PlayDecide: Collaborative Learning to enhance Awareness of Roles Interprofessional Teams supporting older people in the communitY (CLARITY)

What is PlayDecide

PlayDecide is a card-based serious game used internationally to support learning through discussion. It provides a simple structure where participants read short, real-world stories, share perspectives and reflect together.

Key Concepts

Role Awareness: Understanding your own role and how others see it. This includes the scope of practice, boundaries, and responsibilities.

Role Clarity: A shared understanding across the team of who does what, where responsibilities lie, and how roles connect. This reduces duplication, conflict and gaps in care.

Role Evolution: How roles adapt and shift over time as teams collaborate. This can involve expanding scope, sharing tasks or redefining responsibilities to meet changing needs.

Why this game matters

- Working well together as an interprofessional team does not happen automatically; it takes intention, time, dialogue and ongoing reflection.
- Role awareness, clarity and evolution improve teamwork and interprofessional collaboration.

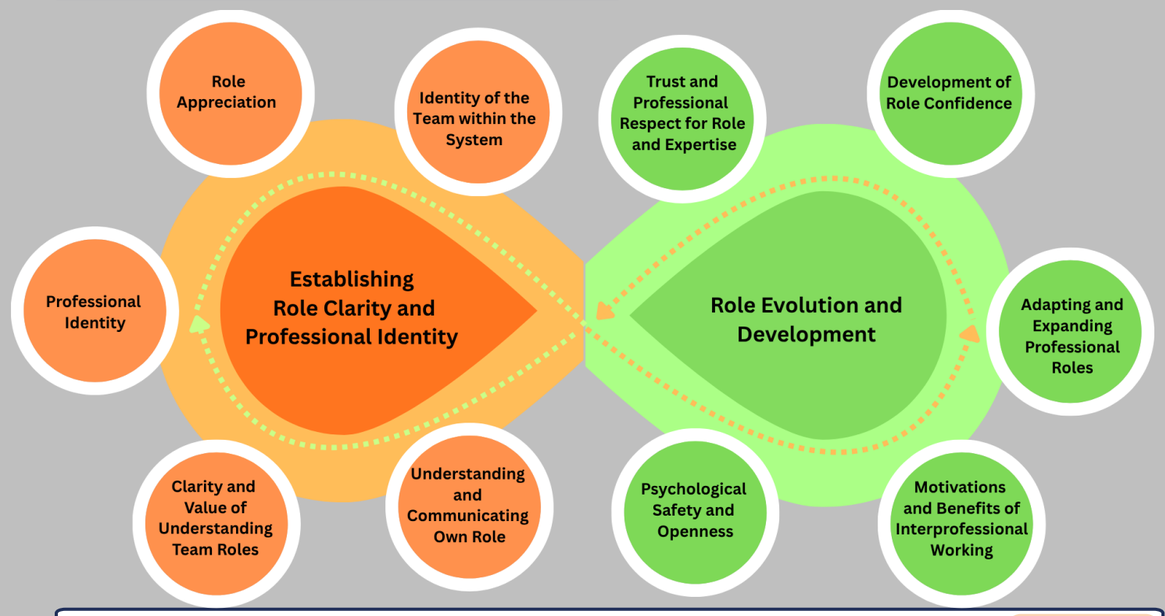
PlayDecide: CLARITY

- CLARITY was co-designed with interdisciplinary members of community specialist integrated care teams, older people, and their families.
- It uses real-world experiences to create stories that spark authentic reflection and dialogue.

What the game focuses on

Role awareness, role clarity and role evolution in interprofessional teams are enhanced by:

- **Communication and reflection** on roles and responsibilities, and how they are understood within the team.
- **Listening and learning** from the perspectives of other team members and disciplines.
- **Discussing and evaluating** where roles overlap, adapt or evolve in practice.
- **Generating and proposing** ideas and actions that support ongoing role clarity and strengthen evolving roles and professional identities within the team and across the system.
- **Appreciating and applying** understanding of different roles to identify opportunities that strengthen collaboration.



This is a visual representation of the dynamic and iterative process of role awareness and clarity formation, as well as role evolution and development, within IPC.

Conceptual Figure

Story Card

Place your chosen story card here

Older adults & patients

Carers

Health professionals

Info Card

Place your linked info card here

Issue Card

Place your linked issue card here

Info Card

Place your linked info card here

Issue Card

Place your linked issue card here

INSTRUCTIONS FOR PLAYING THE GAME

Step 1: Reading	Players read the information on the placemat.
Step 2: Read the stories	Each player selects **one story card** and finds the linked issue and info cards. The player reads through these cards, considering what themes stand out. Browse through the strategy cards.
Step 3: Group Discussion	Players take turns to put their cards on the placemat and summarise them. Discuss why they selected this card, themes that stood out and share experiences relevant to the topic. Strategy cards can be used to help shift thinking from problems to ideas and actions.
Step 4: Individual Reflection	Participants use the reflection sheet to note: 1) Strengths of the team 2) Practical ideas or strategies to strengthen collaboration.
Step 5: Share Ideas	Participants share their reflections. You can document these the ideas that emerge.
Step 6: Next Steps	Based on the discussions and reflection, consider if there are any next steps the team would like to take.

Strategy Card

Place your chosen strategy card here

play decide

Game Themes

IDENTITY WITHIN THE TEAM WITHIN THE SYSTEM

CAPACITY BUILDING AND LEARNING

POWER DYNAMICS

ROLE EVOLUTION AND GROWTH

OLDER PERSONS AND FAMILY PERSPECTIVES

UCD School of Nursing, Midwifery and Health Systems
UCD College of Health and Agricultural Sciences

HSE

NICPOP National Integrated Care Programme for Older Persons

OLDER PEOPLE

Age Friendly IRELAND

Family Carers Ireland Fairness for Carers

Supported by HRB Health Research Board

Story Card 1

Avoiding inappropriate referrals

Susie is an Interai Assessor on an ICPOP team.

I take responsibility for our triaging. We have a persistent problem of single discipline referrals. Our focus is on complex cases requiring multiple specialists, but when we do the assessment, it is clear that the older person only needs single disciplinary intervention, and the older person would be more appropriately cared for by primary care services. This process consumes substantial time and resources. Greater system-wide awareness of ICPOPs role is needed to ensure older adults receive appropriate care and each team functions effectively. We're working to educate referrers about our role and the appropriate use of our services, but this takes time.

Links to: **Issue Cards** 1

Links to: **Info Cards** 1 **or** 2

IDENTITY OF THE TEAM WITHIN THE SYSTEM

Story Card 2

Coordinating care and avoiding duplication when there are multiple teams involved

Sharon is a CNS on the ICPOP team.

We recently received a referral from the hospital for Mrs O'Reily, who was being discharged home after a recent fall and hip fracture. We scheduled an appointment and arranged transport for her as she lived a distance from the clinic. When I was conducting the CGA with Mrs O'Reily, she mentioned answering similar questions the day before when she saw the primary care nurse and had an appointment the following week with a physio at a private clinic. I felt frustrated because there was a lack of coordination across the different teams and systems, which meant Mrs O'Reily was having more appointments than she needed.
Our team could provide the initial specialist support to stabilise her in the home and then involve primary care for longer-term support. This scattergun approach to referrals means care is duplicated. It is not my place to advise Mrs O'Reily to cancel any of her appointments, but I can see the impact that all the running around and retelling of information is having on her recovery and wellbeing.

Links to: Issue Cards 2

Links to: Info Cards 3

IDENTITY OF THE TEAM WITHIN THE SYSTEM

Story Card 3

Continuity of care after discharge

Tom is an Occupational Therapist on an ICPOP team.

The physiotherapist and I were working with Craig, an older person in the community who had been discharged from the hospital following hip surgery. Craig progressed well, so we discharged him to his GP with information on his needs for continued support.

A few weeks later I received a call from Raj, a primary care nurse who was supporting Craig with home adaptations. We had made recommendations for these in the discharge letter provided to the GP, however this had not been passed on. I spent over an hour on the phone with Raj explaining our recommendations. We have great integration and interprofessional working within our team, but there is a major challenge passing on information to others in the system like Raj. Craig deserves continuity of care across the different systems, but there is lots of fragmentation.

Links to: Issue Cards 3 5

Links to: Info Cards 4

IDENTITY OF THE TEAM WITHIN THE SYSTEM

Story Card 4

Collaborating with other teams for the benefit of the older person

Christie is a Dietician on an ICPOP team.

The team received a referral for an older woman, Rachel, who had an extensive mental health background and was struggling with malnutrition and suspected malabsorption. The GP completed a parallel referral to the Psychiatry of Later Life (PoLL) team. Locally, we don't do joint assessments across the different teams. I took the lead on coordinating Rachel's assessment for ICPOP. I noticed that Rachel really needed input from the psychiatric team as well as dietetic intervention. I was able complete a comprehensive care plan for Rachel based on my disciplinary skills and discharged her back to the GP. I felt frustrated that Rachel would need to re-tell her story to the PoLL team. I can't help thinking how much better the system would function if we could collaborate with other teams in the community more directly.

Links to: Issue Cards 6

Links to: Info Card 5

IDENTITY OF THE TEAM WITHIN THE SYSTEM

Story Card 5

Comprehensive inductions support role clarity and collaboration

Anne recently started her role as a Speech and Language Therapist on an ICPOP team.

I was apprehensive joining the ICPOP team as I knew my specialism in communication for people with dementia was different to the previous SLTs dysphagia focus. Upon arriving at the community hub, I was welcomed by Sarah (Operational lead) we went for a coffee and had an informal chat about the team and my background. At the weekly MDT, I felt anxious as the team members confidently contributed to the discussion. However, after the meeting, Sarah spoke with me for over an hour about my areas of expertise and areas I would like to strengthen. We agreed on training to enhance my understanding of dysphagia, whilst also discussing my role setting up a programme for older people with communication difficulties. Even within our disciplines we can have such different expertise, I felt grateful Sarah took the time to understand and appreciate my specialties.

Links to: Issue Card 7

Links to: Info Card 6

CAPACITY BUILDING AND LEARNING

Story Card 6

Balancing power: supporting collective clinical decision making

Claire has been appointed as the new team lead for an established ICPOP team.

I have only been in this role for a couple of months, but I had noticed that senior staff were dominating discussions during meetings. Recognising this issue, I organised external team training focused on teamworking. This initiative has improved collaboration slightly, but we are still experiencing challenges with shared-decision making, as junior staff lack confidence and seem to go along with whatever senior staff say to avoid creating tension or conflict. When every team member can equally contribute their expertise, it creates a more comprehensive understanding of patient needs and ultimately enhances patient-centred care. I just wonder what additional training or supports I could provide that support equal contributions.

Links to: Issue Cards 8

Links to: Info Card 7

CAPACITY BUILDING AND LEARNING

Story Card 7

The Value of Sharing Best Practices with Other Teams

John is a CNM on a regional ICPOP team who recently participated in site visits to other teams.

To help me gain fresh insights, my Team Lead arranged site visits to an urban ICPOP team and a FIT team. I found these visits extremely beneficial, and I learnt a lot.

We have a monthly team engagement day, where I presented my learnings to the rest of the team and introduced some approaches that the urban ICPOP team had to conducting shared assessments. We discussed our strengths and strategies to improve efficiency and collaboration and made a plan to update our assessments and disseminate our work at upcoming conferences. Visiting other teams helped me to gain a new perspective and assess my own team's ways of working. From this, we were able to adopt best practices from other settings and tailor them to our local context and population.

Links to: Issue Cards 9

Links to: **Info Card 8 or 9**

CAPACITY BUILDING AND LEARNING

Story Card 8

Enhancing role awareness by working across disciplines

Jerry is a dietician on the ICPOP team.

Myself and the Occupational Therapist, Jasdeep, recently conducted a joint assessment on a couple, Bill and his wife, Moira. I focused on understanding Bill's daily eating habits to evaluate his nutritional needs, as his appetite had significantly reduced. Together with the OT, we asked practical questions, such as who shops and cooks in their household. It became clear that Bill's appetite had reduced because he was experiencing dysgeusia. By using a taste and texture exploration log, we were able to find foods that both Bill and Moira enjoyed. This led to incorporating supports like food deliveries to the home. This joint assessment and intervention enriched the care, and I really appreciated working alongside Jasdeep. So much learning happens when we collaborate like this.

Links to: Issue Cards 10

Links to: **Info Card 10**

CAPACITY BUILDING AND LEARNING

Story Card 9

Expanding Practice Boundaries whilst staying within scope

Claire is an Occupational Therapist on an ICPOP team.

I was doing a functional assessment with Meredith at her home. While I was there the ANP on the team sent me a message asking if I could do a standing and lying blood pressure test to check for orthostatic hypotension, as this could increase her risk of a fall.

I felt comfortable conducting this test as I'd observed it during joint assessments numerous times. I conducted the test, and her blood pressure readings were normal, so we carried on with the planned functional assessment.

When I met with my clinical supervisor, they told me that I shouldn't have taken responsibility for doing the blood pressure tests. They were worried about the implications for my clinical registration if something went wrong, or if I read the recording wrong. Nothing did go wrong, but I felt really anxious following the interaction with my supervisor. I still think it is important that in an interprofessional team we should safely explore our role boundaries.

Links to: Issue Cards 11

Links to: Info Card 11 or 12

ROLE EVOLUTION AND GROWTH

Story Card 10

Valuing Administrative Staff

Paula is the admin on an ICPOP team.

I received a call from the hospital regarding an older person they were discharging. They wanted to know if the referral was appropriate for the ICPOP team. In that instance, the older person did not meet the criteria, but I could tell that they would benefit from being engaged with the FALLs team. I was able to send the FALLs referral to the doctor at the hospital so they could coordinate the discharge for the patient. When I reported this back to the team, they recognised the importance of this coordination and noted how valuable I was. The older person was able to receive the care that they needed when they left the hospital and we were able to communicate our specialist role in the community. I have developed such an extensive knowledge of the system and network from this role, and it feels nice for this to be recognised and appreciated by others in the team.

Links to: Issue Cards 12

Links to: Info Card 13

ROLE EVOLUTION AND GROWTH

Story Card 11

Enhancing Care Through Skill Expansion

Joe is a social worker on an ICPOP team.

When I started with the team, I shadowed our ANP, Jodie, who showed me how they conducted CGAs and basic things like checking blood pressure. I observed Jodie over several weeks and then completed assessments with supervision. Not long after this, I was working with an older woman in the community who reported feeling lightheaded. I noticed she had a blood pressure machine, so I used it to check if this was the cause. Her blood pressure was low, so I got her to lay down and drink some fluids. I had a discussion with Jodie, the ANP when I was back at the clinic and she decided to arrange an appointment for the older person to see the GP. I was glad I had the knowledge to notice the signs of low blood pressure and the skills to take a blood pressure reading. I have learnt so much from working closely with other disciplines which has really improved the integration of care for older people.

Links to: Issue Cards 13 & 14

Links to: **Info Card** 14 **or** 15

ROLE EVOLUTION AND GROWTH

Story Card 12

Missing disciplines challenge role expansion and growth

Pradeep is an ANP on an ICPOP team.

Our physiotherapist came to me after they had undertaken a CGA with Brendan, an older person who had Parkinson's. The physio noted a clear falls risk and suggested it was related to polypharmacy. I reviewed the medication list and agreed it might be an issue. I brought it up with the consultant and arranged a meeting. The consultant agreed with our concerns and identified that one of the medications was a falls risk-increasing drug; they altered the medications to reduce this risk. It was great that the physio raised this concern and being able to draw on the expertise of our consultant was critical. In our weekly MDT we reflected on this case and agreed that having a pharmacist in our team would support role growth and confidence for all of us to identify and address these kinds of issues which are so important for older people's health and wellbeing. It's the missing piece of the puzzle.

Links to: Issue Cards 15

Links to: **Info Card** 16 **or** 17

ROLE EVOLUTION AND GROWTH

Story Card 13

Working outside of disciplinary scope

Una is a CNS on an ICPOP team.

We don't have a social worker in the team, so I try to fill in the gap. However, we have a number of older people that have complex socio-legal needs. I link them into Family Carers Ireland, but older people and their carers need to be able to access the specialist support of a social worker.

I feel like the family carer is really let down by the absence of a social worker on our team. I can do what I can, but I am a nurse, and I don't feel confident in the case management approaches that social workers use to support older people with complex social needs.

As an interprofessional team member, we can safely expand our roles by working alongside another discipline but when they are missing it's very challenging to fill gaps.

Links to: Issue Cards 16 &19

Links to: **Info Card 18**

ROLE EVOLUTION AND GROWTH

Story Card 14

Finding solutions together through open dialogue

Hau is an operational lead on an ICPOP team.

When we started out, nurses were responsible for conducting CGAs, but as we expanded, health and social care professionals shared the responsibility. When we got busier, we encountered workload challenges and staff shortages and tensions were arising regarding the CGA, as whoever conducted it, was expected to lead on the care.

I arranged a meeting to consider what we could do to alleviate the tension and help one another. We figured out a better approach to distributing the work associated with CGAs and ensured that everyone was involved in the discussion and aware of what their roles and responsibilities were going forward. The team needs to be able to discuss how they are feeling about the operations of the team, so that we can determine solutions collaboratively.

Links to: Issue Cards 17

Links to: **Info Card 19**

POWER DYNAMICS

Story Card 15

Integrating different disciplinary perspectives

Meabh is a consultant geriatrician on an ICPOP team.

At our recent MDT, the social worker shared their concerns about signs of hoarding from an older person we were working with. They felt there was a falls risk, so the OT went to do a home assessment. The OT agreed there was hoarding but felt it wasn't within the scope of the team to intervene. The social worker disagreed and felt it was important to try to support the older person.

There was a clear tension between the OT and social worker, but it was my role to make a decision that considered both perspectives. Our role in the community is specialist support, I felt addressing the hoarding would take significant resources and would be better dealt with by longer term primary care support. I could tell the social worker was frustrated, so I met with them afterwards to explain I had to balance what is best for the older person with the team's scope and resources. We need these interdisciplinary perspectives to help us make the best decision, even when there might be differing views.

Links to: Issue Cards 18

Links to: **Info Card** 20 or 21

POWER DYNAMICS

Story Card 16

Aligning roles to the service model

Mark is an OT on an ICPOP team.

I joined the ICPOP team after 10 years working in primary care. I saw the need for specialist OT for older people in the community and I'm committed to the value of integrated care.

I would like to be able to deliver short term specialist interventions, like cognitive simulation therapy which runs over several weeks and has multiple physical and social benefits. However, the other disciplines on the team don't prioritise these interventions and the full scope of my role is not always fully realised in our integrated care plans.

I sometimes feel frustrated with the specialist remit of our team particularly as we're put under pressure to discharge patients within the 6-week timeframe of the service model.

Links to: Issue Cards 20 7

Links to: **Info Card** 22

POWER DYNAMICS

Story Card 17

Speaking up and being heard

Liam is an Occupational Therapy Assistant who recently joined an ICPOP team.

I was excited to join such an experienced team and was keen to learn from senior members. I had noticed a recurring issue with an older person I was supporting, Mr. O'Malley. He was having difficulty with remembering the exercise programme that had been prescribed by the physiotherapist. During team meetings, the senior physiotherapist focused on his gait pattern improvements and overlooked my observations about his memory. I felt hesitant to contradict his assessment or push the issue, given my junior status and his seniority. However, because my concerns about Mr. O'Malley weren't relayed to the team, his mobility plateaued, and he has become increasingly frustrated and less engaged in therapy. My fear of being perceived as challenging or less knowledgeable prevented crucial information about Mr. O'Malley's reaching the wider team and influencing his care plan.

Links to: Issue Cards 21

Links to: **Info Card** 23 **or** 24

POWER DYNAMICS

Story Card 18

Valuing expertise

Triona is a CNS on the ICPOP team.

I was working with Breda, an older woman who recently received a diagnosis for dementia. I had connected her with dementia support, but over the several weeks we had been working together, it felt like there was something more going on. Breda had mentioned a low mood and appetite, and not wanting to, or being able to get out of bed. I brought my concerns to the MDT, requesting that the consultant geriatrician saw Breda and assessed her mental health to see if there were ways we could help. The team decided that the social worker would do a visit to confirm the concern. The social worker confirmed my concerns, and the consultant geriatrician then agreed to an assessment. I felt like my expertise was undermined. Why did the social worker need to check my assessment of the situation?

Links to: Issue Cards 22

Links to: **Info Card** 25

POWER DYNAMICS

Story Card 19

The Importance of a Key Worker

Brian is an 85 year old living at home independently. He had been suffering from severe leg pain.

I was in constant pain after a bad fall in the garden. I had heard about ICPOP from a friend of mine, so I asked the GP for a referral. I hoped to get better pain relief and rehabilitation support. Sally, a nurse from the ICPOP team visited me at home and conducted an initial assessment. My main goal was to get the pain under control and start driving again. Sally arranged an appointment with the consultant geriatrician, who supported my pain management. She then arranged an appointment for me with the physio. Sally followed up with me after every appointment. She was the one holding it all together. I am now driving again, and my pain is reduced. Sally knew what team members could support me with and understood my needs and goals. I have been discharged from the ICPOP team now and back to gardening!

Links to: Issue Cards 23

Links to: **Info Card** **26**

OLDER PERSONS AND FAMILY PERSPECTIVES

Story Card 20

Siloed care

Kate is a 78-year-old woman who experiences severe pain from her rheumatoid arthritis.

I was prescribed strong medication to manage my rheumatoid arthritis. It was meant to help me manage the pain, but things took a turn when I had a series of falls. I fractured my spine and hip, so the hospital team increased my pain medication. The FALLS team referred me to ICPOP. I hoped they could help me get back to regular activities like yoga without needing such high doses of medication. An OT from ICPOP did a CGA and gave me some strengthening exercises. They said they would be in touch to arrange another appointment, they didn't mention anything about my medication. In the meantime, I was feeling drowsy and experiencing dizzy spells. I decided to stop taking my medication. I didn't speak to a healthcare professional about this, which was a bad idea because I got very sick. I can no longer do the exercises the OT prescribed, because my pain has returned. I am not sure when my next appointment is, but I can't even walk 15 meters. I haven't had a fall since, but I am in a lot of pain now.

Links to: Issue Cards 24

Links to: **Info Card** **17**

OLDER PERSONS AND FAMILY PERSPECTIVES

Story Card 21

Navigating a confusing system

Serena is the primary carer for her mum who needs daily support to stay at home.

Mum is 82 and has had a number of recent falls, and her memory is deteriorating. I called the public health nurse, who had been visiting Mum regularly to get some advice. She referred us to a specialist team for older people's care. Mum had a long assessment with the ICPOP team and we told them our main concern was her memory and getting more help at home. The nurse from the ICPOP team told mum to call the public health nurse to arrange for a referral for home support hours and a memory assessment, as they didn't handle these things. I spent days on the phone, trying to sort it out. Everyone thought someone else was in charge of the basics. We finally got linked with the memory assessment team and someone put an application in for home support. I don't know who did it and I don't know where it is now. I feel like we are going around in circles. The ICPOP team knew what they did, but everyone else thought they could do the other stuff. It shouldn't be this hard. Families shouldn't have to deal with such a confusing system.

Links to: Issue Cards 25

Links to: Info Card 4 or 27

OLDER PERSONS AND FAMILY PERSPECTIVES

Story Card 22

You do what you can do until you can't do it anymore

Jim is providing care to his wife Mary who has significant mental health challenges associated with dementia.

Mary has been deteriorating rapidly, and since our old age psychiatrist retired there's no one overseeing her care or medication. Mary is so agitated at night, so I don't get much sleep. I try my best but I'm barely managing with only one hour of home care a week. Recently, I started experiencing dizzy spells. The GP told me there was nothing physically wrong, but that I was suffering from severe stress. The GP decided to refer Mary to ICPOP and when they assessed her, I was relieved they agreed to manage her medication as a short-term emergency measure. They asked about my needs; I just broke down. I told them I was barely managing and that I was exhausted. They gave me a number for Family Carers Ireland, telling me to call "when I have the time". I haven't called them. I'm too exhausted. I had hoped for something more, something long-term for both of us. I'm still feeling lightheaded, but I put that down to lack of sleep.

Links to: Issue Cards 26

Links to: Info Card 28

OLDER PERSONS AND FAMILY PERSPECTIVES

Story Card 23

Care integration

John was referred to the ICPOP team following discharge from hospital.

I was in hospital after a fall and was referred to the ICPOP team. I wasn't sure what they did, but the discharge nurse told me they would provide me with support at home. A week later, a physio and an OT came to my house and they explained they were part of a specialist team for older persons. They asked me what was important, and I mentioned my concerns about getting up the stairs and my difficulty with everyday tasks. They explained that if they didn't have the answers right away, they had a large team back at the clinic who could help. The physio conducted a long assessment and worked with me on exercises to strengthen my muscles and the OT suggested some equipment for the home to make it easier to get around. They also linked me in with a community connector who helped me to find social activities I was interested in – I didn't even know this was something I was missing. It felt like everyone was on the same page. They even sent all my information to my local GP, who is now managing my ongoing care. The team gave me the boost I needed to regain my independence and get back to living my life.

Links to: Issue Cards 27

Links to: **Info Card 26 or 29**

OLDER PERSONS AND FAMILY PERSPECTIVES

Story Card 24

Valuing the family carer

Sinead is a family carer for her mum.

Last year my mum started to experience bad back pain which coincided with a deterioration in her memory. Our GP referred us to the ICPOP team, and they provided a care plan which included physical exercises. Mums pain was getting worse, and she kept forgetting to take her medications. I received a call from the ICPOP team, and they said there was an appointment available at the clinic that same day. I was working and couldn't change my plans at such short notice. Thankfully, my brother was able to take Mum. That evening, I went to see Mum and my brother was there. When I asked about the appointment, he didn't have any information because he didn't go in with her. I tried to call the clinic, but the paperwork didn't provide a name of the person involved with her assessments or care. I was frustrated because mum has consented for me to be involved in her care. I'm the one who sees her every day, I know her routines and I can provide the most accurate information, but I can't make appointments at the last minute. It is hard to juggle everything. I am just trying to do my best for mum.

Links to: Issue Cards 28

Links to: **Info Card 4 or 30**

OLDER PERSONS AND FAMILY PERSPECTIVES

Story Card 25

Filling the gaps

Margaret is looking after her husband Pat, who had a stroke and just returned home from the hospital.

Pat and I have been married for 60 years. He had a stroke and was in hospital for nearly two months. Now he's home, but he's weak on one side and struggles with everyday things like showering. The doctor at the hospital referred us to the ICPOP team to help. The ICPOP team, including a physio and OT came to our house. They gave Pat exercises and added a shower chair and grab bars. I told them we were only receiving 2 hours of home support a week, when we were approved after assessment for 18 hours. The social worker on the ICPOP team helped us to advocate for the fulfilment of the allocation, but they said there was just not enough home care staff. We're managing for now, but I am always worrying that Pat might fall. I feel awful contacting the ICPOP team all the time to ask questions, but I don't know who else to call. We were approved 18 hours of home care but can't get it. The ICPOP team are specialists who shouldn't need to fill the gaps left by a struggling home support system. It's not fair on them, and it's not fair on us.

Links to: Issue Cards 29 & 30

Links to: **Info Card** 31

OLDER PERSONS AND FAMILY PERSPECTIVES

Strategy Card

Review the key worker/case manager role

What this helps with
A key worker can improve coordination and continuity of care for older people.

Action/ activity
Consider a key worker or case management model that would work for the team and agree on how this could be formalised.

Support/resources
As an example, see the key worker framework for people with dementia living in the community (Renehan et al., 2017).

1

Strategy Card

Reflect on care delivery in real time

What this helps with
Understanding what is happening with patients, the team, and the environment during care delivery.

Action/activity
The TeamSTEPPS Tool (AHRQ, 2020) takes a snapshot of team function, patient needs and environmental risks.

Support/resources
TeamSTEPPS has a number of training tools and simulations for use on the AHRQ website.

2

Strategy Card

Build team huddles into routine case management

What this helps with
Emotional support, shared learning, connection and trust across the team.

Action/activity
Set aside time weekly for a check in: what went well, what was hard, what support is needed?

Support/resources
There is not one right way to conduct a healthy huddle. The Centre for Excellence in Primary Care has created several resources to support healthy huddles.

3

Strategy Card

Peer shadowing

What this helps with
Role clarity and appreciation of one's role and the role of others. Supporting collaboration across professions.

Action/activity
Spend time with a colleague from a different profession to understand their workflow, pressures and approach to care.

Support/resources
The University of Toronto's CACHE has numerous resources that explore shadowing and interviewing team members.

4

Strategy Card

Care information cards

What this helps with
Improves information sharing with older people and their families.

Action/activity
Co-design tools for sharing information with the older people you work with, these can explain care plans and next steps in plain language.

Support/resources
MinD is an EU project that has developed a toolkit for co-designing with people living with dementia, the resources included are useful across other settings.

5

Strategy Card

Create a Team Wall in the clinic and a flyer for community settings

What this helps with
This helps to show who is who in the team and what they do. It improves team visibility, role clarity and communication.

Action/activity
Create a physical wall in the clinic with team members names, roles and photos. Create a flyer or leaflet with similar information. Remember to review this regularly and update as required.

6

Strategy Card

Restorative circles for team wellbeing

What this helps with
Structured time and space to move through tension or conflict can support moral repair.

Action/activity
Discuss with the team a safe way to flag when something feels off or needs attention.

Support/resources
There are a number of resources which support facilitation of restorative circles. Here is one from restorative resources.

7

Strategy Card

Set up a buddy or mentor system across teams

What this helps with
It builds relationships with other teams in the system and supports collaboration and understanding of each others' roles in the system. It can also enhance the capacity of different teams.

Action/activity
Engage other teams and professions to have informal chats, supervision and observation days. Share insights about roles, challenges and how they contribute to care.

8

Strategy Card

Invite relevant stakeholders to participate in MDTs

What this helps with
When different teams and stakeholders in the system are sharing information, there is better care coordination and integration.

Action/activity
In line with GDPR and informed consent, consider how information could be better shared to improve integrated care planning, for example MDTs with multiple system stakeholders.

Support/resource:
The NHS developed a Working Differently together Multidisciplinary Team Toolkit

9

Strategy Card

Use empathy mapping to understand older persons and their families' experiences

What this helps with
Reflecting on how care is experienced by older people and their families. It asks what they might see, hear, feel, fear or want. It supports person-centred thinking and shared insight.

Action/activity
Take a recent case or story and map the perspective of the older person or their family together.

Support/resources
Alberta Health Service – Empathy Mapping Summary

10

Strategy Card

Create social spaces for informal connection

What this helps with
Builds trust and relationship, reduces hierarchies and strengthens collaborations, as people can connect beyond formal roles.

Action/activity
Designate a shared space to host informal gatherings where there is casual interaction.

11

Strategy Card

Expanding roles and building growth pathways

What this helps with
Expanding roles and building growth pathways are essential for role evolution that responds to changing needs, emerging skills and collective goals.

Action/activity
As a team, look at the HSE Knowledge and Skills Framework. Then build growth pathways together, identifying areas where team members want to expand their roles.

Support/resources
The team knowledge and skills growth map.

12

Strategy Card

Review triage processes and models

What this helps with
The triage process is different across ICPOP teams. Some teams use a consultant-led model, whereas others use a team-led/hybrid model.

Action/activity
Review the different triage models described and reflect on the current triage model your team is using. Discuss the advantages and disadvantages of this model. Consider the suitability of other models for your team and what would be needed to enable any member of the team to review a referral and classify the triage level for consideration at MDT.

13

Strategy Card

Engage in team or leadership development

What this helps with
Building confidence, shared purpose and interprofessional collaboration.

Action/activity
Explore the Co-Lead Toolkit as a team and identify modules to complete together.

Support/resources
UCD Co-Lead Toolkit

14

Strategy Card

WILD CARD

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Strategy Card

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Strategy Card

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Strategy Card
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22

Info Card 1

Model of Care for Specialist Geriatric Services (SGS)

The HSE Model of Care for Specialist Geriatric Services (2012) recommends SGS have a defined and agreed referral criteria with their ED, AMU and Community services, for determining whether a patient should be referred.

1

Info Card 2

Referral Criteria

Typically, ICPOP referral requires being 65+ years old, needing short-term multidisciplinary help for a sudden functional decline, and requiring specialist geriatric input to avoid hospital or long-term care (John, HSE, 2024).

2

Info Card 3

InterRAI for Information Sharing

The HSE, through Sláintecare, plans to rollout InterRAI, a comprehensive care needs assessment, to services for Older People and Acute Hospitals. It aims to assist patient involvement in care planning and have all health information stored in one place. This means information can be shared between hospital and community settings (eHealth Ireland; HSE, 2024).

3

Info Card 4

A Case Management Approach

The HSE – Making a Start in Integrated Care (2017, p.24) recommends a case management approach in responding to the care needs of older people who have significant vulnerabilities and where care is fragmented, which involves:

- A named point of access in the health and social care system for older people with complex needs.
- A point of coordination across care settings and between health and social care professionals.

4

Info Card 5

Interagency Approach and Shared Care Planning

Integrating care for older people involves key interventions outlined in the HSE Making a Start in Integrated Care for Older Persons document (2017, p.24), which include:

1. A Case management approach provides a named point of care and coordination of care.
2. Working across care settings adopting an interagency approach (common assessment and shared care plan focused on a high priority population).

5

Info Card 6

Aim of Induction

The HSE Induction Guidelines (2025, V2, p.2) outlines multiple aims of a induction, which includes:

- To clarify expectations of both employee and employer in relation to codes of conduct, policies and procedures, and employee services.
- To clarify the role of the employee and performance expectations.
- To commence a process of structured feedback on performance.

6

Info Card 7

Communication Skills and Emotional Intelligence

Leadership and collaboration in healthcare involves emotional intelligence, which consists of four domains: self awareness, self-management, social awareness and relationship management.

The HSE's National Healthcare Communication Programme explores these domains and aims to enhance communication within an interprofessional healthcare team.

7

Info Card 8

Regional Champions

The World Health Organisation (2010) recommends organising meetings for regional champions to exchange successes and challenges, facilitating the spread of best practices and evidence.

8

Info Card 9

Knowledge Sharing

It is vital to learn from other programmes and adapt successful practices to the local context. Continuous knowledge sharing fosters innovation and collaboration. (Barry et al., 2021)

9

Info Card 10

Interdisciplinary Skills

Integrated care requires both 'shared' skills across clinical backgrounds and 'discipline-specific' skills unique to each profession. A core shared skill is educating and supporting colleagues to develop awareness of age-related conditions and their impact on the older person's quality of life (KSF 1.37, p.37).

10

Info Card 11

Clear Governance

Good governance involves inclusive, participative decision making with clear lines of accountability and responsibility (National Health Service England, 2017, p. 11).

11

Info Card 12

Pathways for Expanding Roles

The HSCP Advanced Practice Framework (HSE, 2023) describes education pathways for HSCPs, "which enable them to work at the top of their licence and realise their full potential (p.25)."

It also supports the establishment of Advanced Practice in HSCP to:

- Bridge the gap between healthcare needs and staff available to deliver the required health and social care services (p.5).
- Support expansion and retention of vital HSCP services by providing a career pathway and enable development and progression in these professions (p.5).

12

Info Card 13

Valuing and Appreciating Team Members

Valuing each disciplines expertise within an interprofessional team improves team function and outcomes. Reflecting on self and team performance to inform and improve team effectiveness, is also a core competency of interprofessional practice (IPEC, 2023, p.19).

13

Info Card 14

Shared Assessment

Participating in interdisciplinary shared assessment of older patients enhances knowledge of colleagues' roles, shares workload, fosters a team ethos, and improves resource allocation (KSF 4.18, p.46). This collaborative approach should be undertaken while working within one's own professional scope and limits (KSF 5.26, p.47).

14

Info Card 15

Making Every Contact Count

The Knowledge and Skills Framework emphasises that all health and social care staff should "make every contact count" by using each interaction to promote healthy living, compensate and prevent further disease-related losses and impairments, promote comfort and facilitate diagnosis and treatment of disease (KSF 3.15, p.42).

15

Info Card 16

Polypharmacy

Older people are at a significantly higher risk of experiencing polypharmacy and drug-related problems. These issues, including inappropriate prescribing, non-compliance, and adverse reactions/ interactions, can lead to a reduced quality of life and an increased likelihood of hospitalisation (KSF 1.25, p.37).

16

Info Card 17

Know, Check, Ask

The HSE ‘Know, Check, Ask Campaign’ aims to empower people and their families to safely use and manage their medications. Anybody who is using a prescribed medicine or caring for somebody who is taking medications should be directed to this campaign. They should be reminded by their prescribing healthcare professional to discuss any issues related to their medicine with a healthcare professional, particularly if they want to stop, reduce or increase a medicine.

17

Info Card 18

Role of the Social Worker

Social workers contribute a specialised psychosocial perspective to interdisciplinary teams. This includes interagency work, coordination, and case management, ensuring a holistic and integrated experience for the older person and their family navigating health and social care services (KSF p.101).

18

Info Card 19

Comprehensive Geriatric Assessment (CGA)

Understanding the CGA's purpose and the distinct roles of each discipline in its conduct and interpretation, alongside ensuring active collaboration is crucial for the coordinated assessment, discussion, and implementation of effective treatment plans
(KSF 4.04 and 4.07, p.45).

19

Info Card 20

Hoarding

Social Workers have an in-depth knowledge and understanding in supporting older persons, their carers, and supporters with issues of self-neglect and/or hoarding (SW3.37, p.104).

20

Info Card 21

Multifactorial Falls Intervention

Multifactorial falls interventions are necessary for addressing risks to the individual, including their living environment (Sherrington 2019). This can involve providing education and information about the risks of clutter and hoarding. Comprehensive care planning should be conducted by a multidisciplinary team, so that the individual physical and mental health needs of the older person are addressed.

21

Info Card 22

National Metrics

The National Services Plan (HSE, 2025) outlines the key areas of focus for integrated care programmes is to reduce emergency department (ED) attendance and hospital admission rates, enable quicker discharge from acute settings and reduce hospital waiting lists.

22

Info Card 23

Interprofessional Communication

The Interprofessional Education Collaborative (IPEC, 2023, p.18) outline communication as a core competency for interprofessional working, which includes:

- Active listening that encourages ideas and opinions of other team members (C5).
- Examining one's position, power, role, unique experience, expertise, and culture towards improving communication and managing conflicts (C7).

23

Info Card 24

Interprofessional Working Relationships

Providing high-quality care for older people relies on strong working relationships built on trust, mutual respect, and an understanding of diverse professional opinions
(KSF G4.01, p.45).

24

Info Card 25

Professional Boundaries

Effective teamwork requires an appreciation of the roles, responsibilities, and professional boundaries of each team member.
This includes recognising the limitations of one's own professional role and knowing when to make appropriate referrals (KSF 4.05, p.45).

25

Info Card 26

Care Coordination

Care coordination is the deliberate organisation of older persons care across two or more participants, with information shared so needs and preferences are known and used to deliver safe, appropriate, and effective care.

The Agency for Healthcare Research and Quality (AHRQ) provide resources that support care coordination into action.

26

Info Card 27

Patient Transfers

An enhanced skill within the Knowledge and Skills Framework for all health professionals is the ability to facilitate the smooth transfer of older patients between different settings or services within the professional network (KSF 1.44, p.38).

27

Info Card 28

Family Carers Stress

A recent national survey of family carers (n=132) in Ireland (Cronin and McGilloway, 2022) found, 61% reported experiencing psychological distress, with more than two-thirds (69%) reporting they were ‘rarely’ or ‘never’ being asked about their own health and wellbeing.

61% also felt misunderstood in terms of the challenges they face in their caring role.

28

Info Card 29

Communication Skills for Building Relationships

The HSE’s National Healthcare Communication Programme provides a simple and clear step by step guide for communicating with service users/ patients and building relationships across the care journey.

29

Info Card 30

Supporting the Family Carer

All healthcare professionals are required to understand the crucial interplay between an older person's physical and mental health needs.
(Knowledge and Skills Framework, 1.26, p.37)

30

Info Card 31

Eircode Lottery

Stark differences in waiting lists and home support exist. Whilst there have been reductions in Dublin and its commuter belt, waiting lists are growing or stagnating in the rest of the country (HCCI Data Series: Review of 2023).

31

Issue Card 1

What are the specific things we can do to ensure referrers know our role in the community?

1

Issue Card 2

Older people deserve coordinated care.

Across different teams and systems, whose role is this coordination?

2

Issue Card 3

What is the role of ICPOP teams in improving care coordination across services?

3

Issue Card 4

What are some strategies that could be used to support communication and information sharing?

4

Issue Card 5

How can information sharing across care boundaries be supported to enable care continuity?

5

Issue Card 6

When shared care across teams isn't an option, what resources and expertise are available within the team to coordinate care for an older person?

6

Issue Card 7

What are some of the specialisations that exist within our own profession that team members might not be aware of?

7

Issue Card 8

How can the team support dialogue and healthy (ideational) conflict, so everyone feels confident to contribute?

Why is this important?

8

Issue Card 9

How do we ensure we are consistently learning from others and integrating best practices into our own work and the team's work?

9

Issue Card 10

What skills or knowledge have you gained from other team members that have improved your assessments and care plans?

10

Issue Card 11

How can team members expand their roles and professional boundaries while staying within their scope?

What needs to be in place to support this?

11

Issue Card 12

How has working in an interprofessional team challenged or expanded your understanding of different disciplinary roles?

12

Issue Card 13

Is it appropriate to expand roles like social work to include clinical tasks?

What needs to be in place to enable this to be done safely and ethically?

13

Issue Card 14

Expanding roles and sharing tasks is crucial for integrating care.

What tasks or responsibilities do you think could be shared across all professions?

14

Issue Card 15

What happens when team members are expected to fill gaps left by missing specialists?

How do you think this should be managed?

15

Issue Card 16

What risks do team members face when they expand their roles to fill gaps in the team?

16

Issue Card 17

What is required for the team to discuss roles, responsibilities and workload tensions?

17

Issue Card 18

When professional perspectives differ, how can teams ensure everyone feels their expertise is valued and appreciated?

18

Issue Card 19

What is the impact of absent roles on the team and the care provided to older people and their families?

19

Issue Card 20

Each discipline has different approaches and interventions to address an older person's needs. How do we understand this within our team and enable team members to fulfill the full scope of their role?

20

Issue Card 21

What practical actions can ensure all team members feel confident to contribute their professional expertise?

21

Issue Card 22

When perspectives are undervalued, it can affect team dynamics and care delivery.

What is required for team members to feel their contributions are valued and appreciated?

22

Issue Card 23

Who should take responsibility of the key worker role when multiple healthcare professionals are collaborating in the older persons care?

23

Issue Card 24

Which roles were missing or under utilised in this scenario, and how could their involvement have changed the outcome?

24

Issue Card 25

How can the scope of our team be better understood by other teams in the system?

25

Issue Card 26

What is the impact of stepping outside of scope to fill gaps in care and how can this be managed?

26

Issue Card 27

What are some ways teams can support older people to understand the roles of different healthcare professions?

27

Issue Card 28

Who is responsible for making sure family carers are informed and actively involved in care and decision-making?

What helps to enable this in practice?

28

Issue Card 29

How can support be provided without blurring the team's specialist role by taking on responsibilities which are out of scope?

29

Issue Card 30

What needs to be done to avoid being seen as a "catch-all" service and prevent the dilution of ICPOPs specialist function?

30