Team Name: Home Care Leadership Team Lead: Regional Director - Home Care Approved by: Executive Director - East	Reference Number: CLI.5415.PL.001 Program Area: Home Care Policy Section: General
Issue Date: June 20, 2018 Review Date: Revision Date:	Subject: Information Transfer at Care Transition–Home Care

POLICY SUBJECT:
Information Transfer at Care Transition–Home Care

PURPOSE:
The purpose of this policy is to promote client safety and continuity of care by outlining the minimal requirements for effective information transfer at care transitions.

BOARD POLICY REFERENCE:
Executive Limitations (EL-01) Global Executive Restraint & Risk Management
Executive Limitations (EL-02) Treatment of clients

POLICY:
Home Care (HC) utilizes standardized documentation tools and/or verbal handovers to support information transfer during care transitions.

Sharing the provider's foresight, intuition and gut sense to guide continued critical thinking and decision-making around what to be worried about, what could go wrong, and what to look out for is a critical component within Information Transfer at Care Transition.

Documented Information Transfer at Care Transition involving admission, referral, transfer or discharge to other programs or services is required and included as a component of the health record.

The SBAR Clinical-Home Care (CLI.5415.PL.001.FORM.01) is used to support information transfer by communicating pertinent verbal or written information within a standardized approach.

Clients and families are supported during care transitions and given information that they need to make decisions and support their own care.

Information shared aligns with the Personal Health Information Act and Southern Health-Santé Sud Policies and Procedures.

DEFINITIONS:

Care transition: Any point in care when one care provider is transitioning care responsibility to another care provider e.g. admission, transfer, discharge and handover.

Client: Any individual recipient of healthcare services. Includes patients and residents

Handover: Information transfer from one provider to another provider assuming responsibility of care, within the same care location and includes but is not limitted to: transferring responsibility of care between shifts, or shorter periods of time such as breaks or change in care assignments.

Health Care Provider: All individuals who provide direct or indirect care as a result of their position and role in client care.

Information transfer: Communication at care transitions of pertinent information relevant to the care of the client to assist the receiving provider to immediately identify and prioritize ongoing care needs and monitoring requirements.

Vulnerable Person – Any individual who by nature of a physical, emotional, or psychological condition is dependent on other persons for care and assistance in day-to-day living to meet their basic needs.

SBAR: acronym for Situation, Background, Assessment, Recommendation(s). A tool to organize pertinent findings, verbally or in writing to support Information Transfer at Care Transitions or consultation with another health care provider ie: nurse to physician.

IMPORTANT POINTS TO CONSIDER:

- Information Transfer supports safe care by providing information reflective of critical inquiry, emphasizing critical thinking and clinical judgment , informed by the condition and care needs of the client.
- Information Transfer includes involving and informing the client, family and/or designate in care and providing them information that they need to support and guide their care.
- At a minimum, information communicated at care transitions includes:
    - Client's first and last name, PHIN, date of birth.
    - Primary contact person (including the Substitute Decision Maker (SDM), primary care provider).
    - Rationale for sending/transitioning client.

- Safety Concerns e.g. Violence Prevention Program (VPP) status, risk for falls, etc.
- Allergies
- Existing health care directive/advance care plan if known.
- Other information may also include list of current medications, diagnoses, recent functional or medical changes, relevant test results and procedures.

- Home care clinical professional staff as part of their admission and ongoing assessment of the client seek information relative to recent hospitalizations and visits to emergency departments (ED).

PROCEDURE

Home Care Client referred to acute care facility, ED, or primary care provider - unscheduled:

- As per "Referral to Emergency Department or Alternate Care Provider guideline (CLI.4110.SG.001), when referring or sending a client to an acute care facility, ED, or primary care provider for an unscheduled visit, home care clinical professional staff (Case Coordinator (CC)/Direct Service Nurse (DSN));
  - Contact the receiving acute care facility, ED, or primary care provider by phone regarding the rationale for referring/sending client for assessment.
  - Complete and provide/send the SBAR Clinical-Home Care by fax or with the client/caregiver identifying:
    - Client's first and last name, PHIN, Date of birth
    - Primary contact person (including the SDM), primary care provider
    - Rationale for sending/transferring client
    - Safety concerns e.g. VPP Status, risk for falls, etc.
    - Allergies
    - Existing health care directive/advance care plan
    - Other information may include; list of current medications, diagnoses, recent functional or medical changes, Wound and Skin Discharge Summary Form, relevant test results and procedures.
    - S - Situation: Reason for transfer/consult/referral.
    - B- Background: Relevant medical and psychosocial history.
    - A - Assessment: Summarize pertinent and significant findings and your assessment. What do you think the problem is? What are you worries about? What is your gut sense?
    - R - Recommendation(s): What do you recommend for immediate care needs? Share your insight regarding what to worry about, what could go wrong and what to look for? Confirm shared understanding with receiving provider.
  - Document all communication in Home Care Interdisciplinary Progress Notes at the time of the event or as soon as possible thereafter.
  - Notifiy the client's primary contact person (including the SDM, other Home Care Providers and community partners (e.g. primary care provider) of transfer.

Home Care client hospitalized

- CC
  - CC is notified of all client hospitalizations via phone or in person.
  - When notified that a client is hospitalized the CC:
    - Contacts the receiving acute care facility to communicate that client is an active home care client and any concerns identified prior to admission related to their functional or clinical health status.
    - Communicates information regarding client's hospitalization to the client's primary contact person (including the SDM), other Home Care providers and community care providers involved in client's care.
    - Conducts follow-up regarding clients status to determine discharge plan.
    - Documents all conversations in Home Care Interdisciplinary Progress Notes.
- Resource Coordinator (RC)/ Scheduling Clerk (SC)
  - Support Direct Service Staff in reporting all hospitalizations to the RC, SC or After Hours.
  - Report all information to CC for follow - up verbally or via procura tasks.
  - Follow-up with CC if clarification required about admission.
- DSN
  - Report immediately to CC and/or RC Nursing and Home Care Manager On call (outside of office business hours) when they become aware client has been hospitalized.
- Direct Service Staff – Home Care Attendant (HCA), Home Support Worker (HSW)
  - Report immediately to RC and/or SC or After Hours (outside of office business hours) when they become aware client has been hospitalized.

Consultation with Client's Primary Care Provider

- When consultation with the client's Primary Care provider is identified, the CC or DSN completes and forwards the SBAR Clinical - Home Care by fax or with the client/caregiver identifying:
  - Client's first and last name, PHIN, Date of birth
  - Primary contact person (including the SDM), primary care provider
  - S - Situation: Reason for consult.
  - B- Background: Relevant medical and psychosocial history.
  - A - Assessment: Summarize pertinent and significant findings and your assessment. What do you think the problem is? What are you worries about? What is your gut sense?
  - R - Recommendation(s): What do you recommend for immediate care needs? Share your insight regarding what to worry about, what could go wrong and what to look for? Confirm shared understanding with receiving provider.
  - Document all communication in Home Care Interdisciplinary Progress Notes at the time of the event or as soon as possible thereafter.

Transfer of client to another Regional Health Authority

- CC/DSN (Treatment Clinic Clients) completes and forwards to the Intake/CC of receiving Regional Health Authority the following documents;
    - Home Care Transfer Form – Agency to Agency (MG-9828) (CLI.5415.PL.001.FORM.02)
    - Client's current care plan; Nursing and HCA
    - VPP status
    - Other information may include: list of current medications, diagnoses, recent functional or medical changes, Wound and Skin Discharge Summary Form, relevant test results and procedures.
    - Verbal report provided to receiving Intake/CC.

Transfer of client to Personal Care Home (PCH)/Supportive Housing (SH)

- CC forwards to the receiving Personal Care Home/Supportive Housing the following documents;
    - Re-Assessment Form for Long Term Care Applicants (MG-1946) (CLI.5413.FORM.001) if client's panel date is greater than 6 months from admission date.
    - Client's current care plan: Nursing and HCA
    - VPP status
    - Other information may include: list of current medications, diagnoses, recent functional or medical changes, Wound and Skin Discharge Summary Form, relevant test results and procedures.
    - Verbal report provided to receiving PCH/SH for clients with complex care needs and where information is required to supplement information in documents provided.

Handover Points

<u>Community</u>

- The nature of care to home care clients residing in the community is episodic.
- The client's chart (health record) and client assignment serves as the means to communicate information relevant to care of the client. The client's chart (health record) and client assignment assists the oncoming home care provider to immediately identify and prioritize ongoing care needs and monitoring requirements.
- Prior to care provision the DSN and HCA review the client's chart (health record) and client assignment to obtain the most current information related to client's health status and care needs.
- When the need for communication of information of a more urgent nature is required this is done verbally to the DSN or HCA/HSW. e.g. change in care plan services requiring immediate implementation.
- The DSN or HCA verbally reports observed client concerns to the CC (DSN), RC (HCA/HSW) and the primary contact person (including the SDM) and document on the Home Care Interdisciplinary Progress Notes (DSN)/Client Care Notes (HCA/HSW).

Treatment Clinic

- Handovers occur at shift change and/or termporary changes in assignment e.g. meal break.
- Information relevant to the care of the client is communicated verbally during the care handover.
- Each DSN provides a verbal handover on their client assignment to the oncoming/temporary nurse responsible for the client care. The verbal handovers include pertinent information necessary for the time period involved:
    - Client's name/location in the treatment area e.g. stretcher one
    - Type of treatment and uncompleted tasks
    - Special monitoring
    - Safety concerns e.g. VPP Status, risk for falls, etc.
- Prior to care provision the DSN reviews the client's chart (health record) to obtain the most current information related to client's health status and care needs.

Transfer of client to another Home Care office in the Region

- CC forwards the client's chart (CC, DSN and HCA records) to the receiving CC in accordance with the Security and Storage of Personal Health Information Policy (ORG.1411.PL.404).
- CC provides a verbal report to the receiving CC identifying;
    - Rationale for transfer.
    - Safety concerns (VPP Status, Fall Risk).
    - Client clinical needs.

Audit process

- To evaluate compliance with the Information Transfer at Care Transition Policy, Home Care conducts the following audits bi-annually:
    - Observation audits for handover in the treatment clinic.
    - Observational audits of care provider review of client chart prior to care provision.
    - Restrospective Chart Audit for use of SBAR Clinical-Home Care.

SUPPORTING DOCUMENTS:

CLI.5415.PL.001.FORM.01	SBAR Clinical-Home Care
CLI.5415.PL.001.FORM.02	Home Care Transfer Form-Agency to Agency (MG-9828)

REFERENCES:

CLI.4110.SG.001	Referral to Emergency Department/Alternate Care Provider Policy
CLI.5413.FORM.001	Re-Assessment Form for Long Term Care Applicants (MG-1946)
ORG.1411.PL.404	Security and Storage of Personal Health Information