Care Home Resident

Transfer Information

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| **Resident Information** |
| Residents Name |  |
| Date of Birth |  |
| Care Home Moving From |  |
| Care Home Moving To |  |
| Planned Move Date |  |
|  |  |
|  |  |
| **Departing Care Home** |
| Transfer Information Provided by |  |
| Designation |  |
| Time of Resident Departure |  |
|  |  |
|  |  |
| **Receiving Care Home** |
| Transfer Information Received By |  |
| Designation |  |
| Time of Resident Arrival |  |

**Guidance operational from: October 2018**

**Version: 2:0 (Reviewed May 2023)**

**Review date: May 2024 Developed By**



**Contents:**

|  |  |  |
| --- | --- | --- |
| **Section** | **Title** | **Page No** |
|  | **Introduction** | **3** |
| **1** | **Consent** | **4** |
| **2** | **This Is Me** | **5** |
| **3** | **Support Summary** | **9** |
| **4** | **Inventory Checklist** | **15** |
| **5** | **Moving Day** | **16** |
|  |  |  |

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| **INTRODUCTION** |
| **The Care Home Resident Transfer Information**: The care home resident transfer information has been developed to support the safe and effective transfer of a resident when they are moving to a new care home. The move to a new care home may be planned to meet the residents care and support needs, or as a result of a care home closure. In all situations, the need to have good quality information to support the continued care of the resident is paramount. Once it is known that a resident is going to be moving to a new home the task of completing the transfer information should begin. Your support in completing the transfer information with accurate information will help to ensure the safe transfer of residents.The Care Home Resident Transfer Information should always go with the resident to their new home. This will provide staff in the receiving care home important information to enable them to support the resident and meet their care needs from the moment the resident arrives.**Who should complete the transfer information?**The information should be completed by people in the care home the resident is moving from who know the resident well. This will usually be senior carers and nursing staff, family members and regular visitors to the resident. Visiting workers, e.g., district nurses or social care support officers may also support with completion of the information.**Preparing for the Move (Departing Home):**Complete the Resident Information (1st box front page), Consent to Share (1), This Is Me (2) and Support Summary (3) in preparation for the residents move.If the departing care home already has a one-page profile or similar, this should be confirmed to be up to date and in line with the person's wishes. This can then be attached to the transfer information, and only the information not already captured need be completed in the This Is Me information. **Moving Day (Departing Home):**On the day the resident moves complete the Inventory Checklist (4) and the Moving Day (5) information. This information is essential to ensure that there are no gaps in the care of the resident during the transfer arrangements. Also fill in the handover details (2nd box front page). The fully completed transfer information should accompany the resident and passed onto the receiving care home. **Moving Day and Beyond (Receiving Home):**When the resident arrives complete the receiving information (3rd box front page). Use the Inventory Checklist (4) to ensure all expected items arrived with the resident. Raise any discrepancies with the departing home without delay. Review the Moving Day (5) information to ensure there are no gaps in the resident's care needs. Consult This is Me (2) and the Support Summary (3) whilst staff get to know the resident and build up their own support plan information. |

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| **1. CONSENT**  |
| I consent to personal information being shared with my transfer care home Yes/NoIf no, please indicate reasons for this decision   |
| Name of Person |  |
| Signature of person |  |
| \* Signature of lasting Power of Attorney  |  |
| Date |  |

***\*Please note if the person does not have capacity, the consent needs to be signed by the lasting power of attorney or a best interest decision documented below***

|  |
| --- |
| **Best interest decision in relation to sharing information on transfer to a new care home**State the decision made and the rationale for it: |
| Name of staff:  | Date: |
| **People consulted as part of decision-making process:** |
| Name:Relationship to person:Name:Relationship to person: |  |

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| **2. THIS IS ME**  |
| My Name is:Date admitted to the care home:Completed by:Relationship to me: | Photograph Here |
| **getting to know me** |  |
| I prefer to be called |  |
| The language I speak is  |  |
| My religion, beliefs, and customs I would like you to keep in mind when caring for me |  |
| My usual warm drink (milk/sugar?) |  |
| My usual cold drink |  |
| I prefer a beaker/cup/mug |  |
| Foods I like |  |
| Foods I dislike |  |
| I am allergic to |  |
| When I eat you need to know *(swallowing, cutting food, etc.)* |  |
| I am right-handed/left-handed | Right[ ] Left[ ]  |
| Equipment I need *(glasses, hearing aid, stick, dentures etc.)* |  |
| My daytime routine *(How I like to spend my time)* Morning: -Afternoon: -Evening: - |  |
| My bedtime routine *(night-time habits, pillows, rails)* |  |
| How I mobilise*(With or without equipment/supervision/distance)* |  |
| Skills I could quickly lose if not actively maintained *(washing self, standing, etc.)* – although I realise success can’t be guaranteed |  |
| Anything else you need to know that would help support me how I like to be supported: |  |
| **MY SAFETY** |  |
| Things that I may do that could be a risk to my safety |  |
| What you need to know now to help keep me safe |  |
| Other things which might help you to care for me(e.g., safeguarding) |  |
| **MY PERSONAL CARE**  |  |
| My toilet related needs*(Reminders, help, equipment, indications of need)* |  |
| When you are helping with my personal care, you need to know |  |
| I prefer male / female carer | Male[ ] Female[ ]  |
| **MY HEALTH & MEDICATION** |  |
| When I take medicines, you need to know |  |
| When I am becoming poorly I may*(E.g., become agitated/sleepy if I have a urine infection)* |  |
|  **MY COMMUNICATIO**N |  |
| Things that will help me communicate *(Hearing aids, picture cards, glasses,Communication passport etc.)* |  |
| If I say or do: -It might mean: -You can help by: - |  |
| Why I might seem unsettled*(My body language, communication)* |  |

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| **MY WELLBEING**  |  |
| What I like to do to relaxWhat helps me to relax |  |
| What makes me anxious, worries, concerns or things that upset me  |  |
| Ways of reassuring me*(Incl. use of special items, name of usual carer, etc.)* |  |
| I enjoy reading/music/radio | Yes[ ] No[ ]  |
| My hobbies (for topics of conversation) are |  |
| Hopes and wishes and what is important to me now |  |
| Regular appointments I would like to keep *(e.g., Hairdresser, nails etc).* |  |
| **MY PAST** |  |
| Things I would like you to know about me and my life so far |  |
| Parts of my life I like to reminisce about *(Jobs, interests, place I grew up, etc.)* |  |
| **people important to me** |  |
| The person who makes me feel safe isThis is my (spouse, friend, etc.) |  |
| These are the other people that are important to me who I would miss if I didn't see them anymore |  |
| Questions for family, carers and friends how would you like to be involved? |  |
| People I would like to be notified that I am moving to a new care home:Family, friends, Church, change of address for mail etc. |  |
| **MY ROOM** |  |
| The things that are important to me in my room (E.g., Where my bed is placed, photographs I like to have near to me etc.) |  |
| I would like my new room, as much as possible, to be set out similar to how my room is now | Yes[ ] NoPreference [ ]  |
| *.(If yes, include a photograph to show the layout)* | Photograph Here |

| **3. SUPPORT SUMMARY** |
| --- |
| Persons Name: | Date Of Birth: | Age: |
| Gender: | NHS No: |
| Religion: |
| **Next of Kin Information:** |
| Name: | Name: |
| Relationship: | Relationship: |
| Contact Details: | Contact Details: |
| **Is there legal Power of Attorney for:** |
| Health & Welfare | [ ]  Yes | [ ]  No | Property and Finance | [ ]  Yes | [ ]  No |
| Name and Contact details: | Name and Contact details: |
|  |  |
| Details of GP (in case of clarification required regarding medical history) |
| Is there a Deprivation of Liberty Safeguard (DOLS) in place? [ ]  Yes [ ]  NoIf yes, what is it for? |
| Admission to hospital in the last 30 days? [ ]  Yes [ ]  NoIf yes, provide details: |
| Number of attendances into hospital in last 12 months *(add dates of any new admissions to update)* |
| Were there any recurrent episodes of illness identified from the reasons for hospital admission or recent GP visits? |
| Relevant Medical History including any known allergies: |
| Any recent illness or treatment? |
| **Medications** |
| Is the person on more than 4 medicines? | [ ]  Yes [ ]  No |
| Is the person given covert medication? | [ ]  Yes [ ]  No |
| Can the person swallow their medications? | [ ]  Yes [ ]  No |
| Is the person on oxygen?If yes, at what level of oxygen therapy? | [ ]  Yes [ ]  No |
| Please list medication and last review date*(Include medicines bought over the counter and herbal/homeopathic preparations):* |
| **Infection prevention and Control** |
| Has the person had a recent infection (past 4 weeks) or are displaying symptomsIf yes, please provide the details: | [ ]  Yes [ ]  No |
| Has the person got a current infection or are displaying symptoms?If yes, please provide the details:  | [ ]  Yes [ ]  No |
| Are they receiving treatment for the current infectionIf yes, please provide the details: | [ ]  Yes [ ]  No |
| Does this person have diarrhoea or vomiting\* as part of their usual presentation?If yes, please provide the details:*\*If diarrhoea or vomiting is not part of their usual presentation the Person should be 48 hours asymptomatic prior to transfer, if this is not possible advice should be sought from the infection prevention service\*)* | [ ]  Yes [ ]  No |
| Has the home had an infection outbreak in the past 6 weeks?If yes, please provide the details: | [ ]  Yes [ ]  No |
| Has the IPC team been informed of this outbreak and provided adviceIf yes, please provide the details: | [ ]  Yes [ ]  No |
| Are you aware of any colonisation?If yes, please provide the details: | [ ]  Yes [ ]  No |
| Has the person had any recent vaccinations?If yes, please provide the details: | [ ]  Yes [ ]  No |
| Is the person due any vaccinations?If yes, please provide the details: | [ ]  Yes [ ]  No |
| For any IPC advice please contact: infectionprevention@lancashire.gov.uk |
| **Communication** |
| Does the person have any communication difficulties? Sight:Hearing:Speech:Language:  | [ ]  Yes [ ]  No[ ]  Yes [ ]  No[ ]  Yes [ ]  No[ ]  Yes [ ]  No |
| If yes, please explain: - |  |
| **Cognition** |
| Does the person have a diagnosis of dementia? | [ ]  Yes [ ]  No |
| Is the person normally confused? | [ ]  Yes [ ]  No |
| **Falls** |
| Is the person at risk of falls? | [ ]  Yes [ ]  No |
| Number of falls in the last year and details: |
| **Skin Integrity** |
| Is skin intact? | [ ]  Yes [ ]  No |
| Pressure Sores (If yes include on body map) | [ ]  Yes [ ]  No |
| Have existing pressure sores been reported? | [ ]  Yes [ ]  No |
| Wounds (If yes include on body map) | [ ]  Yes [ ]  No |
| Waterlow score: |
| Details of any dressings (If yes include on body map): |
| **Nutrition** |
| Current weight:Any unintentional weight loss in the last 3 months?If yes, please provide the details: | [ ]  Yes [ ]  No |
| Any swallowing problems?*Details e.g., thickened fluids or pureed diet* | [ ]  Yes [ ]  No |
| Is this person under the care of S&LT or dietician? | [ ]  Yes [ ]  No |
| MUST Score: |
| Can they feed themselves?*Details: are they slow to eat, on supplements etc?* | [ ]  Yes [ ]  No |
| **Function** |
| Mobility including stairs: |
| Transfers: |
| Use of any equipment or aids: |
| **Continence** |
| Does the person have any continence issues?If yes, please provide the details: | [ ]  Yes [ ]  No |
| Do they use continence aids?If yes, please provide the details (e.g. where are they ordered from?) | [ ]  Yes [ ]  No |
| As per Bristol Stool Chart (if in use), what number are 'normal stools for the person? |
| If long term urinary catheter – please state reasonDate the catheter was last changed: |
| **End of Life Care** |
| Is the person known to the Palliative Care Team?McMillan Nurse's Name: | [ ]  Yes [ ]  No |
| Is there an Advance Care Plan? | [ ]  Yes [ ]  No |
| Is there a DNACPR form? | [ ]  Yes [ ]  No |
| **Other MDT Involvement** |
| Are there any Safeguarding Concerns?Comments/Actions: | [ ]  Yes [ ]  No |
| Are there any open safeguarding alerts?If yes, please provide the details: | [ ]  Yes [ ]  No |
| Are there any safeguarding protection plans in place?If yes, please provide the details: | [ ]  Yes [ ]  No |
| Has there been previous involvement from the Advocacy Service?If yes, please provide the details: | [ ]  Yes [ ]  No |
| **Community services already involved.** (Please tick as appropriate) |
| [ ] Dietician | [ ]  Physiotherapy | [ ]  Tissue Viability Nurse | [ ]  Speech & Language Therapy |
| [ ] Hospice at Home | [ ]  Respiratory Team | [ ]  Social Worker | [ ]  Continuing care for CHC consideration |
| [ ] Mental Health Service | [ ]  Heart Failure | [ ]  Occupational Therapy | [ ]  Integrated Neighbourhood Team |
| [ ]  District Nursing Team | [ ]  Continence Service | [ ]  Pain Team | [ ]  Intensive Home Support Service (IHSS) |
| Completed By:Signature:Designation:Date: |

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| 1. **INVENTORY CHECKLIST**

Tick – items being transferred or N/A - items listed not applicable |
| Departing Care Home items sent. | http://t3.gstatic.com/images?q=tbn:ANd9GcRwHOr0TzqcFgunbjiWW-Eb6sBJIwn0eJaW5kpB1VIYP_CdWzMSdA | Receiving Care Home items received. | http://t3.gstatic.com/images?q=tbn:ANd9GcRwHOr0TzqcFgunbjiWW-Eb6sBJIwn0eJaW5kpB1VIYP_CdWzMSdA |
| **DOCUMENTATION: -** | **DOCUMENTATION: -** |
| Recent social care assessments or reviews |[ ]  Recent social care assessments or reviews |[ ]
| Risk assessments (To self or others) |[ ]  Risk assessments (To self or others) |[ ]
| Copy of care plan records |[ ]  Copy of care plan records |[ ]
| Current MAR sheet |[ ]  Current MAR sheet |[ ]
| Body Map |[ ]  Body Map |[ ]
| DNA CPR Form |[ ]  DNA CPR Form |[ ]
| Advance Care Plan |[ ]  Advance Care Plan |[ ]
| Other documentation: |[ ]  Other documentation: |[ ]
|  |[ ]   |[ ]
|  |[ ]   |[ ]
| **CLOTHING & TOILETRIES: -** | **CLOTHING & TOILETRIES: -** |
| Belongings (labelled/suitably packed) |[ ]  Belongings  |[ ]
| Continence products |[ ]  Continence products |[ ]
| Other personal items: |[ ]  Other personal items: |[ ]
|  |[ ]   |[ ]
|  |[ ]   |[ ]
| **EQUIPMENT: -** | **EQUIPMENT: -** |
| Dentures |[ ]  Dentures |[ ]
| Glasses |[ ]  Glasses |[ ]
| Hearing aids |[ ]  Hearing aids |[ ]
| Walking aids |[ ]  Walking aids |[ ]
| Other equipment: |[ ]  Other equipment: |[ ]
|  |[ ]   |[ ]
|  |[ ]   |[ ]
| **VALUABLES: -** | **VALUABLES: -** |
| Money |[ ]  Money |[ ]
| Jewellery |[ ]  Jewellery |[ ]
| Watches |[ ]  Watches |[ ]
| Other valuables: |[ ]  Other valuables: |[ ]
|  |[ ]   |[ ]
|  |[ ]   |[ ]
| **MEDICATION: -** | **MEDICATION: -** |
| In date medication |[ ]  In date medication |[ ]
| As prescribed |[ ]  As prescribed |[ ]
| Sufficient for 7 days (minimum) |[ ]  Sufficient for 7 days (minimum) |[ ]
|  |[ ]   |[ ]
| Completed by:Signature:Designation:Date: | Completed by:Signature:Designation:Date: |

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| **5. MOVING DAY**  |
| **Belongings** | **Comments** |
| Final check that all my belongings have been packed. Include check in the laundry for clothesAny monies/belongings held securely for me.  |  |
| **Hydration** |  |
| The time of my last drinkDetails of the drink |  |
| **Nutrition** |  |
| The time of my last mealDetails of the food |  |
| **Continence** |  |
| My continence needs addressed in preparation for the journey. |  |
| **Clothing and Footwear** |  |
| I am wearing suitable clothing and footwear for the journey.  |  |
| **Medication** |  |
| Details of last medication that I have taken. |  |
| **Goodbyes** |  |
| I have had the opportunity to say goodbye to the people I have lived with and/or all the people who have supported me in the home. |  |
| Completed By:Signature:Designation:Date: Time Completed: |  |