# PPG-00736

Information Transfer

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| **Area** | Home Care-Services to Seniors | | | |
| **Section** | Administration-General | | | |
| **Subsection** | N/A | | | |
| **Document Type** | Policy | | | |
| **Scope** | All staff | | | |
| **Approved By** | | **Original Effective Date** | **Revised Effective Date** | **Reviewed Date** |
| Glenda Short, VP Community Programs | | 2016-Mar-01 | 2020-Mar-17 | 2020-Jan-15 |

## DEFINITIONS

**Care Transitions**: Any point in care when one care provider is transitioning care to another care provider e.g. facility to facility, facility to program/service, program/service to facility, program/service to program/service.

**Committee**: The person or persons, including the Public Guardian and Trustee (PGT), appointed to be responsible for the client's property and/or personal care.

**Public Guardian and Trustee of Manitoba (PGT):** A provincial government Special Operating Agency that manages and protects the affairs of Manitobans who are unable to do so themselves and have no one else willing or able to act. This includes mentally incompetent and vulnerable persons, minor children, and deceased estates.

**Substitute Decision Maker (SDM):** An individual appointed by the Vulnerable Persons' Commissioner to make decisions for a vulnerable person who is unable to make his/her own decisions regarding personal care and/or property, alone or with the help of a support network. The Substitute Decision Maker has the legal authority to make decisions for those specific areas and for the length of time identified by the Commissioner. In the absence of others, the PGT may be appointed as the Substitute Decision Maker.

**Transitory/Working Records**: Documents of short-term use and significance containing personal health information and are not retained as part of the permanent health record. Examples include report sheets (including taped shift reports), quick reference cards, clinical handover tools, communication books, daily planning checklists, community health clinic group registration sheets, health record audit records.

## POLICY STATEMENT

Information relevant to the care of the client is communicated effectively during care transitions. This would include at minimum, the client's full name and other identifiers, Committee or Substitute Decision Maker (if applicable), contact information, backup plan, reason for transition, safety concerns and client goals. Depending on the setting, information about allergies, medications, diagnosis test results, procedures, and advance care or health care directives may also be relevant. The policy is applicable to points of transition from or to external programs as well as internal client communication between Home Care Team members. All sharing of personal health information is subject to confidentiality. A permanent transfer of a client from one Case Coordinator to another is subject to Home Care Client Transfer policy.

RESPONSIBILITIES

**Case Coordinator (CC):**

- Collect at intake the minimum information of first and last name, address, date of birth and phone number. Additional information would include reason for referral, whether client is agreeable to assessment and name and phone number(s) of contact person(s)
- Communicate reason(s) for non-admission with individuals who are not admitted after intake or assessment. If an assessment has not been completed, the CC would provide written acknowledgment to referred individuals which would include; helpful resources and contact information to reconnect with the Home Care office if needs change. If non-admission status is determined at an assessment visit the reason(s) for non-admission would be discussed verbally and written resources which would include; helpful resources and contact information to reconnect with the Home Care office, would be left in the home
- Intake or hospital based CC will transfer information collected and urgency of need for response to the community CC
- Provide written acknowledgement and disposition of referral to professional referral sources
- Provide written acknowledgement of referrals to individuals who could not be contacted for assessment. This letter would provide contact information for the Home Care office
- For those clients where Home Care services have been refused and the client has dementia, the CC will follow up by telephone with the client every three (3) months until client is either deceased, admitted to a Personal Care Home or transferred to another region. If family or committee/SDM declines further three month follow-up, CC will advise Manager
- Communicate client admission to the program, major changes (including hospitalizations) and client discharge from program to direct service providers and applicable health professionals including the committee/SDM
- Notify emergency department by phone using an SBAR format when arranging for a client to be transported to the emergency room
- Forward a completed Manitoba Information Transfer Referral Form to facility each time an admission to facility is being arranged or when deemed clinically appropriate
- Identify a contact person and backup plan as per policy ensuring all committee/substitute decision makers are listed as a contact person
- Document all communication in dated notes at the time of a care transition or as soon as possible thereafter. Ensure documentation in client file is accurate, complete, concise and client focused

**Resource Coordinator (RC) / Scheduling Clerk (SC) / Nursing Scheduling Clerk (NSC):**

- Distribute service requests/working alone safety assessments to Home Care Attendant (HCA) / Home Support Worker (HSW) / Direct Service Nursing (DSN)
- Ensure client communication received from HCA/HSW/DSN staff is provided to the Case Coordinator
- Ensure that all staff are aware of the On-call/after-hours phone numbers and procedures
- In partnership with CC, notify service providers concerning any hospitalization of their clients Document notification to service providers
- Follow-up with CC if clarification required about client admission to facility including expected length of time of hospitalization and confirmation of admission

## Home Care Direct Service Nurse (DSN)

- Report for messages on a regular basis as identified by the supervisor
- Clarify (as needed) any information on the service request with CC and/or Nursing Supervisor.
- Report any changes in health status, treatment plans, physician consults or care plan changes to the Case Coordinator
- Create or update the Home Care Clinical Handover Tool (transitory document) at the end of each shift, to ensure information remains clear, concise and accurate.
- Provide standardized information at the time of shift handover as per template form.
- Notify emergency department by phone using an SBAR format when arranging for a client to be transported to the emergency room
- Complete and send a Manitoba Information Transfer Referral Form for the receiving facility each time they arrange for a client to present at hospital. Communicate to the CC that this has been done.
- Notify the RC/SC each time DSN becomes aware of a client hospitalization
- Phone 911 in an emergent situation and notify client contacts
- Advise of 911 call (during office hours) to the Nursing SC and CC
- Advise of 911 call (during after-hours) to the afterhours RC/SC to ensure information is transferred to DSS
- Ensure documentation in client file is accurate, complete, concise and client focused

## Home Care Attendant (HCA) / Home Support Worker (HSW)

- Report for messages on a regular basis as per direction from supervisor
- Clarify (as needed) any information on the care plan with the RC or designate
- Report and document any changes in client conditions or care plan as per observation reporting guidelines
- Phone 911 in an emergent situation and notify client contacts
- Report 911 call (during office hours) to the RC or directly to the CC in the RCs absence
- Report 911 call (during after-hours) to the afterhours RC/SC

RELATED MATERIAL

PMH226, Confidentiality and the Personal Health Information Act
PMH1046, Nursing Shift Handover Template
PMH1048, Observation Reporting Form
PPG-00171, Advance Care Planning
PPG-00179, Confidentiality
PPG-00197, Management of Adult Clients Requiring the Care of a Committee or Substitute Decision Maker
PPG-00738, Observation Reporting
PPG-00739, Contact and Back Up Planning
PPG-01260, Care Handovers and Transitions
PPG-01694, Client Not Seen Not Found
PPG-01748, Home Care Resource Coordinator After Hours (In Development)
PMH2927, Home Care Clinical Handover Tool
W-00147, Manitoba Information Transfer Referral Form
Home Care Short Term Assessment/Hospital Discharge Form and Basic Information Form (MB Health)
Information Transfer (Home Care) education video

## REFERENCES

Provincial Court of Manitoba in the matter of The Fatality Inquiries Act and in the matter of Brian Lloyd Sinclair, Deceased. December 12, 2014

Accreditation Canada Required Organizational Practices Handbook 2016 - Transfer of Information

WRHA Interruption of Essential Care and Services Policy

Frank Alexander Inquest: Recommendation Implementation Plan.
http://www.gov.mb.ca/health/documents/fai_report.pdf

## DOCUMENT HISTORY

| Version | Changes |
|---|---|
| 2016-Mar-01 | New. |
| 2017-Feb-01 | Revised. Compare to previous version for details. |
| 2019-Mar-06 | Revised to reflect the language that is compatible with use of the new Electronic Home Care Record. |
| 2020-Jan-15 | Revised. Added PMH2927 to the Related Material list. Added the definition of a transitory document. Added the direction to DSNs regarding the Home Care Clinical Handover Tool (PMH2927). |
| 2020-Mar-17 | Revised. Added link to Information Transfer (Home Care) education video. |