **Identify what the relevant consent policy is and apply it**

- The consent policy should be accessible to all team members as a shared document.
- Elicit and record the older person's preferences and consent for what information can be shared with the team and other relevant parties for example a family carer.

2 **Co-design with the team a standardised dossier for recording information that can be shared**

- Where consent is provided, this dossier should include:
  - a copy of the discharge letter from acute setting as well as any other written documentation between HCPs
  - the comprehensive geriatric assessment
  - the documented care plan with a note on referrals made for the older person and a plan for discharge

3 **Provide a summary information document to the older person (or family carer where appropriate and where there is consent for same)**

- This should include their discharge letter from the acute setting, their care plan (including a medications list with information regarding duration of therapy and deprescibing rationale and plan), their plan for discharge from the interdisciplinary care team and a copy of any other written documentation between HCPs

4 **Identify what is the best available information and communication technology (ICT) system that can be utilised by the team for secure information storage and sharing across settings**

- Liaise with the ICT support services to establish the relevant infrastructure and receive support/training in utilising the platform

How to conduct oneself

The behaviours or attitudes of team members which facilitate or enable the sharing of information include:

- being respectful of older people's rights to privacy, autonomy and self-determination
- attending and engaging in team meetings
- being reflective and open about the type of information that is required by the team members to effectively perform their roles.

Mechanisms for Self-Evaluation:

The following are suggested mechanisms that could be used to monitor or measure competency in this domain:

- The relevant consent policy for information sharing has been identified and is accessible to all team members. This should include reference to accurate documentation about medicines
- The older person's preferences and consent regarding sharing information (who to share with and in what manner) is documented and reviewed regularly
- Every older person (or family carer as appropriate) has a copy of their assessment and care plan, their discharge letter as well as any written documentation between HCPs
- A standardised dossier has been co-designed by the team for recording information that can be shared (with consent) and is accessible as a shared document
- Consistent utilisation of the best available information and communication technology infrastructure

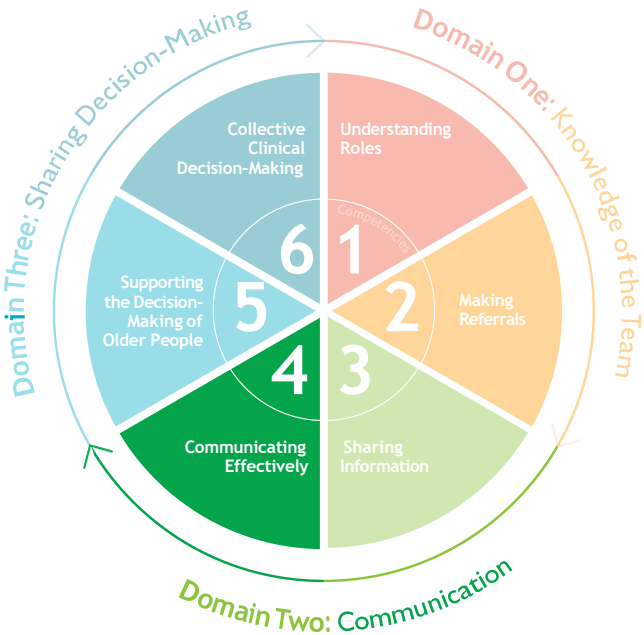
Qualitative extracts

> *That person needs to see six different disciplines to be assessed whereas actually* ***I can go in as one person and do all the basic screens****. I'm not an expert in any of them, but for them to allow me to do that is major because now* ***six people don't have to see the patient*** *and when we set up here, that* ***trust was developed****".*

> *…you'd use that knowledge as well to perhaps change the way you look at that patient. You know, just* ***bringing that knowledge together*** *so that everyone is aware of it, and obviously, your* ***understanding of the patient as a whole*** *would, you know, perhaps affect the way you may advise or educate that patient.* ***The patient gets the benefit*** *of having input from all the different people on the team and also, your* ***own knowledge would be improved****, you know. You know, there are certain times where you have very little insight into what other professions are doing and, yeah, yeah,* ***that's rewarding****, I suppose from your own personal development."*

> *And I think as the older people will be - they might have one person, let's say, who's keeping them in the loop or* ***each team member that does speak to the older person will actually be saying the same thing*** *as opposed to mixed messages from different team members because they're not communicating and collaborating with each other. I think it's more, I suppose, for the older person,* ***it's hopefully less repetitive, less disjointed****."*

Competency Four:
Communicating Effectively



Fundamental to this competency is an understanding of what needs to be understood, by whom and in what format? It involves using appropriate language, mediums and aids, if necessary, when communicating with team members, older people and family carers, as well as other professionals external to the team including voluntary, community groups and other agencies. Competency in effective communication involves seeking clarification of information when required, supporting the communication competence of others where necessary and ensuring that the relevant people are included in any conversation and that their voices are heard and acted upon.

How to do it: Getting started

Key Steps for building competency in **'Communicating Effectively'** within Interdisciplinary Care Teams working with Older People

1 Co-design a strategy for communication within the team and document it in an accessible and shared file

- Agree the format in which different types of information should be communicated within the team; for example what information should be communicated formally (written record or email)
- Limit the use of discipline specific terminology and if it is necessary provide a plain language definition.
- Where appropriate, minute team meetings in a file which is accessible and shared with the team (while adhering to the relevant consent policy for information sharing).

2 Identify the preferred method for communication with the older person (and their family carer where appropriate)

- Document the older person's preferred communication methods on the shared comprehensive geriatric assessment document which is accessible to all team members
- Inform the older person (and family carer as appropriate) who the key worker for their case is and provide their contact details
- Limit the use of discipline specific terminology or jargon when communicating with an older person or family carer; use plain language explanations
- Ensure that the preferred methods of communication are used when informing the older person about their care plan (including referrals and discharge plan).

3 Support the communication competence of older people, and/or their family carer where relevant, who have complex communication needs

- Where support with communication competence is required, engage the member of team who has the relevant disciplinary expertise as the key worker for this case.
- Avail of opportunities to professionally develop skills in accessible communication and supporting communication competence
- Supporting communication competence may involve the engagement of translators. This must comply with the relevant consent policy for information sharing.

4 Identify a key worker in any given case

- The key worker is responsible for ensuring critical information relevant to a case is highlighted and communicated to the necessary team members within the immediate interdisciplinary care team and other relevant services/teams.
- The key worker is a primary point of contact for the older person (and family carer where appropriate) assisting them to coordinate their care and communicate with the team

How to conduct oneself

The behaviours or attitudes of team members which facilitate or enable effective communication include:

- The appropriate use of verbal and non-verbal communication
  - body language (e.g. facial expression, eye contact, gestures, posture)
  - tone of voice
  - words
  - physical space
  - active listening
  - empathy and respect.

Mechanisms for Self-Evaluation:

The following are suggested mechanisms that could be used to monitor or measure competency in this domain:

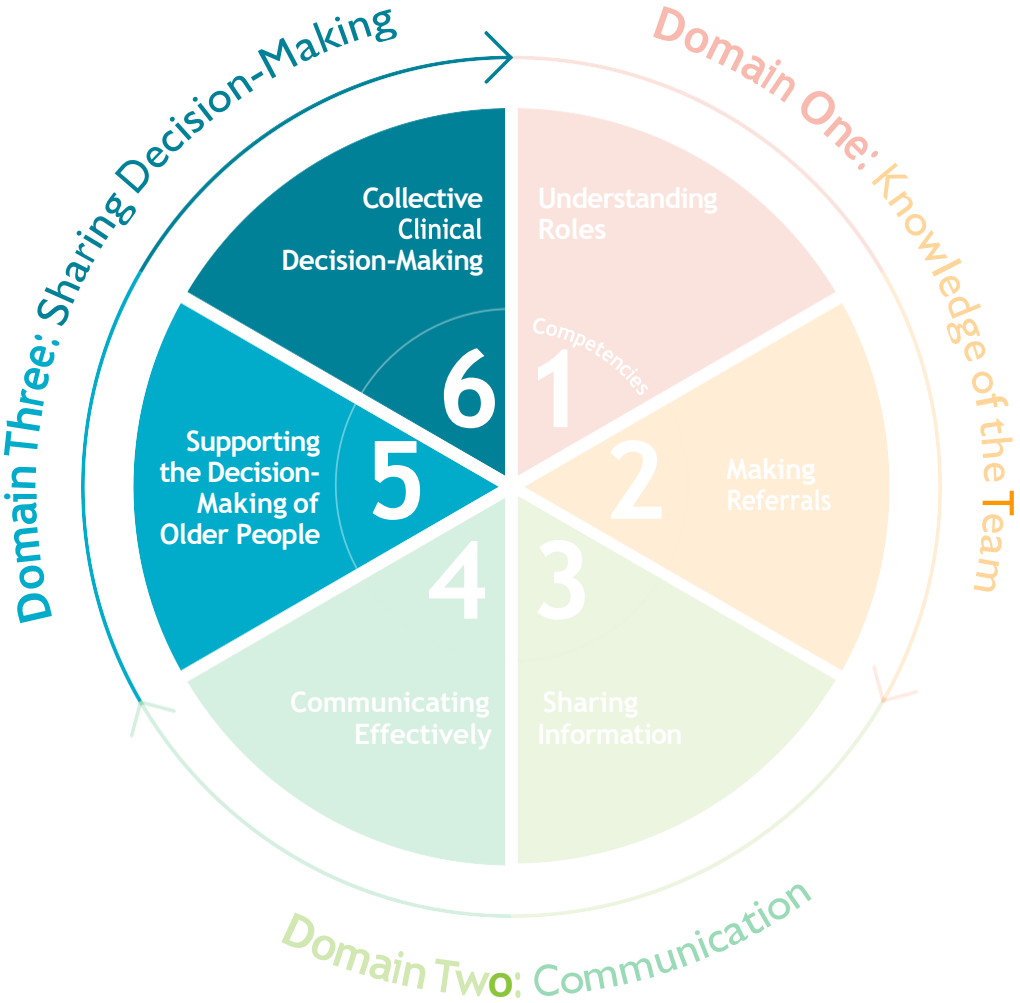
- A strategy for team communication has been developed and is accessible to all team members
- Consistent utilisation of the older person's preferred methods of communication (for example, verbal, written or communication aid)
- Provision of consistent information to older persons (or family carer where relevant) from all team members
- A key worker is identified for any given case. The older person (or family carer where relevant) is aware of who their key worker is
- Regular measurement of conflict with a team approach to resolution should conflict be identified

Qualitative extracts

> *I think **a shared working space**. So, at the moment we all work in different offices and hospitals and I think we should all be in the same office. I'm used to working in places where we all shared offices and I think that breaks a lot of barriers. It really helps communication for patients. Everything I think is a lot better. So, I think that is a really key thing to have. And obviously good communication between teams, **weekly meetings** is really important. I believe in **joint goal planning.** I came from a place where we would've done that weekly and also **joint outcome measures**."*

> *I suppose the skills would be just communication skills because you know, **all the verbal and written** and all of that. And I think just being a **good listener and asking the right questions** to patients and that as well to find out what they might benefit from or who they've already seen."*

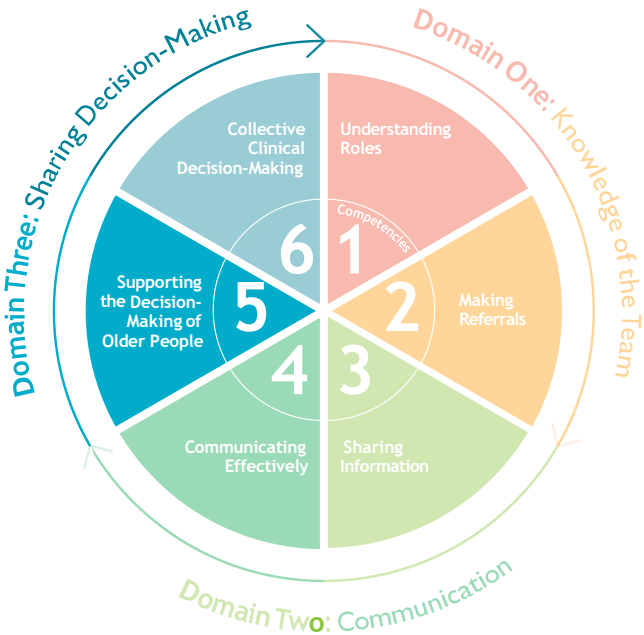
> *But there's no **formal information sharing** at all other than, I suppose, you might - again for time reasons and because the caseload, we don't always even do a discharge letter, but you might do at that point, or if you're concerned about something badly enough, you might write a letter to the GP. Other than that, it tends to be a phone call. But like there's no way at the moment of me saying, let's say the occupational therapist or the speech therapy knows or saying what they are thinking. So other than communicating directly with that person, there isn't really any sharing of information. There's **no single file** or anything like that",*



Domain Three:
Sharing Decision-Making

The third domain refers to the knowledge, behaviours and skills required by interdisciplinary care teams working with older people to harness collective intelligence to share decision-making within teams as well as with older people. This core competency, for interprofessional collaboration, includes proficiency in supporting older people to be involved in decisions that affect their lives. Furthermore, knowledge and skills related to collective and shared approaches to decision-making within the team are recognised.

Domain Three:
Sharing Decision-Making



Central to this competency is that the will and preference of the older person take centre stage. This requires knowledge and skills in supporting the decision-making capacity of all older people, including those with cognitive or communication impairment. Mechanisms for assisting the decision-making of older people include the strategic use of decision-supporters such as family carers as well as knowledge of advanced care plans, enduring powers of attorney, or statements of values and preferences. This competency necessitates a shared commitment within the team to proportionality in balancing the care of an older person with their right to autonomy, freedom of choice and control over what is important to them.

Competency Five:
Supporting the Decision-Making of Older People

How to do it: Getting started

Key Steps for building competency in 'Supporting the decision-making of older people' within Interdisciplinary Care Teams working with Older People

1 Undertake continuing professional development and training in supporting the decision-making capacity of all older people

- Review the resources and information on the Assisted Decision-making (Capacity) Act 2015 provided by the HSE National Quality Improvement Team
- Download and play the UCD Promoting Assisted Decision-making with Older People in Acute Care Settings (PADMACS) educational discussion game. Estimated time to complete is one hour: **www.tinyurl.com/UCD-PADMACS**

2 Foster a team culture of including the older person as a partner in their care

- Complete this Co-Lead module to explore the strategies and tools that can be used to create a culture of person-centred care as a team. Estimated time to complete is one hour: **www.ucd.ie/collectiveleadership/resourcehub/toolkit/enhancingperson-centredcare**

3 Co-design with the team a values statement which recognises an older person's will, preferences and values as the drivers for all care planning and decision-making

- The values statement should be accessible to all the team members as a shared file (see **Appendix Four**)
- Team meetings and discussions for care planning should be underpinned by the values statement

4 Encourage and where necessary assist an older person to express their will, preferences and values in relation to their care

- Ascertain and document the older person's will, preference and values in relation to their health and social care with reference to an advance healthcare directive should one exist.
  - This may require consultation with decision-supporters such as family carers.
  - This may require the utilisation of professional expertise in supporting communication competence
- Team meetings and discussions for care planning should refer explicitly to the documented will, preferences and values of the older person

How to conduct oneself

The behaviours or attitudes of team members required to facilitate assisted decision-making with older people include:

- actively seeking, encouraging and supporting the older person to input into care planning conversations and decisions
- being open and reflective about one's values concerning balancing individual autonomy with a duty of care
- recognising the centrality of the older person in all decision-making

Mechanisms for Self-Evaluation:

The following are suggested mechanisms that could be used to monitor or measure competency in this domain:

- The older person's will, preferences and values for care planning and decision-making have been ascertained and are documented in an accessible file.
- The older person's will, preferences and values are identified and discussed in all care planning conversations
- Where clinical and care planning decisions are made, they are explicitly aligned with the older person's will, preferences and values
- All team members are undertaking CPD concerning the implementation of the ADM(C) Act 2015. Opportunities for training and professional development are available from the National Office for Human Rights and Equality Policy (HSE)

Qualitative extracts

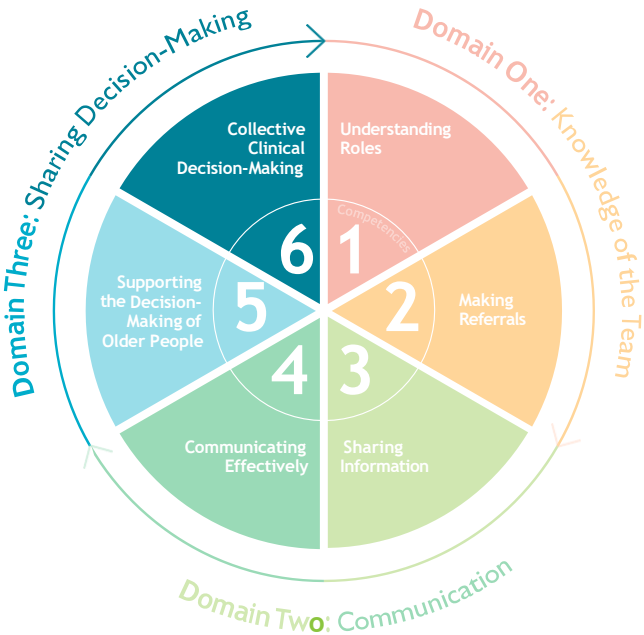
I find that from my perspective when it works well, that I'm able to make sure that the person, that the interventions I'm suggesting for them, […] People are ***still able to make their own choices and decide*** *whether they want to do that or not. So, when we work pretty well together, and people's choices are at the higher self".*

Being able to create, I suppose, almost like ***joint goals for your patient*** *can be helpful sometimes and being quite organized, a bit of fun actually, like that, you're able to get along with your colleagues and it's not just - obviously that it is work - but it* ***doesn't always feel totally like work****. I'm trying to, I think. I think you have to be there sometimes to be, you know, a solidified member of a team and I think that can kind of be hard.* ***You need to be seen - not just seen to be there, but you just need to be present****, and I think that's very important."*

Helping people to, I suppose, ***consider what their wishes would be in the future, making sure that the voice of the service user is heard****, mediating between family members and assessing capacity. […] a family member might want long term care, but the person doesn't want it and assessing whether there's any cognitive issues or any concerns that the person might be forced into something that they don't want."*

Domain Three:
Sharing Decision-Making

Competency Six:
Collective Clinical Decision-Making



Central to this competency is inclusivity and value for disciplinary knowledge and expertise. This competency requires the harnessing of collective input for care planning by actively eliciting every team members' insight and expertise into the discussion. The individual with the relevant expertise/disciplinary competence related to the decision being made is enabled to take the lead with the older person. However, they do so following collaboration, and the team takes collective responsibility for the care planning.

How to do it: Getting started

Key Steps for building competency in **'Collective Clinical Decision-making'** within Interdisciplinary Care Teams working with Older People

1 Set the team goals to include a commitment to collective decision-making in care planning with older people

- Complete this module to obtain clarity around your team goals for integrated care and develop assessment criteria to monitor progress on these goals. Estimated time to complete is one hour: **www.ucd.ie/collectiveleadership/resourcehub/toolkit/teamgoalsetting**
- Co-design and document the team goals on an accessible and shared file

2 Gather collective input of all team members for collaborative team decisions

- Elicit every team members' input into decision-making. Particular emphasis should be given however, to the input of team members who have the most relevant professional expertise for a particular decision.
- Complete this module on developing a positive work environment through collective leadership. Estimated time to complete is one hour: **www.ucd.ie/collectiveleadership/resourcehub/toolkit/developingapositiveworkenvironment**

3 Build and measure psychological safety in the team

- Encourage inter-personal relationship building within the team to build confidence for free expression of ideas and opinions
- The instrument developed by O'Donovan et al. (2020) is suggested here for measuring Psychological Safety within interdisciplinary healthcare teams. (See **Appendix Three**)
- Agree with the team what are the processes for addressing any psychologically unsafe behaviours within the team.

4 Schedule regular team meetings and monitor attendance

- Attend and participate in scheduled team meetings
- Encourage open and honest reflection upon team working and collaboration with regular (at least monthly) retrospective case review of decision-making

How to conduct oneself

The behaviours or attitudes of team members which enable or facilitate collective clinical decision-making include:

- open debate and negotiation of positions with respectful, active listening
- speaking up and advocating for an older person from one's own disciplinary and professional expertise
- a willingness to change opinion because of emerging and synthesised evidence and/or team disciplinary knowledge and expertise
- all team members are encouraged to express their ideas even if other team members disagree
- teams take collective responsibility for team decisions regardless of who led on implementing the decision

Mechanisms for Self-Evaluation:

The following are suggested mechanisms that could be used to monitor or measure competency in this domain:

- Knowledge of the team's co-designed goals and every team member has access to a shared file that documents these goals
- Team discussions for care planning actively elicit the input of all team members
- Issue-specific decision-making is led by the team member with the most professional competence for that issue.
- Frequency of team meetings and regular attendance
- Psychological safety within and across the team (see **Appendix Three**)
- Regular measurement of conflict with a team approach to resolution should conflict be identified

Qualitative extracts

> *I suppose like the behaviours towards your colleagues. I think again, it comes back down to sort of* ***openness, willingness****. You know, that's just huge, you know, for any kind of the professions other than medicine. You know, I think you kind of need to* ***feel that you're there for a purpose****. You know, we're all kind of quite highly trained and highly educated. You don't want to be there thinking that you're not wanted or you're wasting your time. So, I think that there has to be* ***an openness****. I mean, invariably it comes out that the medic is the lead. They're the person who diagnoses, treats, you know, and then everything else is a little bit kind of more specialist or peripheral. There has to be openness and willingness to* ***utilise colleagues, colleagues' skills and expertise*** *[…] we're all there kind of for the same end, you know, like we're all there for the patient."*

> *I suppose in an ideal world, we all, we all do want the best outcome for the patient, but there are different personalities and priorities,* ***people will have different opinions as to what their priorities are.*** *And that is, I suppose, one of the beauties and one of the hardest things about working Interdisciplinary is that you do have like competing priorities amongst the MDTs I think that's something that I've learned quite a lot over my last year kind of working in the team- is making sure that, even though you put your priorities across****, it's important to listen to other people*** *because at the end of the day, it's not about my priorities,* ***it's about the patients' needs****. […] it's down to not letting personalities dictate or to change what's at the core".*

> *I think our MDT meetings have evolved to kind of where there's really* ***good trust in opinions****. And I think something that's kind of helped with that is when you see other people* ***acting on what you've said*** *at the meeting. So, at our meetings now, the consultant turns around to the therapists and says, "you know this person, do you think they're a good candidate for rehab?", and on the basis of what is said in that two-minute conversation, the consultant goes, "okay, I'll take them across this afternoon" and that kind of, you know, not questioning. […] that seems to have really strengthened our meetings and* ***it means that everybody goes to the meeting****. So, like, you're actually at a loss if you don't turn up at it".*

Conclusion

This framework has described six co-designed core competences grouped within three domains for effective interprofessional collaboration in an interdisciplinary care team integrating older people's care. This resource can be used within teams as well as across teams (for example community ambulatory hubs and primary care teams) to develop and enhance interprofessional collaborative working. We provide step-by-step guidance on getting started in building these competences within, and between, interdisciplinary health and social care teams working with older people. This guidance resulted from a co-design process with key stakeholders. These stakeholders included experts by experience and public and patient representatives as well as health and social care professionals. These HCPs represented multiple disciplines collaborating in the care of older people including all those represented by the Health and Social Care regulatory body (**www.coru.ie**) as well as medicine, nursing and pharmacy. The guide describes the knowledge, practices and skills for demonstrating competence in interprofessional team working in the context of older people's care. These competences are aligned to collective and shared approaches to leadership and decision-making within healthcare teams. Furthermore, mechanisms for developing and monitoring proficiency are suggested for each of the core competences.

The framework aligns with the Sláintecare Implementation Strategy and Action Plan (Government of Ireland, 2020, 2021). The ultimate goal of Sláintecare is a reorientation of the health service in Ireland towards a high quality integrated system where the vast majority of care takes place in primary and community settings (Committee on the Future of Healthcare, 2017). The first phase of its implementation strategy has identified new models of care to deliver more effective and integrated care as a strategic action. The guidance for building competences in interprofessional collaboration described in the framework will support the planned scale-up of integrated care for older people in Ireland, in line with the Sláintecare strategy (HSE, 2017).

Next Steps

The next phase of the ECLECTIC programme of research will involve implementing and evaluating the competences outlined in this framework within interdisciplinary care teams delivering integrated care with older people. This will include a realist process evaluation approach in examining what works, for whom and in what contexts for developing competence in interprofessional collaboration within interdisciplinary teams integrating care with older people? This will progress the framework by examining its application to the developing integrated care teams in Ireland. A significant element of this evaluation will be the prospective exploration of the care experiences of older people and their carers who are collaborating with integrated care teams in their own care. This will add a powerful dimension to the programme of research as we examine what matters for older people in their care and how integrated care teams respond to the changing care needs of older people over time. This realist evaluation will provide a contextual understanding of the competences and importantly will assist with developing appropriate mechanisms for implementation and outcomes for assessing impact.

The final phase of the ECLECTIC programme will be to embed the competences, including the mechanisms and outcomes relevant for implementation, into the education of all health and social care professionals who work across the healthcare system providing integrated care to older people. This will involve co-design with stakeholders, including older people, of inter-disciplinary professional programmes for graduate and continuing professional education and development. In this way, the ECLECTIC programme of research will contribute to the implementation of Sláintecare through the building of a sustainable and resilient workforce who are supported to collaborate in interdisciplinary disciplinary teams integrating care with older people across healthcare settings.

Appendix One: Collective Leadership (Co-Lead) Modules

The UCD Co-Lead Toolkit is a series of modules designed to enhance collective leadership among interdisciplinary healthcare teams. The modules take the form of group workshops, each lasting approximately one hour. The following seven modules align with the six domains of competences described in this framework. They are:

Module		The link to resources/materials on Co-Lead Website is
Establishing Team Values, Vision and Mission	This module enables the team to collectively develop their vision for integrated care and set a series of goals to achieve interprofessional working, which is fundamental to establishing integrated care.	www.ucd.ie/collectiveleadership/resourcehub/toolkit/teamvaluesvisionandmission
Team Goal Setting	This module enables the team to obtain clarity around their goals for integrated care and develop assessment criteria to monitor their progress on these goals. The module will help to create a shared team vision.	www.ucd.ie/collectiveleadership/resourcehub/toolkit/teamgoalsetting
Role Clarity of Team Members	Through this module, team members are enabled to learn of the impact of role clarity for successful interprofessional working, through an exercise to explore and enhance role clarity.	www.ucd.ie/collectiveleadership/resourcehub/toolkit/roleclarity
Collective Leadership for Enhancing Patient-Centred Care	Through this module, team members will explore the strategies and tools that can be used to create a culture of person-centred care as a team. This module introduces team members to the basic concepts of including the patient as a partner in their care, fostering empathy and ensuring that their voices are heard, and their experience is valued.	www.ucd.ie/collectiveleadership/resourcehub/toolkit/enhancingperson-centredcare
Collective Leadership for Developing a Positive Work Environment	Through this module, team members will be enabled to discuss possible steps to create a more positive work environment where members feel more engaged and valued. The goal is to agree on three key initiatives to implement and concrete actions to make them happen so that team members' sense of meaning and fulfilment in work can be improved.	www.ucd.ie/collectiveleadership/resourcehub/toolkit/developingapositiveworkenvironment
Building Trust	Through this module, team members will identify the strong areas of their teams and build mechanisms of mutual support. The goal is for team members to feel more supported in times of difficulty, and to foster a climate of trust to facilitate people in being open about errors and mistakes.	www.ucd.ie/collectiveleadership/resourcehub/toolkit/monitoringcommunicatingsafetyperformanceatteamlevel/
Monitoring and Communicating Safety at Team Level	Through this module, team members develop an improved understanding of how they collectively perform from a safety perspective and identify particular quality and safety performance measures that would be meaningful for them to understand/improve performance.	

Appendix Two: Guide for Standard Operating Procedures for Making Referrals

It is recommended that teams develop standard operating procedures (SOPs) to rationalise and prioritise referrals with input from all disciplines. The following guidance for developing an SOP has been developed from the qualitative research conducted for this project as well as from a review of key HSE reports:

- HSE (2016) *HSE National Framework for Developing Policies, Procedures, Protocols and Guidelines (PPPGs).* National Quality Improvement Division and National Clinical Strategy and Programmes Division **www.hse.ie/eng/about/who/qid/use-of-improvement-methods/nationalframeworkdevelopingpolicies/hse-national-framework-for-developing-policies-procedures-protocols-and-guidelines-pppgs-2016.pdf**
- HSE (2021) *Practice Guidance for Older Person Multi-Disciplinary Teams.* National Integrated Care Programme, Older Persons.

  https://e5d92a21-97f5-4bb2-a19b-4faf7c230064.filesusr.com/ugd/29601c_95cb3cf0224346658f8bf734a3c934f6.pdf
- HSE. *Enhanced Community Care Implementation Guidance.* National Clinical and Integrated Care Programmes. **www.hse.ie/eng/about/who/cspd/icp/older-persons**. (This guide contains a resource pack to provide information to local sites as they implement their end-to-end pathway for integrated care of older people).
- HSE. (2017). *Making a Start in Integrated Care for Older Persons: A practical guide to the local implementation of Integrated Care Programmes for Older Persons*. National Clinical and Integrated Care Programmes. **www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/a-practical-guide-to-the-local-implementation-of-integrated-care-programmes-for-older-persons.pdf**
- HSE. (2012). *Advancing the Shared Care Approach between Primary Care & Specialist Mental Health Services: A Guidance Paper*. HSE National Vision for Change Working Group. **www.hse.ie/eng/services/publications/mentalhealth/advancing-the-shared-care-approach-between-primary-care-specialist-mental-health-services.pdf**

Team members must know what services are available to the older persons in their care and what each service involves, how to access them (the pathways), waiting times, what the referral criteria are, what information is required to be provided in the referral, how this information should be shared, how each of the services prioritises patients/older persons, how information is to be shared with the older person, the older person's will and preferences and whether they would be able to avail of and benefit from the service.

Team members must be particularly aware of the different elements of the integrated services for older people, as they develop (specialist ambulatory care hubs, frailty at the front door service and the acute inpatient pathway of care for older people), and understand the services each provides, the pathways/links between the services and, where appropriate, the point of contact for the older persons and their families and carers.

Mapping services

The HSE (2017) practical guide to local implementation of integrated care programmes for older people details an Action Point entitled "Map local care resources", within the ten-step framework for implementation contained in the guide. This action point refers to the need to,

> *Identify, map and develop a directory of all healthcare resources, agencies and groups in the area, that are central to the development of sustainable integrated care for older people"*
> *(HSE, 2017, p. 14)*

The report proceeds to identify categories and types of services relevant to local implementation (HSE, 2017, p. 15). These include:

- Existing health and social care resources, for example, acute hospitals, day hospitals, rehabilitation, long term care facilities, ambulatory care, primary care teams, day centres, home care, pharmacies
- Structures in place spanning hospital and community, for example, community intervention teams, OPAT programme, palliative care services, integrated care teams for older persons
- Special interest groups in the community, for example, active retirement, older person councils, age and opportunity, local community development committees, Muintir Na Tire
- Existing community resources, for example, family resource centres, senior citizens' clubs, day centres, GAA social initiatives, community groups
- Existing initiatives for older persons in the community, for example, OPRaH (Age Friendly Ireland) and the Nesting Project in County Louth.

A coordinated approach to this mapping process was identified as important by the co-design team for this project. This was also highlighted by the qualitative interview participants. They noted this approach should involve representatives from all services and should include organised networking and collaboration events for representatives to attend and share information.

Standardising procedures for making effective referrals

Members of the teams involved might consider,

- The adoption of agreed standardised referral and discharge forms that could improve the communication pathway between the services
- A structured assessment process is identified as being a key factor in identifying patients for appropriate services; a detailed and structured assessment at the time of referral, such as the interRAI, which screens for frailty, helps to determine the most appropriate care pathway and avoid inappropriate referrals. The use of the Comprehensive Geriatric Assessment (CGA) is advocated by the local implementation guide developed by the HSE (2017):

> *"Comprehensive Geriatric Assessment (CGA) is the organised approach to assessment designed to determine an older person's medical conditions, mental health functional capacity and social circumstances. Its purpose is to co-ordinate and develop an integrated plan for treatment and rehabilitation, support and long-term follow up" (HSE, 2017, p. 17).*

- Developing a practical guide on differences in the referral criteria between the services and how each service prioritises referrals
- Include in the guide, information as to what constitutes an appropriate referral to service. This will improve understanding of what problems, issues and conditions are appropriate to refer to and those that are not
- Include in the guide information on what engagement in the service will involve for the older person and, if appropriate, whether the condition of the older person, including their physical, social, mental and/or cognitive condition, might preclude them from availing of the service
- The average waiting times for priority and non-priority referrals

Standardising processes for effectively sharing information among services

Members of the teams involved might consider,

- The communication pathways for sharing information regarding the referral between relevant services, including a process for acknowledging receipt and acceptance of referrals
- Understanding what information and community technology platforms are available/accessible by team members and ensuring that people are skilled in using them
- Consider how information might be shared in the absence of information and technology platforms
- Including contact details of team members in the directory of services
- The role of the case manager and/or keyworker, if one were appointed, in sharing information

Standardising processes for effectively sharing information with the older person

Older persons must know,

- What is being proposed in terms of referral to services, the reason for the referral and what availing of the service will entail and what to expect at the appointment, as well as waiting times, so that they can provide informed consent

Appendix Three: Resources for Measuring and Monitoring Competences

Psychological Safety

Recent literature reviews have highlighted the need for mixed-methods (surveys and observational methods) approaches to explore teamwork in healthcare and psychological safety (Edmondson & Lei, 2014; O'Donovan & McAuliffe, 2020).

Research undertaken by O'Donovan et al. (2020) describes how existing measures of psychological safety (surveys and observational methods) were adapted and developed to measure psychological safety in healthcare teams. The resulting measurement tool is based on valid and reliable survey items and was validated by healthcare professionals to ensure it is tailored for healthcare settings. It is the first survey measure of psychological safety to have involved the target audience (healthcare professionals) in the developmental stage. The observational component is equally grounded in the healthcare and psychological safety literature and offers a dynamic, team level measure of psychological safety. The authors state that healthcare teams can use this composite measure to learn about and improve psychological safety within their team and say that, "By gaining a better understanding of psychological safety in healthcare teams and using this knowledge to develop and implement interventions to improve psychological safety, we can increase the team's ability to learn, co-ordinate care and make decisions that will ultimately result in higher team performance" (O'Donovan et al., 2020, p. 16).

The measurement tool developed by O'Donovan, et al (2020) appears below. It is intended to be used by healthcare teams to assess team psychological safety and track changes over time. The measurement tool has yet to be fully validated.

O'Donovan, R., Van Dun, D., & McAuliffe, E. (2020). Measuring psychological safety in healthcare teams: Developing an observational measure to complement survey methods. BMC Medical Research Methodology, 20(1), 203. https://doi.org/10.1186/s12874-020-01066-z

Please respond to the following questions by indicating your response between 1 = strongly disagree and 7 = strongly agree

Section 1. Please answer the following questions in relation to your team leader

	Strongly disagree ◀						▶ Strongly agree
Questions	1	2	3	4	5	6	7
1. If I had a question or was unsure of something in relation to my role at work, I could ask my team leader							
2. I can communicate my opinions about work issues with my team leader							
3. I can speak up about personal problems or disagreements to my team leader							
4. I can speak up with recommendations/ideas for new projects or changes in procedures to my team leader							
5. If I made a mistake on this team, I would feel safe speaking up to my team leader							
6. If I saw a colleague making a mistake, I would feel safe speaking up to my team leader							
7. If I speak up/voice my opinion, I know that my input is valued by my team leader							
8. My team leader encourages and supports me to take on new tasks or to learn how to do things I have never done before.							
9. If I had a problem in this company, I could depend on my team leader to be my advocate							

Section 2. Please answer the following questions in relation to your peers/the other members of your team

	Strongly disagree				Strongly agree		
Questions	1	2	3	4	5	6	7
10. If I had a question or was unsure of something in relation to my role at work, I could ask my peers							
11. I can communicate my opinions about work issues with my peers							
12. I can speak up about personal issues to my peers							
13. I can speak up with recommendations/ideas for new projects or changes in procedures to my peers							
14. If I made a mistake on this team, I would feel safe speaking up to my peers							
15. If I saw a colleague making a mistake, I would feel safe speaking up to this colleague							
16. If I speak up/voice my opinion, I know that my input is valued by my peers							

Section 3. Please answer in relation to your team as a whole

	Strongly disagree						Strongly agree
Questions	1	2	3	4	5	6	7
17. It is easy to ask other members of this team for help							
18. People keep each other informed about work-related issues in the team							
19. There are real attempts to share information throughout the team							

Compared to similar meetings with your team how different was

Questions	Very different	Different	Slightly Different	Neutral	Slightly different	Not different	Not at all Different
20. This meeting?							
21. Your behaviour during this meeting							
22. The behaviour of your colleagues							

Observation Template and Survey Results

Measurement	Psychological Safety Towards Team Leader		Psychological Safety Towards Other Team Members		Psychological Safety in Relation to Team as a Whole	
Survey Results	Mean	Standard Deviation	Mean	Standard Deviation	Mean	Standard Deviation
Total Observed Behaviours Displayed by:	**Team Members**		**Team Leader**	**Team Members**	**Team Leader**	**Team Members**
Voice Behaviours						
• Communicating opinions to others even if they disagree						
• Asking questions						
• Providing information						
• Providing feedback						
• Providing help or solutions						
• Correcting others						
Defensive Voice Behaviours						
• Denying faults or blame others						
• Showing aggression						
• Evading confrontation by focusing only on positives						
Silence Behaviours						
• Facial expression or body language indicates fear						
• Facial expression or body language indicates disengagement						
• Closed body language						
Supportive Behaviours						
• Sharing procedures, knowledge and experience						
• Sharing future plans						
• Active listening						
• Use of inclusive language such as “we”						
• Agreeing/Responding positively or enthusiastically to input						
• Acknowledging achievements/ congratulating						
• Delegating tasks						

Total Observed Behaviours Displayed by:	Team Members	Team Leader	Team Members	Team Leader	Team Members
Unsupportive Behaviours					
• Interrupting					
• Discussions within small sub-groups					
• Reacting cold/ignoring a joke					
Learning or Improvement Oriented Behaviours					
• Reviewing own progress and performance					
• Asking for feedback					
• Asking for help or solutions					
• Asking for input from all meeting participants					
• Informing the team about issues or mistakes related to patient safety or staff safety					
• Looking for improvement opportunities and speaking up with ideas					
• Acknowledging own mistake					
Familiarity Behaviours					
• Talking about personal, non-work matters					
• Laughing about a joke					
Total Observed Behaviour					
Categories indicating high psychological safety: (voice behaviours, supportive behaviours, learning or improvement behaviour and familiarity behaviours)					
Categories indicating lower psychological safety: (defensive voice behaviours, silence behaviours and unsupportive behaviours).					

Trust

High levels in team trust have been found to result in more positive workplace behaviours and attitudes such as more open communication and information sharing, high job satisfaction, organisational citizenship behaviour and greater commitment to the organisation (Feitosa et al., 2020). Within teams, trust is associated with improvements in communication, teamwork and superior levels of communication (Costa & Anderson, 2011).

There is no established widely used measure of team trust in healthcare. The instrument developed by Costa and Anderson (2011) is suggested here as having a potential application for interdisciplinary healthcare teams. It is a multifaceted measure of intra-team trust using four indicators (propensity to trust, perceived trustworthiness, cooperative behaviours and monitoring behaviours). The instrument was piloted with employees of three hospitals and three social care organisations in the Netherlands. The instrument may be used to obtain a better understanding of trust within a team as it enables teams to recognise the presence or absence of trust through the four indicators and to intervene if necessary to improve or maintain that trust.

Costa, A. C., & Anderson, N. (2011). Measuring trust in teams: Development and validation of a multifaceted measure of formative and reflective indicators of team trust. *European Journal of Work and Organizational Psychology*, *20*(1), 119-154. https://doi.org/10.1080/13594320903272083

Items and subscale composition of the final 21-item measure of trust in teams

(All items measured on a 7-point response scale (1 = "completely disagree", 7 = completely agree"). Reverse scored items denoted by (r))

Propensity to trust

1. Most people in this team do not hesitate to help a person in need
2. In this team most people speak out for what they believe in
3. In this team most people stand behind their convictions
4. The typical person in this team is sincerely concerned about the problems of others
5. Most people will act as, "Good Samaritans" if given the opportunity
6. People usually tell the truth, even when they know they will be better off by lying.

Perceived trustworthiness

1. In this team people can rely on each other
2. We have complete confidence in each other's ability to perform tasks
3. In this team people will keep their word
4. There are some hidden agendas in this team (r)
5. Some people in this team often try to get out of previous commitments (r)
6. In this team people look for each other's interests honestly

Cooperative behaviours

1. In this team we work in a climate of co-operation
2. In this team we discuss and deal with issues or problems openly
3. While taking a decision we take each other's opinion into consideration
4. Some people hold back relevant information in this team (r)
5. In this team people minimise what they tell about themselves (r)
6. Most people in this team are open to advice and help from others

Monitoring behaviours

1. In this team people watch each other very closely
2. In this team people check whether others keep their promises
3. In this team most people tend to keep each other's work under surveillance

Appendix Four: Co-designing a Values Statement

A key step for interdisciplinary teams building proficiency in supporting the decision-making of older people (Competency Five) is to co-design a values statement that recognises an older person's will, preferences and values for all care planning and decision-making.

Agreeing and establishing the values of the interdisciplinary team is an ongoing process and require regular review and discussion to ensure they continue to be fit for purpose.

Values:

- Provide a common sense of purpose and identity;
- Provide long-term direction; and
- Communicate internally and externally what this interdisciplinary team is about.

A sample values statement

Our work is guided and informed by our beliefs and commitments to:

- **Shared decision-making**– we respect older people's right to autonomy, freedom of choice and control over what is important to them.
- **Participation** – we value and recognise the contribution of all team members as well as older people in inclusive care planning
- **Quality** – we strive for optimum and safe outcomes for older people which is proportionately balanced with the autonomous will and preferences of the older person
- **Openness** - we are committed to a culture of collective clinical leadership which values each disciplinary input and voice in decision-making and care planning

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