Team Name: PCH Standards Team Team Lead: Regional Director – Seniors, Palliative Care & Cancer Care Approved by: Executive Director - West	Reference Number: CLI.6410.PL.003 Program Area: Personal Care Home Policy Section: General
Issue Date: July 14 2017 Review Date: Revision Date: March 24 2020	Subject: Information Transfer at Care Transition–Personal Care Homes

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POLICY SUBJECT:
Information Transfer at Care Transition–Personal Care Homes

PURPOSE:
To provide guidance to health care providers about care transition communication in personal care homes (PCHs).

Care transitions are complex, high-risk processes in which effective communication is a critical element in improved resident safety.
The Frank Alexander Inquest recommendation FAI-07 requires that PCHs have a process to communicate to staff when a resident has refused medications or has had an aggressive or violent incident.

Accreditation Canada and the Personal Care Home Standard 6: Communication requires organizations to develop effective processes to support information transfer at care transition.

BOARD POLICY REFERENCE:
Executive Limitation (EL-02) Treatment of Clients

POLICY:
- In compliance with the Brian Sinclair inquest recommendation #1, communicating that a client is under a Committeeship, such as Public Guardian and Trustee of Manitoba, must be highlighted within Information Transfer at Care Transition between all program areas, service and health providers, including Fee for Service Physicians. This includes flagging the client's health record and communicating Committeeship in recognition of the risks inherent for the client's vulnerability and the complexities within the health system and a

shared responsibility for ensuring safe care for the client. See Policy Public Guardian and Trustee of Manitoba Committeeship (CLI.4110.PL.020).

- Care transitions follow a standardized process for transfer of accountability and communication of significant information about each resident between and amongst staff at change of shift and when transfer to another unit or facility is required.
- Information about acute, high risk and specific resident safety care issues is shared at each transition point.
- Health care providers involved in the transition have an opportunity to clarify information prior to transfer of accountability.
- A written tool is used to exchange information at change of shift, with other health care providers and when transfer to another unit, facility or health care provider is required.

PROCEDURE:

Shift Exchange

1. Nursing staff review the Integrated Care Plan for Residents in Personal Care Home Form (ICP) (CLI.6410.PL.002.FORM.01) of each resident for whose care they are responsible for each shift.
2. The nurse responsible for a resident's care provides a verbal or taped report to the on-coming nurse and health care aides assigned to the resident's care at each shift change.
3. The verbal or taped report is done in private to ensure that personal health information is not inadvertently disclosed.
4. The off-going nurse provides a written summary of the shift. This may be provided using the Personal Care Homes Inter-Shift Report Tool (CLI.6410.PL.003.FORM.01). The written shift summary should:
    - Be brief;
    - Capture significant data about each resident, including high risk or acute issues such as illness, medication refusals, aggressive or violent incidents, infection, hydration, falls, occurrences, etc.;
    - Not replace documentation in the ICP and Integrated Progress Notes (IPN) (Integrated Care Plan Integrated Progress Notes Form (CLI.6410.PL.002.FORM.06));
    - Be kept in a secure location for a minimum of two months.
5. Following the report, the off-going and on-coming nursing staff discuss any questions or care issues using the Personal Care Homes Inter-Shift Report Tool as a guide.
6. The Personal Care Home Inter-Shift Report Tool is retained for a minimum of two (2) months.

Communication with Other Health Care Providers

1. When communicating with other health care providers about the following resident care needs, nurses in PCH may use the SBAR-Clinical (CLI.4110.PL.010FORM.01):
    - Illness;
    - Medication needs (i.e. changes, efficacy, new symptoms, side effects);
    - Aggressive or violent incidents;
    - Infection;
    - Hydration;
    - Falls; and

- Occurrences.

2. The SBAR is provided in writing to the other health care provider (e.g. by facsimile) or may be used as a telephone script to guide a conversation.
3. Outcomes of a telephone conversation or consultation with another health care provider are documented in the IPN and in the prescriber's orders if applicable.
4. The SBAR Clinical is retained in the resident Health Record.

Transfer to another Unit in the Same PCH

1. When a resident moves to another care area, or unit, in the same PCH, the sending nurse provides the receiving nurse with a verbal report, using the ICP as a guide to provide the report.
2. The sending nurse makes a note of the transfer in the Personal Care Home IPN.
3. The receiving nurse makes a note of the transfer and receipt of the information in the IPN.

Transfer to another Health Care Facility (via Emergency Medical Services)

1. Adhere to the policy Information Transfer at Care Transition – Interfacility Transfer (CLI.4110.PL.007) for any transfers to another Health Care Facility.
2. The nurse at the PCH reviews the information on the Manitoba Information Transfer Referral Form (CLI.4110.PL.007.FORM.01) with the Emergency Medical Services (EMS) providers transferring the resident.
3. If the transfer is for a service where there is no nurse to receive the resident (e.g. diagnostic services) there is no need for a nurse-to-nurse transfer.
4. The nurse documents that the information has been reviewed in the IPN.

Non-EMS Transfers to any Receiving Location or Provider (e.g. hospital, other PCH, physician's office, dentist, optometrist etc.)

1. The nurse at the PCH completes the Manitoba Information Transfer Referral Form.
    a. The nurse may choose to complete the SBAR-Clinical in addition, if clinical information will assist with the transition of care, or a component of care, as per Referral to Emergency Department or Alternate Care Provider (CLI.4110.SG.001).
2. The nurse reviews the information on the form(s) with the resident or their representative if applicable prior to transfer. The nurse documents that the transfer form(s) was reviewed and with whom in the IPN.
3. The nurse either:
    a. Sends the completed transfer form along with the resident in a sealed envelope with instructions to either the resident or a person accompanying them to give the form to the provider the resident is going to see.
    b. Faxes the completed transfer form to the receiving location or provider.
4. The nurse completes a nurse-to-nurse verbal communication when the receiving location is a hospital or a PCH. There is no need for a nurse-to-nurse transfer when the resident is going to a physician's (or similar) office.
5. The PCH retains a copy of the transfer form(s) on the Health Record.

Discharge from PCH

1. When a resident is discharged from PCH, follow the steps for End of Service Reconciliation in the Medication Reconciliation (CLI.6010.PL.009) policy.
2. Provide the resident with a copy of the most recent Integrated Care Plan and review the current care plan with the resident and/or his/her substitute decision maker.
3. Document that the resident has been provided with a copy of the Integrated Care Plan.
4. If required, refer the resident to Home Care (see policy Home Care Referral and Intake Process for Home Care Services (CLI.5410.PL.003)).

Quality Improvement

- Information transfer components are assessed and reviewed through the Manitoba Personal Care Home Standards process in two ways:
  - Information transfer at shift exchange is assessed under Standard 6: Communication every two (2) years at selected PCHs;
  - Information transfer between providers is assessed under Standard 6: Communication every two (2) years at selected PCHs; and
  - Information transfer on transfer or discharge is assessed under Standard 13: Health Records every two (2) years at selected PCHs.

SUPPORTING DOCUMENTS:

CLI.6410.PL.003.FORM.01	Personal Care Home Inter-Shift Report Tool

REFERENCES:

Accreditation Canada (2014). *Long Term Care Standard*.

Canadian Nurses Protective Society (2007*). InfoLAW, Vol 1(1). Quality Documentation: Your Best Defense.*

College of Licensed Practical Nurses of Manitoba (2013). *Standards of Practice*.

College of Registered Nurses of Manitoba (2013). *Standards of Practice for Registered Nurses*.

Manitoba Health, Healthy Living and Seniors (2015). *Personal care home standards: Self-assessment tool*. Standard 6: Communication, Standard 13: Health Records.

Registered Nurses Association of Ontario (2014). *Clinical Best Practice Guidelines: Care Transitions.*

Registered Psychiatric Nurses of Canada (2010). *Code of Ethics and Standards of Psychiatric Nursing Practice*.

CLI.6410.PL.002.FORM.01	Integrated Care Plan for Residents in Personal Care Home Form
CLI.6410.PL.002.FORM.06	Integrated Care Plan - Integrated Progress Notes Form
CLI.4110.PL.010.FORM.01	SBAR-Clinical
CLI.4110.PL.007	Information Transfer at Care Transition – Interfacility Transfer
CLI.4110.PL.007.FORM.01	Manitoba Information Transfer Referral Form
CLI.4110.SG.001	Referral to Emergency Department or Alternate Care Provider
CLI.6010.PL.009	Medication Reconciliation
CLI.5410.PL.003	Home Care Referral and Intake Process for Home Care Services
CLI.4110.PL.020	Public Guardian and Trustee of Manitoba Committeeship