

i. **Title:** Key stakeholders' perspectives on the development of a national transfer document, for older persons, when transferring between the residential and acute care settings: A qualitative descriptive study.

ii. **Running Title:** A national transfer document: Key perspectives

iii. **Full Names of Authors**

Pauline O'Reilly¹, Brid O'Brien¹, Margaret M.Graham¹, Jill Murphy¹, Louise Barry¹, Owen Doody¹, Anne Fahy¹, Carmel Hoey^{5,6}, Michelle Kiely², Deirdre Lang³, Pauline Meskell¹, Jane O'Doherty¹, Jonathon O'Keefe⁴, Dymphna Tuohy¹, Alice Coffey¹

Corresponding Author: Dr Pauline O'Reilly, Senior Lecturer, Department of Nursing & Midwifery, HRI, University of Limerick, Limerick, Ireland.

Telephone: +353 61- 234210.

E-mail: pauline.oreilly@ul.ie

iv. **Acknowledgements**

The research group would like to acknowledge all stakeholders who have given their time and shared their experiences and stories during this study.

Conflict of interest

The authors declare that they have no conflict of interest.

Disclosure

The final article version has been agreed by all authors. Furthermore, the criteria as per the International Committee of Medical Journal Editors (ICMJE) have been upheld by all authors.

Funding

This paper is part of a large national project on the development of a national transfer document for older people. The project is funded by the Health Service Executive (HSE) Ireland.

¹ Department of Nursing & Midwifery, University of Limerick, Limerick

² St. Patrick's Hospital, Waterford

³ HSE Clinical Strategy and Programmes Division and the Royal College of Physicians of Ireland

⁴ St. Vincent's University Hospital, Dublin

⁵ Nursing and Midwifery Planning and Development Unit, HSE West/Mid-West, Galway

⁶ School of Nursing & Midwifery, National University of Ireland, Galway

- i. Title: Key stakeholders' perspectives on the development of a national transfer document, for older persons, when transferring between the residential and acute care settings: A qualitative descriptive study.

A national transfer document: Key perspectives

Abstract

Aims and objectives: This study has aimed to examine key stakeholders' perspectives, views and experiences regarding transfer documents, used when an older person is being transferred from a residential to an acute care setting. The objective of the study is to inform, in part, the development of an effective national transfer document.

Background: For the effective and safe transfer of older persons from residential to acute care settings it is important to ensure that the transfer document encapsulates relevant, current and person-centred information to ensure a smooth, quality and safe transition. Evidence highlights that, where documentation has lacked vital and relevant information, the older persons experience negative impacts during the transfer process.

Design: A qualitative descriptive study was conducted, following the COREQ checklist, to establish participants' perspectives, views and experiences of using transfer documents.

Methods: Focus group interviews (n=8) were conducted with a convenience sample of key stakeholders (n=68) in an Irish setting. The data were analysed using content analysis.

Results: The findings have highlighted the important aspects for consideration in the development of future transfer documentation. The three broad categories, used to present the data findings are 1) existing transfer documentation, 2) design framework, and 3) essentials of care.

Conclusions: The transfer document of the future is required to be concise, regularly reviewed, and with a user friendly colour coded design. Essential and current information, with an emphasis on

person centeredness, must be in the first page, with more detailed supporting information in the subsequent sections.

Key Words: Older person, transfer document, person-centred care, evidence-based, essential care, residential care, emergency department

ii. SUMMARY STATEMENT OF IMPLICATIONS FOR PRACTICE

What does this research add to existing knowledge about gerontology?

- This study provides cross multidisciplinary insight into the information and documentation necessary for collaborative multidisciplinary transfer of older people between care settings.
- Our findings reiterate the importance of person specific information in transfer information relating to current health status, biographical, functional and psychological needs.

What are the implications for this new knowledge for nursing care with older people?

- It is essential to use standardised, consistent and user friendly transfer documentation to ensure an effective and safe transfer of older people from residential to acute care.
- Transfer documentation should be designed so that there is immediate visibility and a standard format of communication of critical information to enable the prioritisation of care in the acute care setting.
- Transfer documentation should provide essential information for care that is person specific.

How could the findings be used to influence policy or practice or research or education?

- This study emphasised the importance and need for the standardisation of transfer documentation between care settings for older persons.
- The results of this study are currently used to inform the development of a standard person centred national transfer document for use when older people are transferred from residential to acute care.

Introduction

Worldwide, there is a projected increase of more than double the number of adults aged 60 years by 2050 and triple by 2100, with Europe having the highest number of persons over 60 years of age (United Nations, 2017). In line with an ageing population, there is evidence of an increase in the rate of chronic diseases. Globally, 71% of all deaths are accounted for by cancer, diabetes, lung and heart disease (WHO, 2018). In Ireland, predicted statistics indicate that, by 2050, adults over the age of 65 years will make up 26% of the population (OECD, 2017). The most recent Irish census has highlighted that the proportion of the population over 65 years has increased by 19.1% since 2011 (CSO, 2017). Furthermore, the number of older persons who reside in residential settings has increased by 9.4% (CSO, 2017). Compared to the EU average, the life expectancy of adults over 65 years is higher in Ireland, for both males and females, 83.3 and 79.9 years respectively (Department of Health, 2016). Consequently, with people living longer and an increasing incidence of chronic disease, admissions to acute care services will inevitably escalate (HSE, 2018). Emergency Departments face many challenges in managing the safe admissions of older persons who have complex needs and multiple co-morbidities (Baumbusch, Dahlke & Phinney, 2012). The effective management and care of older persons remain high on the agenda for government health policy, service planning, and management.

With the increased number of older persons residing in residential settings, the transfer of patient information between residential and the acute care settings requires rigorous consideration to aid safe and effective patient transfer. For too long communication problems and deficits have arisen due, in part, to incomplete transfer documentation along with a lack of document standardisation (Dalawari, Duggan, Vangimalla, Paniagua & Armbrecht, 2011; Griffiths, Morphet, Innes, Crawford & Williams, 2014). In addition, person-centred information related to the individual, such as their normal sleeping

patterns, their preferred name, is vital to ensure a personalised, safe and effective transfer process. Griffiths, Morphet, Innes, Crawford, and Williams (2014) purported that there is evidence of a lack of consensus as to what constituted essential information to support a quality, safe, person-centred care. Whilst person-centred care is a broad concept, McCormack & McCance (2016) have defined it as; "... 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. It is enabled by cultures of empowerment that foster continuous approaches to practice development" (p. 3).

Engagement with all stakeholders is critical in developing communication networks that not only provide reliable and valid information during transfer (Matic, Davidson & Salamonson, 2011), but also provide relevant information about what matters to the person to demonstrate a person-centred approach to care. In light of an absence of a standardised transfer document for older persons in Ireland, the Health Service Executive (HSE) has commissioned a funded project to develop such a document. This study forms part of the overall project.

The national study report, which is referred to here, has examined the perspectives, views and experiences of key stakeholders, in the use of transfer documents, when an older person is being transferred between care settings. The objective of the study is to outline, describe and utilise participants' knowledge and experience to inform, in part, the development of an effective national transfer document. This study is part of a larger Health Service Executive (HSE) funded national project. In particular, it is commissioned by the Office of Nursing & Midwifery Services Director on behalf of the National Clinical Programme for Older People (NCPOP). The focus of the

commissioned study is to improve communications between health care providers and outcomes for older persons, on transferring to the acute hospital from the residential setting.

The study sample is a national representation of key stakeholders involved in the care of the older person. The participants were mindful of the need to standardise current transfer documentation and valued and welcomed the opportunity, that the research study provided, to impart their views, perspectives and experiences on the area.

Methods

Design

The aim of this national study is to examine key stakeholders' perspectives, views, and experiences of using transfer documents for the older person being transferred between the residential and acute care setting. The qualitative descriptive study, has involved focus group interviews, using a convenience sample (Creswell & Plano Clark, 2017; Sandelowski, 2015). The Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist has been applied to the study (Tong, Sainsbury & Craig, 2007). In line with the research aim, this design is considered to be most suitable in obtaining straight meaningful answers to questions that relate to practice and policy (Sandelowski, 2015). In conjunction with the National Clinical Lead for Older People, a team from the Department of Nursing and Midwifery, University of Limerick has led the process. Prior to commencement of the study, institutional ethical approval was obtained from the Research Ethics Committee of the Faculty of Education and Health Sciences, University of Limerick (UL), (2018_03_04_EHS).

Data collection

The focus group interviews aimed to capture the views and experiences of key stakeholders, involved in older person care and services, which would in turn, assist in the development of an effective

national transfer document, suitable for multidisciplinary use. The purpose of focus group interviews is to “encourage a range of responses to provide a greater understanding of the attitudes, behaviour, opinions or perceptions on the research issues” (Hennick, 2007, p.6). Interviewing styles, according to Stewart and Shamdasani (2014), vary from directive to non-directive with most focus group interviews falling between these two extremes. For the focus group interviews to be successful in generating productive group discussion, it is important to create an atmosphere where participants feel comfortable to share their opinions and experiences. This has been a once off opportunity to get as many stakeholders together in one place at the same time. The planning and organisation of the focus groups was conducted in conjunction with the National Clinical Lead for Older People. An older person participates in the project steering group and has had input into all aspects of the design and development of the research project, particularly in relation to person centeredness. Potential research participants were emailed, through the National Clinical Programme for Older People (NCPOP) email distribution list, with details of the study and were invited to express their interest in partaking in the project. The participants were a clearly defined target audience, of those working with older people, as recommended for focus group methodology (Krueger, 2014). All members of the multi-disciplinary team were invited to participate. In addition, the NCPOP, on behalf of the research team, invited older person advocacy groups to nominate older persons and their representatives to participate in the focus groups. Information about the study was provided and participation was voluntary. Unfortunately they were unable to attend on the day.

68 individuals agreed to attend the focus group interviews. The convenience sample (Creswell & Plano Clark, 2017), came from a wide geographical spread, and included nurses working with older persons in the acute and residential care settings, representatives from allied health professionals and representatives of the public e.g. members of an older persons’ advocacy group. The interviews were convened at a central national location, in May 2018. Each participant completed a consent form and

biographical questionnaire. Of the 68 participants only eight were male. There was a relatively even representation of participants from both the acute and residential setting. The majority were from the nursing profession with eight allied health professionals, including physiotherapists, pharmacists, and an occupational therapist. There were two participants who represented older persons' advocacy groups (Table 1). The participant sample was divided into eight focus groups representing a mix of disciplines and care settings, where possible. To observe the principle of confidentiality, codes were assigned to each participant and each focus group was accorded a number.

Table 1: Focus group participants

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 processes. The focus groups were guided by a semi structured interview schedule as outlined in Appendix A. Furthermore, 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. It was a central tenet, within the study, that the questions needed to maximize an in-depth exploration of how to make the transfer document person-centred and individual to the specific requirements of the older person. Consequently, an expert in person-centred care acted as an advisor to the study. They were involved in the design of the project. Whilst they were not directly involved in the focus groups, they did review the interview schedule. With the permission of participants, the interviews were audio-recorded, using digital recorders, and later transcribed. The interviews lasted, approximately, one hour.

Data analysis

Data were analysed inductively using content analysis until data saturation was reached. A three step framework was used to assist in identifying themes, in the participants' responses (Bengtsson, 2016; Krippendorff, 2004; Silverman, 2016). The first stage of the content analysis process '*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, data sets were examined and read, while repeatedly listening to the interview. Meaning units were derived from the combination of words or statements that related to the same central meaning. Independently, four researchers have 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, and codes with similar content were sorted into sub categories and broad categories. Nine sub categories and three broad categories emerged. (Table 2).

Table 2: Content Analysis Framework

Findings

The focus group interviews yielded a rich description of participants' knowledge and experiences of using transfer documents. The benefits of standardisation and consistency across health care settings were identified and aspects for improvement in guiding the development of future documentation were highlighted. Whilst the study focused on transfer documents between services, the participants

in their responses, tended to lean towards commenting on documentation used when transferring from the residential to the acute care setting.

Broad categories, used to present the data findings; were, (1) existing transfer documentation, (2) design framework and, (3) essential elements of care.

Category 1: Existing transfer documentation

The first category outlines participants' experiences of what worked and did not work in transfer documentation which was in current use. The findings highlighted a lack of standardisation, a diversity in documentation design and called for consistency as represented in the following.

‘This is a great opportunity to have consistency and a standardised approach’ (FG7)

‘Whatever transfer document it is, it has to be clear and concise’ (FG4)

Different approaches and systems in collating patient information when transferring patients were described. Participants welcomed the opportunities to address such anomalies. Participants within the focus groups expressed a consensus of opinion that disparities existed in both the content and structure of existing transfer documentation.

‘From residential to acute, there are different systems. Some people have electronic, others have a hard copy and that can impact on the quality of information that is being produced’ (FG5).

Problems within existing transfer documents were noted for example,

‘Information that we are putting in the transfer documents is not always used by the hospital. We find that we will get a call back to ask the same questions that were already given on the information...’ (FG2)

The majority of participants articulated the importance of reviewing and developing a national patient transfer document.

‘We need a document that is user-friendly and universal to all’ (FG1)

‘What might be valuable is a two-part document. The first section is the emergency information that is needed in the Accident & Emergency department with second section covering more detailed information’. (FG4)

The importance of using uniform evidence-based assessment tools was also discussed. A number of assessment tools were mentioned as worth retaining, provided that they were evidence based. Assessment tools referred to are outlined in Table 3. It was important to participants that the transfer document prioritised safety needs of patients who are being transferred to the acute care setting.

‘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)

‘Evidence-based assessment tools should be used’ (FG3)

Activity of daily living assessments were identified as fundamental for inclusion in the transfer documentation. These were not always included in some existing transfer documents.

‘I know, definitely, some of the phone calls we get back are questions related to the activities of daily living. So important things that need to be included are, for example, how the individual eats and drinks, their preferences, how they sleep, and what assistance they need.’ (FG5)

‘It needs to be consistent with layout and information and should give a picture, of the person, rather than just the facts. We need to remember that they stay in hospital but they live with us in the nursing home’ (FG2)

Significantly, participants preferred and welcomed an electronic format.

‘I am not going to have paper. My nurses are not going to go back to writing. We are going electronic’. (FG4)

‘The good thing about it is that it is paperless and it is a very comprehensive document’. (FG6)

Having an electronic transfer document would help allay any potential difficulties encountered with variations in handwriting. Care settings which did not have electronic records saw this as a barrier.

‘I would hope that it would be electronic-based. Then you could just print it off and the whole issue around handwriting is sorted’ (FG8)

Almost all focus group participants highlighted the importance of including a signed Advanced Care Directive and Do Not Resuscitation (DNR) details.

‘I suppose going forward, it is very important to include an Individual’s Advanced Care Directives including DNR’. (FG5)

Having a named representative and contact person, for the older person, was deemed imperative, as oftentimes difficulties arose over who to contact during times of need.

‘... next of kin may not always be the person that they would want as their representative. So, I think maybe we need to look at the wording of that; for instance, who is their day to day family representative for their basic needs and document them as patient representation as opposed to next of kin. For example, a son or a daughter does not make them an automatic choice’. (FG6)

‘... what is the next of kin responsible for? Sometimes you will find that there is a son who is looking after the money, a daughter looking after the medicines and another looking after other matters which can cause endless confusion’ (FG8)

The point was made that a clear distinction is necessary between the next of kin and the named contact person as next of kin may not be available whilst the named contact person could be the older person’s designated representative regarding practical matters.

Table 3: Assessment tools identified

Category 2: Design framework

The focus group results identified several key aspects to inform the design of a national transfer document. There was good general agreement regarding the necessity for consistency of content and design. Reference was made to adopting a user friendly, colour coded document indicating areas of priority. Participants commented on the importance of layout and the format of the document. It was stressed that the first page should include priorities to be structured in 'tick box' and use traffic light format to indicate priority areas, the more detailed information and assessments should follow in the subsequent sections.

The focus groups results have reflected on the importance of adopting a person-centred care approach to all aspects of the transfer document. However, it was clear that the front page of the transfer document should show essential information to enable health care practitioners, in the acute setting, to provide essential treatment and safe care, without looking through an entire document, with areas requiring high alert coloured in red to aid prompt noting.

'I would use a short document with the inclusion of tick boxes as they are easy for everybody to fill'. (FG2)

The 'tick box' system could be used to indicate the presence, or not, of devices and prostheses for example, hearing aid, dentures, glasses.

It is important that the new document still has essential information including, name, the name the person likes to be called, religion, next of kin, decision maker...'(FG5)

'The most important aim is to keep people safe'. (FG3)

The importance of the contributions of the Multi-Disciplinary Team was identified as essential in collating patient information.

‘...input from all members of the Multi-Disciplinary Team, especially physiotherapy.... with regard to mobility, the dietician in relation to special requirements for diet, and the speech and language therapist for assessing swallow...’. (FG5)

It was thought that assessments, with narrative details, could follow in the subsequent pages. The inclusion of the values of the individual was described as critical information.

‘Another nurse sees ‘My Day, My Way’. She picks up that transfer letter and knows exactly what the person likes’. (FG3)

‘My Day, My Way’ refers to a method used to document personalised information, in practice, to ensure a person-centred approach to care. Participants welcomed the emphasis on person-centred care approaches underpinning a new national transfer document. It was felt that this would allow for a holistic approach and provide a more coherent and concerted approach focused on the care needs of the individual (Table 4). Nevertheless, challenges were noted regarding compliance with the new General Data Protection Regulations (GDPR). The next phase of the multi-stage research project will consider any potential issues related to implementation.

Table 4: Proposed Design and Format

Category 3: Essential elements of care

The data analysis revealed essential elements of care, identified by participants, for inclusion in transfer documentation. These were; Personal Biography; Current Health Status; Functional Assessment; and Psychological Assessment. Further details in relation to the suggested essential elements of care are outlined in Table 5.

Personal Biography

Biographical information, to be included, are the resident's preferred name accompanied with a photo identification. Consent to transfer to the acute setting, with a signed Advanced Care Directive, was considered essential. In addition, details such as 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; family doctor details, and medical card/ insurance number with expiry date, were all considered necessary for inclusion.

Person-centred practices and values were mentioned during all focus group discussions, especially amongst participants from the residential care settings.

'The transfer document needs a holistic approach, incorporating everything from personal details to sleep patterns to behaviours'. (FG3)

A description which would create a picture of the person should include, for example, personal preference information; likes and dislikes of food and drinks, preferred means of communication, normal sleeping pattern, hobbies, clothing preferences, smoker/non-smoker and alcohol consumption.

'It would then tell a story about the patient's life and include critical information'. (FG4)

- *Health Status*

The importance of providing vital information regarding the resident's current health status, including diagnoses and reason for transfer was stressed. Baseline data, such as weight, height, allergies, skin integrity, medication review and reconciliation were viewed as essential information for continuity of care. Infection control information and safety trigger alerts, recent laboratory test results and outpatient or other appointments are also necessary for inclusion.

‘Their past medical history, their medical surgical history and what their current and present health status and complaint should be included. In addition, any allergies and prescribed medications including medication which was given on that day should be included’ (FG1)

The importance of effective communication, to all relevant stakeholders, regarding medication changes made during the transfer process, was noted, especially amongst participants from the acute care setting. Furthermore, the provision of information, regarding details of the last administered medication dose, was viewed as vital for inclusion.

‘Well, one of the biggest concerns is medication. Medication reconciliation is probably not actually happening to the extent that it really should be’. (FG4)

- *Functional Assessment*

Participants suggested that a summative score of standardised evidence-based functional assessments, assessing a range of areas such as falls risk, balance, frailty, mobility, speech and language assessment, swallow and a nutritional assessment including weight and height, were important data to be included. The majority of focus group participants stressed the importance of uniformity of assessments across all care settings and identified a variety of assessment tools, outlined in Table 3.

- *Psychological Assessment*

Participants also highlighted the importance of including the older person’s cognitive status, mood and emotional wellbeing;

‘Specific triggers like that for agitation...that will soothe or maybe prevent harm’ (FG5)

Participants emphasised the importance of using evidence-based assessments.

‘All assessments tools need to be evaluated’. (FG1).

Table 5: Proposed Essential elements of care of Transfer Document

Discussion

Globally, clinicians within health care facilities are caring for a population with an increasing age profile, along with changing health care needs which reflect the increased incidence of chronic disease (United Nations, 2017; WHO, 2018). Health care policy has also evolved with increased emphasis on improving patient outcomes which must be managed with an ever reducing budget. The transfer of older persons across different health care settings is identified as a time of particular vulnerability, therefore, there is a need to monitor and evaluate the transfer process to ensure that it is safe, effective and person-centred. During and after the transfer process, it is imperative that the older persons receive quality and optimum care. The information, relayed between health care settings, frequently exposes many gaps. Evidence from research literature highlights that transfer documents quite often fail to include vital information regarding the older person, for example, reason for transfer and mental status, leading to the probability of unmet patient needs (Boockvar, Fridman & Marturano, 2005; Campbell, Stirling, & Cummings, 2017; Morphet et al., 2014). In addition, lack of standardisation of transfer documents is a matter which requires further investigation (Cwinn et al., 2009; Nelson, Washton & Jeanmonod, 2013; Pauls, Singer & Dubinsky, 2001).

The data from this study provides essential information, from key stakeholder perspectives, that will inform the development of an effective national transfer document. Whilst most participants had experience of using transfer documentation or knowledge of same, the disparity in both the content and layout was noted as a major disadvantage to ensuring safe effective patient care. Overall, the findings from the study indicated a clear commitment and interest in the improvement and standardisation of a transfer document. Negative impacts have been experienced by patients when transfer documentation is poorly written and fails to contain essential information (Morphet et al., 2014). A standard document that is clear, concise, user friendly with a person-centred ethos was

recommended by our focus group participants. Standardised documentation can assist in reducing relevant information omissions (Cwinn et al., 2009; Dalawari et al., 2011) and helps to improve the transfer of essential information (Nelson, Washton & Jeanmonod, 2013; Pauls, Singer & Dubinsky, 2001). In the study reported here, the need for including essential information at the front of the document was stressed as essential to assisting in delivering critical care and for an effective transfer. Furthermore, participants suggested that current Advanced Care Directives (ACD) and Do Not Resuscitate (DNR) orders needed to be documented in the transfer. These sensitive areas need to be discussed, with residents, in advance and not during an emergency transfer. The literature has similarly highlighted that having timely discussions with residents, and their relatives, and, education for clinicians, in relation these areas, are important for a seamless and safe transfer (Lahn, Friedman, Bijur, Haughey & Gallagher, 2001). In relation to the design format, participants spoke about the importance of having the document available in electronic format. This can reduce information ambiguities and potential medication errors. However, this may have financial implications in terms of putting EHealth systems in place in all health care settings and in the staff training of the system. However, in the long term it may be cost effective in reducing problems occurring (Devriendt et al., 2013; Murray & Laditka, 2010). At the time of the study, new General Data Protection Regulations (GDPR) (European Commission, 2018), were being enacted nationally, and this posed some concerns for participants in relation to ownership of the document and security of data.

Participants referred to the importance of having essential information, which was person specific, included in the document. From a safety and effective perspective, a great deal of time was spent on discussing what would constitute essential information. Similar to previous research, evidence highlights a lack of consensus as to what constitutes essential information (Griffiths et al., 2014) and more research is needed to determine the optimum amount of information required (Morphet et al.,

2014). Our findings emphasised the importance of including information related to personal biography; current health status; functional assessments; and psychological assessments. Interestingly previous research found that that many transfer documents failed to include such vital information as; current mental status, reason for transfer, vital signs, medication reconciliation, ADCs and DNR orders (Boockvar et al., 2005; Cwinn et al., 2009; Dalawari et al., 2011; Klingner & Moscovice, 2012; Murray & Laditka, 2010). The vast majority of participants recommended the need for all relevant members of the multi-disciplinary team to be involved in the documentation process. In relation to person-centred care information, the focus group participants discussed the lack of person-centred information in current transfer documentation and stressed significance of creating a story of the person. This related to information which was important to the individuals such as their preferred name, normal daily routine and likes and dislikes regarding food and drinks. Similarly, Boltz, Parke, Shuluk, Capezuti and Galvin (2013) found that the majority of standardised documents were designed more to reflect the needs of the services rather than those of the older persons'. It is clear from our findings that there is a need for transfer documents that reflects essential, person-centred information in a clear, concise design, preferably in an electronic format.

Limitations and strengths

The study was not without its limitations, one of which was the absence of older persons residing in residential care settings, within the focus groups. However, two participants who represented older persons' advocacy groups participated in the groups and it is proposed to include residents' views during piloting of the prospective transfer document. Whilst every effort has been made to be as inclusive as possible, in terms of participants, having the focus group interviews at one venue and on the one day may have impacted on the attendance. Despite this, a strength of the study was the collaboration between clinical and academic staff. Thereby the project provided an ideal opportunity

to capture key stakeholders' views and have real input into the development of new transfer documentation.

Conclusion

Worldwide our population growth is experiencing a particular increase in the number of persons in the age profile of 60 years and over. As people are living longer, healthcare facilities in both the acute and residential settings are consequently witnessing increasing admissions of older persons. Transferring older persons between the residential setting and the acute care setting, in particular Emergency Departments, requires careful consideration in terms of information sharing to ensure that the best possible outcome can be achieved for the individual. Much of the research to date has clearly indicated that patient information imparted during the transfer process is not always what it should be. Lack of document standardization and omission of vital information, including, reasons for transfer and current diagnoses, have impacted negatively on patient care. Omissions of current Advanced Care Directives and Do Not Resuscitate orders for individuals can cause unnecessary distress for both patients and their families.

The findings from this study reflects the knowledge, experiences and perceptions of key stakeholders, in older person care, on what a prospective transfer document, within the Irish context, should look like in terms of design and content. Welcoming the opportunity to participate in the focus groups, participants expressed a need to develop a national transfer document, one which is standardized, concise, regularly reviewed, person-centred, and user friendly. Findings endorse the criticality of patient views throughout the transfer process. Patients need to be cared for in an environment that recognises, respects and acts on the individual nature of their being. It is not sufficient to have a transfer document that is optimum in content and design without the ethos of person-centred care as central within it. Therapeutic relationships encompassing empathy, compassion and excellent

communication skills are necessary for patients to be treated in a respectful, caring way. Care provision, including clinical practice education, must continue to focus on ensuring that the patient is listened to and valued throughout the care pathway. It was evident from this study that there is a need for a transfer document that ensures the older person is central in their care. However, it is equally important that the context of care respects and values not just the essential information regarding the older person but also the person behind the document.

iv. References

- Baumbusch, J., Dahlke, S., & Phinney, A. (2012). Nursing students' knowledge and beliefs about care of older adults in a shifting context of nursing education. *Journal of Advanced Nursing*, 68(11), 2550-2558. doi: 10.1111/j.1365-2648.2012.05958.x.
- Belfrage, M. K., Chiminello, C., Cooper, D., & Douglas, S. (2009). Pushing the envelope: clinical handover from the aged-care home to the emergency department. *The Medical Journal of Australia*, 190(11), 117-120.
- Bengtsson, M. (2016). How to plan and perform a qualitative study using content analysis. *Nursing Plus Open*, 2, 8-14. <https://doi.org/10.1016/j.npls.2016.01.001>.
- Boltz, M., Parke, B., Shuluk, J., Capezuti, E., & Galvin, J. (2013). Care of the Older Adult in the Emergency Department: Nurses Views of the Pressing Issues. *The Gerontologist*, 53(3), 441–453. <http://doi.org/10.1093/geront/gnt004>.
- Boockvar, K., Fridman, B., & Marturano, C. (2005). Ineffective communication of mental status information during care transfer of older adults. *Journal of General Internal Medicine*, 20(12), 1146-1150. doi: 10.1111/j.1525-1497.2005.00262.x.
- Campbell, B., Stirling, C., & Cummings, E. (2017). Continuity matters: Examining the 'information gap' in transfer from Residential Aged Care, ambulance to emergency triage in southern Tasmania. *International Emergency Nursing*, 32, 9-14. doi: 10.1016/j.ienj.2016.05.001.
- Central Statistics Office (CSO). (2018, July 6). Press Statement Census 2016 Results Profile 3 - An Age Profile of Ireland. Retrieved from <https://www.cso.ie/en/csolatestnews/pressreleases/2017pressreleases/pressstatementcensus2016resultsprofile3-anageprofileofireland/>
- Creswell, J., & Plano Clark, V. (2017). *Designing and conducting mixed methods research*. USA: Sage Publications.

Currie, C., & Hutchison, J. (2005). Audit, guidelines and standards: clinical governance for hip fracture care in Scotland. *Disability and Rehabilitation*, *15*(27), 1099-1105. doi: 10.1080/09638280500056329.

Cwinn, M., Forster, A., Cwinn, A., Hebert, G., Calder, L., & Stiell, I. (2009). Prevalence of information gaps for seniors transferred from nursing homes to the emergency department. *Canadian Journal of Emergency Medicine*, *11*(5), 462-471.

Dalawari, P., Duggan, J., Vangimalla, V., Paniagua, M., & Armbrecht, E. (2011). Patient Transfer Forms Enhance Key Information Between Nursing Homes and Emergency Department. *Geriatric Nursing*, *32*(4), 270-275. doi: 10.1016/j.gerinurse.2011.05.001.

Department of Health. (2018, October 15). Health in Ireland: Key Trends. Retrieved from https://health.gov.ie/wp-content/uploads/2016/12/Health_in_Ireland_KeyTrends2016.pdf

Devriendt, E., Wellens, N., Flamaing, J., Declercq, A., Moons, P., Boonen, S., & Milisen, K. (2013). The interRAI Acute Care instrument incorporated in an eHealth system for standardized and web-based geriatric assessment: strengths, weaknesses, opportunities and threats in the acute hospital setting. *BMC Geriatrics*, *13*(90). doi: 10.1186/1471-2318-13-90.

Dizon, M., Zaltsmann, R., & Reinking, C. (2017). Partnerships in Transitions: Acute Care to Skilled Nursing Facility. *Professional Case Management*, *22*(4), 163-173. doi: 10.1097/NCM.0000000000000199.

Elia, M. (2003). The 'MUST' report. Nutritional screening for adults: a multidisciplinary responsibility. Development and use of the 'Malnutrition Universal Screening Tool' ('MUST') for adults (Report 127). Retrieved from <https://www.bapen.org.uk/pdfs/must/must-report.pdf>

European Commission. (2018, October 15). What does the General Data Protection Regulation (GDPR) govern? Retrieved from https://ec.europa.eu/info/law/law-topic/data-protection/reform/what-does-general-data-protection-regulation-gdpr-govern_en

Griffiths, D., Morphet, J., Innes, K., Crawford, K., & Williams, A. (2014). Communication between residential aged care facilities and the emergency department: a review of the literature. *International Journal of Nursing Studies*, 51(11), 1517-1523. doi: 10.1016/j.ijnurstu.2014.06.002.

Hennink, M. (2007). *International Focus Group Research*. USA: Cambridge University Press.

Health Service Executive (2018). Acute Hospital Services Divisional Plan: Building a Better Health Service. Retrieved from <https://www.hse.ie/eng/services/publications/serviceplans/service-plan-2018/operational-plans-2018/acute-operations.pdf>

Klingner, J., & Moscovice, I. (2012). Development and testing of emergency department patient transfer communication on measures. *Journal of Rural Health*, 28(1), 44-53. doi:10.1111/j.1748-0361.2011.00374.x.

Krippendorff, K. (2004). Reliability in content analysis. *Human Communication Research*, 30(3), 411-433. <https://doi.org/10.1111/j.1468-2958.2004.tb00738.x>.

Krueger, R. (2014). *Focus Groups: A Practical Guide for Applied Research*. USA: Sage Publications.

Lahn, M., Friedman, B., Bijur, P., Haughey, M., & Gallagher, E. (2001). Advance Directives in Skilled Nursing Facility Residents Transferred to Emergency Departments. *Academic Emergency Medicine*, 8(12), 1158-1162. doi: 10.1111/j.1553-2712.2001.tb01133.x.

LaMantia, M., Scheunemann, L., Viera, A., Busby-Whitehead, J., & Hanson, L. (2010). Interventions to Improve Transitional Care Between Nursing Homes and Hospitals: A Systematic Review. *Journal of the American Geriatrics Society*, 58(4), 777-782. doi: 10.1111/j.1532-5415.2010.02776.x.

Mahoney, F., & Barthel, D. (1965). Functional evaluation: The Barthel Index. *Maryland State Medical Journal*, 14, 61-65.

Matic, J., Davidson, P., & Salamonson, Y. (2011). Review: bringing patient safety to the forefront through structured computerisation during clinical handover. *Journal of Clinical Nursing*, 20(1-2), 184-189. doi: 10.1111/j.1365-2702.2010.03242.x.

McCormack, B. and McCance, T. (2016) *Person-centred Practice in Nursing and Healthcare*. Oxford: Wiley-Blackwell.

Morphet, J., Griffiths, D. L., Innes, K., Crawford, K., Crow, S., & Williams, A. (2014). Shortfalls in residents' transfer documentation: Challenges for emergency department staff. *Australasian Emergency Nursing Journal*, 17(3), 98-105. doi: 10.1016/j.aenj.2014.03.004.

Murray, L., & Laditka, S. (2010). Care transitions by older adults from nursing homes to hospitals: implications for long-term care practice, geriatrics education, and research. *Journal of the American Medical Directors Association*, 11(4), 231-238. doi: 10.1016/j.jamda.2009.09.007.

Nandy, S., Parsons, S., Cryer, C., Underwood, M., Rashbrook, E., & Carter, Y. et al. (2004). Development and preliminary examination of the predictive validity of the Falls Risk Assessment Tool (FRAT) for use in primary care. *Journal Of Public Health*, 26(2), 138-143. doi: 10.1093/pubmed/fdh132.

Nelson, D., Washton, D., & Jeanmonod, R. (2013). Communication gaps in nursing home transfers to the ED: impact on turnaround time, disposition, and diagnostic testing. *The American Journal of Emergency Medicine*, 31(4), 712-716. doi: 10.1016/j.ajem.2012.11.024.

Organisation for Economic Co-operation and Development (OECD). (2018, October 18). Elderly population. Retrieved from <https://data.oecd.org/pop/elderly-population.htm#indicator-chart>

Pauls, M., Singer, P., & Dubinsky, I. (2001). Communicating advance directives from long-term care facilities to emergency departments. *The Journal of Emergency Medicine*, 21(1), 83-89. doi: 10.1016/s0736-4679(01)00344-4.

Rockwood, M., MacDonald, E., Sutton, E., Rockwood, K., Baron, M., & Pope, J. et al. (2014). Frailty Index to Measure Health Status in People with Systemic Sclerosis. *The Journal Of Rheumatology*, 41(4), 698-705. doi: 10.3899/jrheum.130182.

Rubenstein, L. (1995). *An overview of comprehensive geriatric assessment: rationale, history, program models, basic components. Geriatric Assessment Technology: The State of the Art*. New York: Springer.

Sandelowski, M. (2015). A matter of taste: evaluating the quality of qualitative research. *Nursing Inquiry*, 22(2), 86-94. doi: 10.1111/nin.12080.

Silverman, S. (2016). *Qualitative Research*. USA: Sage Publications.

Stewart, D., & Shamdasani, P. (2015). *Focus Groups: Theory and Practice*. USA: Sage Publications.

Tsai, H., Tsai, Y., & Huang, H. (2016). Nursing home nurses' experiences of resident transfers to the emergency department: no empathy for our work environment difficulties. *Journal Of Clinical Nursing*, 25(5-6), 610-618. doi: 10.1111/jocn.13084.

Tong, A., Sainsbury, P., & Craig, J (2007). Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, 19(6), 349-357.

United Nations. (2018, October 15). Ageing. Retrieved from <http://www.un.org/en/sections/issues-depth/ageing/index.html>

World Health Organisation (WHO). (2018, June 1). Noncommunicable diseases. Retrieved from <http://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases>

v. Tables

Table 1: Focus group participants

| Characteristics | Acute setting | Residential setting | Total |
|-----------------------------|---------------|---------------------|-------|
| Nursing | 32 | 26 | 58 |
| Allied Health Care | 4 | 4 | 8 |
| Service user representative | 1 | 1 | 2 |
| Female | 33 | 27 | 60 |
| Male | 4 | 4 | 8 |

Table 2: Content Analysis Framework

| Broad Category | Subcategory |
|---------------------------------|---|
| Existing transfer documentation | Items to change Items to retain |
| Design framework | 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 |

Table 3: Assessment tools identified

| |
|---|
| • The Malnutrition Universal Screening Tool (MUST) (Elia, 2003) |
| • The Barthel Index (Mahoney & Barthel, 1965) |
| • Falls Risk Assessment Tool (FRAT) (Nandy et al., 2004) |
| • Rockwood Frailty Index (Rockwood et al., 2014) |
| • Older People in Acute Care (OPAC) (Currie & Hutchison, 2005) |
| • The Comprehensive Geriatric Assessment (Rubenstein, 1995) |

Table 4: Proposed Design and Format

| Design | Format |
|---|---|
| User Friendly Colour coded Traffic light system | Essential information on first page More detailed information in subsequent section Clear |

| | |
|-----------------------|--|
| Symbols Tick boxes | Concise Regularly reviewed Paper Electronic |
|-----------------------|--|

Table 5: Proposed Essential elements of care 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 Date of Birth Religion/spiritual needs Next of kin and/or contact person (with designated role) Contact number of the resident’s ward in the residential centre 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 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 |

vi. **Appendix A: Semi-structured Interview Schedule**

| |
|---|
| <ul style="list-style-type: none">• What are your experiences of using transfer documentation when older persons are being transferred between a residential and acute care facility and vice versa? |
| <ul style="list-style-type: none">• If you were to redesign the current document what would you change? |
| <ul style="list-style-type: none">• If you were to redesign the current document what would you retain? |
| <ul style="list-style-type: none">• What is your vision of an optimum transfer document? |
| <ul style="list-style-type: none">• 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) |
| <ul style="list-style-type: none">• What do you see as the essential information that should be included to support an effective person-centred transfer? |
| <ul style="list-style-type: none">• What clinical/essential information is required to provide safe effective person-centred care to the older person admitted to the ward/unit? |
| <ul style="list-style-type: none">• How can we make the transfer tool individual and unique to the care needs of the person? |
| <ul style="list-style-type: none">• Please discuss ways in which we can ensure that the resident's beliefs and values are considered in the transfer documentation |
| <ul style="list-style-type: none">• What do you think would help to ensure that the essence of person-centred care is being addressed? |
| <ul style="list-style-type: none">• Is there anything else that you would like to add? |