ECLECTIC STUDY Resource Pack

Strengthening Interprofessional Collaboration for The Integrated Care Programme for Older People (ICPOP) Community Specialist Teams

UCD DUBLIN

HSE

ncpop National Clinical Programme for Older People

HRB Health Research Board

Age Friendly IRELAND

OLDER PEOPLE

Family Carers Ireland Fairness for Carers

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Introduction

This resource pack is designed to support the Integrated Care for Older People – Community Specialist Teams (ICPOP-CST) participating in the UCD ECLECTIC project. It aims to assist teams in developing priority areas identified during data collection for the project.

Background

The ECLECTIC project aims to support ICPOP-CSTs in the optimisation of interprofessional collaboration in their teamwork. It is a multi-phase project involving three waves of data collection. During the first wave, qualitative and quantitative data were gathered through one-to-one interviews with ICPOP team members, operational leads, and clinical leads. Weekly team meetings were observed, and documents such as admission/referral criteria, discharge criteria, and policies were collected from the four teams. Additionally, an online survey was completed by the ICPOP team members. The first wave was completed in September 2024.

Following the analysis of wave one data, feedback reports were prepared for the participating teams. These reports highlighted key findings from the analysis of the data. The main findings were categorised into *"Existing strengths for optimising performance"* and *"Potential focus areas for optimising performance."* Feedback sessions were then held with the four ICPOP teams in October and November 2024, where findings were presented. At the end of each session, teams reflected on the feedback and identified priority areas for optimising team performance over the next six months.

As a result, this resource pack was developed to support ICPOP teams in addressing their prioritised focus areas.

Purpose of the Resource Pack

This resource pack provides resources and strategies to support ICPOP teams in addressing their prioritised focus areas.

The focus areas are grouped under three domains. These are: *Professional Identity and Growth*, *Information Sharing and Care Coordination across Boundaries*, and *Quality Improvement and Programme Development*. For each focus area, we have identified activities as outlined below, which have been designed to help teams optimise their performance in that area. Each activity is linked to a resource that provides more details on completing the activity and the related topic.

1. Professional Identity and Growth

- Developing a Mission, Vision, and Values Statement
- Creating Role Descriptors
- Team Goal Setting
- Psychological Safety
- Interprofessional Team Building
    - PADMACS PlayDecide Game
    - CLARITY PlayDecide Game

2. Information Sharing and Care Coordination across Boundaries

- ICT infrastructure for information sharing and management for care planning
- Care Coordination and Workflow Models
- Triage Processes

3. Quality Improvement and Programme Development

- Building competency
- Measuring Impact
- Mapping Patients Care Journeys

1 Professional Identity and Growth

This section provides resources to help teams establish a strong shared identity, enhance awareness of their own professional roles and those of their team members, and strengthen interprofessional collaboration.

Included are resources for:

- **Developing a Mission, Vision, and Values Statement**
- **Creating Role Descriptors**
- **Team Goal Setting**
- **Psychological Safety**
- **Interprofessional Team Building**

Professional Identity and Growth

Mission, Vision and Values Statement

Why this matters?

There is strong evidence that healthcare teams function more effectively when they have a clear and shared sense of purpose. Creating a mission, vision and values statement together as a team means that there is a collective sense of ownership of the team goals and accountability in how those goals are achieved.

Activity 1

Complete the Co-Lead Module on Team Values, Vision, and Mission. This activity will assist in collectively establishing and agreeing on team values, vision, and mission for delivering integrated care. *Estimated time to complete is one hour.*

Click Here- Co-Lead Module – Team Values, Vision and Mission

Activity 2

Co-design and document the team values, vision and mission in a document. Save this on an accessible and shared file and print off a hard copy to put up in the clinic space. Agree on a timeframe to revisit this.

Click Here - Mission, Vision and Values Blank Document

Professional Identity and Growth

Creating Role Descriptors

Why this is important?

Role awareness is essential for working well in interprofessional teams. Role descriptors enable team members to establish greater clarity for their role and the roles of other team members. Developing role descriptors together as an interprofessional team provides a valuable opportunity for different professions to describe their disciplinary and professional expertise and communicate roles and responsibilities. It also helps professionals to discuss their values and priorities and to convey the strengths that they bring to the team. This reflective communication enhances individual perception of roles, supports professional growth and increases understanding of roles within the team.

Activity 1

Complete the Co-Lead module on Role Clarity to support successful interprofessional working. *Estimated time to complete is one hour.*

Click here – Co-Lead module – Role Clarity

Creating Role Descriptors

The HSE Knowledge and Skills Framework for Healthcare Professionals Working with Older People (see link below), describes discipline-specific and shared knowledge and skills required by healthcare professionals providing care to older people. The framework supports individual healthcare professionals and interprofessional teams to identify professional development opportunities and it supports role awareness for interdisciplinary team working.

Click here - The HSE Knowledge and Skills Framework for Healthcare Professionals Working with Older People

Activity 2

Use the HSE Knowledge and Skills Framework to complete the downloadable template available as an Appendix at the end of this document (Appendix B). Complete the template for your own role first and then discuss your notes with your teammates and get feedback. This can be done informally in a one-to-one context or collectively as a team. Use the template and the team feedback to create a professional role descriptor for your role on the team. Once completed, upload professional role descriptors for each team member onto an accessible shared file.

Click Here - Role Descriptor Worksheet

Professional Identity and Growth

Team Goal Setting

Why this is important?

Establishing shared goals as a team is known to support a collective ownership and commitment to implementing actions which help to achieve the goals. This also leads to more effective collaboration and coordination.

Activity 1

Complete the Co-Lead Module on Team Goal Setting to align team goals. Which will result in the following key team outputs:

1. A set of agreed, measurable goals for the team to work towards
2. Sub-groups to work towards these goals
3. An action plan

Estimated time to complete is one hour

Click here – Co-Lead module – Team Goal Setting

Why this is important?

Research shows that when team members feel psychologically safe, they are more engaged and motivated. Psychologically safe work environments involve team members feeling valued for their contributions and ensures they can speak up without fear or risk of retribution. A major feature of creating psychological safety is through building trust and acknowledging power dynamics. That is why this section provides resources to build trust and recognition of how power can influence people's perceptions and experiences of being valued in a team.

Activity 1

Complete the Co-Lead building trust module which facilitates team discussion around establishing mutual support and creating a culture of trust within the team.

Click here – Co-Lead module – Building Trust

Activity 2

Complete the Co-Lead Emotional Support in Teams module which aims to increase understanding within the team of how to emotionally support one another, particularly after intense events.

Click here – Co-Lead module – Emotional Support in Teams

Professional Identity and Growth

Interprofessional Team Building

Why this is important?

Interprofessional teamwork brings together professionals who have diverse knowledge and skills, with distinct but equally valuable perspectives on care. Creating opportunities for discussion and dialogue among team members supports a shared understanding and awareness of one another's perspectives. Activities which support team building and group learning, including serious games that prompt critical discussion and reflection, have proven effective in improving collaboration and integrating team perspectives on care.

Activity 1

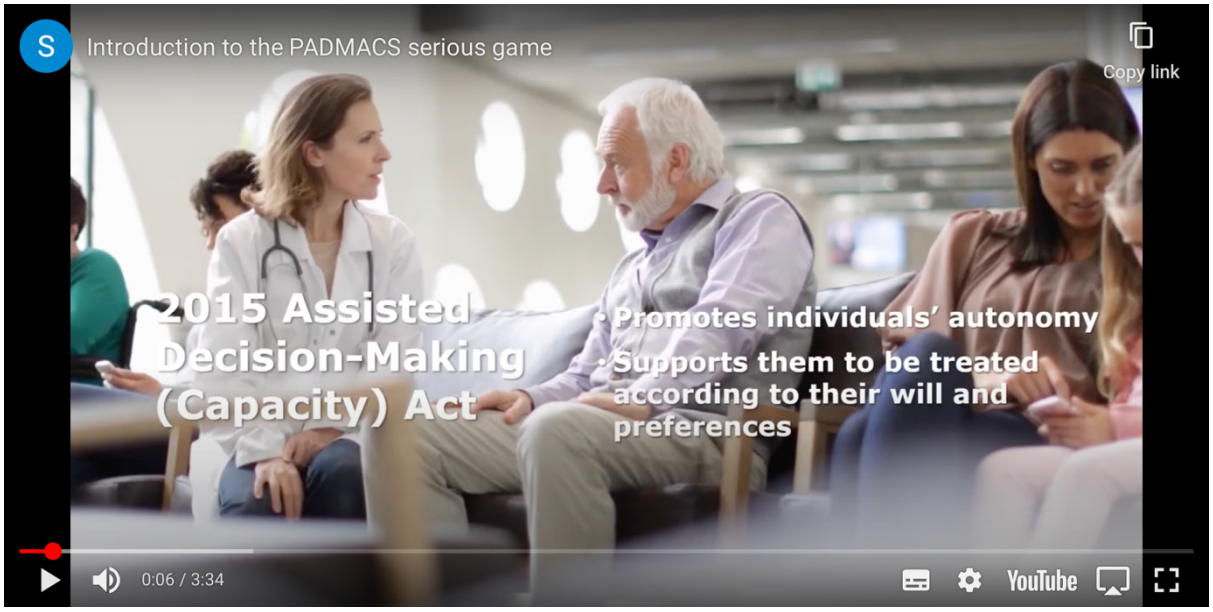
Play the Promoting Assisted Decision-Making with Older People in Acute Care Settings (PADMACS) Educational Discussion Game. Instructions and links to the downloadable version are on the following page.

PlayDecide: PADMACS
Promoting Assisted Decision Making in Acute Care Settings

The PADMACS Game

PADMACS is an educational tool for furthering understanding of assisted decision making for health and social care professionals working in acute care settings. It consists of story cards based on real stories from HSCPs, older people and family carers, issue cards based on meaningful issues identified by research and information cards based on the 2015 ADM Capacity Act (ADMCA). This serious game is specifically designed to facilitate discussion about the nuances and complexities of assisted decision-making with older people and to educate professionals about the ADMCA.

Click Here - [Introduction to PADMACS Video]



Click here - [A guide for facilitating the PADMACS serious game]

Downloading PADMACS

If you wish to download the free PADMACS serious game, you have the choice between downloading the longer version of the serious game (it includes ALL story cards and is approximately 1.5 hours in duration) or a shorter version (selected themes which take approximately 40 minutes in duration).

Download the Longer Version of the Serious Game- Here

Download Facilitator Guide for the Longer Version of the Serious Game - Here

Download the Facilitator Guide for the Shorter Version of the Serious Game Here

Download a Shorter Version of the Serious Game by Theme (click on the Theme)

Theme 1 'Communication' - Theme 2 'Environment' - Theme 3 'Resources' - Theme 4 'Control and Power' - Theme 5 'Sharing Information'

The CLARITY Game

Activity 2: - Play the CLARITY game - Collaborative Learning to enhance Awareness of Roles in Interprofessional Teams supporting older people in the communitY

The ECLECTIC Team, in collaboration with ICPOP team members, older people/carers, policymakers, and researchers developed a serious game to support ICPOP team members to discuss and understand their professional roles and those of others. This interactive game focuses on:

- Role awareness, role clarity and role evolution in interprofessional teams.
- Building skills in listening, reflecting and communicating roles and responsibilities, scope of practice and boundaries.
- Dialogue and reflection as tools for collaboration.

Facilitators Guide

A facilitators guide was designed to help confidently plan and run a PlayDecide CLARITY game session with interprofessional teams. The guide provides step-by-step instructions, suggested scripts, and practical prompts to guide participants through a structured conversation about roles, scope of practice, boundaries, and interprofessional collaboration. You don't need to be a content expert to facilitate a session. Any team member can be nominated to facilitate the game. The role of facilitation is to support open dialogue, equal participation, and reflection, helping the group make visible the often unseen dynamics of teamwork and role evolution.

Download Facilitators Guide

If you wish to download the free CLARITY serious game, you can download the game materials below. Download CLARITY Game Materials

Downloading CLARITY

2 Information Sharing and Care Coordination across Boundaries

Interprofessional community teams who deliver specialist care to older people need to be able to share information effectively within their team and with the broader intersectoral care system.

Across Ireland, ICPOP teams utilise different information systems and have varying access to electronic data sharing systems and standardised templates. This section aims to provide information on the different approaches used by teams and resources which may be useful for teams to utilise in visualising their workflows and care coordination processes.

Included is information relating to:

- **ICT Infrastructure**
- **Care Coordination Workflow Tracker**
- **Triage Models and Processes**

Information Sharing and Care Coordination across Boundaries

ICT infrastructure for information sharing and management for care planning

Why this is important?

Interprofessional collaboration for older person care is complex and requires multiple collaborations across care sectors within primary, community and hospital contexts. Systems which support communication can improve workflow and improve teamwork and care coordination, which results in the delivery of timely and responsive care for older people in the community.

We acknowledge that ICT infrastructure for information sharing, and standardisation of referral pathways and care standards requires national-level support.

Recommendations

1) For teams that do not have a dedicated file management and information sharing system, consider using the InterRAI system as an information management system where all documents related to the older person can be uploaded and accessed by the team.
2) The ECLECTIC team will assess the changes and the impact of using InterRAI as a file management system during the next wave of data collection in summer 2025.
3) Please Liaise with the UCD ECLECTIC team if you are interested in hearing from a team already using InterRAI as a file management system, and we can put you in touch with them to learn from their experience.

Information Sharing and Care Coordination across Boundaries

Care Coordination Workflow Tracker

Why this is important?

Mapping the care pathway, focusing on information flow and case management processes enables understanding of the roles and responsibilities within an interprofessional team and enhances continuity for a patient's care journey. This section provides a care coordination workflow tracker created by the ECLECTIC team to support ICPOP teams in mapping case management processes from referral to discharge, with clear roles and responsibilities outlined.

Activity 1:

Complete the care coordination workflow tracker prepared by the ECLECTIC team (Appendix C) The sheet is divided into sections illustrating the care pathway of the older person, including referral, communication, information gathering, triage, decision-making. When populating the tracker, review the roles and responsibilities for each activity.

Activity 1.2

Using the completed care coordination workflow tracker template, complete the Co-Lead Module on Removing Frustrations/ Blockers to collectively reflect on your operational processes and identify areas that could be improved, as well as the barriers and enablers of improvement. *Estimated time to complete is one hour.*

Click here – Co-Lead Module: Removing Frustrations/ Blockers

UCD DUBLIN Co-Lead

Resource -

Output: Once these activities are completed, you will have a map of your team's case management pathway, which can be transformed into a visual flow chart and stored on an accessible shared file.

Triage Models and Processes

The triage process is different across ICPOP teams. Some teams use a consultant-led model, whereas others use a team-led/ hybrid model where one or two team members are assigned to triage each day (or every two days). When a new referral comes in, the assigned team member reviews the referral letter, checks for any missing information (and follows up as needed), and decides whether to accept or reject the referral. The team then discusses all new accepted referrals at the next MDT with the consultant, and they agree on a case management plan and identify the professions relevant for each case.

Choosing a triage process that works for your team is important and is often based on the team resourcing and interprofessional structure. We have created a summary of some of the different models used on the following page.

Triage Processes

A Triage Model largely refers to the roles and responsibilities in the activity of triaging. The process relates to how referrals are coordinated and categorised. For many ICPOP teams, urgency levels (Urgent, Semi-urgent and Routine) are utilised for triage and are based on referral criteria.

Recommendations

As a team, review the different triage models described overleaf which are used by other ICPOP teams. Identify which triage model your team is currently using and discuss the advantages and disadvantages of this model. Consider the suitability of other models for your team. When reviewing triage processes, consider developing a checklist that would enable any member of the team to review a referral and classify the triage level for consideration at MDT.

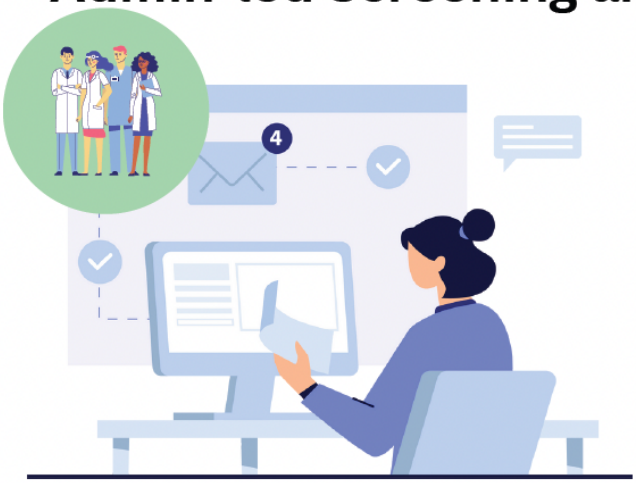
Consultant-led Model

In this model, referrals are received by the admin team, which screens them for completeness before passing them to the consultant. The consultant leads the triage MDT meeting, reviews the referrals with the interprofessional team, determines urgency, and allocates tasks accordingly.

Nurse/Allied Health-led Model

Referrals are received by an admin or nurse intake coordinator. Nurses screen the referrals using predefined criteria, such as falls, frailty, or social isolation, and gather relevant assessment information. The triage MDT meeting is led by a nurse or allied health professional, who assesses cases and assigns them to the appropriate team members. This model allows for quicker assessments and delegation, reducing delays that may occur with consultant-led processes.

Admin-led Screening and Team-based Triage



In this model, referrals are received and logged by admin staff, who use a checklist to ensure they meet the required criteria. Admin staff also organize relevant documentation, gather any missing information, and prepare summaries for team meetings. During the triage MDT meeting, a rotating lead presents the referral summaries for discussion. This approach enables clinical staff to focus on care delivery while minimizing delays in referral processing and triage decisions.

Hybrid Model: Rotating

Referrals in the hybrid model are received by a rotating nominated team member, who screens them and follows up on assessments. During the triage process, the nominated team member introduces the referral and relevant information to the group, which then collaborates to review the older person's needs and determine the appropriate care and urgency. This model promotes shared accountability among the team and recognizes the value of each profession.

3 Quality Improvement and Programme Development

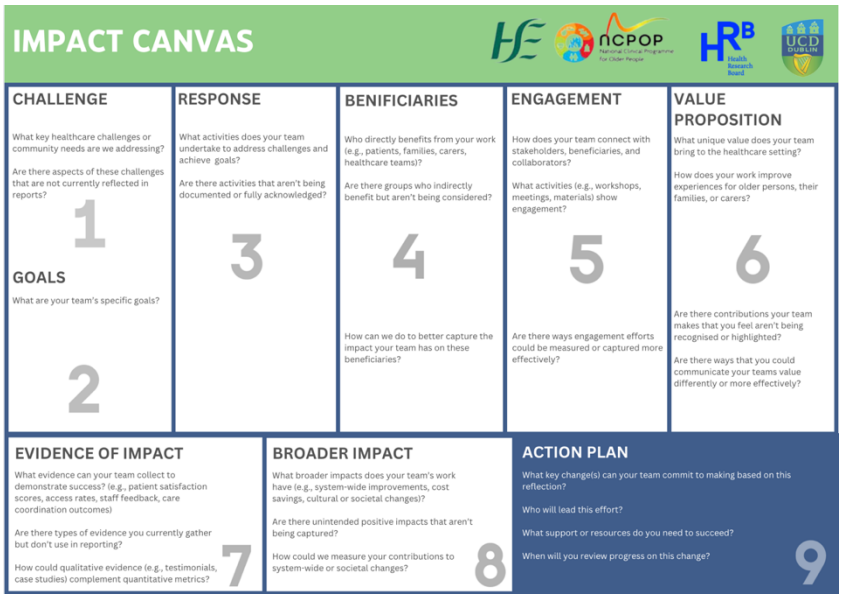
This section includes resources which aim to support improving systems through collaboration, including co-designing resources and service improvements, developing impact reporting, and defining ICPOP's role in the healthcare system and the role of care, this includes:

- **Impact Canvas Framework**
- **Developing Competencies for Interprofessional Collaboration**

What is the Impact Canvas Framework Tool?

The impact assessment framework tool adapts the UCD Impact Canvas to assist in identifying stakeholders of the ICPOP team, capturing knowledge dissemination events (e.g., knowledge exchange activities at different sites, including nursing home visits, posters, networking meetings, etc.), and tracking interactions with other community and primary sector organisations (e.g., Dementia Alliance). It also helps teams to identify challenges and reflect on team experiences and community needs, consider the changes that result from the team's efforts across the system, the sector and patients and caregivers. The canvas enables the team to track, assess, and measure its impact.

Download the Impact Canvas Here



Prioritisation Matrix

A prioritisation matrix was developed to support decision making and enable teams to agree on actionable solutions that emerge from the Impact Canvas. This consists of four quadrants with prompts that assist determining the impact and feasibility of activities.

Download Prioritisation Framework

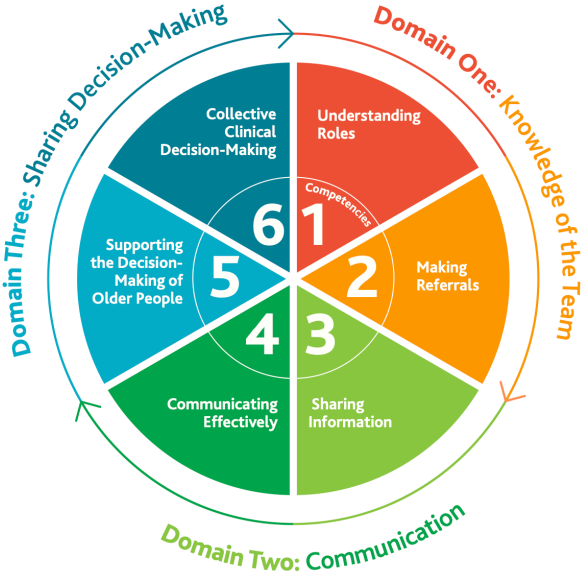
Quality Improvement and Programme Development

Developing Competencies for Interprofessional Collaboration

Why this is important

The ECLECTIC Framework was co-designed by healthcare professionals working with older people, public representatives of older people and family caregivers with the support of academic researchers. The framework was developed in partnership with the National Integrated Care Programme for Older Persons. It provides a useful resource for teams looking to enhance their interprofessional collaboration with their teams, with older persons and their families and the broader system. This guide provides actionable steps to increase knowledge of the team, enhance communication and effectively share decision-making.

Click Here – Step-by-Step Guide for Interprofessional Collaboration in Integrated care for Older People



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)

Patient Journey Mapping

Journey Mapping is a method utilised in healthcare to outline and describe the different stages of interaction between a health service user and healthcare providers. This process enables reflection on the strengths and or gaps in care and provides an opportunity for identifying areas of improvement. Aligning the patient experiences with each stage of care provision is useful in establishing a deeper and richer understanding of the perspectives of patients, families and healthcare providers.

Activity 1: Using the Mapping Older Persons Care Journeys Resource, work through the templates provided and populate the information based on a case the team is familiar with.

Resource: Mapping Older Persons Care Journeys in Community Specialist Care - A Case Study Approach to demonstrating interprofessional collaboration

This resource was developed based on a co-design workshop held with an ICPOP team The team identified the need to capture the full scope of interprofessional collaboration and coordination involved with caring for older people and their family in the community. A key idea was the development of case studies that capture and reflect this often invisible work. As such, the UCD research team developed this resource document, which compliments the existing ECLECTIC resource pack and provides a step-by-step guide for ICPOP teams **to tailor a patient mapping and case study approach** to their settings and for their intended purposes.

Appendix A: Mission, Vision and Values Statement Presentation (editable version as an attachment)

MISSION

A mission statement defines the team's shared purpose, goals, and commitment to collaboration and quality care.

WRITE YOUR AGREED MISSION STATEMENT HERE:

VISION

A vision statement describes the team's aspirational goals, outlining the ideal future they aim to achieve through their collaboration and care.

WRITE YOUR AGREED VISION STATEMENT HERE:

TEAM VALUES

Values outline the core principles and beliefs that guide the team's actions, decisions, and interactions.

DOCUMENT YOUR AGREED TEAM VALUES HERE:

TEAM GOALS

Goals are clear, specific things the team wants to achieve, based on their shared purpose, future hopes, and core beliefs.

DOCUMENT SOME OF THE GOALS YOU HAVE HERE:

1-

2-

3-

Appendix B: Role Descriptor Worksheet (editable version as an attachment)

Role Overview	
Name	
Discipline	
Role in the team	
Key Responsibilities	
Clinical	
Patient/ Client Advocacy	
Team Collaboration	
Other roles/ responsibilities	
Strengths	
What skills and knowledge do I bring?	
What is my area of expertise?	
What Matters Most to Me? *Reflect on your values and what feels most Important in your role*	
Personal Values	
Professional Goals	
Collaboration	
What do I find helps me to work effectively in the team?	
What are my communication preferences	

Appendix C: Care Coordination Workflow Tracker – Template (editable version as an attachment)
ICPOP Team: [INSERT]

Care Process	Questions	Person Responsible
Referral	How are referrals received?	
	Who receives the referral?	
	What is the referral criteria?	
Information Gathering	What information is gathered for the older person?	
Triage Process	How are referrals prioritised?	
	Who decides on the prioritisation?	
	How is a lead team member decided?	
Communication	When and how is the older person contacted?	
Assessment	What does the assessment process involve?	
Care Planning	How is the care plan developed?	
	Who contributes TO CARE planning?	
	How is the care plan implemented?	
	How is progress reviewed?	
Discharge	When are older people discharged?	
	Where are older people discharged to?	
	How is follow up coordinated?	
Reflection	Did anything surprise you with this mapping?	
	Where do you think the biggest challenges are?	
	Do you have any ideas of how these challenges could be addressed?	