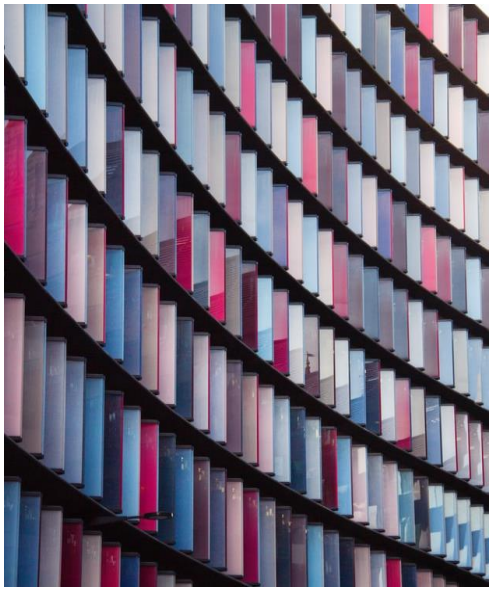

The Development of a National Transfer Document

For use when an older person is being transferred from residential to acute care settings

December 2019

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Abbreviations

ACD	Advanced Care Directives
A&E	Accident and Emergency Department
CCAT	Crowe Critical Appraisal Tool
CVI	Content Validity Index
ED(s)	Emergency Department(s)
FRAT	Falls Risk Assessment Tool
H&SCP	Health & Social Care Professionals
MUST	The Malnutrition Universal Screening Tool
NCPOP	National Clinical Programme for Older People
NH(s)	Nursing Home(s)
OPAC	Older People in Acute Care
PEO	Population, Exposure, Outcome/Theme
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
UL	University of Limerick

Executive Summary

The effective management of care for older people across all sectors of healthcare is a key issue for health care policy and practice. Transitions of older adults with multiple chronic conditions are particularly vulnerable and frequently characterised by breakdowns in communication both within and between services that can lead to poorer outcomes for the older person. The provision of quality care to older adults is dependent upon clear concise and contemporary communication. However, international research suggests that documentation and handover deficiencies between age care facilities and acute services are common and in some cases absent. A variety of nursing transfer documents exist and there is a lack of consensus regarding the information considered essential for inclusion in transfer documentation. Standardised tools have demonstrated improvements in the quality of communication from aged care facilities and the acute hospital. The National Clinical Programme for Older People in Ireland, supported by Office of Nursing and Midwifery Services Director in recognition of the importance of improving communication between residential and acute care facilities, commissioned this research.

To develop an evidence based and person centred national transfer document for use when an older person is being transferred from residential to acute care settings.

Stages of development included: an integrated review of international literature, a stakeholder focus group study, a consultative process with an expert advisory group and an expert in person centred care. A pilot of the transfer document was then conducted, in twenty-eight residential and three acute care sites, across three geographical locations over a three-month period. Staff surveys were conducted, to ascertain their perceptions on the usability, layout and design of the document.

Results: There was general agreement in the literature, the focus group study and pilot study that a standardised transfer document was required for safe and effective transfer of older people from residential to acute care and a need for a holistic, person-centred approach to this documentation. Results of the pilot were used to inform revisions to the design and layout of the national transfer document i.e. to divide the piloted document into two parts (Transfer Document and Health Profile/Passport) retaining the evidence based content and the person centred perspective. A consultation/focus group discussion with participants in the pilot study was then convened to reach consensus on the final design and layout.

In this report, the research approaches and findings that culminated in the development of the national transfer document are outlined and the final National Transfer Document is presented in Appendix 7.

Key recommendations from this study

- **Implementation of a national standardised transfer documentation from residential to acute care**
- **The National Transfer Document to be available in electronic format**
- **Development of an educational resource to accompany the National Transfer Document**
- **Further research to underpin the implementation of the National Transfer Document to include dissemination, implementation and evaluation**
- **Further research to develop a complimentary discharge / transfer document from acute to residential care**

Introduction

Background and Policy context

The effective management of care for older people across all sectors of healthcare is a key issue for health care policy and practice. The effects of hospitalisation on an older person can be overwhelming. Frail patients experience an age related increase in rate of decline in multiple organ systems and therefore they are particularly susceptible to the hazards of inpatient hospitalisation (Levy-Storm 2008). Older people represent the largest group presenting to acute hospitals with medical illnesses and this age group accounts for 40% of all acute emergency medical admissions and 47.3% of total hospital bed days (Smith *et al.* 2017).

Care is based on an assumption that patients are able to express their wishes and will move through the system seamlessly. This is not always possible for frail older adults who move frequently from components of the healthcare system that have different goals and cultures, with few bridges to connect them. Transitions of older adults with multiple chronic conditions and complex therapy regimes are particularly vulnerable. Consequently, transitions are often characterised by serious breakdowns in communication both within and between services, which creates gaps in care, which can lead to poorer outcomes for the older person. Boltz et al. (2013) contend that inefficient assessment and communication processes encumber timely treatment and discharge. Robinson et al. (2012) identified elements that contributed to the success of the transition and these elements are reflected in a person-centred approach. A person centred approach involves, knowing the person and what is "normal" for them and the provision of critical reference points for assessing often subtle but important changes in health status. Effective collaboration and communication have an influence on the extent to which person-centred care is practiced (Sjögren *et al.* 2017) and there is empirical evidence of positive outcomes from the use of validated transfer checklists, such as a reduction in 30-day readmission rates when residents were transferred to the emergency department (ED) (Tsai *et al.* 2018). The provision of quality care to older adults is dependent upon clear concise and contemporary communication. Communication approaches and admission procedures need to be able to contribute to preserving continuity that is familiar to the individual.

International studies suggest that documentation and handover deficiencies from age care facilities and acute services are common and in some cases absent. There is also a lack of consensus regarding the information considered essential for inclusion in transfer documentation and a variety of nursing transfer documents exist. In a review of 96 nursing transfer letters in the Irish context, conducted by the National Clinical Programme for Older People various documents and approaches were found. This varied approach to communication contributes to gaps in care during what are critical transitions (Naylor and Ware 2007) and it is at these junctures that the provision of timely and documented relevant information is vital for the assessment and management of older patients (Kessler *et al.* 2013).

Standardised forms for communication have demonstrated improvements in the quality of communication from aged care facilities and the acute hospital. However, the majority of these are designed to reflect the needs of the ED and focus on process and outcomes as opposed to resident experiences (Bolz *et al.* 2013). This reflects the norm in healthcare documentation, which

focuses on biological referents in order to diagnose and treat a disease, without any consideration of the person behind the condition. In Ireland, the National Early Warning Score: National Clinical Guideline Number 1, is important in helping to standardised assessment for acute illness, which has been positively affected by the use of a common language (Department of Health 2013). While this type of information is important to enable diagnosis, recording patient preferences, beliefs and values in patient records give legitimacy to patient's perspectives. The registration of such information therefore must be considered equally mandatory as any clinical or laboratory findings. Therefore, engagement with all stakeholders is necessary to develop mechanisms of communication that not only provide reliable and valid information (Matic *et al.* 2011) during transfer, but also provide relevant information about the person, what matters to the person and demonstrates person-centeredness.

In Ireland, national policy supports the improvement and standardisation of patient care. The Health Services Executive (HSE) Clinical Design and Innovation (CDI) (formerly known as Clinical Strategy and Programmes Division (CSPD)), brings together clinical disciplines to share innovative solutions to deliver greater benefits to users of HSE services, and The National Clinical Programme for Older People (NCPOP) is aimed at developing comprehensive, integrated and patient focused services for older people (NCPOP 2012). In recognition of the importance of improvements in the quality of communication from residential to the acute hospitals, the NCPOP supported by the Office of Nursing and Midwifery Services Director (ONMSD) commissioned research to develop and pilot a person centred national transfer document for use when transferring older persons from residential to acute care.

Aim of the study

The overall aim of this study was to develop an evidence based national transfer document for use when an older person is being transferred from a residential to acute care facilities.

The commissioning brief of this project, agreed with researchers prior to commencing the study, specified three objectives to inform the development of a national nursing transfer document:

1. Conduct a review of international literature and map results to work completed by St Vincent's and St Michael's Hospital and St Patricks Hospital Waterford (CHO5).
2. Conduct focus groups with nurses who work with older people in acute, primary, community and continuing care settings, with colleagues in education, health and social care professionals and service user representatives.
3. Develop and pilot the national transfer document and report on the findings

Definition of person centeredness

The definition of person centeredness for the purpose of this research is that of McCormack and McCance (2017, p.3) *"person-centeredness is an approach to practice established through the formation and fostering of healthful relationships between all care providers service user and others significant to them in their lives. It is underpinned by values of respect for persons (personhood), individual right to self- determination, mutual respect and understanding and enabled by cultures of empowerment that foster continuous approaches to practice development"* (Dewing and McCormack 2017).

Outline of the report

To meet the overarching aims of this project, the work plan was divided into five parts, which form the outline of this report.

Chapter One: Reports on the results of an Integrative Literature Review conducted to identify national and international research, which focused on communication and/or handover documents used in the transfer of an older person from residential care facilities to acute care services.

Chapter Two: This chapter reports on findings of the focus group study conducted with stakeholders to gain their perspectives on the design and content a national transfer document.

Chapter Three: This chapter reports the stages of development of the transfer document informed by the integration of findings from the literature review, data from the focus group study and consultation with expert advisory group.

Chapter 4: This chapter outlines the methodology and reports on findings of the pilot study to test feasibility and usability of the new transfer document.

Chapter 5: The national transfer document is presented and the report is concluded with recommendations for next steps.

Chapter 1. Integrative Literature Review

Introduction

Transitions for older people with multiple chronic conditions between care facilities are recognised as particularly critical and vulnerable periods for them and have been recognised as an important area for inquiry (Arendts *et al.* 2010; Gozalo *et al.* 2011; McCloskey and Van Den Hoonaard 2007; Mitchell and Young 2010). Transferring patients from residential care to emergency departments (EDs) often involves a number of clinical handovers between staff through various forms of communication (Belfrage *et al.* 2009). As a result, the documentation accompanying these residents provides the critical link between residential care and ED staff to enable optimal decisions to be made about care (Morphet *et al.* 2014). Transfer of patients from residential care to EDs involves a handover of documented information (Belfrage *et al.* 2009) but there is no consensus on what essential information must be given during transfer (Griffiths *et al.* 2014). Recent studies have found that documents in some residential care facilities had incomplete or missing information (Arendts *et al.* 2010; Cwinn *et al.* 2009; Morphet *et al.* 2014) and that information gaps occurred during transfer (Coleman 2003). To ensure continuity of care, and improve patient safety during transitions, there have been recommendations for the use of more standardised, structured and explicitly designed forms of communication (Dayton and Henriksen 2007). These standardised transfer documents are reported to reduce ambiguity, enhance clarity, and signal that specific action is required (Dalawari *et al.* 2011). In the United States, Lahn et al. (2001) found that information such as advanced care directives (ACDs) were lacking in most transfers from residential care facilities to EDs (Lahn *et al.* 2001). Despite attempts to improve quality and safety, transfer of information from residential care to ED using transfer documents have had limited improvement (Cwinn *et al.* 2009; McCloskey 2011). Therefore, it is necessary to develop mechanisms of communication that not only provide reliable and valid information during transfer, but also provide relevant information about the person and what matters to the person (Matic *et al.* 2011).

1.1 Aim

The aim of this integrative review was to identify and report on empirical national and international research focusing on communication and/or handover documents used in the transfer of an older person from long term/nursing home care facilities to acute care services.

1.2 Methodology

1.2.1 Design

The framework developed by Whittemore and Knafl (2005) which was developed to facilitate the concurrent synthesis of qualitative and quantitative research guided the review. Data from studies using both quantitative and qualitative methodologies were extracted, analysed, subcategorised and categorised until clear themes were developed that reflected the patterns in the data. Developed themes were further analysed to extrapolate key summary statements that reflect the findings across studies. The stages utilised in the process are detailed in Table 1.

Table 1: Methodological stages in the integrative review process

Stage of Integrative Review	Steps in the Process
Problem formulation	Formulation of topic area using PEO (population/problem, exposure, outcome/theme (Khan *et al.* 2003)
Literature search	Defining search strategy Selecting Databases Testing search strategy Database searches, retrieval and export of search results Removal of duplicates Inclusion/exclusion criteria defined
Data evaluation	Screening of search results: title and abstract (two independent reviewers) Full text of salient articles sourced Full text screen (2 independent reviewers) Citation searching on identified articles to identify any additional sources not identified in search. Data extraction from final relevant identified articles Appraising the quality of articles using Crowe Critical Appraisal Tool (CCAT)
Data analysis	Synthesis of results from included studies Development of sub-themes & themes from the data
Presentation	Generating the report of the findings

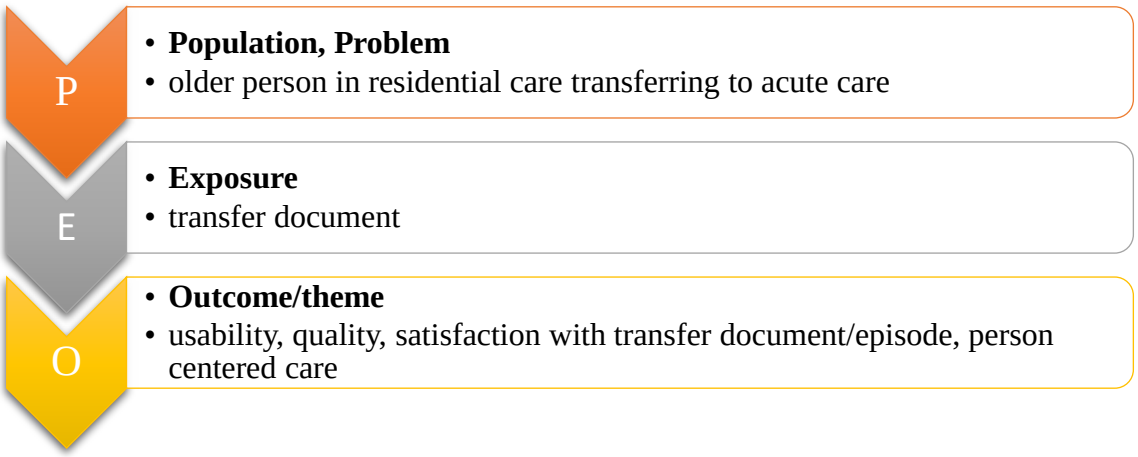
1.2.2 Problem Formulation

The research question that guided this integrative review was:

What information is required to support the safe, seamless transfer of the older person from residential care facilities to an acute hospital in a manner that enhances person centred care and better patient outcomes?

The problem was broken down using the PEO acronym (Population, Exposure, Outcome/Theme) (See Figure 1). The participant groups focused on in this review were: healthcare personnel with direct experience of transfer of older persons from care facilities and either "older person" over 65 years or a senior person older than 65 years being transferred from residential care facilities to acute care. Health care personnel refers to all clinical staff (e.g. nurses, physiotherapists, occupational therapists, speech and language therapists, physicians, radiotherapists, general practitioners and surgeons). This review explored transfer documents currently in use, the level of detail being recorded and any information on the enablers and barriers to using identified documents. Details of any documented reports on the quality of the documents was also explored.

Figure 1: PEO acronym (Population, Exposure, Outcome/Theme)



1.3 Literature Search

1.3.1 Defining Search Strategy

The transfer documentation requirements were defined as documents that involved the use of checklists, flow-charts, templates or any healthcare communication documentation used to impart clinical and personal patient information from long-term/residential care facilities and an acute care facility. The search strategy was developed considering the types of articles for inclusion, the types of studies, types of participants in the studies, the types of facilities, and the types of outcomes. Limiters were then considered in terms of years for inclusion.

Table 2 details the criteria for selection and the inclusion and exclusion criteria around those parameters. The PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) guidelines were used for the reporting of this integrative review (Moher *et al.* 2009).

Table 2: Criteria for searching and inclusion

Criteria for selection	Included	Excluded	Search Terms
Types of Article	Systematic reviews, Primary research including qualitative, quantitative and mixed method, literature reviews, PhD theses, grey literature, Studies that describe the implementation or evaluation of a transfer tool.	Descriptive articles, opinion pieces, and discussion papers	
Types of studies	Specific study types will not applied in order to identify all resources relevant to the topic	Qualitative, quantitative or mixed methods studies that do not have a transfer tool/document/event as the focus	Assessment instrument OR Transfer Document OR Transfer Checklist OR information gaps OR discharge Management OR communication tool OR Transfer tool OR Transition Or transitions of care OR Transfer Or communication OR SBAR OR ISBAR or patient transfer OR interprofessional communication.
Types of Participants	People with direct experience of transfer of older persons between care facilities: either "older person" (>65 years) Or senior person >65years being transferred between care facilities 'Health care personnel' refer to all clinical staff (e.g. nurses, physiotherapists,		Aged OR older person OR geriatric OR elderly Healthcare worker OR nurse Or Nur* Or Healthcare professional Or Healthcare practitioner

	occupational therapists, speech & language therapists, physicians, radiotherapists, GPs and surgeons) and/or non-clinical staff involved in transfer of older persons between care facilities.		
Types of Facilities	Residential, long stay facilities and acute care facilities.	Non-health care RCTs Non-human/Laboratory RCTs	Emergency Department OR Hospital admission OR acute care OR Emergency transfer AND nursing home OR long stay care OR aged facility OR care home OR Homes for the Aged OR continuing care OR long stay residence
Types of Outcomes	Usability, quality, satisfaction with transfer tool/episode.	Qualitative findings that do not specifically focus on perceptions and experiences of the process of transfer	"experience* OR perceive* OR perception OR attitude* OR patient transfer OR quality* OR satisfaction* OR usability Or patient outcomes Or safe care OR continuity of care OR Readmission rates OR Person centered OR adherence OR Compliance
Limiters	Year of publication: 2000-2018		

1.3.2 Selecting Databases

A total of nine electronic databases were searched: Cochrane library, Pubmed – Medline, Medline (EBSCO), Medline (Ovid), Cinahl Complete, Scopus, Web of Science and Embase. Databases searched for salient grey literature were Open Grey, Google Scholar, Lenus Irish Health Repository, DART-Europe E-theses portal, MedNar, Proquest Dissertations & Theses A & I, World Health Organisation Global Index Medicus and Science.Gov. Four international trial registries were also searched: the Cochrane Central Register of Controlled Trials (CENTRAL), PROSPERO, ClinicalTrials.gov, WHO International Clinical Trials Registry Platform (ICTRP) portal. Multiple searches were conducted using strategies suitable for each database (Appendix 1).

1.3.3 Testing search strategy

The search strategy was developed in collaboration with the team librarian (LD). A multistep approach was used to source primary literature. This included keyword searching of electronic databases, using medical subject headings (MeSH) and specific database headings to further identify search terms, using truncation e.g. nurse Or Nur*, and the use of search field descriptors (e.g. Title/abstract, author, publication type, text word) to broaden the search and ensure all appropriate key words were used. The literature published in journals between January 2000 and July 2018 was examined. These dates were chosen to ensure the most up to date salient literature was sourced given the changes in healthcare and technology in recent years.

1.3.4 Database searches, retrieval and export of search results

All of the searches were saved within the specific databases and imported into Endnote version X8. The Endnote library was then imported into Covidence, which is a screening and data extraction software tool, which aids in the management of a systematic review of academic papers. It enables searches to be imported and reviewed by more than one reviewer. It also enables duplicates to be removed and for a third reviewer to resolve any conflicting opinions (Covidence 2016). After duplicates were removed, title and abstract of all sourced articles were screened independently by two reviewers based on the inclusion and exclusion criteria. Any conflict in the title and abstract screening was resolved by an independent third reviewer.

1.3.5 Removal of duplicates

Following the search of identified databases and export of search results from Endnote 2546 papers were imported to Covidence (Covidence 2016). 458 duplicate papers were identified and were then removed, leaving 2088 records for title and abstract screening.

1.3.6 Inclusion/exclusion criteria defined

The inclusion and exclusion criteria were defined as follows:

Inclusion Criteria: Published literature (empirical research, policy, systems, models, education/training/competencies development programmes) pertaining to transfer tools/documents or communication tools exemplars; English language publication; primary and secondary studies.

Exclusion Criteria: Case studies, discussion or opinion papers that do not present research findings; Published in a language other than English; Publications prior to 2000.

1.4 Data Evaluation

1.4.1 Screening of search results: title and abstract

Following the search of the literature, 2088 papers were identified for title and abstract screening. All records were screened by two independent reviewers using the Covidence software. The software allowed for the viewing of both the title and abstract concomitantly with details of the inclusion/exclusion criteria available in a drop down menu as an aide memoire. This enabled reviewers to make more informed decisions about what to include or exclude. A total of 1923 articles were excluded leaving 157 articles to go to full text screening.

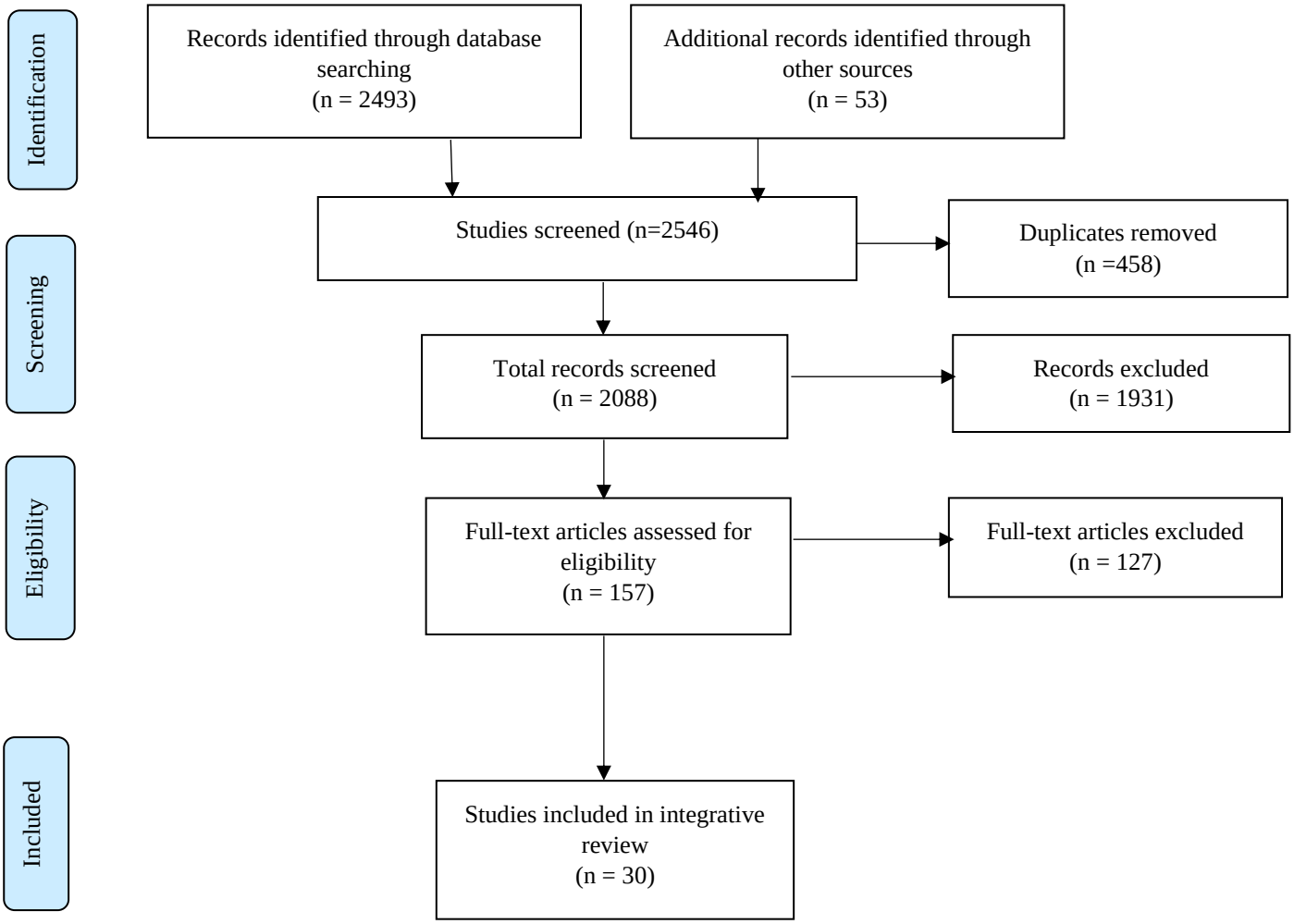
1.4.2 Full text of salient articles sourced

Full text of identified salient articles were sourced by one reviewer (PM) in collaboration with the team librarian (LD). Unavailable articles were sourced through the Interlibrary Loan facility, particularly important for those recently published (e.g. Dizon *et al.* 2017; Tsai and Tsai 2018). Full details of the complete search and screening process are presented in PRISMA format (Moher *et al.* 2009) in Figure 2.

1.4.3 Full text screen (Two independent reviewers)

A total of 157 articles were identified for full text screening. Two reviewers reviewed each article independently in cognisance of the inclusion/exclusion criteria. Any conflict or disagreement about inclusion was discussed with the review team, until consensus was reached in order to ensure the aims of the search were being met, and that only papers relevant to the study were data extracted. The most common reason for exclusion was ‘wrong study focus i.e. non NH/Acute hospital/ED setting’ (n=79).

Figure 2: PRISMA 2009 Flow Diagram (Moher et al. 2009)



1.4.4 Citation searching on identified articles to identify any additional sources not identified in search

The citation details of all full text articles included in the final screen were checked to identify any salient sources that had not already been identified in the original search. Two articles were identified (Campbell *et al.* 2016; Jusela *et al.* 2017) from citations of identified articles that had not been identified in the search. The articles focused on what information should be included in a transfer document when transferring patients from nursing homes and hospital. These articles were then included for full text review. A total of 157 articles were screened at full text and a total of 30 articles were included in the integrative review.

1.4.5 Data extraction from final relevant identified articles

Data extraction was performed on the 30 articles that were identified as relevant to the review. A data extraction table was drafted and each reviewer (PM, AC, MK, OD) extracted data from two

articles using the draft document. A team discussion was then held to discuss the extracted data and modifications were then made to the data extraction table and all data was then extracted by the reviewers using this table. In addition to the outcomes measured (definitions, documents for transfer, and time-points), descriptive data was also extracted to summarise the studies including: study design, author details, year and journal of publication, transfer conditions, criteria for diagnosis of transfer need and interventions under investigation.

1.4.6 Appraising the quality of articles using CCAT

Each study was appraised using Crowe Critical Appraisal Tool (CCAT) and scoring categories include preliminaries, introduction, design, sampling, data collection, ethical matters, results and discussion (Crowe 2013; Crowe and Sheppard 2011). CCAT facilitates the appraisal of a variety of research designs using the same evaluative tool. All categories are scored, regardless of research design used. The lowest score for a category is 0 (no evidence), the highest score is 5 (highest evidence) and the total score (out of 40 or as a percent) is reported in addition to each category score. CCAT has been extensively validated across studies (Crowe 2013; Crowe and Sheppard 2011). Using the CCAT tool studies are appraised across eight categories: preliminaries, introduction, design, sampling, data collection, ethical matters, results and discussion. Within this review scores were converted to an overall percentage and the score achieved by each article was included in the data extraction form.

Results of using the CCAT tool showed four studies scored 95% (McCloskey 2011; Olsen *et al.* 2013; O'Neill *et al.* 2015; Pauls *et al.* 2001), two scored 93% (Murray and Laditka 2010; Nelson *et al.* 2013), two 92% (Campbell *et al.* 2016; Cwinn *et al.* 2009), one 90% (Devriendt *et al.* 2013), one 88% (Morphet *et al.* 2014), two scored 86% (Belfrage *et al.* 2009; Tsai and Tsai 2018), three scored 85% (Hustey and Palmer 2010; Lahn *et al.* 2001; LaMantia *et al.* 2010), one 82% (Boockvar *et al.* 2005), one 81.25% (Terrell *et al.* 2005), four scored 80% (Arendts *et al.* 2013; Klingner and Moscovice 2012; O'Connell *et al.* 2013; Scott *et al.* 2012), two scored 78% (Dalawari *et al.* 2011; Jusela *et al.* 2017), two scored 75% (Dizon *et al.* 2017; Zamora *et al.* 2012), two 74% (Edwards *et al.* 2012; Robinson *et al.* 2012), one 70% (Terrell *et al.* 2009), and two 65% (McCloskey and Van Den Hoonard 2007; Tsai *et al.* 2016). As previously detailed each study is viewed in their own merit rather than compared to other studies and there is no hierarchy in evaluation.

1.5 Data Analysis

1.5.1 Synthesis of results from included studies

Because of the diversity in study type included in the review and the lack of homogeneity it was not possible to perform meta-analysis. Thematic analysis was therefore used to synthesise the findings across the studies. Results from studies within the data extraction table were considered line by line and similarities and differences in the findings verified for accuracy and relevancy by reviewers. The predefined data extraction table included author, date, country, aim of study, sample/setting, main results/outcomes, enablers of transfer, and barriers to transfer, key messages and quality score. The tabulated findings from all the included studies were analysed to look for

patterns in the data. Themes were developed to reflect the content identified in the data extraction phase, following this cross comparisons made across themes to ensure consistency and rule out any duplication (Braun and Clarke 2006).

1.6 Results

The initial search identified a total of 2546 papers, after removal of duplicates, title and abstract screening, application of inclusion/exclusion criteria a total of 30 papers were subject to full review (Figure 2). The 30 papers integrated in the final review incorporated several research designs, including ten quantitative studies (Devriendt *et al.* 2013; Dizon *et al.* 2017; Hustey and Palmer 2010; Klingner and Moscovice 2012; Lahn *et al.* 2001; Nelson *et al.* 2013; Terrell *et al.* 2005; Terrell *et al.* 2009; Tsai and Tsai 2018; Zamora *et al.* 2012), nine retrospective studies (Boockvar *et al.* 2005; Campbell *et al.* 2016; Cwinn *et al.* 2009; Dalawari *et al.* 2001; Edwards *et al.* 2012; Jusela *et al.* 2017; Morphet *et al.* 2014; O'Connell *et al.* 2013; Olsen *et al.* 2013), six qualitative studies (Arendts *et al.* 2013; McCloskey 2011; Pauls *et al.* 2001; Robinson *et al.* 2012; Scott *et al.* 2012; Tsai *et al.* 2016), two systematic reviews (LaMantia *et al.* 2010; O'Neill *et al.* 2015), two literature reviews (McCloskey and Van Den Hoonaard 2007; Murray and Laditka 2010) and one mixed method study (Belfrage *et al.* 2009). Sample sizes of participants ranged from 20 to 715. The year of publication ranged from 2001 to 2018, with most conducted between 2014 and 2018. All studies analysed were in the English language and almost half of the studies were conducted in the United States (n=14).

Three main themes were identified following analysis of included studies; the first theme focused on the design of the transfer document and included aspects of content, usability and quality. The second theme related to factors that facilitate safe and effective transfer or enablers of transfer and the third theme related to factors that hinder safe and effective transfer or barriers to transfer.

1.6.1 Design aspects of the Transfer Document

There is an increasing pool of older patients experiencing transfer episodes from aged care facilities and emergency departments (Griffiths *et al.* 2014). Many of this older person cohort experience declining physical and cognitive function (Arendts *et al.* 2013; Jusela *et al.* 2017; McCloskey 2011; Pauls *et al.* 2001; Robinson *et al.* 2012; Scott *et al.* 2012). Cognitive impairment among older people being transferred to an acute hospital can impact their ability to provide details on their health status to healthcare personnel which subsequently can impact their health outcomes (Cwinn *et al.* 2009; Dalawari *et al.* 2011). It is therefore a necessary prerequisite to ensure that appropriate, relevant clear communication is provided to healthcare staff in the receiving institution during the transfer process.

There was a general consensus among authors that information needs to be concise, readily available, well ordered and easily accessible and read (Cwinn *et al.* 2009; Hustey and Palmer 2010; Klingner and Moscovice 2012; McCloskey 2011; Morphet *et al.* 2014; Pauls *et al.* 2001; Terrell *et al.* 2005; Tsai and Tsai 2018; Zamora *et al.* 2012). This information should accompany the patient as otherwise delays ensue while healthcare personnel attempt to obtain required

information by contacting the residential care facility or family members of the person being transferred into acute services (Dizon *et al.* 2017; Edwards *et al.* 2012; Robinson *et al.* 2012).

Several studies identified key information, which should be included in transfer documentation to inform a comprehensive health assessment by healthcare personnel (Boockvar *et al.* 2005; Cwinn *et al.* 2009; Dalawari *et al.* 2011; Terrell *et al.* 2005). Information can be limited to date of birth, baseline cognitive function, reason for transfer and phone number of the nursing home (Edwards *et al.* 2012; Morphet *et al.* 2014; Pauls *et al.* 2009; Terrell *et al.* 2005). However, most studies suggested that, patient details such as name, date of birth, next of kin, aged care facility, person in charge contact details and the reason for transfer to the ED, were crucial pieces of information required (Devriendt *et al.* 2013; Dizon *et al.* 2017; Hustey and Palmer 2010; Klingner and Moscovice 2012; Lahn *et al.* 2001; Nelson *et al.* 2013; Terrell *et al.* 2009; Terrell *et al.* 2005; Tsai and Tsai 2018; Zamora *et al.* 2012). Other details seen as necessary were past medical history, current medications, most recent clinical parameters including vital signs, usual functional status, baseline cognitive status and mobility and independence status (McCloskey 2011; Tsai and Tsai 2018). Information such as background of the person, any medical issues, allergies, medical record number, mobility issues and ability to communicate were deemed essential and should be included as part of a standardised form (Cwinn *et al.* 2009; Hustey and Palmer 2010; Klingner and Moscovice 2012; McCloskey 2011; Morphet *et al.* 2014; Pauls *et al.* 2001; Terrell *et al.* 2005; Tsai and Tsai 2018; Zamora *et al.* 2012).

Some authors (Cwinn *et al.* 2009; Dalawari *et al.* 2011) suggested that details of bowel and urinary continence status should be provided, while others (Boockvar *et al.* 2005; Dalawari *et al.* 2011; Hustey and Palmer 2010) suggested that most recent blood results should be included. More detailed information which could be communicated during transfer are advanced care directives and living wills (Lahn *et al.* 2001). When discharging patients, it was recommended that hospitals need to provide the residential care facility with important details such as test results, medication lists and follow up treatment for patients (McCloskey 2011, Tsai and Tsai 2018).

Inadequately completed transfer documents were highlighted as a common occurrence and many authors identified incomplete information or absent details in transfer documentation (Cwinn *et al.* 2009: Jusela *et al.* 2017; Klingner and Moscovice 2012; McCloskey 2011; Morphet *et al.* 2014). Terrell et al. (2005) reported more than 40% of transfers from a long term care facility had incomplete and inadequate information on the transfer document. Some authors (Boockvar *et al.* 2005; Dalawari *et al.* 2011) suggested that when a transfer occurred out of office hours there was a greater likelihood that information would be omitted. Campbell et al. (2017) reported missing information in relation to reason for transfer in 46% of patient notes examined, and components of vital signs were missing in 50% of cases. Jusela et al. (2017) reported the transferring physician contact details as the most often omitted information, together with medication list and specific medication instructions such as steroid tapering and anti-arrhythmic instructions.

Many authors (Arendts *et al.* 2013; McCloskey 2011; Pauls *et al.* 2001; Robinson *et al.* 2012; Scott *et al.* 2012; Tsai *et al.* 2016) identified the use of headings and a consistent layout as important determining factors in the provision of relevant up to date information on the patient being transferred. The majority of transfer documents were reported as still the paper and pen

variety, but electronic versions of transfer documents were also identified in the literature (Campbell *et al.* 2016; Hutsey and Palmer 2010). In one study (Dizon *et al.* 2017) follow up phone calls were used to check on the status of the transferred patient and to fill any evident information gaps in the transfer documentation.

According to the majority of studies reviewed, the use of a standardised document increased the likelihood of information adequacy and relevancy (Cwinn *et al.* 2009; Dalawari *et al.* 2011; Hustey and Palmer 2010; Klingner and Moscovice 2012; McCloskey 2011; Morphet *et al.* 2014; Pauls *et al.* 2001; Terrell *et al.* 2005; Tsai and Tsai 2018; Zamora *et al.* 2012). Cwinn et al. (2009) and Dalawari et al. (2011) in their comparison of information transfer from an aged care facility to an ED with and without the use of a standardised form concluded that information quality and relevancy was increased significantly when a form was used in comparison to no form being used.

1.6.2 Factors that facilitate safe and effective transfer or enablers of transfer

It is argued that having a transfer document enables accountability (Dizon *et al.* 2017) and effective communication between staff in residential care and hospitals (Dizon *et al.* 2017; McCloskey 2011; Scott *et al.* 2012). Having a transfer document allows for follow-up (Edwards et al. 2012) making the transition from residential care and hospitals easier and safer for both residents and staff (Robinson *et al.* 2012). It was also suggested that a transfer document in electronic format would reduce errors such as incomplete information when transferring patients from nursing homes to hospital (Murray and Laditka 2010; Zamora *et al.* 2012).

Educational interventions would be required in order to use a standardised document, and staff would need training in its use (Zamora *et al.* 2012). Authors suggest that it would enable staff to provide better care for patients (Cwinn *et al.* 2009) and help to save time (Devriendt *et al.* 2013). Education of staff to facilitate patient assessment, improve nurses knowledge and skills and enable correct assessment of the need to transfer to acute care would assist in avoiding unnecessary transfers (O'Neill *et al.* 2015). Having an emergency response team that assesses and reviews patients would also help to avoid the unnecessary transfer of patients to hospital (O'Connell *et al.* 2013). Having a standardised transfer document enables staff both in residential care facilities and hospitals to be more comfortable in the information being shared (Pauls *et al.* 2001; Terrell *et al.* 2005) and over time and with consistent use of a standardised instrument health care personnel can become more comfortable using the transfer document (Tsai and Tsai 2018).

1.6.3 Factors that are barriers to transfer

It is argued that there is a need for established procedures in order for patients to be transferred more effectively and easily (Ardent *et al.* 2013; Tsai *et al.* 2016). Lack of established procedures can negatively impact a smooth care transition (Boockvar *et al.* 2005; Tsai *et al.* 2016). Communication challenges can negatively impact the transition process as the sharing of complex medical histories from residential care and hospital staff can be difficult (Cwinn *et al.* 2009).

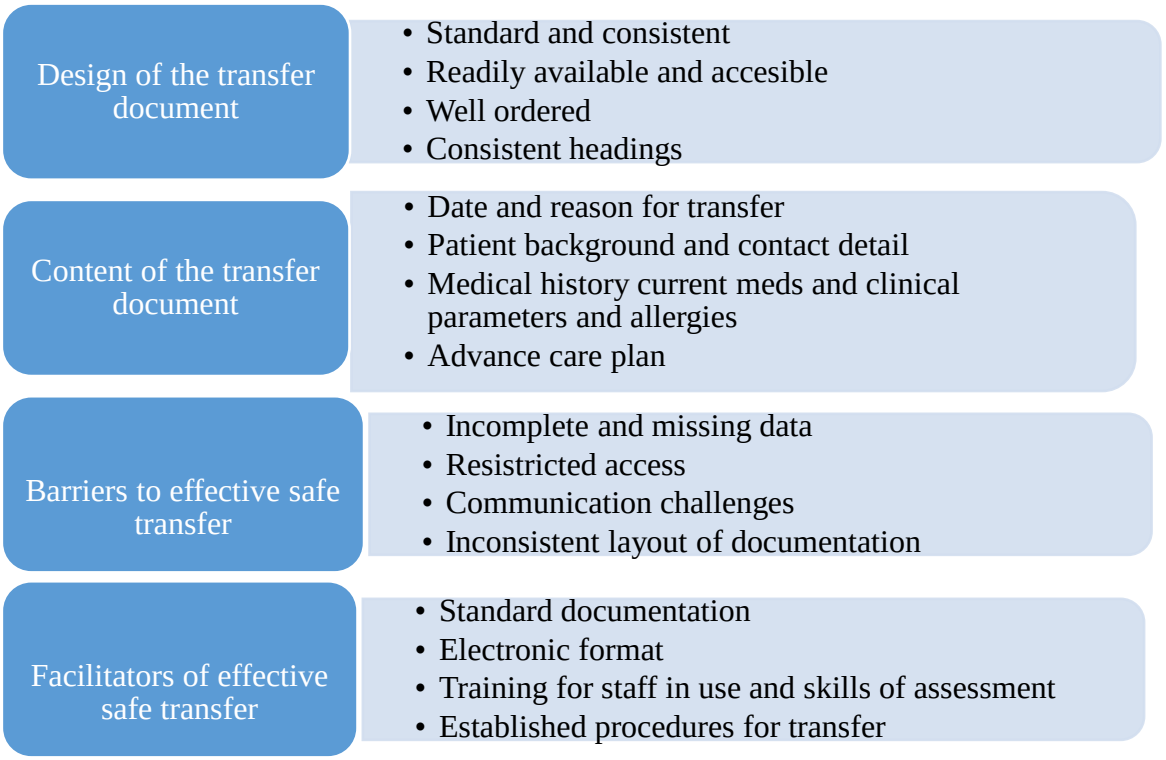
Some staff may lack the medical vocabulary to describe the patients' conditions effectively (Boockvar *et al.* 2005; Tsai *et al.* 2016) and this can result in tension and misunderstanding in the communication process (Olsen *et al.* 2013; Tsai and Tsai 2018). Layout of transfer forms are cited as reasons for non-completion (Dalawari *et al.* 2011) as are the lack of access to records both physical and electronic by staff completing the documentation (Olsen *et al.* 2013; Zamora *et al.* 2012). Some studies found that healthcare staff considered the transfer forms used as time consuming and arduous to complete and suggested that the forms are unimportant in the transfer process because relevant details would be available in the case notes as well as verbally reported during the transfer episode (McCloskey 2011; McCloskey and Van Den Hoonard 2007).

Sometimes patients expressed concerns about being transferred to hospital because they had a fear of being alone or ignored (Arendts *et al.* 2013) and without a person who knew them well, transfer to an acute facility engendered feeling of fear (Campbell *et al.* 2016). Often essential patient information such as vitals, baseline cognitive function and contact details of nursing home and physician can be missing on forms (Dalawari *et al.* 2011; Dizon *et al.* 2017; Morphet *et al.* 2014; Nelson *et al.* 2013; Edwards *et al.* 2012). There is a need for patient privacy and access to patient data can be restricted, leading to limited information on patients being transferred (Devriendt *et al.* 2013).

Summary

Evidence from our review highlighted a number of consistencies necessary as core elements of the document design. These were that information needed to be standard, of consistent layout, concise, well ordered, relevant, up to date and clear and should accompany the patient on transfer. Transfers can occur from residential to acute care services during their treatment and information can be lost. The content should include detailed demographic and contact information, reason for transfer, current clinical parameters, past medical history, allergies and current medications, ability to communicate and any issues with mobility. Main factors that were barriers to safe and effective transfer were inadequate and incomplete information and inconsistent layout. Factors that facilitated safe and effective transfer were standardisation, document in electronic format, training of staff in skills of assessment and established procedures. Figure 3 provides an overview of these findings.

Figure 3. Overview of literature review findings



Conclusion

This review of literature provided empirical evidence of the need for better communication and standardisation of transfer documentation and our findings identified a number of essential design, and content features needed for safe and effective transfer of older people from residential to acute care facilities. It was clear from the review that the established procedures are needed and collaboration involving all stakeholders in the transfer to develop an appropriate and relevant documentation to enable safe and effective transfer of older people from residential to acute care facilities.

Chapter 2. Stakeholders' perspective on the development of a national transfer document

Introduction

It was clear from our review of literature that documentation structures and processes, when transferring older persons require attention to assist in the provision of quality, safe, effective and person-centred care practices. Processes involve the communication of essential information regarding the older person from both care facilities. Such communication needs to reflect the collaborative input from all relevant health care practitioners in determining the essential patient information for the transition process. Having a well-developed, comprehensive document should lead to improvement in patient outcomes. Safe care is more likely to occur with the effective use of transfer documents (Belfrage *et al.* 2009). It has been acknowledged that more research is required in determining what constitutes the optimum amount of information required for inclusion in transfer documents (LaMantia *et al.* 2010). In terms of transfer method, Devriendt et al. (2013) have advocated an electronic format. The electronic system was found to facilitate the maintenance of centralised multi-disciplinary team information and allowed for ease of transfer across different care facilities, within a secure medium. Embarking on the development of a national standardised transfer document, the following chapter reports on the results of qualitative research using focus group interviews to capture the views and experiences of key stakeholders in the transfer process in order to enrich and inform the design and content of a national transfer document.

2.1 Aim

The aim of the focus group interviews was to capture the views, perception and experiences of key stakeholders to aid in the development of an effective national transfer document, for the older person being transferred from residential to acute care facilities.

2.2 Methodology

2.2.1 Design

The qualitative descriptive study involved focus group interviews using a convenience sample (Creswell and Clark 2017; Sandelowski 2015). This design is a productive means of obtaining straight meaningful answers to questions that relate to practice and policy (Sandelowski 2015). In conjunction with the Director of Nursing, National Clinical Programme for Older People (NCPOP), a team from the Department of Nursing and Midwifery, University of Limerick led on the process, including the analysis of the findings. Ethical approval to conduct this study was obtained from University of Limerick Research Ethics Committee.

2.2.2 Data Collection

Invitations to attend the focus groups were sent by the Director of Nursing National Clinical Programme for Older People through their database (Appendix 2). Stakeholders in the transfer process representing health care professionals working in residential and acute care older people and their representatives were invited via email to participate in a number of focus groups to be held in one central location. The participants were a clearly defined target audience, as recommended for focus group methodology (Krueger 2014). All members of the multi-disciplinary team were invited to participate. Sixty-eight individuals agreed to attend the focus group interviews. The convenience purposive sample (Creswell and Clark 2017) included nurses who worked with older people in the acute, primary, community and continuing care settings, representatives from nursing education, Health & Social Care Professionals (H&SCP), pharmacy and service user representatives. Participants came from a wide geographical spread. The interviews were convened at a strategically chosen national location, in May 2018.

The invitees were provided with an information sheet outlining the study, a consent form and demographic questionnaire to be completed before the focus groups commenced. A semi-structured topic guide was used to guide the focus group discussion (Appendix 3). The objective of the focus group interviews was to "encourage a range of responses (to) provide a greater understanding of the attitudes, behaviour, opinions or perceptions on the research issues" (Hennink 2007, p.6) with an emphasis on the design and content of a national transfer document. Of the 68 participants who gave informed written consent to the interview, eight were male. The majority of participants were nurses (n=58) working in the acute care services, community or residential services. Two participants were service users, and the remaining eight were H&SCP's. The group was divided into eight focus groups. In maximising representation across groups, there was one H&SCP at each table, with the majority of focus groups comprising eight participants. To observe the principle of confidentiality, codes were assigned to each participant and each focus group was accorded a number. Each focus group was conducted by skilled facilitators (n=2), one interviewing and the second taking field notes. On the morning of the interviews, all facilitators and scribes were briefed to ensure consistency of questions and processes. All focus group interviews ended with the question "Is there anything else you would like to add?" to ensure that participants had the opportunity to raise unanticipated issues not covered by the topic guide. The interviews were audio recorded (with the permission of participants) and transcribed.

2.2.3 Data Analysis

In line with the aim of the study, the data was analysed inductively using content analysis to identify themes in the participants' responses (Bengtsson 2016; Krippendorff 2004; Silverman 2016). The first stage of the content analysis process viz: 'decontextualisation', involved the development of a coding list which was based on the areas of research questioning. To become familiar with the data and to make sense of what the participants were saying, within the context of the study, data sets were examined and read in detail alongside listening to the interview. Meaning units were derived from the combination of words or statements that relate to the same central meaning. To ensure rigour, four researchers independently analysed the data and consequently shared findings in terms of similarities and differences. The second stage of analysis

involved 'recontextualisation', whereby the meaning units were checked to ensure the content addressed the aim of the study.

During the 'categorisation' stage of content analysis, the researchers met on a number of occasions to discuss findings and to reach consensus. The meaning units were accorded codes. All codes with similar content were sorted into sub categories and broad categories. There were nine sub categories and three broad categories (Table 3).

Table 3: Content Analysis Framework

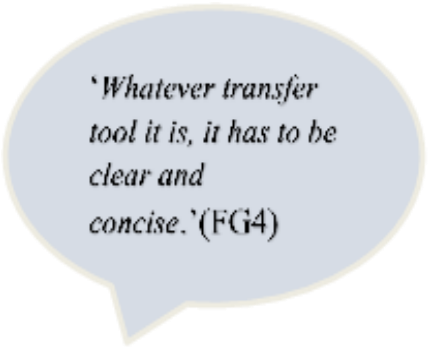
Broad Category	Subcategory
Existing transfer documentation	Items to change Items to retain
New Design	Appearance/Design Format/Layout
Essential elements of care	Essential information Information which is safe effective and person centred Unique to care needs of the person Beliefs and values of the person Essence of person centred care

2.4 Findings

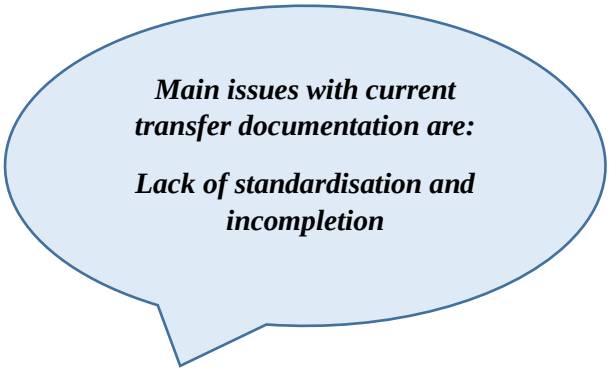
The focus group interviews yielded very interesting and informative data. Three broad categories were used to present the findings:

2.4.1 Category 1: Existing transfer documentation

The focus group interviews yielded very interesting and informative data. The three broad categories were used to present the data findings. The following category outlines the views and experiences of the focus groups, relating to their use and/or knowledge of current transfer documents. Furthermore, the account outlines what should be retained or changed within the current transfer documents. The findings clearly highlighted that some of the main issues that arose with current documentation were both the lack of standardisation and the incompletion of the transfer document. As there is, currently, no national standardisation of transfer documentation, participants welcomed the current research project to address this anomaly. In relation to what should be retained in the current documentation, the majority of participants strongly articulated the importance and need for the current review and development of a national transfer document. Apart from the retention of some assessments tools, already in use, a new format, including design, focus and content was required. The majority of focus groups highlighted the importance of using uniform evidence based assessment tools when completing the transfer document. During the interviews, many



assessment tools were noted which should be retained with the caveat that they are the most up to date evidenced based available at the time.



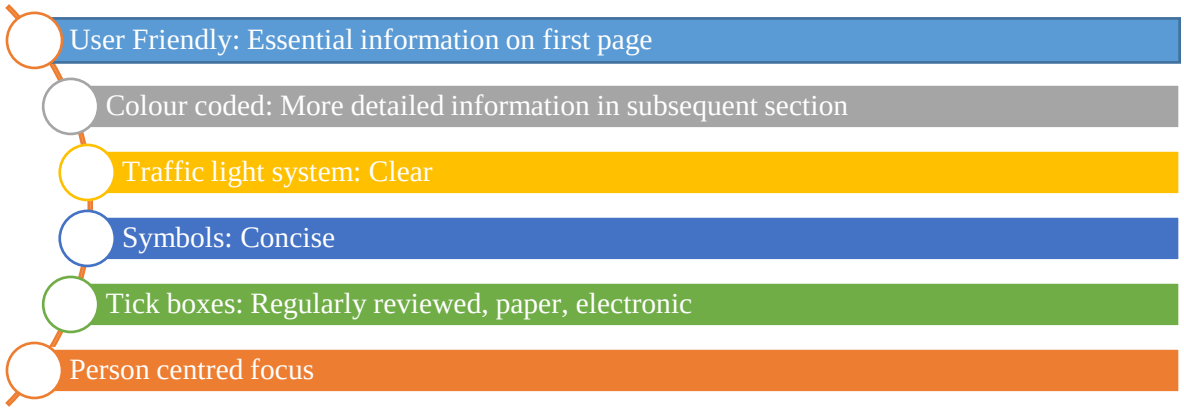
Assessment of activities of daily living (ADL), was deemed to be an essential part of the transfer document and a number of assessment tools identified such as: Montreal Cognitive Assessment (MoCA) (Nasreddine *et al.* 2005); Malnutrition Universal Screening Tool (MUST) (Elia 2003); The Barthel Index (Mahoney and Barthel 1965); Falls Risk Assessment Tool (FRAT) (Nandy *et al*. 2004); Rockwood Frailty Index (Rockwood *et al.* 2014), Older People in Acute Care (OPAC) (Scotland 2005); The Comprehensive Geriatric Assessment (Rubenstein 1995).The ISBAR (Introduction, Situation, Background Assessment, Recommendation) communication tool (Haig *et al.* 2006) was recommended and participants stressed that all assessments conducted required dating and the signature of the assessor.

In terms of format, the majority of focus groups would welcome an electronic document. Research participants highlighted that transfer documents need to have an up to date and signed Advanced Care Directive, including a do-not resuscitate DNR order. Furthermore, the clearly available identification of a named person to contact in addition to the next of kin is necessary. There was a clear distinction made between both as the latter, whilst they may be a close relative, may be out of the country and the former is the person who has been identified to contact regarding practical matters.

2.4.2 Category 2: New Design

This category reflects data related to the proposed design and format of the prospective national transfer document. There was general agreement on what the document format. A concise, regularly reviewed, document with a design, which is user friendly, colour coded e.g. a traffic light system (including use of symbols), was strongly advocated. In addition, it is important that the document is available in an electronic format. The prospective transfer document requires input from all members the multi-disciplinary team. As well as being holistic in approach the information provided would have a more coherent and concerted approach to documenting the care needs of the individual, reflecting the nature of person centred care (Figure 4).

Figure 4. Proposed Design and Format



The front page of the transfer document needs to reflect essential information so that health care practitioners, in the acute facility, as a starting point, can make an effective and safe inference without looking through an entire document (Figure 4). The use of tick boxes may be suitable for the front page with areas requiring high alert coloured in red, to aid prompt noting. The assessments with more narrative details can follow, on the subsequent pages including the resident's story, to ensure a patient centred focus e.g. 'My Day, My Way' or 'This is Me' or 'What Matters to Me' which include the individual's beliefs and values. Assessment tools need to reflect the best available evidence based practice.

'Current information is important as if something changes, the document for transfer, needs to be capable of capturing any changes to ensure information is safe, relevant and up to date'. (FG4)

The majority would welcome an electronic format

In addition, it was noted that a standardised discharge page, to be completed by the acute facility, was required, including information on changes that have been made to care including medication changes. Many of the focus groups highlighted the importance of staff education in terms of person centred care approaches and how best to complete the new proposed national transfer document. Furthermore, the new General Data Protection Regulations (GDPR) requires consideration in the document.

2.4.3 Category 3: Essential elements of care

The focus of this category, related to what constitutes essential information to be included in the first page, along with the relevant information in the subsequent pages of the prospective national transfer document. As outlined in the previous sections, focus group participants strongly argued for a standardised transfer document that contained the essential information in the first page with the subsequent pages containing the evidenced based assessments and other relevant information. Having essential information readily available will assist in ensuring a safe, effective and efficient transfer of the older person into the acute facility. In terms of layout a tick box and traffic light format, especially, for the first page was highlighted. Matters of high alert could be coloured in red to ensure timely noting. More detailed information and assessments, mirroring the summative information on the first page, can follow in the subsequent section. The focus group discussions reflected the importance of applying a person centred care approach to all aspects of the transfer document. In general, the transfer document needed to ensure that the information, contained within, should be cognisance of safety, effectiveness, with the most up to date evidence based assessments and an approach to care which is person centred.

The focus groups yielded valuable data in relation to the areas of content of a proposed document. For the purpose of presentation the information will be broadly outlined under the following headings viz. Personal Biography; Current Health Status; Functional Assessment; and Psychological Assessment. Further details in relation to suggested content are outlined in Table 4.

Table 4: Proposed Content of Transfer Document

Areas of Content	Essential/ Supporting Information
Personal Biography	Resident's preferred name Photo Identification Consent to transfer; Signed Advanced Care Directive Nationality; Ethnicity; Date of Birth; Religion/spiritual needs Next of kin and/or contact person (with designated role) Contact number of the resident's ward in residential GP's name and contact details Geriatrician's name and contact details; Medical card/private insurance number and expiry date Aids, devices and prostheses e.g. hearing aids, glasses, dentures etc. What matters to Me' or 'My Life Story' ; Normal daily routine Likes and dislikes of food and drinks; Preferred means of communication Normal sleeping pattern; Hobbies; Smoker; Alcohol
Health Status	Current health status – reason for transfer; Diagnoses; Co-morbidities Temperature, pulse, respiration, Blood pressure (baseline) Safety trigger alerts Recent laboratory results Outpatient appointment date Weight; Height Allergies Current skin integrity Date when last seen by GP/Geriatrician Medications with date when last given Medication reconciliation form Infection control information
Functional Assessments	Summative assessment scores of : Frailty Mobility, Falls Elimination promoting continence and aids Nutrition Speech and Language - swallow
Psychological Assessments	Summative assessment scores of : Mood, Hearing Vision Normal sleeping pattern, Pain, language, Literacy Level of independence

Content recommended: Document first Page

Personal Biography

The biographical information to be included were the resident's preferred name accompanied with a photo identification. Consent to transfer to the acute facility with a current and signed advanced care directive was deemed essential. Furthermore, this section needed to include the resident's nationality; date of birth; religion/spiritual needs; next of kin; and/or contact person; contact number of the ward in the residential centre; GP contact details; and medical card/private insurance number with expiry date. A user friendly tick box could be used to indicate the presence or not of aids, devices and prostheses, e.g. hearing aid, dentures, glasses etc.

Health Status (Current)

Strongly voiced within the focus groups, was the importance of providing vital information regarding the resident's current health status, including diagnoses and reason for transfer. To out rule unnecessary repetition, recent laboratory test results and future outpatient or other appointments were to be noted. In addition, vital signs (baseline information), weight, height, allergies, current skin integrity, when last seen by GP/Geriatrician (with report), medications (date/time when last dose was given) and medical reconciliation form, infection control information, and safety trigger alerts (e.g. urinary tract infections may lead to a confused state), were deemed essential for inclusion.

Functional Assessment

A summative score of functional assessments (Activities of Daily Living), to be included in the essential information, in tandem with a 'traffic light' system indicating the propensity for areas of high risk. More detailed information to be provided in the subsequent sections. Standardised evidence based functional assessments, assessing areas viz. falls and balance, frailty, mobility, elimination, speech and language assessment, including swallow and a nutritional assessment, were noted for inclusion.

Psychological Assessment

A summative account of assessments, related to the following areas, were purported for inclusion in the document e.g. cognitive status, mood, hearing and sight, sleeping pattern, pain, language, literacy and level of independence. Scoring classification could be developed indicating escalating risk in a colour coded 'traffic light' alert system.

Subsequent Sections of the document

In line with the layout of the essential page information, it is important that the layout is mirrored in the subsequent sections and perhaps colour coded.

Personal Biography

Participants suggested personal information formats, such as 'What matters to Me' or 'My Life Story', as ways of including information specific to the resident e.g. their normal daily routine. A detailed account of 'creating a picture of the person' to include, for example, personal preference information; likes and dislikes of food and drinks, preferred means of communication, normal sleeping pattern, hobbies, what I like to wear, smoker/non-smoker, alcohol.

Functional Assessment

Examples were provided of assessments of activities of daily living, and it was emphasised that all selected assessment tools evidence based and required date, review date and signature of assessor. Examples: The Malnutrition Universal Screening Tool (MUST) (Elia 2003); The Barthel Index (Mahoney and Barthel 1965); Falls Risk Assessment Tool (FRAT) (Nandy *et al.* 2004); Rockwood Frailty Index (Rockwood et al. 2014); Older People in Acute Care (OPAC) (Scotland 2005); The Comprehensive Geriatric Assessment (Rubenstein 1995)

Psychological Assessment

Once again the detailed evidence based assessments need to mirror those summarised in the essential information page. Cognitive assessments, mentioned in the focus groups, were the Montreal Cognitive Assessment (MoCA) (Nasreddine *et al.* 2005). Whilst assessment for other areas such as mood, hearing and sight, sleeping pattern, pain, language, literacy and level of independence, were mentioned, no specific tools were alluded to. All assessments must be evidence based, dated, reviewed and signed.

Summary

This chapter reported on results of eight stakeholder focus groups (n=68 participants) to inform the design and content of a new national transfer document.

Key findings were:

- Need standard design, clear concise using evidence based communication and assessment tools
- Electronic format
- Essential information for acute care needs to be up front and easily identifiable – colour coded
- Essential content was identified which included functional and person centred information
- Emphasis on input from all members of Multidisciplinary team

Conclusion

The results of our focus group interviews highlighted the importance and need for standardising transfer documents for older people. During the transfer process from the residential to the acute setting, which usually takes place during an acute or an emergency, the need for ease of access to current essential information is heightened. Consequently, having a document in electronic or paper format, with this information on the first page, assists in an effective and safe handover. Whilst information relating to current health status, biographical, functional and psychological areas are crucial, it is equally important that the information is person-centred and outlines the person's likes and dislikes and normal living pattern.

Chapter 3. Development and Pilot of the transfer document

Introduction

The development of the national transfer document was not only informed by a review of literature and qualitative study, but also advised by a multidisciplinary expert group and an international expert on person centeredness, Professor Jan Dewing. The expert advisory group convened by the Director of Nursing of the National Clinical Programme, consisted of a range of professionals with expertise in gerontology; emergency and acute care; in services for older people; regulatory, policy and advocacy. The group representatives were from nursing in residential and acute services, providers of nurse education and practice development, representative from H&SCP office, general practice, representatives from Health Information and Quality Authority (HIQA) and Nursing Homes Ireland and included an older person representative. This group advised the project team on the design and content of the national transfer document through a process of consultation and feedback. In this chapter the process and outcome of consultation with the expert advisory group is described and the pilot study is outlined.

3.1 Integration of results and consultation with expert advisory group

Following completion of the literature review and focus group study, results were cross-referenced by the research team and also compared with previous work by St Vincent's and St Michael's Hospital and St Patricks Hospital Waterford (CHO5). The qualitative data complimented and authenticated the information derived from the literature review. Key findings from all results were integrated and a draft transfer document was submitted for review and feedback from the expert advisory group. The group were invited to provide feedback on the design and the content. A content validity index (CVI) was provided to the group to score the content of the transfer document (Appendix 4). Following the CVI process the transfer document underwent several iterations through consultation with the expert group to ensure that all items of content e.g. criteria for assessment; methods of recording were underpinned by up to date policy and evidence based practice. A final draft transfer document was agreed signed off by the expert group for use in pilot sites.

3.2 Guide on use of the national transfer document

The UL research team in consultation with the expert advisory group then created a complementary guidance document.This document was to assist staff within the pilot sites to understand the aims and purpose of the pilot project, the roles and responsibilities of the staff in each sites relating to completion of the transfer document and the procedures of how to complete the document in consultation with the resident or designated representative. The guidance document included a draft of the transfer document and was approved by the expert advisory group.

3.3 Pilot Study

3.3.1 Aims

This pilot study aimed to obtain the views, perceptions and experiences of nursing staff in residential care facilities and acute hospitals to judge whether this pilot transfer document could be an effective national transfer document for older persons in comparison with the existing documents currently in use.

Objectives were to ascertain:

- Staff perception of their current resident transfer information /communication (residential care staff)
- Staff perception of the feasibility and usability of the pilot transfer document and applicability to the care facility (residential and acute care staff).

3.3.2 Research Design

The pilot study used a pre post-test design (Creswell and Clark 2017; Sandelowski 2015). Three questionnaires were developed by the researchers (1) Site profile-residential sites (2) Pre-pilot questionnaire (Residential sites) (3) Post-Pilot questionnaire (Residential and acute care sites).

3.3.3 Ethical Approval

Before commencement of the project, ethical approval was obtained from the Research Ethics Committee of the Faculty of Education and Health Sciences, University of Limerick, St. Vincent's University Hospital and the Research Ethics Committee at University Hospital, Waterford.

3.3.4 Sample details and recruitment methods

A purposive sample of residential (n=28) and acute care sites (n=3) were recruited to take part in this pilot study. These sites were located with the University Hospital Limerick, St Vincent's University Healthcare Group Dublin and University Hospital Waterford catchment areas. Our sample of residential care sites included Health Service Executive residential care facilities and private nursing homes. All staff in the EDs and Medical Assessment Units of the acute care facilities and all staff in each of the participating residential care sites were invited to take part in the pilot via letter of invitation to the Director of Nursing.

Inclusion criteria for staff in both services included all staff (H&SCP) in residential care sites; Emergency Department and Acute Medical Unit General Medical and General Surgical Wards as required (Nursing, Medical and H&SCP) at University Hospital Limerick, University Hospital Waterford and St. Vincent's University Hospital.

3.3.5 Introduction of the Transfer Document/training workshop

Prior to data collection each residential site was contacted individually to gauge interest and to organise a date for researchers to visit the site to inform staff about the study and provide them with instruction on how to use the document when transferring a patient to acute services. Staff were provided with a verbal introduction, explanatory pack to retain on site containing a PowerPoint Presentation, guidance document, example of a completed transfer document, an example of a resident's story and survey questionnaires.

3.3.6 Data Collection

Pre and Post-pilot questionnaires (Site Profile, staff demographic and pre-pilot questionnaire related to current documentation) were developed by the research team to capture the design layout and content of their current transfer documentation and the new transfer document. Both pilot questionnaires contained questions on a five point Likert Scale and a number of free text comment sections. Pre-pilot questionnaires were distributed in January 2019 and staff were requested to return the pre-pilot questionnaires to a sealed designated collection box with in each site (Appendix 5). Pilot of the new documentation was conducted over a three-month period from February to May 2019.

Post Pilot questionnaires were then distributed in May 2019 (Appendix 6). For over half of the sites, post-pilot questionnaires were sent in the post with a stamped addressed envelope and cover letter outlining the procedure for completion and collection by a particular date. The other half were returned to a sealed designated collection box within each site and then collected directly from the sites by the researchers of the questionnaires in person. To observe the principle of confidentiality, all questionnaires were anonymized and codes were assigned to a site and each survey was accorded a number.

3.3.7 Pre and Post Pilot questionnaires: Quantitative analysis

Anonymized questionnaires were entered into a single database and SPSS Statistics Version 25 for Windows was used to conduct the analysis. A descriptive analysis of staff demographics and staff perceptions of the transfer document was carried out. Chi-squared test for trend was used to test for associations between levels of experience of staff and how long they have been working in the facility.

3.3.8 Pre and Post Pilot questionnaires: Qualitative analysis

Thematic analysis, as described by Braun and Clarke (2006) was used to analyze the data gathered from the open-ended text boxes within the questionnaire. Six phases in the analysis consist of "familiarizing yourself with your data, generating initial codes, searching for themes, reviewing themes, defining and naming themes and producing the report" (Braun and Clarke 2006). Two researchers met to generate initial codes and develop the codes into themes.

3.4 Results

3.4.1 Pre-Pilot

Of the 28 residential facilities that were contacted, 26 residential sites (93%) agreed to participate in the study and returned completed questionnaires. Two sites were unable to be involved due to time constraints and workloads within their services. The pre-pilot questionnaire asked the staff (n=875) in residential facilities their thoughts on the transfer document currently in use. There was a 23% response rate.

3.4.2 Site and Staff demographics

The site profile

Of the 202 responses, 47 responses were from the Limerick/Clare/Tipperary area, 68 from Waterford and 87 from Dublin. Study sites in Limerick/Clare/Tipperary area were all public residential care settings. In Waterford only two of eight of the sites were public residential care settings; the remainder were private. All sites in the Dublin area were private nursing homes. The number of residents in each site ranged from 12 to 120, with the number of male residents ranging from 3 to 48 and female from 4 to 72. The number of residents transferred to acute hospital ranged from 2 to 65 and between 2 and 54 were admitted to hospital. The numbers of staff working in the residential care sites ranged between two and seventeen daytime nurses, one and eight night nurses. The number of healthcare assistants in each sites ranged from one and twenty four during the day and one and seven at night. Data from all sites were collated and presented together.

Staff demographic

Of the 202 completed questionnaires, completed the questionnaire 68% (n=137) of respondents were nurses and aged between 30-39 years of age (34%, n=68) compared to those between 60-69 years of age (6%, n=13). The highest level of education among staff was a bachelor's degree (48%). Over half of the nurses worked in public nursing homes (53%).

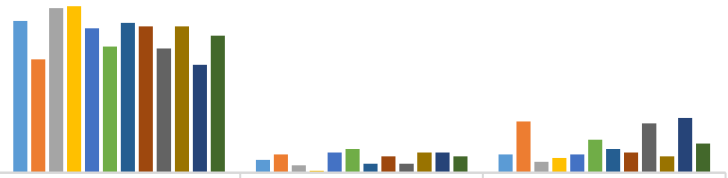
Table 5: Overview of pre-pilot participants

Category of participant	Number	Percentage
Nurse	137	68%
Clinical Nurse Manager	44	22%
Clinical Nurse Specialist	2	1%
Director of Nursing/Person in Charge	18	8%
Other (Student Nurse, Healthcare Assistant, Senior Health Manger)	1	1%

3.4.3 Perception of current transfer document

When asked about their current transfer document, participants expressed their views on a scale of strongly agree, agree, no opinion, disagree and strongly disagree. Figure 5 contains an overview of participants' views relating to the current transfer document in use.

Figure 5. Pre-Pilot Transfer Document Components



	Strongly agree/Agree	No opinion	Strongly disagree
Easy to complete	83%	7%	10%
Could be less time consuming	62%	10%	28%
Relevant information about the patient	90%	4%	6%
Relevant personal information about the patient	91%	1%	8%
User friendly document	79%	11%	10%
Promoted person centered care	69%	13%	18%
Appropriate level of information	82%	5%	13%
Layout was easy to follow	80%	9%	11%
Feasible to complete in a short time frame	68%	5%	27%
Essential information is visible	80%	11%	9%
Resident is involved in the decision to transfer	59%	11%	30%
Document could be used by all members of the multidisciplinary team	75%	9%	16%

3.4.4 Open-ended question results

In the pre-pilot survey, three opened ended questions were asked: "In general what are your thoughts on the National Transfer Document", "do you have any specific areas of concern about the documentation" and "do you have suggestions for improvement". These open-ended text boxes were thematically analysed as mentioned in the data analysis section above. The main findings are outlined in Table 6.

Table 6: Pre-Pilot Themes and Subthemes

Theme	Subtheme
1. Design of the existing document	a) Usability and ease of use
	b) Relevance of clinical and personal information
	c) Layout
	d) Pre-populated form
2. Length of time to complete	a) Timing in emergency situations
	b) Level of detail required for completion
3. Person-Centered Care	
4. Communication between residential and acute care staff	a) Follow up documentation

1. Design of the existing document

This theme looked at the design of the transfer document currently in use within residential care facilities. Participants explored their thoughts and opinions related of the design of the document.

a) Usability and ease of use needed

Nursing staff working within the residential care facilities described the need for ease of use and ease of completion for a transfer document to be used effectively, especially by nursing staff who are working every day with residents with comments such as:

"*A national transfer letter should be a document that contains all the relevant information of a resident which helps to commence patient centered care in a new care setting. It should be easy to complete*" (S15)

and "*Should be clear, easy to follow, concise*" (S9)

b) Relevance of clinical and personal information

A number of residential care staff stressed the importance of recording comprehensive overall description of the residents' clinical and personal needs to enable better patient care.

As the following staff member articulated

"*Overall insight into the clinical and personal/social details relevant to the client. I would expect then that the receiving facility will have a much more structured picture of the clinical condition of the resident"* (S4)

c) Layout

While many staff members were happy with the content of their current transfer document, some staff members were unhappy with the layout and design. Concerns were expressed such as in the comment below in relation to headings within the documents that were unclear and not conveying the information correctly.

"*I feel that this transfer document layout is very unclear as the headings are not highlighted"* (S21)

"*More space needs to be allocated to clinical summary"* (S4)

The layout of the document was thought to have direct impact on how and whether it is completed correctly by staff. Some residential sites in this study already used electronic documents particularly the private nursing home sites but others sites continued to use paper based documents. Staff using electronic systems were reluctant to return to a paper based system and suggested that if possible part of a new transfer document could be pre-populated and that this would be beneficial to both staff and residents during a transfer; in both emergency and non-emergency situations.

"*It could be uploaded to (online software name) and have most of the section pre-populated"* (S20)

2. Length of time to complete

There were mixed reports from staff in relation to the current documentation and whether it was time-consuming to complete. Many noted that their time is limited especially in an emergency and that the forms were "*Extremely time-consuming when there are limited staff resources*" (S18) but that the *information recorded about the patient was relevant*.

a) Timing in emergency situations

In a number of sites, a short (one page) transfer document was in use and it was thought that

"*In an emergency, it is very easy to complete when the time frame is short and the person needs urgent transfer"* (S20)

However another respondent felt that this page "*doesn't reflect other important information that are needed or essential*" (S22)

b) Level of details required for completion

Some staff argued that they felt although the document could be effective, the current transfer document is too detailed and not effective when transferring to acute services. They suggested that by requiring such detailed information, challenges for staff could arise, especially when transferring in emergencies.

"*A far too detailed transfer form from residential to acute. Ideal for transfer from one residential setting to another. It can only be as efficient based on admission and subsequent reassessments*" (S6)

3. Person-Centred

In this context, many staff perceived that their current transfer document was person-centred as it was usually completed with the resident in non-emergency situations and residents were consulted about their personal needs rather than just focused on clinical needs. Overall, respondents were positive and thought that it was enabling person-centred care.

4. Communication between residential and acute care staff

a) Follow up documentation

Many of the residential care staff mentioned that although they currently provided transfer information, they were often contacted by acute care staff for follow up information about the resident. This indicated a need for improved communication between residential care staff, ED and ward staff.

"*Most times, we had filled in more than enough into our own transfer letter, A&E would still ring us and ask about the information that was written on the transfer letter*" (S17)

"*No matter how much information we send to A&E with the resident, it is always disregarded and their staff will always ring for info on the resident*" (S17)

It was suggested that a transfer document should follow the resident through the different departments within the acute care service.

3.5 Pilot

The new paper based transfer document was piloted in all care facilities over a three-month period. During the pilot period residential care staff agreed to use the document for all transfers

of residents to acute care facilities. Post the pilot period both staff in the transferring care site and acute care staff in the receiving care facility were invited to use their experience of the documentation to complete a post – pilot survey questionnaire which contained questions related to the design, layout, usability and feasibility of the new document (Appendix 5).

3.5.1 Post-Pilot Results

Of the 26 residential and 3 acute facilities which were agreed to take part in the post-pilot questionnaire, 19 residential (73%) and all acute sites (100%) returned completed questionnaires (n=124). The post-pilot questionnaire asked the staff in residential and acute care facilities their thoughts on the pilot transfer document which was used.

3.5.2 Quantitative results

3.5.3 Site and Staff demographics

The post-pilot questionnaire asked the staff in residential and acute care facilities their thoughts on the pilot transfer document (n=1085). Of the 124 responses, 34 responses were from the Limerick/Clare/Tipperary area, 40 from Waterford and 50 from Dublin. Sixty-two percent of responses were from staff in acute care services. Nurses were most commonly completed the questionnaire (50%) and the majority of the sample was aged between 30-39 years of age (37%) (Table 7). The highest level of education among staff was a degree (40%).

Table 7. Overview of post-pilot participants

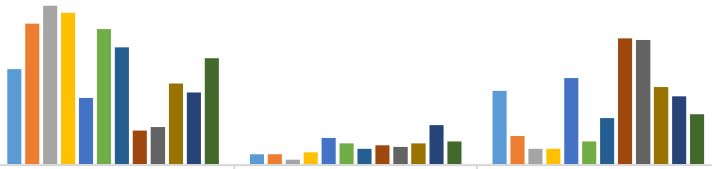
Category of participant	Number	Percentage
Nurse	62	50%
Clinical Nurse Manager	34	27%
Advanced Nurse Practitioner (cANP/ANP)	3	2%
Director of Nursing/Person in Charge	7	6%
Doctor (NCHD or Consultant)	7	6%
Physiotherapist	3	2%
Occupational Therapist	1	1%
Pharmacist	1	1%
Other (Student Nurse, Healthcare Assistant, Senior Health Manger)	6	5%

3.5.4 Pilot Transfer Document Components

Respondents expressed their views on the new transfer document using a five point Likert scale (strongly agree, agree, no opinion, disagree and strongly disagree). Figure 6 contains an overview of participants' views.

It is clear from the responses that the respondents felt that the documentation could be less time consuming (78% strongly agreed). There were mixed opinions about ease of completion but there was high agreement regarding the relevance of the information about the patient (84%) and that it was person centred (75%). Respondents were less convinced that the information was easily visible and about half agreed that the multidisciplinary team could use it.

Figure 6. Post-Pilot Transfer Document Components



	Strongly agree/Agree	No opinion	Strongly disagree/Disagree
Easy to complete	53%	6%	41%
Could be less time consuming	78%	6%	16%
Relevant information about the patient	88%	3%	9%
Relevant personal information about the patient	84%	7%	9%
User friendly document	37%	15%	48%
Promoted person centered care	75%	12%	13%
Appropriate elvel of information	65%	9%	26%
Layout was easy to follow	19%	11%	70%
Feasible to complete in a short time frame	21%	10%	69%
Essential information is visible	45%	12%	43%
Resident is involved in the decision to transfer	40%	22%	38%
Document could be used by all members of the multidisciplinary team	59%	13%	28%

3.5.5 Open-ended question results

In the post-pilot survey, three opened ended questions were asked: "In general what are your thoughts on the National Transfer Document", "do you have any specific areas of concern about the documentation" and "do you have suggestions for improvement". These open-ended text boxes were thematically analysed as mentioned in the data analysis section above. The main findings are outlined in Table 8.

Table 8: Post-Pilot Themes and Subthemes

Theme	Subtheme
1. Design of the document	a) Ease of use and completion
	b) Level of details of clinical and personal information
	c) Layout issues
2. Length of time to complete	a) Compliance with completion
3. Person-Centered Care	a) Improved patient care
4. Communication between residential and acute care staff	
5. Changes proposed to the new document	a) Computerised document
	b) Summary sheet rather than new document
	c) Changes in layout

1. Design of the document

a) Ease of use and completion

Respondents from both residential and acute care facilities reported that the new document was "*Easy and clear to follow*" (S22) and staff in acute care found it "*very useful*" (S29)

b) Level of details of clinical and personal information

Nevertheless, others reported missing some clinical or personal information due to the layout of the document. It was strongly suggested the first page should contain essential clinical information such as whether the resident had allergies.

There was a lack of consensus regarding the preferred location of next of kin details, with some participants suggesting it should be located with the key personal details while other suggested it was not required within the key information section.

However all agreed that information about "*person of contact and phone number should be clearly seen and be on the front page*" (S9)

And it was necessary to "*make it easy to read-essential information"* (S22)

c) Layout issues

Many respondents were unhappy with the layout particularly stating that some of the information was not clearly visible and should be moved into priority one section

As one respondent in residential care stated:

"*Relevant and essential info such as resuscitation wishes are not contained. The layout is packed and essentials not stressed enough or visible*" (S17)

Others suggested specific information that should be prioritised for example a respondent from acute care stated:

"*I feel mobility should be in priority one section. Mobility and falls are usually the reason that increases length of stay once initial medical issues are dealt with"* (S29)

2. Time to complete

Most respondents stated that at in its current format, the transfer document was very time consuming to complete. During emergency transfers, the main concern of staff is the patient and their needs and a number of respondents stated that this document was not practical and could not be completed in these situations but might be feasible to complete appropriately in non emergencies. As one staff member in residential care stated:

"*It is too time consuming, one would have to start completing it and then call the ambulance, just to make sure it is accurate and whole*" (S15)

a) Compliance with completion

Many of the staff in residential care reported poor compliance with completing this new document.

Time consuming but could be excellent if filled out properly. Very poor compliance" (S3)

Acute care staff also noted that when they received patients, the document was only partially completed and argued that if the pilot transfer document was electronic, it may improve the likelihood of it being completed. As a respondent from acute care stated the document:

"*Should work when filled out correctly and used efficiently*" (S29).

3. Person-Centred Care

Respondents from both acute and residential care endorsed the person-centered nature of the pilot transfer document. It was noted that *all patient care needs clinical and on a person level* (S29) were recorded and many felt that it was more person centered than their existing transfer document and "*encourages person centered care*" (S15)

As one respondent stated, "*Its very good tool. Gives enough clinical information, unlike other transfer documents. It gives more personal information and is person centered*" (S1)

However respondents also expressed the opinion that the document is best completed with the resident in non-emergency situations and that residents should be consulted about their personal needs rather than just a focus on clinical needs.

a) Improved patient care

Respondents also pointed to the fact that the pilot transfer document enabled the transfer of much more clinical and person centered information about residents, which should lead to improved patient care. The holistic view of the patient and more comprehensive information about how the resident is prior to an acute episode was thought to lead to care that is more appropriate to need.

As one respondent stated:

"*It encourages hospital members to not only treat the acute problem but to help residents to return to their baseline. And to understand how the acute illness in fact has changed the patients baseline/overall condition*" (S15)

4. Communication between residential and acute care

Respondents in both residential and acute care services stated that the transfer document could improve communication both between and within care settings. It aids the transfer of key information about the resident thereby improving communication and patient care. Comments from respondents suggested the need for standardisation of information to improve communication and patient care. Many of the respondents from acute care also noted the reduction experienced in follow up with residential care due to the comprehensive nature of the information in this pilot transfer document.

As one respondent in acute care stated:

"*The document has more information and detail is provided on it, No need to ring nursing home for information anymore*" (S20)

5. Changes proposed to the new document

Respondents were invited to feedback on changes they would propose to the pilot document. There was a resounding call for a computerised, rather than paper based version.

a) Computerised document

The staff argued that computerising this document, would reduce errors due to illegible handwriting, staff would spend less time writing down information on paper and enable the document to be printed and sent swiftly with a patient to acute services in emergency situations.

"It may prove beneficial if documentation is type written as handwritten can be difficult to read and may cause potential for errors" (S23)

"It may be easier and quicker to use if the document was computerised" (S23)

b) Summary sheet

A number of respondents wanted a shorter one-page summary document with person centred information to accompany an existing transfer document in use in the nursing home. It was suggested that the summary document could be populated in advance within the residential care service.

"*Maybe a summary, person centered sheet that is pre-filled"* (S11)

c) Changes in layout

Changes in the layout were also suggested to enable the pilot transfer document to be used effectively. These included making the document shorter, adding more space for certain sections and reason for transfer. Most respondents agreed with the suggestion below:

"*Front pages should have the emergency details of condition and current treatments being undertaken*" (S9)

In addition, to:

"*Shorten the form. Include only relevant information regarding the reason for transfer"* (S22)

Table 9. Overview of Pilot Findings

Themes	Subtheme	Key results	Changes suggested

Design of document	Usability	Too long Not enough space	Ease of use and completion
	Relevance of information	Information comprehensive and relevant	Level of details of clinical and personal information Prioritise the information needed for acute care
	Layout / format	Information for essential acute care needs to be on first page- easily accessed	Form should be electronic Non acute information could be pre-populated
Length of time to complete	Timing in emergency situations Level of detail required	Issue with length of time to complete in emergency situation Lack of compliance with completion	Short summary person centred document to accompany transfer document with acute medical information
Person-Centred Care	Evidence of person centredness	More person centred and holistic than current documents	Retain person centred and holistic focus to improve patient care. Pre- populate form with resident.
Communication between residential and acute care staff	Role of transfer document in communication	Will improve communication between residential and acute care Less follow up phone calls from acute to residential sites following transfer	Need to use to communicate between departments Need to add discharge document back to residential care

Summary

The new transfer document was piloted with staff in 28 residential care and three acute care settings over a three- month period. Pre pilot questionnaires were distributed to residential care sites to identify staff perceptions of the current transfer documentation prior to the introduction of the new transfer document. Results showed that most staff reported ease of use and relevance of their current transfer documents but there were reports of a need for follow up with further information to acute care after following the residents transfer. A lack of consistency and standardisation was also highlighted and a lack of person centeredness. Following the pilot of the new transfer document, staff in both acute and residential care were invited to complete a post pilot questionnaire to ascertain their perceptions of the design, layout, content, and usability of the new document. Finding show that there was general agreement that a standard document was required for safe and effective transfer and that there is a need for a more holistic, person-centred approach to this documentation. However, staff reported concerns about the overall length of the document and time to complete particularly in an emergency transfer.

Key suggestions for change to this document were: (1) an electronic version, (2) Prioritise and the information required by acute care staff make easily accessible. (3) Provide a summary page with person centred information that could be prepopulated with the resident and

accompany the transfer document containing acute medical and priority information for acute care.

Conclusion

Results of the pilot were used to inform revisions to the design and layout of the national transfer document. While the evidence based content of the document was retained, a decision was taken to divide the piloted document into two parts (Transfer Document and Health Profile/Passport) retaining the evidence based content as before and the person centred perspective. The first section containing priority information identified as necessary for acute care and the second section containing comprehensive information with person centred focus on how the resident is usually. The new layout and design were reviewed by the Professor Dewing from a person centred perspective and the revised documents were also reviewed by the expert advisory group to ensure that all information and assessment methods documented were relevant and in accordance with current best clinical practice and policy. Two draft designs were then created for a final consultation meeting with participants in the pilot study.

Chapter 4. Revised Transfer Document and Health Profile

Introduction

Following revisions to the transfer document resulting from the pilot study and advisory group feedback, a consultation/focus group discussion was convened to ascertain the views of participants in the pilot study. An invitation email was circulated to all residential care and acute care sites that participated in the pilot inviting them to take part in the consultative focus group in Dublin in October 2019. Permission to conduct this consultative focus group was obtained via an amendment to ethical approval submitted to the UL research ethics committee.

4.1 Participant Consultation Meeting Method

Attendees were provided with a revised information sheet outlining the rational for the meeting, topics to be discussed and written consent was obtained. The participants were divided into two groups and a member of the UL research team facilitated each group discussion. Discussions were recorded with the participant's permission. The two documents were presented to the participants and they were invited to give their opinions on the layout and design and to reach a consensus on one of the documents presented.

4.2 Results

The meeting lasted over an hour and was attended by 14 people comprising of nursing staff (n=12), a social care professional (n=1) and a service user representative (n=1). All attendees were female (n=14).

There was a consensus reached in both groups on the design and layout of the revised transfer document with some minor amendments. The name of the document was agreed to be National Transfer Document and Health Profile. The Health Profile section was agreed to be pre-populated and attached to the transfer document when the resident is transferred to acute care. The amendments suggested related to the order of the document, with some changes needed in formatting and merging of sections and the addition of information related to health insurance or medical cardholder. There was some discussion about the use of icons or images within the Health Profile section under the headings: nutrition, mobility, communication, skin integrity and elimination. It was agreed, that icons could be made available in a toolbox to be used in conjunction with the document if clarifications are needed when completing this with the resident.

The Transfer Document and Health Profile are in Appendix 7.

Conclusion to the report

The effective management of care for older people across all sectors of healthcare is a key issue for health care policy and practice and international research suggests that documentation deficiencies between age care facilities and acute services are common. There is also a lack of consensus regarding what information is considered essential on transfer, with a variety of nursing transfer letters being used across Ireland. In recognition of these inconsistencies and a lack of evidence based transfer documentation in the Irish context, the National Clinical Programme for Older People supported by the ONMSD commissioned this research to develop a person centred National Transfer Document for use when older people are being transferred from residential to acute care. This report has outlined and described the processes used in the development the National Transfer Document. The stages of the development included an integrated review of international research to identify national and international research, which focused on communication and/or handover documents used in the transfer of an older person from residential care facilities to acute care services. A focus group study conducted with stakeholders to gain their perspectives on the design and content of a national transfer document. A consultative process with an expert advisory group, an expert in person centred care and a pilot of the transfer document in residential and acute care sites across three geographical locations in Ireland to test and ascertain staff perception of the usability, design and layout of the document. Our extensive research and consultation have resulted in the development of a two-part National Transfer Document and Health Profile.

Key findings from our research have led to the following recommendations:

1. **Document in electronic format:** Results from the review of literature, focus group study and pilot provide evidence of the desire for an electronic form of documentation for ease of use and compliance and to reduce the risk of errors in recording and communication.
2. **Implement national standardised transfer documentation:** results from this study show that staff working with older people see the need for standardisation of transfer documentation to promote continuity of care and patient safety as identified in our review of literature.
3. **Development of an educational resource to** accompany the National Transfer Document
4. **Further research to implement the National Transfer Document** with a larger sample at national level underpinned by an implementation science framework that will test the implementation and promote uptake and sustainability of the document.
5. **Research to develop a complimentary discharge document from acute care** that is compatible with the national transfer document for use when transferring the resident back to residential care.

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List of Appendices

1. **Search strategy for each database for the Integrative Review**
2. **Invitation to Participate in Focus Group**
3. **Focus Group Interview Schedule and Interview Guide**
4. **Content Validity Index (CVI)**
5. **Pre-Pilot Questionnaire**
6. **Post-Pilot Questionnaire**
7. **National Transfer Document and Health Profile**

Appendix 1. Search strategy for each database for the Integrative Review

Database/Source	Number of results (Year 2000-)	Date
Cinahl Complete	142	13/03/2018
Embase	165	14/03/2018
Web of Science	681	16/03/2018
Cochrane Library	230	16/03/2018
Dart-Europe	1	16/03/2018
Lenus	357	16/03/2018

SEARCH STRATEGIES – 16/03/18

S18	S3 AND S6 AND S9 AND S14 AND S15 AND S16	Limiters - Published Date: 20000101-20181231 Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL Complete	142
S17	S3 AND S6 AND S9 AND S14 AND S15 AND S16	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL Complete	148
S16	TI (experience* OR perceive* OR perception OR attitude* OR patient transfer OR quality OR satisfaction OR usability Or patient outcomes Or safe care OR continuity of care OR Readmission rates OR Person centered OR adherence OR Compliance) OR AB (experience* OR perceive* OR perception OR attitude* OR patient transfer OR quality OR satisfaction OR usability Or patient outcomes Or safe care OR continuity of care OR Readmission rates OR Person centered OR adherence OR Compliance)	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL Complete	773,685
S15	TI (Assessment instrument OR Transfer Document OR Transfer Checklist OR information gaps OR discharge Management OR communication tool OR Transfer tool OR Transition Or transitions of care OR Transfer Or communication OR SBAR OR ISBAR or patient transfer OR interprofessional communication.) OR AB (Assessment instrument OR Transfer Document OR Transfer Checklist OR information gaps OR discharge Management OR communication tool OR Transfer tool OR Transition Or transitions of care OR Transfer Or communication OR SBAR OR ISBAR or patient transfer OR interprofessional communication.)	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL Complete	130,441
S14	S10 OR S11 OR S12 OR S13	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases	74,253

			Search Screen - Advanced Search Database - CINAHL Complete	
S13	TI (nursing home OR long stay care OR aged facility OR care home OR Homes for the Aged OR continuing care OR long stay residence) OR AB (nursing home OR long stay care OR aged facility OR care home OR Homes for the Aged OR continuing care OR long stay residence)	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL Complete	45,739
S12	(MH "Residential Care+")	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL Complete	6,371
S11	(MM "Long Term Care")	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL Complete	16,023
S10	(MH "Nursing Homes+")	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL Complete	23,976
S9	S7 OR S8	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL Complete	94,207
S8	TI (Emergency Department OR Hospital admission OR acute care OR Emergency transfer) OR AB (Emergency Department OR Hospital admission OR acute care OR Emergency transfer)	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL Complete	69,474
S7	(MH "Emergency Service+")	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL Complete	44,567
S6	S4 OR S5	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL Complete	479,690
S5	TI (Healthcare worker OR nurse Or Nur* Or Healthcare professional Or Healthcare practitioner) OR AB (Healthcare worker OR nurse Or Nur* Or Healthcare professional Or Healthcare practitioner)	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL Complete	468,487
S4	(MM "Nurses")	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL Complete	31,053
S3	S1 OR S2	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL Complete	762,824

S2	TI (Aged OR older person OR geriatric OR elderly) OR AB (Aged OR older person OR geriatric OR elderly)	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL Complete	203,507
S1	(MH "Aged+")	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL Complete	660,151

Cinahl Complete – 142 results 13/03/18

Embase®

Embase Session Results

No.	Query	Results
#19	#18 AND (2000:py OR 2001:py OR 2002:py OR 2003:py OR 2004:py OR 2005:py OR 2006:py OR 2007:py OR 2008:py OR 2009:py OR 2010:py OR 2011:py OR 2012:py OR 2013:py OR 2014:py OR 2015:py OR 2016:py OR 2017:py OR 2018:py)	165
#18	#3 AND #7 AND #10 AND #15 AND #16 AND #17	178
#17	experience*:ab,ti OR perceive*:ab,ti OR perception:ab,ti OR attitude*:ab,ti OR 'patient transfer':ab,ti OR quality:ab,ti OR satisfaction:ab,ti OR usability:ab,ti OR 'patient outcomes':ab,ti OR 'safe care':ab,ti OR 'continuity of care':ab,ti OR 'readmission rates':ab,ti OR 'person centered':ab,ti OR adherence:ab,ti OR compliance:ab,ti	2,916,171
#16	'assessment instrument':ab,ti OR 'transfer document':ab,ti OR 'transfer checklist':ab,ti OR 'information gaps':ab,ti OR 'discharge management':ab,ti OR 'communication tool':ab,ti OR 'transfer tool':ab,ti OR transition:ab,ti OR 'transitions of care':ab,ti OR transfer:ab,ti OR communication:ab,ti OR sbar:ab,ti OR isbar:ab,ti OR 'patient transfer':ab,ti OR 'interprofessional communication':ab,ti	885,496
#15	#11 OR #12 OR #13 OR #14	1,503,507
#14	'nursing home':ab,ti OR 'long stay care':ab,ti OR 'aged facility':ab,ti OR 'care home':ab,ti OR 'homes for the aged':ab,ti OR 'continuing care':ab,ti OR 'long stay residence':ab,ti	28,913
#13	'long term care'/exp	1,445,106
#12	'residential care'/exp	11,027
#11	'nursing home'/exp	49,014
#10	#8 OR #9	216,826
#9	'emergency department':ab,ti OR 'hospital admission':ab,ti OR 'acute care':ab,ti OR 'emergency transfer':ab,ti	146,437
#8	'emergency health service'/exp	87,332
#7	#4 OR #5 OR #6	1,585,431
#6	'healthcare worker':ab,ti OR nurse:ab,ti OR nur*:ab,ti OR 'healthcare professional':ab,ti OR 'health care practitioner':ab,ti	482,339
#5	'nurse'/exp	151,987
#4	'health care personnel'/exp	1,295,227
#3	#1 OR #2	3,207,377
#2	aged:ab,ti OR 'older person':ab,ti OR geriatric:ab,ti OR elderly:ab,ti	917,036
#1	'aged'/exp	2,683,145

Embase Search – 165 results 14/03/18

Set	Results	Save History / Create Alert	Open Saved History
# 1	681	**TOPIC:** (aged OR older person OR geriatric OR elderly) *AND* **TOPIC:** (healthcare worker OR nurse OR nur* OR healthcare professional OR healthcare practitioner) *AND* **TOPIC:** (Emergency Department OR Hospital admission OR acute care OR Emergency transfer) *AND* **TOPIC:** (nursing home OR long stay care OR aged facility OR care home OR Homes for the Aged OR continuing care OR long stay residence) *AND* **TOPIC:** (Assessment instrument OR Transfer Document OR Transfer Checklist OR information gaps OR discharge Management OR communication tool OR Transfer tool OR Transition Or transitions of care OR Transfer Or communication OR SBAR OR ISBAR or patient transfer OR interprofessional communication) *AND* **TOPIC:** (experience* OR perceive* OR perception OR attitude* OR patient transfer OR quality OR satisfaction OR usability Or patient outcomes Or safe care OR continuity of care OR Readmission rates OR Person centered OR adherence OR Compliance) *Indexes=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH, BKCI-S, BKCI-SSH, ESCI, CCR-EXPANDED, IC Timespan=2000-2018*	

Web of Science Search –681 results 16/03/2018

Cochrane Library Search Name: Transfer Tool Older Person – 230 results

Date Run: 16/03/18 12:08:46.875

Description:

ID Search Hits

#1 aged or older person or geriatric or elderly:ti,ab,kw (Word variations have been searched) 516494

#2 MeSH descriptor: [Aged] explode all trees 1252

#3 healthcare worker or nurse or nur* or healthcare professional or healthcare practitioner:ti,ab,kw (Word variations have been searched) 27483

#4 MeSH descriptor: [Nurses] explode all trees 1223

#5 MeSH descriptor: [Health Personnel] explode all trees 8312

#6 Emergency Department or Hospital admission or acute care or Emergency transfer:ti,ab,kw (Word variations have been searched) 30365

#7 MeSH descriptor: [Emergency Service, Hospital] explode all trees 2448

#8 nursing home or long stay care or aged facility or care home or Homes for the Aged or continuing care or long stay residence:ti,ab,kw (Word variations have been searched) 32426

#9 MeSH descriptor: [Nursing Homes] explode all trees 1358

#10 MeSH descriptor: [Homes for the Aged] explode all trees 627

#11 MeSH descriptor: [Long-Term Care] explode all trees 1257

#12 Assessment instrument or Transfer Document or Transfer Checklist or information gaps or discharge Management or communication tool or Transfer tool or Transition or transitions of care or Transfer or communication or SBAR or ISBAR or patient transfer or interprofessional communication:ti,ab,kw (Word variations have been searched) 32745

#13 experience* or perceive* or perception or attitude* or patient transfer or quality or satisfaction or usability or patient outcomes or safe care or continuity of care or Readmission rates or Person centered or adherence or Compliance:ti,ab,kw (Word variations have been searched) 394352

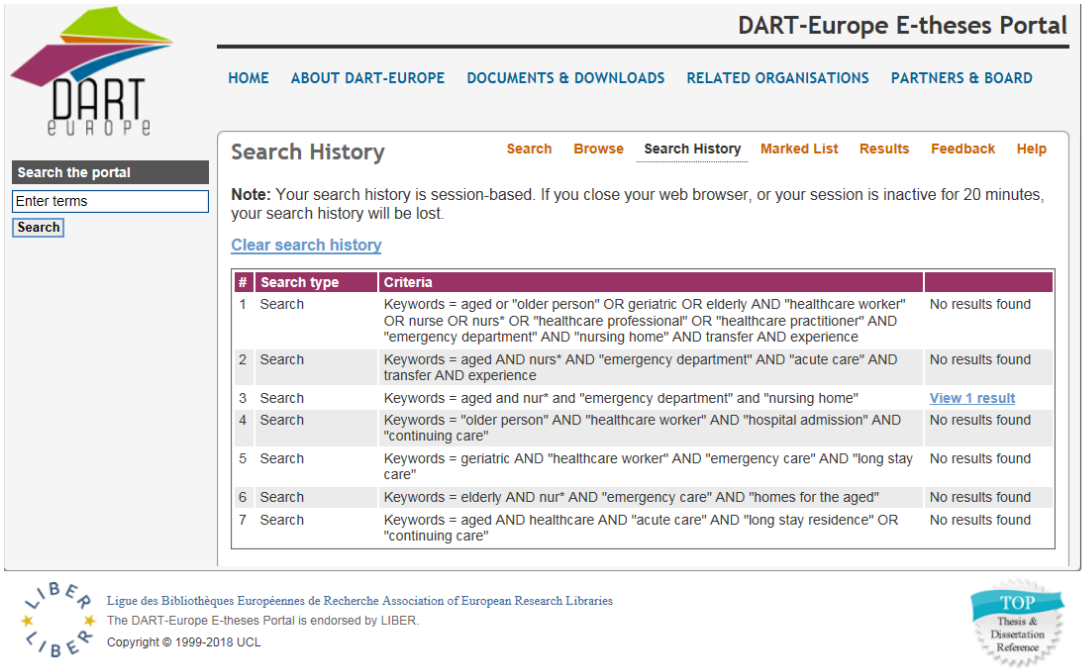
#14 #1 or #2 516494

#15 #3 or #4 or #5 32830

#16 #6 or #7 30954

#17 #8 or #9 or #10 or #11 33253

#18 #12 and #13 and #14 and #15 and #16 and #17 230



DART-Europe E-theses portal – 1 result – 16/03/18

LENUS Irish Health Repository – 16/03/2018

aged AND nur* AND "emergency department" AND "nursing home" AND transfer – 357 results

"older person" AND nur* OR "healthcare worker" AND "acute care" OR "hospital admission" AND "continuing care" OR "care home" AND transfer OR transition – 1 result

Appendix 2. Invitation to Participate in Focus Group

Developing a Validated Transfer Tool for Use When an Older Person is Transferred Between a Residential and Acute Care Facility.

Invitation to Participate in a Focus Group

The effective management of care for older people across all sectors of healthcare is a key issue for health care policy and practice. Transitions for older people with multiple chronic conditions between care settings are recognised as particularly critical and vulnerable periods for them. Consequently, transitions are frequently characterised by serious breakdowns in communication both within and between services, which creates gaps in care and can lead to poorer outcomes for older people.

Next Steps:

The Office of the Nursing Midwifery Services Director and the National Clinical Programme for Older People in partnership with University of Limerick would like to invite you to attend a focus group to inform the development of a national transfer tool.

Date & Venue

8th May 2018
10.30 am to 12midday
Liffey Suite
Ashling Hotel
Parkgate Street
Dublin 8

You can register for the event by contacting Deirdre Lang: Director of Nursing National Clinical Programme for Older People @ deirdrelang@rcpi.ie Ph: 0877662466

Appendix 3. Focus Group Interview Schedule and Guide

Background and Context

With the significant increase in concerns about standards of care for older people, there is growing evidence about what matters to the well-being of older persons transferring from residential to acute settings. The knowledge and interpersonal skills that are required to support older residents in a residential setting transferring to an acute setting in a meaningful way must include a person-centered approach. According to Sjögren et al. (2017) effective collaboration and communication have an influence on the extent to which person-centered care is practiced and there is empirical evidence of positive outcomes from the use of validated transfer checklists, such as a reduction in 30-day readmission rates when residents were transferred to ED (Tsai *et al.* 2018). Nevertheless, further engagement with all stakeholders is necessary to develop mechanisms of communication that not only provide reliable and valid information (Matic *et al.* 2011) during transfer, but also provide relevant information about the person, what matters to the person and demonstrates person- centeredness. As a result this one-year project is building on the learning and recommendations from the stakeholder engagement and aims to develop and validate a national nursing transfer tool for use when an older person is being transferred from residential to acute care facilities.

Focus Group Interview Schedule and Guide

The aim of the focus group interview is to capture the views and experiences of key stakeholders to aid in the development of an effective national transfer document of older persons from residential to acute care facilities. It is envisioned that the document/tool will fosters a person-centered approach, meeting the care needs of the patient, in the development, process of completion, and content of the document.

The interview guide aims to capture core areas, which are grounded in the philosophy of person-centred care, outlined below.

- What in your opinion are the key elements of information required to safely transfer the older person from the residential setting to the acute hospital?
- What information enhances nurses' ability to deliver safe, person centred care?
- What hinders nurses' ability to deliver safe person-centred care?
- What information is required to provide safe effective person centred care to the older person in the Emergency Department or Acute Medicine Units?
- What information is required to provide safe effective person centred care to the older person admitted to the ward/unit
- What format would assist the residential setting provide different types and volumes of information across different points of care in the acute hospital

FOCUS GROUP INTERVIEW GUIDE

Thinking about the current transfer process from residential to acute care…

- Tell me about your views on the process?
- What are your experiences of using transfer documentation when older people are being transferred between residential and acute care facility?
- How would you describe the skills and knowledge required to transfer safely and sensitively?
- What information is currently on the document about the resident and their individuality and preferences and needs?
- Please discuss your perception of current shared decision making with you and the resident and those involved
- What else is needed to help you and the resident with the transfer?
- If the resident/next of kin/were involved in the development of the transfer documentation how were they involved?
- What barriers (if any) exist hinder the transfer for you and the resident?
- Are there presently any factors that support the transfer?
- If you were to redesign the current document what would you change?
- If you were to redesign the current document what would you retain?onsidering a new design for transfer documentation…
- What is your vision of an optimum transfer document?
- Please discuss ways in which we can ensure that the resident's beliefs and values are considered in transfer documentation
- How can we encourage person centeredness in our transfer documentation?
- Please consider how residents and family can be involved in the design
- Please consider the format that would best assist the residential setting to provide different types and volumes of information across different points of care in the emergency and acute hospital (in your opinion)
- What in your opinion would make the transfer process smoother for the services; for staff; for the person?

Considering the specific content within a new transfer document…

- What do you see as the essential information that should be included to support an effective person-centered transfer?
- How can we make the transfer tool individual and unique to the care needs of the person?
- What do you think would help to ensure that the essence of care is addressed?
- Is there anything else that you would like to add?

Prompts:

- patient preferences and viewpoints ; Emotional responses; Communication style; Cues or signals – non-verbal facial expressions ; Medication regime; Level of mobility ; Eating preferences; Sleep pattern

Appendix 4. Content Validity Index (CVI)

Dept of Nursing &
Midwifery Health Sciences
Building University of
Limerick

7th June 2018

Members of the Expert Advisory Group

The Development of a validated National Transfer Tool for use when an Older Person is being transferred from Residential to Acute Care Facilities

Dear expert group member
Please find attached

1. Draft National Transfer Tool
2. Content Validity Index (CVI)

This draft transfer document has been informed by the results of a literature review and focus group study and mapped to transfer documents in use nationally and available to the research team.

Please review the draft document and score each item based on your consideration of its relevance to person-centred transfer of older persons from residential to acute care.
Please use the CVI scale attached for this purpose. Guidance for use of the CVI is provided on page 1 of the scale.
I will be grateful if you could complete the CVI rating with your comments and have this available for collection and discussion at our meeting on the 19th of June. If you cannot attend the meeting, please return to me via post or scanned copy via email (details below)

Should you have any questions in relation to this request please contact me. Thank you for your consideration and assistance.

Yours sincerely,

Professor Alice Coffey Principle Investigator: alice.coffey@ul.ie

Dear expert group member

(EXAMPLE)

The following is a **Content Validity Index (CVI).** This is a scale used to judge the content of the draft transfer tool

Please refer to the draft transfer tool attached, evaluate each of the items and make a decision on whether the item is (1) not relevant, (2) relevant with major revision, (3) relevant with minor revision or (4) relevant.

NB: If you choose 2 or 3 please provide a suggested edit, addition or alteration in the comment box.

Each item is listed in the table below with corresponding heading and page number (note item may be abbreviated)

Please rate (tick✓) each item in the Draft Document for its relevance on the scale 1- 4

THIS IS ME					
PAGE 1 **Please judge the relevance of each item below to the process activities, or goals of person centred transfer**	**1** **Not relevant**	**2** **Relevant but needs major alteration**	**3** **Relevant but needs minor alteration**	**4** **Relevant**	**Comment:** **Please suggest any edits, alteration or additions (as necessary) for each item**
Page 1					
Page 1					

PLEASE COMMENT ON THE OVERALL DESIGN OF THE DRAFT TRANSFER DOCUMENT

PLEASE COMMENT ON THE STRUCTURE / LAYOUT OF THE DRAFT DOCUMENT

CALCULATION OF CVI SCORE

The I-CVI is **the proportion of experts assigning a rating of 3 (relevant but needs minor alteration) or 4 (relevant).** The I-CVIs were calculated for each item for the total group (n XXX; I-CVI-ALL). Traditionally, an I-CVI is calculated for each item for the entire group of experts.

The selection of .80 as the required I-CVI should be explained. Lynn (1986) supplied a table of cut-off I-CVIs when the total number of expert panel members goes up to 10. In Lynn's table, the required magnitude of I-CVI is a function, in part, of the number of judges used i.e. the greater the number of judges, the lower the required I-CVI. However, she recommended not lowering the CVI below .78. In a recent review, Polit and Beck (2006) recommend an I-CVI of 1.00 when 3 to 5 experts are used and an I-CVI of no lower than .78 when 6 to 10 experts are used.

Therefore the score from the expert panel will calculated for each item and those items in receipt of the higher proportion of rating 3 or 4 will be retained.

THANK YOU

Appendix 5. Pre-Pilot Questionnaire

The Development of a Validated National Transfer Tool For Use When An Older Person Is Being Transferred From Residential to Acute Care Facilities

PILOT

QUESTIONNAIRES

Version 5 28th January 2019

CONTENTS

1. **Care site profile questionnaire for Residential Sites**
2. **Staff demographic questionnaire**
3. **Staff perception of CURRENT transfer documentation (pre pilot)**

PROFILE OF RESIDENTIAL SITE

Note: This section is to provide contextual information for research and may be completed by the Director of Nursing / Person in Charge of the Residential Care Facility.

1. Total number of residents in the Residential Care Facility ☐

2. Gender: number of Male ☐ Female ☐ residents

3. Age range of residents ☐

4. Number of residents transferred to acute hospital in last year ☐

5. Number of residents admitted to acute hospital in the last year ☐

6. Staff:

Number of Nurses Day ☐ Night ☐

Number of HCA Day ☐ Night ☐

STAFF DEMOGRAPHIC QUESTIONNAIRE

Staff at each study site please complete the following sections

1. ***Please place ✓ in the answer box that best applies to you.***

What age are you (years)?

□ <30
□ 30-39
□ 40-49
□ 50-59
□ 60-69

2. **Please tick ✓the category of staff that best represents you:**

□ Nurse
□ Clinical Nurse Manager
□ Clinical nurse Specialist
□ Advanced Nurse Practitioner (cANP/ANP)
□ Director of Nursing / Person in charge
□ General Practitioner
□ Doctor (NCHD or Consultant)
□ Physiotherapist
□ Speech and Language Therapist
□ Occupational Therapist
□ Pharmacist
□ Other (if yes, please specify_____

_____

3. **What is the highest educational level you have attained?**

□ Secondary School
□ Professional qualification (certificate or diploma)
□ Degree
□ Postgraduate (e.g. postgraduate certificate/diploma)
□ Masters
□ Doctorate

4. **Please indicate ✓ the care setting where you currently work**

□ Residential Care (public)
□ Residential Care (Private)
□ Acute Hospital Emergency Department
□ Acute Hospital Medical Assessment Unit
□ Acute Hospital Surgical Ward

5. **How long have you worked in your current care setting? (Years)**

□ <5 □ 10-14
□ 5-9 □ 15-19 □ ≥20

STAFF PERCEPTION OF TRANSFER DOCUMENTATION (PRE-PILOT)

Please **tick (✓) the number (1 to 5)** that best represents your opinion/ experience of the National Transfer Document you use currently**:**

Q.1. The transfer documentation	**1 Strongly Disagree**	**2 Disagree**	**3 No opinion**	**4 Agree**	**5 Strongly Agree**
Is clear and easy to complete					
It could be less time consuming					
Contains relevant *clinical* information about the resident					
Contains relevant *personal* information about the resident					
It is a user friendly document					
Promotes *person centred* care					
Contains *appropriate level* of information *relevant* to initiating acute care					
Layout / design easy to follow					
Is feasible to complete in a short timeframe i.e. emergency					
Essential information is easily visible					
It is clear that the resident is involved in the decision to transfer					
Can be used by all members of the multidisciplinary team					

Q.2. In general what are your thoughts on the National Transfer tool? *please comment here:*

Q.3. If you have any specific areas of concern about the documentation: *please comment here:*

Q.4. If you have suggestions for improvement – *please comment here*

Thank you for completing this questionnaire

Your views are strictly confidential.

Appendix 6. Post-Pilot Questionnaire

The Development of a National Transfer Tool for use when an Older Person is being transferred from Residential to Acute Care Facilities

POST PILOT

QUESTIONNAIRES

Version 5 28th January 2019

CONTENTS

1. **Care site profile questionnaire for Residential Sites**
2. **Staff demographic questionnaire**
3. **Staff perception of NEW transfer documentation (post pilot)**

STAFF DEMOGRAPHIC QUESTIONNAIRE

Staff at each study site please complete the following sections

1. ***Please place ✓ in the answer box that best applies to you***.

What age are you (years)?

□ <30
□ 30-39
□ 40-49
□ 50-59
□ 60-69

2. **Please tick ✓the category of staff that best represents you:**

□ Nurse
□ Clinical Nurse Manager
□ Clinical nurse Specialist
□ Advanced Nurse Practitioner (cANP/ANP)
□ Director of Nursing / Person in charge
□ General Practitioner
□ Doctor (NCHD or Consultant)
□ Physiotherapist
□ Speech and Language Therapist
□ Occupational Therapist
□ Pharmacist
□ Other (if yes, please specify_____

_____

3. **What is the highest educational level you have attained?**

□ Secondary School
□ Professional qualification (certificate or diploma)
□ Degree
□ Postgraduate (e.g. postgraduate certificate/diploma)
□ Masters
□ Doctorate

4. **Please indicate ✓ the care setting where you currently work**

□ Residential Care (public)
□ Residential Care (Private)
□ Acute Hospital Emergency Department
□ Acute Hospital Medical Assessment Unit
□ Acute Hospital Surgical Ward

6. **How long have you worked in your current care setting? (Years)**

□ <5 □ 10-14
□ 5-9 □ 15-19 □ ≥20

STAFF PERCEPTION OF TRANSFER DOCUMENTATION (POST-PILOT)

Please **tick (✓) the number (1 to 5)** that best represents your opinion/ experience of the **new National Transfer Document:**

Q.1. The transfer documentation	**1 Strongly Disagree**	**2 Disagree**	**3 No opinion**	**4 Agree**	**5 Strongly Agree**
Is clear and easy to complete					
It could be less time consuming					
Contains relevant *clinical* information about the resident					
Contains relevant *personal* information about the resident					
It is a user friendly document					
Promotes *person centred* care					
Contains *appropriate level* of information *relevant* to initiating acute care					
Layout / design easy to follow					
Is feasible to complete in a short timeframe i.e. emergency					
Essential information is easily visible					
It is clear that the resident is involved in the decision to transfer					
Can be used by all members of the multidisciplinary team					

Q.2. In general what are your thoughts on the National Transfer tool? *please comment here:*

Q.3. If you have any specific areas of concern about the documentation: *please comment here:*

Q.4. If you have suggestions for improvement – *please comment here*

Thank you for completing this questionnaire

Your views are strictly confidential.

Appendix 7. Transfer Document and Health Profile

NATIONAL TRANSFER DOCUMENT AND HEALTH PROFILE FOR RESIDENTIAL CARE FACILITIES

The Health Profile, up to date copy of Medication List and Administration Record of the person being transferred, should accompany this document. Please ensure that these and any other relevant information is attached. All documentation regarding transfer to be completed with the resident in so much as possible.

<table>
<tr><td colspan="3">Priority 1: THINGS THAT YOU <u>MUST</u> KNOW ABOUT ME
This Section should be completed at time of transfer</td></tr>
<tr><td colspan="3">ISBAR₃ Communication Framework (*Based on NCG No.11, NCEC, DOH, 2015 and NMPD DML, 2018)</td></tr>
<tr><td rowspan="11">I</td><td colspan="2">Identify: Identify yourself, who you are talking to and who you are talking about</td></tr>
<tr><td colspan="2">Recipient of Information (Please circle): e.g Hospital/Staff (ED) or Staff (MAU), Paramedics</td></tr>
<tr><td>GP Name:</td><td>GP Number:</td></tr>
<tr><td>Referred by:
e.g. GP, GP Out of Hours, Nurse in charge</td><td>Seen by GP (Please circle): Y/N</td></tr>
<tr><td colspan="2">At present the resident is receiving care in:</td></tr>
<tr><td>Unit Name :</td><td>Unit Telephone Number:</td></tr>
<tr><td colspan="2">Health Mail Address of Unit/ Email Address of Unit:</td></tr>
<tr><td>Nurse in Charge of Unit:</td><td>Key worker (If applicable):</td></tr>
<tr><td colspan="2">Named Designated Representative/ Contact Person (including wards of court):</td></tr>
<tr><td>Designated Rep/Contact Person notified of transfer (Please circle): Y/N</td><td>Phone Number:</td></tr>
<tr><td>Medical Card (Please circle): Y/N</td><td>Health Insurance (Please circle): Y/N</td></tr>
<tr><td>Religion / Spiritual Needs:</td><td>Ethnicity:</td></tr>
<tr><td rowspan="2">S</td><td colspan="2">Situation: What is the current situation/change in condition, concern, observations etc?
Why am I (resident) being transferred?</td></tr>
<tr><td colspan="2">Brief summary of resident's current status/identification of the problem requiring transfer (including suspected delirium)</td></tr>
</table>

B	**Background**: Summary of Treatment to Date, Relevant Medical/Surgical History, Vital Signs (Please complete with resident if possible)
	MY MEDICAL INFORMATION
	Have I (resident) been involved in the decision to transfer me to hospital? (*Please circle):* Y/N If no, please state reason:
	A copy of my medicines prescription is attached *(Please circle):* Y/N
	Do I present as acutely confused *(Please circle):* Y/N Do I present with symptoms of pain*:* Y/N
	Do I present with a choking risk (*Please circle*): Y/N *(Please see eating and drinking in my health profile)*
	My bowels last opened Time__:__ Date __/___/___ I last passed urine Time__:___ Date ___/__/___
	I use breathing support (*Please circle as appropriate*): BiPap NIV LTOT Please provide details:
	I have a history of adverse drug reactions/ allergies *(Please circle):* Y/N If Yes please specify:
	I have a history of adverse other reactions/ allergies *(Please circle):* Y/N e.g. (anaphylaxis, medication allergy, food allergies and/ or intolerances *etc.*) *(Please give details including what my reactions would be)*
	I have an Advanced Health Care Plan/ Directive *(Please circle):* Y/N/ copy attached

	I have an End of life care plan dated and attached: *(Please circle):* Y/N Active Safeguarding Concerns *(Please circle):* Y/N (*If Yes Please Contact Residential Care Setting*)	
	I **currently** have a health-care associated infection *(Please circle):* Y/N/Unknown *If known please circle* : HCAI/ MDRO/ BBV[1] status, Influenza, Norovirus, Hep B, Hep C, HIV, *Clostridium difficile*, MRSA, CPE/ CPE contact, VRE **Other** *(Please specify):*	I have **a history** of a health-care associated infection status *(Please circle):* Y/N/Unknown *If known please circle* : HCAI / MDRO/ BBV[2] status, Influenza, Norovirus, Hep B, Hep C, HIV, *Clostridium difficile*, MRSA, CPE, VRE **Other** *(Please specify):*
	I have been informed of my HCAI/ MDRO/ BBV status (*Please circle):* Y/N	**Eradication / screening protocol attached** (If relevant)*(Please circle):* Y/N
	SUMMARY OF TREATMENT TO-DATE	
	RELEVANT MEDICAL/SURGICAL HISTORY/KEY MEDICAL INFORMATION	

[1] HCAI= Healthcare- associated Infection/ MDRO= Multi- drug Resistant Organism / Blood- Borne Virus= Hepatitis B, Hepatitis C, Human Immunodeficiency Virus

[2] HCAI= Healthcare- associated Infection/ MDRO= Multi- drug Resistant Organism / Blood- Borne Virus= Hepatitis B, Hepatitis C, Human Immunodeficiency Virus

Resident Name _____Date of Birth_____Completed by_____ Date_____ PIN____

	VITAL SIGNS					
	Recorded by:		**Time recorded:**			
	B.P.	**Pulse Rhythm** Regular / Irregular	**Pulse Rate**	**Temperature**	**Respiratory Rate:**	
	O_2 Sat (R/A):	**O_2 Sat** (O_2 therapy):	**Blood Sugar:**	**GCS:**	**AVPU**	**Other:**
A	**Assessment: What is the problem/your assessment of the situation?**					
R	**Recommendation, Read-back, Risk**					
	Specify your (nurse) clinical recommendations					
	Identify possible risks					
	Date and time:	Signature:	Print Name			

Checklist of Supporting Documentation	***Please attach Health Profile**
Health Profile	Y/N
Medication List	Y/N
Medication Administration Record	Y/N
End of Life Care Plan *(If applicable)*	Y/N
Advance Care Plan/Directive *(If applicable)*	Y/N
Medical Transfer Letter	Y/N
Enteral Feeding Regimen *(If applicable)*	Y/N
Healthcare Associated Infection Protocol	Y/N
List accompanying equipment :	
Other relevant information: Please state:	

Resident Name _____Date of Birth_____Completed by_____ Date_____ PIN____

MY HEALTH PROFILE

My Personal Preferences

MY NAME IS:

I WANT TO BE CALLED:

MY DATE OF BIRTH __ /__/____

I CURRENTLY RESIDE AT (Nursing Home/Community Hospital)

WHAT I WANT YOU TO KNOW ABOUT MY IDENTITY (e.g. Gender)

IMPORTANT PEOPLE IN MY LIFE:

WHEN I SEEK ADVICE, I ASK THE FOLLOWING PEOPLE:

HOW I RESPOND TO NEW ENVIRONMENTS OR EVENTS:

WHAT CAN BE DONE TO SUPPORT ME:

THINGS I LIKE: (e.g. what makes me happy, things I like to do, see or talk about)

THINGS THAT WORRY OR UPSET ME:

SPECIAL ITEMS I LIKE TO HAVE WITH ME

(e.g. pillow, blanket, photograph)

Resident Name _____Date of Birth_____Completed by_____ Date_____ PIN____

My Personal Preferences

MY SLEEP PATTERN

Usual bedtime:

Usual clothing:

Time of settling:

Time of waking:

You can help me settle by:

I usually sleep in bed *(Please circle):* Y/N

I usually have ____ pillows

I usually call out for assistance *(Please circle):* Y/N

I need a bell/I need an adapted bell *(Please circle):* Y/N

MENTAL HEALTH

How do I describe my mental well-being?

SMOKING

I smoke *(Please circle):* Y/N

If yes, how much daily?

I vape *(Please circle):* Y/N

ALCOHOL USE

I drink alcohol *(Please circle):* Y/N

If yes, how often and how much?

Resident Name _____Date of Birth_____Completed by_____ Date_____ PIN____

HOW I AM USUALLY

Please circle answers unless otherwise indicated

MY COMMUNICATION

My comprehension:

No Difficulty/ Mild / Moderate/ Severe

My expression:

No Difficulty/ Mild / Moderate/ Severe

My first language is: _____

I need an interpreter: Y/N

How to support me to communicate e.g. key phrases / terms for understanding/ communication board:

SIGHT: I wear glasses: Y/N

Other_____

HEARING: I wear hearing aids: Y/N

What aids are with me:

Spectacles/ Hearing aids/Dentures/ Assistive Technology/Communication boards

MY COGNITIVE FUNCTION

My cognitive score: *(Please circle relevant score)*

MMSE	/30	AMTS	/ 10,
MOCA	/30,	4AT	/12 (Max)
Date completed	/ /		Deficit Y/N

MY MOBILITY

Independent / Supervision

Assistance x1/ Assistance x2
Immobile/Wheelchair

Standing Hoist /Full Hoist

I have a mobility aid: Y / N

Walking Stick/ Frame/ 4 Wheeled Walker/

3 Wheeled Walker /Wheelchair

I am at risk of falls: Y/N

My Functional Level: (Barthel /20)

Clinical Frailty Score:

(Specify scale used)

Other_____

MY SKIN INTEGRITY

Intact/ Grade 1/ Grade 2 /Grade 3 /Grade 4

(Please complete one scale below as appropriate)

Water low Score: 10+ (at risk), 15+ (high risk), 20+ (very high risk)

Braden Score: <11 (high risk), 12-14 (moderate risk), 15-16 (low risk), ≥ 17 (no risk)

Norton Score: _____

I use a pressure-relieving device: Y/N

(Please specify):

Wound location: *(If applicable)*_____

Dressing used :(*If applicable*)_____

Resident Name _____Date of Birth_____Completed by_____ Date_____ PIN____

HOW I AM USUALLY

Please circle answers unless otherwise indicated

MY NUTRITION

I require assistance with eating/drinking: Y/N

Support I may need with eating/drinking *(please specify)*_____

My Foods & Drinks/ Modification Requirements: *(please circle)*

Level 0-Drinks (Thin),

Level 1-Drinks (Slightly Thick),

Level 2-Drinks (Mildly Thick),

Level 3-Drinks & Foods (Moderately Thick-Liquidised),

Level 4-Drinks & Foods (Extremely Thick- Pureed),

Level 5-Foods (Minced and Moist),

Level 6-Foods (Soft and Bite Sized),

Level 7-Foods (Easy to Chew/Regular)

If unsure, please describe:

Special diet: Y/N *(Please specify)*

Fluid restriction: Y/N

MY WEIGHT_____

Date recorded: __/___ /___

Any recent change: Y/N

Specify loss/gain:

M.U.S.T score:

I have a feeding tube in place: Y/N

If yes, Please indicate type:

Size: ___

Date last inserted: __ /__ /__

Regimen attached: Y/N

I wear dentures/bridges: Y/N

I have crowns/implants: Y/N

Foods & Drinks: Likes/Dislikes preferences

Resident Name _____Date of Birth_____Completed by_____ Date_____ PIN____

HOW I AM USUALLY

Please circle answers unless otherwise indicated

MY NORMAL BOWEL PATTERN

I am continent: Y/N

I am not fully continent: Day/Night /N/A

Continence-wear type I use *(If applicable):*

How often I need to go to the toilet:

___ (hours)

I have a Stoma in place: Y/N

Equipment required:

MY NORMAL URINARY PATTERN

I am continent: Y/N

I am not fully continent: Day/Night /N/A

Continence-wear type I use *(If applicable):*

How often I need to go to the toilet:

___ (hours)

I have a urinary catheter in situ: Y/N

Last changed:___/___/_____**Size:**

Type: Urethral or Supra-pubic

I have a stoma in place: Y/N

Equipment required:

ADDITIONAL INFORMATION

Please let us know any further information that would help make your care more individual to your needs (e.g. What support I may require?)

Office of the Nursing & Midwifery Services Director

UNIVERSITY OF LIMERICK OLLSCOIL LUIMNIGH

OLDER PEOPLE

The Development of a National Transfer Document for use when an older person is being transferred from Residential to Acute Care Settings

Funded by the Health Service Executive

Published 2020

HSE Office of the Nursing & Midwifery Services Director

UNIVERSITY OF LIMERICK OLLSCOIL LUIMNIGH

OLDER PEOPLE