## CENTRAL ZONE - INFORMATION TRANSFER ENGAGEMENT ACTIVITY RESULTS, Fall Forums 2018

### Question 1: What client information do you need in order to plan and deliver care?

| | ***Who is this information important to …*** | | | | |
|---|---|---|---|---|---|
| ***Information that is critical to plan and deliver care*** | Client/ Family | Home Care | Facility | Cont Care | Other |
| Demographic information - contact info, DOB, HCN | | x | x | x | |
| Health History-Past medical diagnosis | | x | x | x | |
| Infections, complications | | x | x | x | |
| Recent health issues, diagnosis, recent hospitalizations | | x | x | x | |
| Medication History - allergies, accurate list of current meds | | x | x | | |
| Med routine | | x | x | | |
| Lab history associated with medication changes | | x | x | | |
| Care needs - bathing, retention - mobility status - esp for 1st 24 hrs | | | x | | |
| care needs - service authorization | | x | | | |
| From LTC - a solid social history - clients with dementia may transition easier. Behavioural issues | | | x | | |
| From community care - clear, concise presenting situations, proper and up to date medical orders, back up plans | | x | | | |
| Where is client currently? Hospital/home? | | | x | | |
| Current MDS has lots of info/screening tool | | | | | |
| only need info pertinent to admission/ facility does their own care planning | | | | | |
| Information re: past interests helpful | | | | | Behavioural Consultant |
| Social history is important but not deep details - can be gathered after admission with case conference | | | | | |
| Med. Reconciliation is repetitive but needs to be up to date | | | | | |
| Detailed history smoking - can they manage independently - risks? | | | | | |
| Look for flags in MDS - ? Behaviours - more detail in notes - some repetition in notes | | | | | |
| LTC often gets more detailed info after admission - social history - rec. services | | | | | |
| Diagnosis, family dynamics, service plan | | | | | |
| Accurate financial information (correct POA/SDM) | | | | | |
| Consistent health history, medications/behaviours/social history | | | | | |
| previous care plans - to transition | | | | | |
| Blood work results - laboratory results | | | | | |
| what pharmacy they deal with | | | | | |
| *Up to date - recent from Continuing Care/VON/Home Care/hospital | | | | | |
| Big issues with clients that are under Adult Protection - big gaps in info that is shared | | | | | |
| *Not recent enough assessments from Continuing Care | | | | | |

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| | | | | | |
|---|---|---|---|---|---|
| Medication List/Med rec | | x | x | | |
| personality characteristics - need as much info as possible | | | | | Behaviour Consultant |
| Diagnosis, family dynamics, service plan | | x | x | | |
| Abilities re: self care | | x | x | | |
| Needed equipment ie: wheelchair. Have wheelchair in place while in hospital waiting LTC | | | x | | |
| Specific nursing care plans esp. post-op | | x | | | |
| acute up-to-date information (MDS can be old & Med status report not useful) | | x | x | | |
| Social History | | | x | | |
| Accurate/On time assessment - complete package | x | x | x | x | |
| Updated information - if there is change in status | | | x | x | |
| Equipment/tools needed/support involved | | | x | x | |
| Transfer of information from ER to LTC | x | | x | x | |
| Presenting Situation - allergies/risk | x | x | x | x | |
| medications | x | x | x | x | |
| client capabilities/limitations | x | x | x | x | |
| dietary needs | x | x | x | x | |
| equipment needs | x | x | x | x | OT/PT |
| Family dynamics - support in home , who is SDM | x | x | x | x | |
| Behaviour challenges | x | x | x | x | Behaviour Consultant |
| Client/family expectations - back up plan in community | x | x | x | x | |
| Advanced directives, PDA | x | x | x | x | |
| Comprehensive Social History | | | | | |
| Updated/current information - medical & Behaviour - behaviour plans, compliance with plan, medical compliance refusal/acceptance of supports e.g. psych. What are the triggers of behaviour, history of causes of behaviour *Staff need to be prepared to support clients and staff | | | x | | |
| Updated info from acute care re: behaviours - info related to potential safety issues from others. Recommend summary sheet from family re; preferences, etc. | | | x | | |
| Current working behaviour strategies or suggestions | | | | | |
| If have attendant care in hospital would this transition help to settle client in LTC | | | | | |

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### Question 2: How can we use this information to reduce the amount of repetition for clients and families?

| Client/Family | Continuing Care | Home Care | Facility | Other |
|---|---|---|---|---|
| | info included @ point of transfer needs to be complete & up to date (current) | clear care plan, ?? Plan complete & accurate | comprehensive tool to capture accurate history | |
| Current information, same tool (form) | | | | |
| Checklist - what does family need, what does Continuing Care need, What does LTC/facility need | | | | |
| travelling chart and initial information travels with client | Use CC SP but need to confirm the information | | | |

### Question 3: How can we use this information in our practice to improve care planning for better outcomes for clients?

| Client/Family | Continuing Care | Home Care | Facility | Other |
|---|---|---|---|---|
| | | | collaboration between transferring facility to receiving facility | |
| Current, up to date, relevant and shared so proper care planning can take place | | | | |
| Combined effort | | | | |
| Reduced instance of Med errors | | | enhance continuity messaging to family & client | better prepared to meet client needs |