Developing the ‘Gearbox Tool of Transitional Care’ (GTTC): a teaching tool designed to teach students as well as team members new to transitional care of older adults

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Abstract

This article describes the contributions to knowledge development and clinical practice during the author’s first year in the role of transitional care practitioner within a rural county setting in England, the UK. The development of a transitional care training tool was deemed essential as the author found that the definition and or constituent stages of transitional care seemed to differ among practitioners, social services, frailty teams and emergency care departments.

The author enrolled on the Mary Seacole Local Development Programme and set out to develop the proposed teaching tool. The Gearbox Tool for Transitional Care (GTTC) was the result of reflection on practice and consultation with transitional care stakeholder colleagues including university teaching staff and students, social services, established and new starter transitional care practitioners among others.

The Tool consists of the stages of transition from acute care to home and is based on varying degrees of care intensity. Older adults who transition from acute hospital to home are particularly vulnerable: many of them have co-morbidities that impact on their quality of life beyond discharge (Naylor, 2004). According to Moreno (2014), quality transitional care is therefore imperative in addressing the health and social needs of this vulnerable group and in preventing deterioration and or a readmission roller coaster once patients are deemed medically optimised for discharge from acute care.

It is hoped that the proposed GTTC (Takavarasha, 2022) training model is an essential contribution and stimulus into contemporary and improved instruction and orientation in national transitional care debates and pedagogy.

'Gearbox **Tool**' for Transitional Care **Training**

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Development Project

Part 1

This paper describes my journey as a Mary Seacole Local Programme (MSLP) candidate, I shall attempt to demonstrate my application of learning in practice. I shall use the Healthcare leadership Model to reflect on my feelings about the area I have developed and how these shaped my understanding of myself as a practitioner and inspired my leadership in developing a teaching tool for transitional care and how this shaped my development as a leader.

This teaching model was developed in 2020 when I took up a new role as a transitional care nurse practitioner in Lincolnshire, UK. Transitional care refers to care that addresses the transitional needs of the patient when discharged from acute healthcare following a period of recent frailty and/or falls (Caramanica et al, 2019). When I joined my role, I was placed to shadow various members of the team to get oriented and gain the competencies necessary for carrying out my role. On gaining an insight into the role, I was struck by the passion and enthusiasm among my team members, and I was able to learn from their broad and varied expertise in the role. Over the first few weeks in the role, I struggled to grasp the components of transitional care and how a patient transitions across such components.

I noticed that colleagues had disparate teaching styles that ranged from:

1. What constitutes the role to
2. The sequence of the constituent components of and
3. The various services available to patients being transitioned.

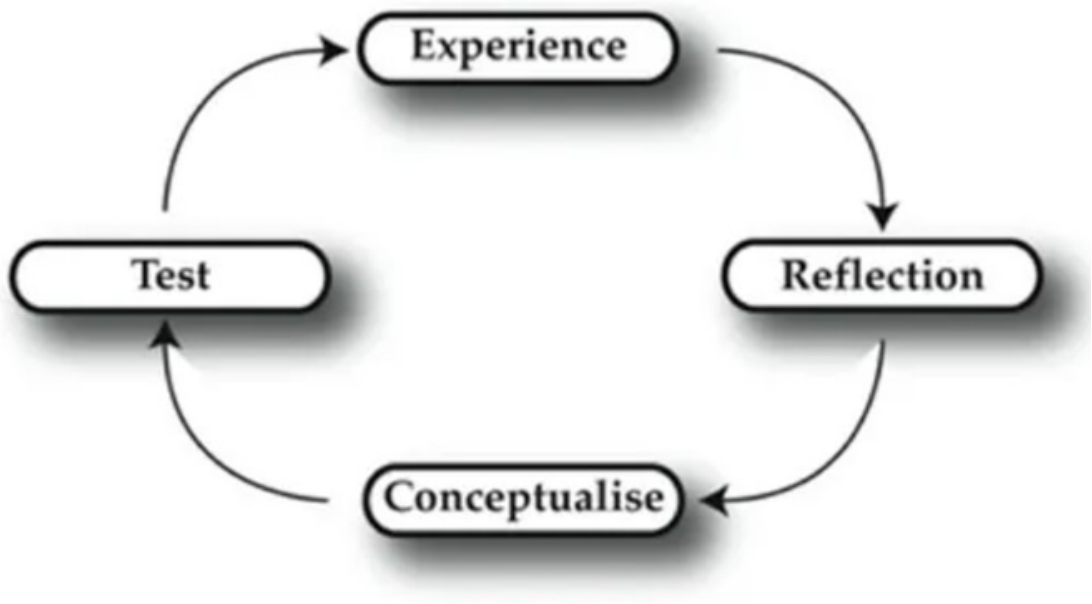
I immediately approached my manager and shared my concern that as a learner in the field, I was confused by the contrasts that existed within my team as to what constitutes transitional care. My manager, a Mary Seacole Development

Programme (MSLP) Alumni then shared his thoughts about my concern and tasked me with creating a teaching tool that could be used for new starters to the role including students who attend placements in transitional care.

My manager said to me that the development of such a tool is best achieved by me because I had the clearest insight of what I needed and therefore I was well placed as a new starter to create the change that I needed to see. My manager then urged me to apply for the MSLP and tasked me with developing the tool that I wished had existed when I was first oriented to my new role.

Upon starting the MSLP, I was able to appreciate a deeper understanding of myself as a leader. Having approached my manager to provide me with a learning tool and my manager placing that duty back at me, showed me that the needs of frontline staff do not have to be met by managers only but are best met by the ones who are in the line of sight of the user, who are able to see and seek to improve the need.

The need for a training tool for new starters wasn't necessarily a management issue but a leadership responsibility. In being tasked to develop and present the training tool I was given the opportunity to both develop and showcase my leadership attributes using experiential learning. The theory of experiential learning emphasises the central role that experience plays in the learning process (Kolb et al, 2014).



Kolb's Experiential learning cycle (1984)

I was able to reflect upon this during the MSLP tutorial comparing leadership and management that the manager administers, the leader innovates, and the manager maintains while the leader develops (Warren and Townsend, 1989). This helped me to embrace the task and so I set out to draft what I learned and developed it into what I considered an

easy reference tool for the components of transitional care. Through the experience I was gaining in transitional care, I was inspired to translate that into the teaching tool that I was developing. “Learning is the process whereby knowledge is created through the transformation of experience” (Kolb, 1984, p. 38). Additionally, Kolb (1984) sees learning as an integrated process with each stage being mutually supportive of and feeding into the next. I was therefore able to reflect on my experience of struggling to grasp the transitional care spectrum and managed to conceptualise the sequential nature of the spectrum as like the transitions of the motor gearbox.

As a great car enthusiast, I have spent a lot of my pastime sketching cars and or tinkering with motors. My inspiration for most of my innovative contributions comes from the world of cars. It was therefore not surprising that when I set out to demonstrate the incremental stages of the transitional care continuum, I used the car gearbox as a model.

As I developed the learning tool, I was able to reflect upon the Healthcare Leadership Model’s dimensions of leadership that work both independently as well as together to develop leadership (Ellis and Abbott, 2014). The individual dimensions I considered include, my managers ‘Inspiring shared purpose’ and ‘Developing capability’ through tasking me with creating the teaching tool I wished I had seen when I started in my role. The task of developing the teaching tool allowed me to reflect upon the above dimensions in my personal development as a leader.

When I first sketched the learning tool, it made a lot of sense to me and aided my understanding of the components of transitional care. I was however mindful that the use of this tool had to have relevance outside my own study. It had to meet the learning needs of those new to transitional care as well as my colleagues. This reflection caused me to ask myself the question, ‘What would it be like to be on the receiving end’ of both me and my teaching tool? The leadership dimension of ‘evaluating information’ gave me an opportunity to see what my colleagues would see rather than my limited and subjective view of the tool.

The Healthcare Model dimension that I found the most discomfort was the opportunity to share the vision (Windschitl et. al 2019). My vision was clear to me, that we needed as a team, a teaching tool for transitional care that provided a quick reference guide to what our role entails including the components of transitional care. I was however aware that I needed to justify the existence of such a tool to colleagues who had been in the role for over 10 years and had managed without my proposed tool. Kolb’s cycle of experiential learning includes ‘testing’ and for me, this involved presenting my gearbox tool for the scrutiny of other stakeholders. This made me especially nervous because the manager with whom I had shared the vision had now left. I reasoned that had my manager been around at this time, he would have helped me articulate the source and purpose of the vision and sold the idea to the team in a more compelling style perhaps than I could as a relatively new member of the team.

Part 2

In part 2 of this paper, I will seek to demonstrate how I was able to develop and increase my team’s engagement and motivation around my vision of the teaching tool. Additionally, I will seek to demonstrate how I was able to develop and increase engagement and motivation around my vision of the Gearbox Tool for Transitional Care with key stakeholders of

the tool, including Students, new as well as senior team colleagues, and the local university lecturers.

The exemplary aspect of **'making courageous challenges'** for the benefit of the service poses the crucial question, Do I have the courage to challenge beyond my perceived remit? And how do I take the initiative and responsibility to put things right outside my remit if I see others fearing to act? (Kumar and Khiljee, 2016)

The opportunity to transcend my influence outside my own microsystem into other microsystems and organisations gave me a clearer opportunity to map my own role in the wider context of the transitional care landscape in relation to other stakeholder organisations including acute care and adult social care services.

Feedback from Adult Social Service colleagues and acute care was also sought to both create interest and motivation around the acceptance and also to gain varied perspectives on the training tool. Appendix 1 shows the tool's presentation that was communicated to stakeholders and Appendix 2 shows the feedback given by stakeholders as well as the consequent actions to the feedback.

The task to engage the teams and stakeholders was for me the most challenging part of developing the transitional care training tool. I felt hesitant to share the vision of the tool and its use. I was particularly afraid that the tool may be misunderstood at best or even worse, rejected by my colleagues and other key stakeholders.

I focused on the 'Sharing the vision' and 'engaging the team' dimensions of the Health Leadership Model. I was determined to pitch a compelling and credible presentation that colleagues would not only accept but also embrace as an achievable and exciting tool that stakeholders would see fitting into the training facet of our roles. The use of the car gearbox as an inspiration for the tool was geared to present a vivid and attractive picture of something, familiar and applicable to the different dimensions of our practice.

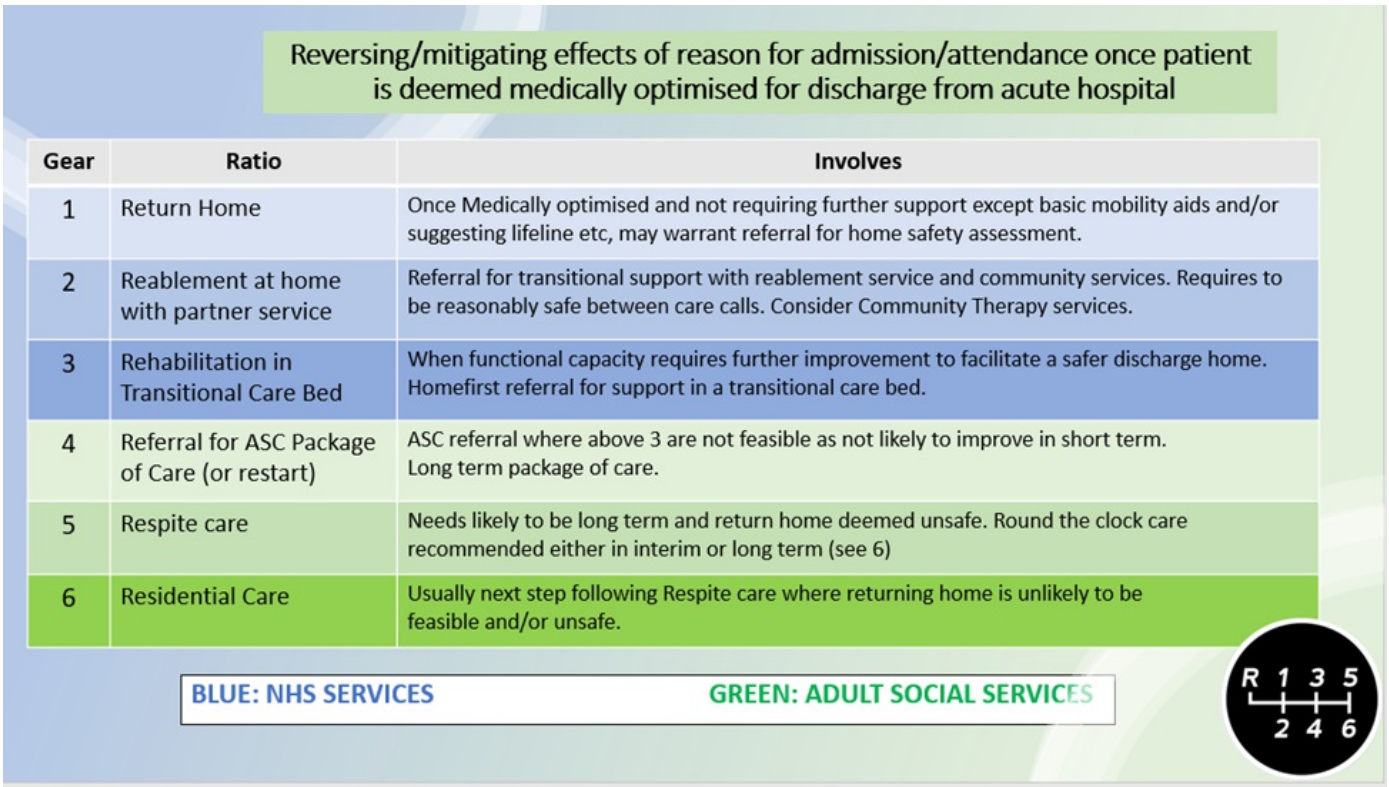
One key aspect I wanted to avoid was merely talking about the vision for a collaborative teaching tool without acting to gain that collaboration and feedback from stakeholders and although this was uncomfortable at first, I was able to gain insight into the expertise of colleagues who gave feedback and I was also able to polish the presentation of the model, taking account of the feedback.

Colleagues who participated in the feedback exercise remarked that their involvement showed that their contributions and ideas were valued and essential to the development of the training tool important for delivering outcomes and continuous improvements in transitional care. It was essential for such sentiments to be voiced by colleagues because it demonstrated that the very teams who would need to embrace and use the tool, felt part of it through its development phase. This phase of the training tool development fostered creative participation among team and stakeholders

I gained feedback from my team and stakeholders on the components and structure of the tool, including areas of improvement (see Appendix 2). Effective leadership, therefore, relies upon the ability to influence others to accomplish one's desired objectives (Noureddine, 2015). Influence can come in the form of impacting the other person's ideas, opinions, and even actions to employ the pull influencing style of persuasion (St Aubin and Pater, 2021).

St Aubin and Pater (2021) go on to remark, persuasion seeks that; if leaders want to be able to influence others, they also

must be willing to be influenced themselves. This implies going beyond mere conversation with stakeholders and actively prompting ideas as well as objections. I received some objections to my 1st presentation among colleagues who felt that I should not have placed timelines on the different gears/stages of the transitional care tool continuum. I, therefore, removed the initial six-week timelines that had been part of the preceptorship I received from one of the senior colleagues. Apparently, the timelines had become obsolete. The training tool was therefore giving the team the opportunity to revisit our service and to review and root out aspects that were no longer uniformly acceptable.



6 Stages of Transitional Care per the Gearbox Tool of Transitional Care, M Takavarasha (2022)

One of the key elements of the transitional care training tool is its ability to transcend across acute care, transitional healthcare, and Adult social care. The seven gears or ratios of the gearbox model represent R-the reversal of illness, frailty, and/or illness in the acute setting through tests and treatment. The 1st three gears 1 to 3 represent NHS transitional care services and the 2nd set of gears 4 through 6 represent Adult social services. It was therefore an attempt to seek both collaboration and feedback from colleagues at all 3 levels of the tool.

This process of collaborative testing of the tool required the stakeholders to feel that they were an equal party to the tool's development and usage. Furthermore, the inclusion of the 3 strands of transitional care into one seamless tool enabled colleagues across to unite in shared ownership of the tool. Shared purpose has been described as the golden thread which holds organisations together (Scroggs, et al 2009).

The feedback that colleagues provided as represented in Appendix 2 showcased a beginning in shared purpose among the stakeholders and this has the scope for further sharing and influence.

While it has been identified that the public sector environment poses unique challenges for seeking to develop a knowledge-sharing capability, the experience and potential gained in this exercise revealed an appetite for joined efforts to contribute to the teaching tool. I have come out of this exercise more confident not only as an innovative leader but also as a collaborative one. I was able to develop and increase engagement and motivation around my vision of the Transitional Care Teaching Tool with key stakeholders of the tool and in the process gain their acceptance and buy-in. I have now been invited to present the tool at our stakeholder team meetings so that the tool may become available across our stakeholder preceptorship and student placement programmes in Transitional care.

Appendix 1

The file *appendix-1-gttc.pptx* can be downloaded from the *Supplementary data* section.

Appendix 2

Appendix 2: Stakeholder Engagement and Feedback

Organisation	Role	Feedback
NHS Trust	Transitional Care Practitioner	Some feedback from your presentation. Feel that is similar to pathways we already have in place for discharge planning Factually we would not say to patients you are going into rehabilitation for up to 6 weeks, would normally only say 2-3 weeks, I realise they often do end up being longer but if we say 6 weeks then they are under the impression this is then written in stone so to speak. Patients never go into long term care placement only ever into respite or short term (again ongoing assessment once in placement) On a positive note the gears were nicely set out but need to ensure we have back up information if it was to role out for students, as in more reading around the points you have set out And one more thing unsure as to reasons around calling it reverse gearbox
University	Senior Lecturer: Nursing	Thanks for this and for running through it just now. I think it is a really useful tool for supporting students arriving on TC placements and also new staff - across all grades and types of role. As discussed, - I think the abbreviations need to be removed - or the page moved to near the beginning. I think the concept of moving up and down great is really great - and helps to facilitate understanding of the fluid nature of the process/patient.
NHS Trust	Care Homes Facilitator	A great and concise tool that provides clear guidance to health and social care professionals in their discharge planning and thus reduce the chances of 'failed discharges'. It will also make it easy for professionals to explain to students the reasoning and rationale behind the clinician's decision on the patient's discharge destination.
University	Student Nurse	The model is unique and unlike other current trends of learning (acronyms, catchy phrases etc). This helped me remember the methods and points more specifically, as it is much harder to confuse the method with anything else (for example, confusing ABCDE and ACE assessments – even though they are very different things, the idea behind how to remember them is very similar).

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