

POSTER ABSTRACT

Developing a National Patient Transfer Letter for use by both the Nursing Home (NH) & Acute Hospital (AH) Sectors

17th International Conference on Integrated Care, Dublin, 08-10 May 2017

Jonathon O'Keefe¹, Jean Barber², Deirdre Lang³, JJ Barry², Graham Hughes¹,
Diarmuid O'Shea¹

1: St Vincent's University Hospital, Ireland;

2: St Michaels Hospital, Ireland;

3: National Clinical Programme for Older People, Ireland

Background: This project was initially undertaken by the Department of Medicine for Older people in two Academic Teaching Hospitals in Dublin. It is led by two Clinical Nurse Specialists in Gerontology and is supported by geriatricians in both sites. It has recently gained the support of the Irish Hospice Foundation (IHF) Nursing Homes Ireland (NHI) and National Clinical Programme for Older People (NCPOP).

Problem: Information sent from local nursing homes to the acute hospital Emergency Department often lacks the information required to provide safe quality care to the older person in an emergency situation. Hence, members of the interdisciplinary team spend inordinate amounts of time contacting these NH's in order to obtain basic information that will support important care and treatment decisions in the acute setting for this complex, frail patient group. Information on medications, infection status, diet, cognition, functionality, advanced care planning are essential if we are to determine patient need.

Assessment of problem and analysis of its causes: A prospective audit was carried out in 2011 to assess the problem outlined above in which 35 transfer letters from 29 different NHs were reviewed. A questionnaire was used to assess 24 aspects of information been received at the point of hospital entry. A template transfer letter was devised from the questionnaire to capture demographic information, baseline medical information, physical information and the cognitive status of the patient being transferred to hospital from each NH. The template was sent at the end of the audit period to all Directors of Nursing in each NH. All were requested to send feedback on the template so it could be modified for phase 2 of the project.

Intervention: As a result of the consultative process a new transfer document was developed. Support from the national advisory body Nursing Homes Ireland (NHI) was ascertained. In order to enhance accessibility and promote usage, the document was made available on both hospital websites and a care planning database 'Epicare' which is used by 60% of NH's nationally.

Strategy for change: From the outset of the project in 2011, we consulted with Directors of Care from NH's through NHI; in order to ascertain that: 1) the proposed content of the

Transfer letter was appropriate and, 2) that updates on the transfer document were communicated to reflect national standards / guidance.

Measurement of improvement: Continuous audit cycles (4) and on-going consultation with NH's; allowed us measure improvements in the quality of transfer information. In 2015, 62% of NH were using the standardised template document (n=37) a decrease from 73% in 2012. However, baseline demographic & medical information was well documented, as were Functional Scores (90-100%). Other Results show improvements & areas for concern

Effects of changes: Improvements in transfer communication meant clinicians in Acute Hospitals (AH)'s and NH's spent less time looking for information deemed vital to patient care. One of the challenges was that NH's wanted more information on the document at each stage of the consultation process. Its' success as a single page document at local level allowed the document to be trialled at regional level with funding support from the IHF. 189 NH's were contacted and 83% (81 replies) used the document and reported it to be useful and comprehensive.

Lessons learnt: The document is currently undergoing an integrated consultation process between both the NH & AH Sectors for National application with the support of NCPOP. Other stakeholders challenge its single page status and its' scope has been broadened to include other areas of the residential care sector. Quality of transfer information from AH to NH will need to be considered following this phase as requested by NH's.

Messages for others: A single page document with key information that represents patient need is vital during transitions of care. It helps reduce incidences of missed care through the provision of appropriate information between healthcare stakeholders.

Consultation with Directors of Care or Clinicians from both NH & AH respectively is essential on behalf of NH patients to ensure that the information been transferred is satisfactory and that patient need is been met through appropriate transfer of information when developing or using a standardised template.

Keywords: communication; safe; transfer; nursing home
