newcastle safeguarding adults board

Care to Care

Best Practice Standards for Safe Transfers of Care

Updated: September 2019
Review: October 2022

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Introduction

Aim

These Best Practice Standards relate to transfers from one care setting to another. Their aim is to ensure that appropriate timely communication (verbal and written) occurs whenever a person moves from one care setting to another.

Four key principles of good communication

1. Communication should be **person centred**
2. A **named professional** should be identified in relation to every transfer of care from one care setting to another
3. In every case you should **communicate with**: a) the person being transferred, b) their carer / family and c) the individuals providing health and social care services, also adhering to the law on confidentiality
4. **Gaining consent** from the person at the earliest opportunity to facilitate **information sharing** across care providers is essential.

Scope of communication about transfers of care

Written and verbal communication includes appropriate details on:
- Health and social care needs, including the needs of people who are homeless and any behavioural issues (triggers to certain behaviours),
- Communication needs of person, especially need for communication support e.g. interpreter, BSL signer, advocate,

- Infection and associated care required (e.g. MRSA, clostridium difficile[1], need for contact precautions / isolation),
- Assessment of mental capacity (if carried out) and the decision it relates to,
- Safeguarding issues, especially those that are current or ongoing,
- Deprivation of Liberty (DoL) safeguards / authorisation,
- Cultural and religious needs e.g. religious observances, relevant religious holidays.

What can happen as a result of poor communication

Medication changes at or around the time of transfer that are not communicated adequately can cause unnecessary harm to the person. You should take particular care in communicating the correct details about medications to the person, their carers/family and care providers.

Not only does poor communication compromise safety and threaten wellbeing, it is often an indication of poor care and leads to safeguarding concerns / referrals. In a recent report of investigations into unsafe discharge from hospital, out of the four key issues highlighted, three related to poor communication (Parliamentary and Health Service Ombudsman, 2016):

- Relatives and carers not being told that their loved one has been discharged
- Patients not being consulted properly before their discharge
- Poor communication across services

Policy context

Other national documents worthy of note are:

- Transition between inpatient hospital settings and community or care home settings for adults with social care needs NICE guideline (NICE, 2015)

[1] Patients with clostridium difficile must not be transferred until free from diarrhoea for 48 hours and a formed stool achieved. Details of any recent c. diff. history must be passed on when patient is transferred.

Both should be read in conjunction with these Best Practice Standards for Transfers.

Staff members are also referred to other relevant policies within their employing organisation, and in particular to those on discharge and transfer.

Where standards of communication relating to transfers of care have fallen below the required standard you should consider making an adult safeguarding referral. In considering this you should refer to the Safeguarding Adults Threshold document. For a link to Newcastle Safeguarding Adults Policy and Procedures, including the Threshold document, go to:

www.newcastle.gov.uk/node/109156

These standards were written by a multi-agency working group in 2009 and updated in 2017 and 2019. The current working group was convened in 2016 by the Improving Practice Group, which is a sub committee of the Newcastle Safeguarding Adults Partnership Board.

Section One

Transfer from home (including sheltered housing, supported living environments, and housing with care schemes) to another setting

What to do first:	Remember:
For a short notice transfer to hospital: • ensure that the person being transferred knows and understands the reason for transfer, reinforce/ repeat this information if necessary, • agree with the person being transferred, who if anyone they wish to be informed about their transfer, • GP to speak to the bed bureau (Hospital Bed Bureau will then speak to and pass on or email relevant information from GP to admitting area) • Bed Bureau to contact North East Ambulance Service (NEAS) and arrange ambulance transport within specified time frame. • GP letter (or letter from the 'out of hours' doctor) and / or electronic summary to be completed and sent with the person being transferred. For planned admission to hospital, support the person being transferred in completing the 'patient	A number of health and social care providers can be involved with people living in the community. The main care provider must take responsibility for communicating with professionals who receive the person. This main care provider may be: • District nurse or community matron • Community mental health team • Care agency (responsibility for communication sits with the social worker who manages the care package) • An independent supported living housing provider/housing with care scheme (may be called ExtraCare) • GP / Practice Nurse If the person is to be transferred to a nursing home and special equipment / aids are required, the district

questionnaire'. **Ensure that the person being transferred takes their current medications with them whenever possible.** **As a minimum ensure that a list of medications with frequency and dosage details is sent with the person (see Appendix 1 for Recommended Core Content of Records for Medicines when Patients Transfer Care Providers).**	**nurse (DN) (or other main care provider) must inform the care home manager so the necessary equipment can be obtained, giving as much notice as possible and a minimum of 2 working days.** **If the person is being transferred to a residential home and special equipment is required, this must be requested by the DN, or the request passed to another DN colleague i.e. the DN who covers the residential home.**
What to do next: **Main care provider to consider what other information needs to be forwarded to the team receiving the person e.g. ability to carry out activities of daily living, person's mental capacity, other details relating to care needs.** **If the above is necessary ensure the information is handed over verbally and backed up by copies of written documentation e.g. assessments and care plans.** **As a minimum there should be a phone hand over covering (SBAR):** • **Situation** • **Background**	**What else you need to know:** **For a person who has a community social worker, that social worker is likely to stay involved with a person whilst they are in hospital, rather than the person being allocated a hospital social worker.** **If the person is being transferred to a residential home and a district nurse (DN) is involved, the DN should contact the DN that covers the residential home and give a verbal handover.** **The person in charge of the care home (residential or nursing) is responsible for ensuring that any special equipment / aids are in place prior to transfer.** **If a person is being transferred to a care home, a**

• **Assessment** • **Recommendations** **Social worker (if involved) to contact the hospital social work team to hand over any concerns /care needs.** **If person has care at home, Inform care provider that person has been transferred. If possible 'keep in touch' with care provider whilst person is in hospital / other setting, to facilitate continuity when the person returns home.**	**Continuing Care Checklist or Continuing Care 'fast track' from must be completed.**

Section Two

Transfer from care home (residential and nursing homes) to another setting

What to do first:	Remember:
Discuss arrangements for transfer with person being transferred. Inform relatives about reasons for transfer and the transfer arrangements. If there is a change of health needs, complete a Continuing Care Checklist or a Continuing carer 'fast track' form and send to the continuing care assessors.	The written documentation that you complete will depend on the documentation used by the care home and also on whether the person is being transferred as an emergency. It is important that information on the following is included: • Person's key details (name, address, next of kin, GP etc). If an electronic summary sheet is available this should be printed off and included. • Current medication details • Infection and associated care required e.g. MRSA, clostridium difficile, need for contact precautions/ isolation • Care Coordination documentation (for mental health and learning disabilities specialities only). • Care needs • Assessments of mental capacity • Safeguarding issues (information should be provided on a need to know basis only and not

	passed on without due consideration to confidentiality) • Deprivation of Liberty (DoL) authorisation, if in place • Details of preferred place of care • Details of advanced decisions • Cultural and religious needs • Any specific communication needs e.g. need for an interpreter, BSL signer, advocate
What to do next: **Book ambulance transport at least two working days in advance, or make alternative transport arrangements.** **Complete and / or photocopy the necessary written documentation to ensure that the staff receiving the person (e.g. another care home, a district nurse) are fully informed about the person's care needs.** **If the person's needs have changed, social worker to update any assessments including risk assessments and care plans, and if appropriate complete a capacity assessment.** **If a new care package is required, social worker to discuss the person's needs with the care agency and send copies of risk assessments and care plans to the care agency. Is care agency the best term to use?**	**What else you need to know:** **A person with cognitive impairment should be accompanied by a relative or member of the care staff to provide reassurance.** **A Deprivation of Liberty authorisation for a person in a care home ceases when the person is transferred to another setting.** **If a person is being transferred from one residential home to another and has input from a district nurse, remember to inform the community nursing team so they can handover to colleagues in the new team.** **For transfers from one care home to another the social worker should identify risks and make the new care home provider aware of this.** **If there has been a change in status i.e. from**

If person is returning to their own home and previously had a care package, person in charge of care home to speak to social worker requesting that care package is resumed (giving at least two days notice). Check that any aids required, e.g. mobility, transfer, toileting aids etc, will be available when the person is transferred. If person has direct payments, social worker in conjunction with the person, to ensure that the care package is re-started. Check that a minimum of 7 days medication is available for the person to take with them.	residential care to nursing care, then the social worker must update assessments and care plans. An assessment of mental capacity may be required, together with the necessary documentation related to best interest decision making. This information should be forwarded to the new care home. If equipment is being transferred with the person, remember to contact the loan equipment service, informing them of a change of address. Loan equipment items should not go outside Newcastle city boundaries. Care homes are introducing transfer bags (black bag scheme) in 2017. The transfer bag contains information and documentation about the person being transferred as well as medications and other important possessions / equipment e.g. dentures. This bag should remain with the person throughout their stay.
What to do on the day of transfer: Make sure that the patient has 7 days supply of medication. If the person is returning to their own home, medication may be available at home. Check that there have been no changes to medication whilst the person has been in the care home.	For a person who needs input from a district nurse, the referral should be made giving at least 2 working days notice. If pressure relieving equipment (or other equipment provided by the loan equipment service) is required, this is arranged by the district nursing service. Give as much notice as possible.

GP to write hand written referral if in attendance and person being transferred to hospital at short notice. **For a transfer to another care home, GP to do a letter if person transferring to a new GP practice; letter to be sent with the person.** **Person in charge of the care home to speak to the person in charge where the person is being transferred and provide a verbal 'handover' using SBAR.** **Ensure that the person's GP is informed that the transfer has taken place.** **Person in charge of care home to inform relatives when transfer has taken place and details of information provided to be documented in the person's record.** **NEAS staff to ensure that written documentation is handed over to the nurse / person in charge on arrival (for transfers to hospital).**	• **Oxygen is arranged by GPs and generally takes 3 days to arrange** • **Suction machines are generally only provided for people who are terminally ill** **For medical equipment:** • **Feeding equipment and giving sets have to be ordered on a named person basis which takes more than 3 days. Send 7 days supply with the person when they are transferred.** • **For catheters and dressing changes, send enough equipment for 3 changes.** • **For blood glucose monitoring, check that the person has a BM machine and contact the Diabetes Nurse Specialist with any queries.** **NEAS does not have a contract to provide transport for people being transferred from one care home to another. In exceptional circumstances NEAS may be able to provide transport e.g. closure of a care home. This requires authorisation and subsequent payment by the CCG.**

Section Three

Transfer from hospital (or hospice) to another setting

What to do first (as soon as a date for transfer is set):	Remember:
Discuss arrangements for transfer with the person being transferred. Discuss arrangements for transfer with carer / family. Find out what support family members can offer (if required). Do not presume. Family members often have their own care needs. Ensure their needs are assessed too. Speak to all the necessary health or social care providers in person and discuss plans for transfer • Care agency (social worker) • Care home (nurse) • Community nursing team (nurse) • Community Rehabilitation and Re-ablement Team (CRRT) (social worker/nurse) • Other Intermediate care provider	A date for discharge from hospital should be set on admission wherever possible. At ward level, there should be a nominated member of staff who takes overall responsibility for the transfer of care. If the person being transferred has physical and mental health care needs, both should be considered. A person who is homeless may not be registered with a GP. A person may be transferred at short notice e.g. to receive palliative care in their preferred place of care. Particular attention should be paid to communication with 'short notice' transfers.

• Hospice (nurse) • Resource centre (social worker/nurse) • Supported living housing provider (social worker / nurse) • Housing with care scheme manager (social worker) • Community social worker (social worker) • Community care alarm provider • Loan equipment service If the person has been homeless prior to admission, ensure that future living situation is discussed / reviewed.	Keep (and then file in patient notes) a written copy of details handed over by telephone e.g. SBAR form. Residential care homes do not provide nursing care, so if the person needs nursing care e.g. wound care, injections; you need to refer the person to the Community Nursing Service. If you are in any doubt about a person's capacity to make a decision about moving to a new home/care environment on a permanent basis, an assessment of mental capacity should be undertaken (usually by the social worker). Subsequent action must be in line with the Mental Capacity Act. If the person is being transferred to a care home (new or returning), a reassessment of needs must be done. In the past this has been done by the care home, however in certain circumstances this can be completed by a designated assessor employed by the Trust. If a person is being transferred to a new care home, it is likely that their GP will change. Make sure you send the necessary information to the new GP. Where possible 'shared decisions' about transfer and ongoing care (between the health/social care professionals and the person) should be made.

What to do next:	What else you need to know:
Arrange transport and if person is returning home. Check person will have access. Social worker to assess and update any assessments including risk assessments / care plans, and ensure these are sent to relevant care providers / community social work team. Consider whether person will be able to manage their own medication post discharge, if in doubt assess ability to do so. If necessary make alternative arrangements for taking medications e.g. order 'dosette' box, arrange for a carer to administer medications. Have on-going conversations with the person and their carer/family about the person's needs post transfer and related arrangements. Ward nursing staff to check that all the necessary aids and equipment are available for the person on transfer (including for transfers to care homes). Do community nurses still need a written prescription to give meds?	If an adult with on-going mental health care needs is being transferred from a hospital setting, you need to ensure that they know how to contact the crisis team. If referring to the community nursing service the notice you give the service must be proportionate to the complexity of the person's needs (minimum of one working day). If the person is being transferred to a care home, is it a nursing home or a residential home? If the person is being transferred to a housing provider, is it sheltered housing, independent supported living or a housing with care scheme? If the person will be receiving personal care from the housing provider, you need to ensure that the person's care needs are communicated to the care provider. Any increase in the level of support must be agreed by the allocated Social Worker/ Social Worker attached to the scheme prior to discharge. Where mobility aids are required, these are provided by the hospital based PT / OT. To obtain equipment from the Loan Equipment

Ward nursing staff to complete the "Transfer of Care" form and ensure that copies go to all relevant health and social care providers. **Ward doctor to complete an electronic summary letter for the GP. Does the nurse print this off – does it go with the patient or go in the post?** **Formal discharge summary letter to be sent to person's GP within 2 weeks of transfer.**	**Service e.g. pressure relieving equipment, you should contact the community nursing service.** **Is there a Deprivation of Liberty Authorisation in place? If so, and the person is transferring to a care home, the care home must be informed as soon as possible, so they can make the necessary arrangements.** **All care providers (Is this clear enough? Should we say health and social care providers? Is this just care home providers?) should have an "SBAR" form, which they should complete with the information handed over on the telephone.** **If the person is being transferred to a care home, you need to complete a Continuing Care Checklist or Continuing Care 'fast track' form and forward it to the Continuing Care Assessors.** **If the person being transferred has direct payments then the social worker and the person being transferred will need to ensure that the support package is restarted.** **Suction equipment can be requested by contacting the community nursing service, giving as much notice as possible.**
What to do on the day of transfer: **Speak to whoever is meeting the person being transferred; inform them when the person will arrive; provide updates if the situation changes.** **If person has been referred to the community nursing service, ring the appropriate clinic when the person leaves the hospital.** **If handing over to a health or social care professional, do so by telephone, giving information using "SBAR":** • **Situation** • **Background** • **Assessment**	

• **Recommendations** **Update the person and their GP about any medication changes made whilst the person has been in hospital.** **Give person a minimum of 7 days supply of medication. Check the person understands TTA (to take away) medication and that they are able to self-medicate (unless alternative arrangements have been made).** **If medical equipment is required e.g. feeding and other giving sets, send 7 days supply with the person being transferred. For catheters and dressings, send enough for three changes.**	**If blood glucose monitoring is to be done at home, ward staff should check that the person has a blood glucose monitoring machine at home and contact the diabetes nurse specialist with any queries e.g. if person is unable to use equipment.** **Home oxygen can be requested by completing a home oxygen order form (HOOF) available on the Trust intranet.**

APPENDICES

Appendix 1
Recommended core content of records for medicines when patients transfer care providers (Picton and Wright, 2012)

PATIENT DETAILS	Last name, first name, date of birth, NHS number, patient address
GP DETAILS	GP / Practice name
OTHER RELEVANT CONTACTS DEFINED BY THE PATIENT	For example: - • Consultant name: usual community pharmacist; specialist nurse
ALLERGIES	Allergies or adverse reactions to medicines • Causative medicine • Brief description of reaction • Probability of occurrence
MEDICATIONS	Current medicines • Medicine – generic name and brand (where relevant) • Reason for medication (where known) • Form • Dose strength • Dose frequency / time • Route
MEDICATION CHANGES	Medication started, stopped or dosage changed, and reason for change

MEDICATION RECOMMENDATIONS	Allows for: - • Suggestions about duration and/or review, ongoing monitoring requirements, advice on starting, discontinuing, or changing medicines • Requirements for adherence support, for example compliance aids, prompts and packaging requirements • Additional information about specific medicines, for example brand name or special product where bioavailability or formulation issues
INFORMATION GIVEN TO THE PATIENT AND/OR AUTHORISED REPRESENTATIVE	If additional information supplied to the patient / authorised representative on transfer For example: - • Patient advised to visit community pharmacist post discharge for a medicines use review (MUR) • Where capacity, sensory or language barriers, how all necessary support information has been given to authorised reprecsentative / carer
PERSON COMPLETING RECORD	Name, time, date, job title Contact telephone number for queries Signature (if paper based)

Appendix 2

Useful links

Website	Address	Purpose
Newcastle Safeguarding Adults Board	https://www.newcastle.gov.uk/social-care-and-health/safeguarding-and-abuse/safeguarding-information-professionals	Webapegs of the Newcastle Safeguarding Adults Board include multi-agency policy and procedures tools and resources.
My Care Newcastle	https://mycarenewcastle.org.uk/home	Contains a directory of all of the organisations Newcastle City Council Commissions to provide care
Tyne and Wear Care Alliance	http://www.twca.org.uk/default.asp	Provides updates on the latest regional and national strategies relating to health and social care.
Social Care Institute for Excellence	http://www.scie.org.uk/	Research and resources for the social care and health sectors from independent charity and improvement agency.

REFERENCES

National Institute for Health and Care Excellence (2015) Transition between inpatient hospital settings and community or care home settings for adults with social care needs : NICE Guideline. NICE London.

Parliamentary and Health Service Ombudsman (2016) A report of investigations into unsafe discharge from hospital. London May 2016.

Picton, C and Wright, H (2012) Keeping patients safe when they transfer between care providers - getting the medicines right: final report. Royal Pharmaceutical Society, London June 2012