NATIONAL TRANSFER DOCUMENT FOR USE WHEN AN OLDER PERSON IS TRANSFERRED FROM A RESIDENTIAL CARE SETTING TO AN ACUTE HOSPITAL

Seirbhís Sláinte Níos Fearr á Forbairt | Building a Better Health Service

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OLDER PEOPLE

UNIVERSITY OF LIMERICK OLLSCOIL LUIMNIGH

nhi

Health & Social Care Professions

Rationale

- In 2019 there were 11,600 transfers of residents from nursing homes to acute hospitals by the National Ambulance Service alone
- A lack of consensus regarding the information considered essential on transfer internationally.
- Experience replicated in Irish context in a review of 96 nursing transfer letters by the NCPOP

The Current Situation

The majority of forms are designed to reflect the needs of the ED and focus on process and outcomes as opposed to resident experiences

Reflects norm in healthcare documentation: focus on biological referents in order to diagnose and treat a disease without consideration of the person behind the condition.

While this type of information is important; patient preferences, beliefs and values must be considered equally mandatory as any clinical or laboratory findings.

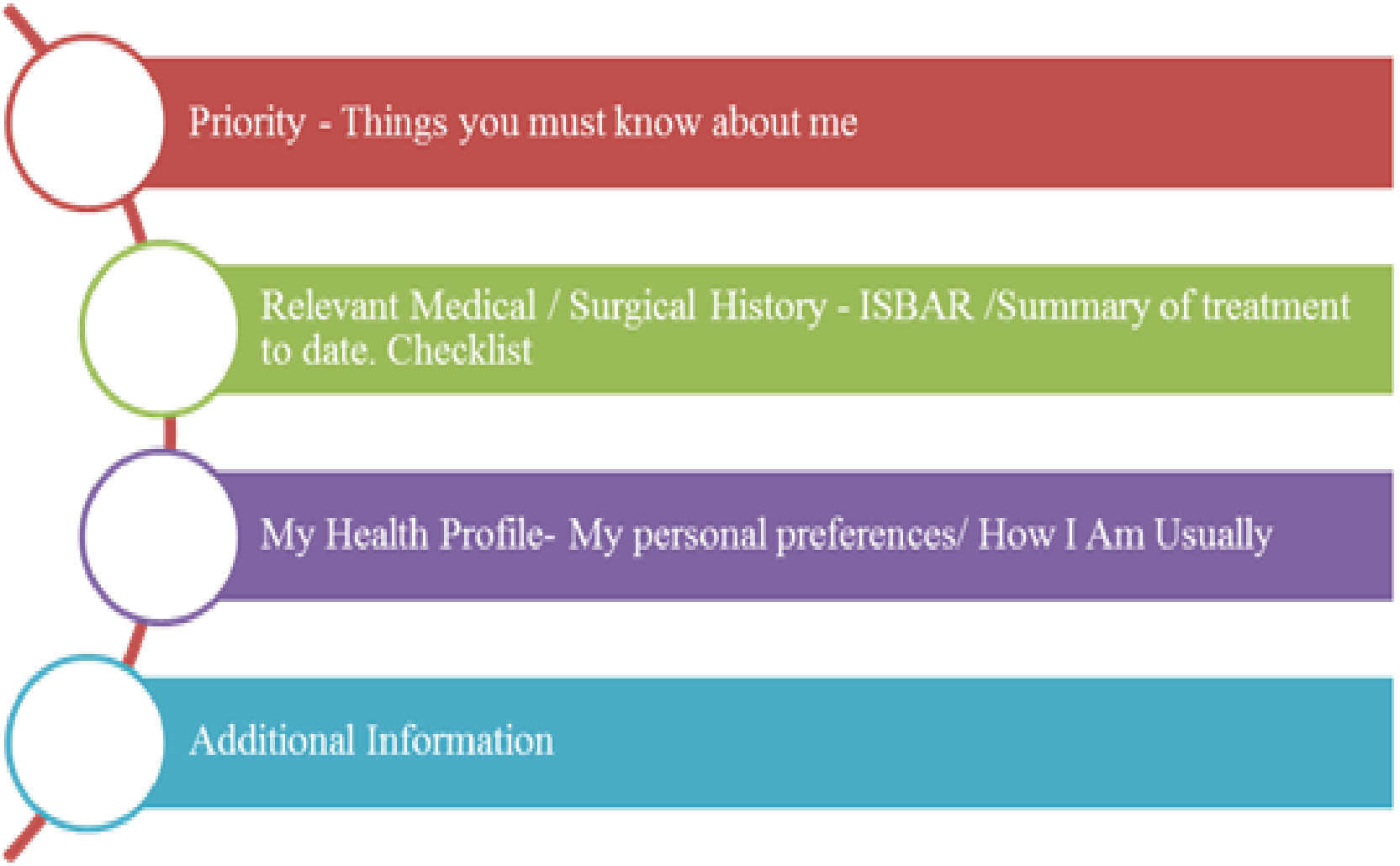
BENEFITS OF A STANDARDISED APPROACH

- Reduces medication errors.
- Significantly improves treatment.
- More efficient use of resources.
- Shorter AVLOS.
- Decreased mortality outcomes
- Timely treatment and discharge.
- Efficient assessment.
- Consistency in Care
- Continuity in Care
- Improved Residents journey.
- Delivers better experiences.
- Decreases readmission rates.
- Prevents decline during hospitalisation.
- Facilitates appropriate discharge planning.
- Optimises quality.
- Optimises Cost Outcomes.

National Research Project

- ✓ WP 1 – Preparatory Work
- ✓ WP 2 – Literature Review
- ✓ WP 3 – National Focus Groups
- ✓ WP 4 – Pilot Study
- ✓? WP 5 – Dissemination/Digitalisation/Implementation

The Document



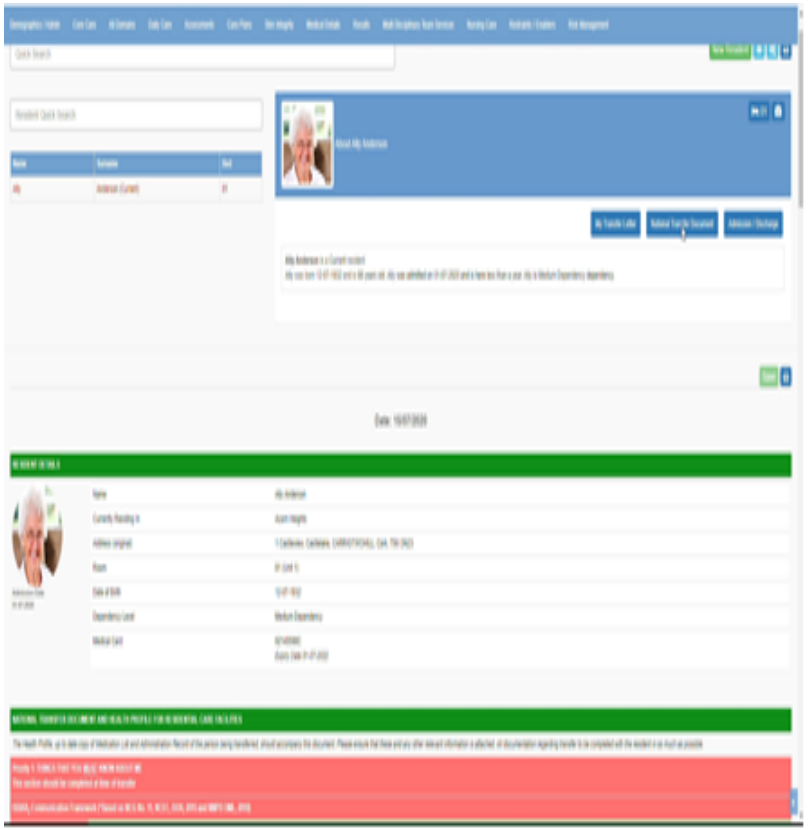
Front Page Priority 1 – Things that you must know about me

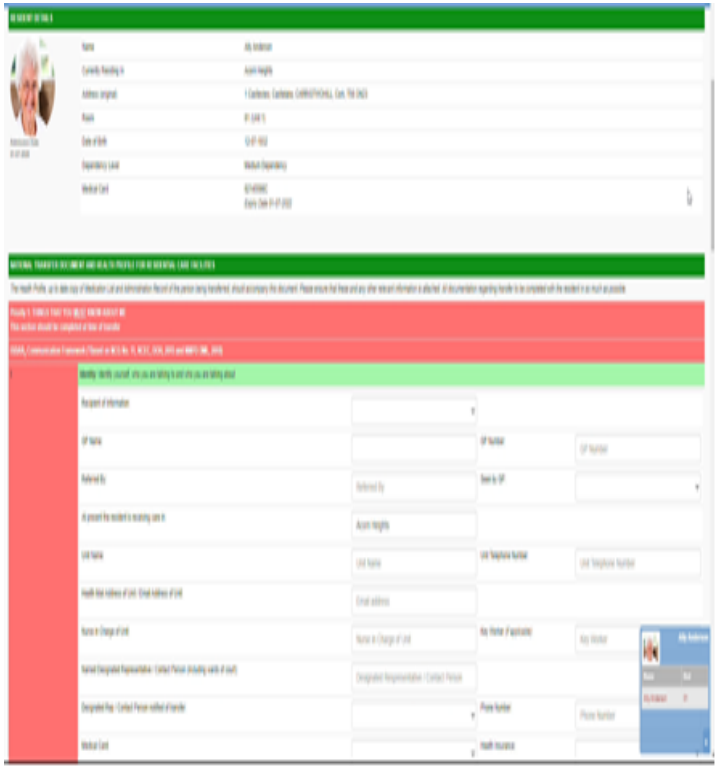
- This contains the priority information required to get a clearer picture on transfer to the acute setting using the Identify Situation-Background- Assessment-Recommendation (ISBAR) communication Framework.
- This approach assists in the safe, effective and efficient transfer and enables healthcare professionals make prompt clinical decisions at the initial stage of treatment

ISBAR Communication Framework	
Identity	• Identity of person providing handover • Identity of individual(s), team receiving the handover • Identity of patient
Situation	• Provides a brief summary of patient's current status • Identifies the problem requiring transfer
Background	• Concise summary of treatment to date • Current medication information • Relevant Medical/Surgical Information/ Health-care associated

ISBAR and Communication of Clinical Handover https://www.hse.ie/eng/about/who/qid/resourcespublications/tool-box-talks/effective-clinical-communication-isbar-.pdf

Epicare





Transfer Document & Health Profile

- We will bring you through the document and take questions

FAQ

- **Q: Is this filled in as typed or handwritten?**

A: The form can be both typed and handwritten.

Some sites have IT system which prepopulates the document. Other services the document is hand written.

Part B; completed on the residents admission, then maintained along with the patients care plan in line with local arrangement. It will be part of the local audits in relation to care planning.

Part A; The ISBAR is complete when the resident requires a transfer to the acute sector, either A&E/MAU/AMAU Etc. emergency or a planned transfer.

- **Q: How long does it take to complete NTD?**

A: Part B is completed on admission, approx. 30-40 minutes. Part A is completed when the resident has to be transferred to the acute setting, approx. 10-15 minutes, it depends on each individual nurse and service area.

FAQ cont.

Q: Is relevant medical history on Page 2 of ISBAR section the same as information required on Page 4

A: The information on page 2, the ISBAR, is relevant to the reason of the transfer out.

It deals with present situation, treatment so far-and relevant past history

Q: Does the summary of treatment to date on Page 4 relate to past medical history

A: Deals with present situation

FAQ cont.

- **Q: Is this document for use in independent/supported living facilities as well as nursing homes?**
- **A:** At the moment it is for use in Residential settings only

- **Q: Can you comment on information being transferred out of hospital back to nursing homes in time**
- **A:** There is a plan to produce a return document, this piece of work will be carried out in the future

FAQ cont.

- **Q: Can it be prepopulated?**
- **A:** The Electronic care plan provider will be contacted and asked to pre populate information to make use of the form more streamlined
- **Q: Who audits the document?**
- **A:** Each residential care setting is responsible for the audit of the document. It is audited in line with local Audit strategy and timetables in each Residential Care Setting.

FAQ cont.

Q: When does this document come in to use for Nursing homes?
A: It for immediate use in all Nursing Homes across the country, it is currently in use
Is this document applicable to all Nursing homes, HSE & Non HSE?
A: yes

Q: Where can we get a copy of the latest version with updated vaccine information?
A: A copy of the form can be found on the ONMSD webpage Here
Alternatively you can contact your local NMPD Officer for a copy of the form