**This is my Trusted Transfer of Care Document**

**My name is: Betty Boop**



If I have to go to hospital this document needs to go with me, it gives the hospital staff important information about me, when I am well.

If my care provider calls to discuss my care the following password will confirm their identity: **Security 123**

The Situation, Background, Assessment & Response (SBAR) tool explains the reason why I have been transferred to hospital.

**Attached to my Document are:**

Original - Do Not Attempt CPR [x]

ReSPECT Form [ ]

Advanced Care Plan No

Date last seen by a Health Professional: Click here to enter a date.

Copy of Consent form [ ]  Advanced Decision to refuse treatment (ADRT) No

Body Map [x]  Lasting Power of Attorney (LPA) Included No

Copy of current MAR Chart [x]  Deprivation of Liberty Safeguard (DoLS) in place No

Copy of Inter Health and Social Infection Control Transfer Form ☐

This document belongs to me and should follow me throughout my hospital stay.

Please return it with attached documents when I am discharged.

Clinical staff should refer to this document for important information about me.

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| **Personal Belongings transferred from Care Home** | **Tick all that apply** | **If no- reason** |
| Change of clothes |[ ]   |
| Slippers |[ ]   |
| Toiletries |[ ]   |
| Glasses |[ ]   |
| Hearing aid |[ ]   |
| Dentures |[ ]   |
| Personal items/Valuables (specify):  |[ ]   |
| Mobility aids |[ ]   |
| Other (specify): Click here to enter text. |[ ]   |

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| SBAR Tool  |
| Date: Click here to enter a date. |
| **Situation:** (how is my current state & symptoms different from my usual state)? |
| Click here to enter text. |
| **Background:** (how long has this been going on for)? |
| Click here to enter text. |
| **Assessment**: (has a clinical diagnosis been identified? Is there a management plan in place and has it been followed?) |
| Click here to enter text. |
| **Response:** Responding Service Notified ……………… Date……../….…/..…… Time (am/pm) ………………….Actions you were advised to take and those the responding service will perform:  |
| **Any other information/notes**: |
| Click here to enter text. |

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| Date completed: | Click here to enter a date. | By: | Click here to enter text. |

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| **Important contacts for me** |
| Name: | **Betty Boop** |
| Likes to be known as: | **Betty** |
| NHS Number: | **123 345 7890** |
| Date of Birth: | **25/03/1931** |
| Address: | **Care Home****Care Home Way****York** |
| Tel No: | **01904 123456** |
| Care Home Manager | **Mrs** **Bucket** |

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| Next of kin or primary contact |  **Martin Boop** |
| Relationship |  **Son – Next of Kin** |
| Address |  **1 Long Road, Long Place, Longford** |
| Tel No | **07123456789** |
| When can they be contacted e.g. day or night and for particular occasions such as accompanying a relative in ED/ XRAY etc. |  **At any time day or night if there is a deterioration in physical health or medical emergency.**  |

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| GP: | **Dr Doolittle**  |
| Address: | **Dr Doolittle Practice, Animal Way, York** |
| Tel No: | **01904 654321** |
| Other services/professionals involved with me: | None  |

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| Religion: | **Catholic** |
| Religious/spiritual needs: |  **Practicing**  |
| Ethnicity: | **White British** |

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| Allergies: **Penicillin, Alendronic Acid, Fludrocortisone** |
| Click here to enter text. |
| **For MEDICATION please see accompanying copy of MAR Chart. Inhalers, GTN spray, eye drops, insulin and creams are with me if prescribed** |

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| How I take medication: (whole tablets, crushed tablets, injections, syrup) |
| **Medication taken whole in tablet/inhaled form. Please put in my hand so I can see them.** |
| Is there a covert medication agreement? Yes No N/A |
|  **No – Accepting of medication.**  |

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| My current medical problems including any cognitive issues : |
|  **Impaired Cognition****Diabetes – Type II****Osteoporosis****Hypotension****Chronic Kidney Disease**  |

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| My relevant past medical history: |
| **Loose Bowels: Can experience sudden onset of loose bowels which causes pain. Prescribed Loperamide PRN to support with this.****High Risk of Falls: Fell and broke left arm just below the shoulder in April 2019.** |

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| **What is ‘normal’ for me** |
| How I communicate/what language I speak | English – I can communicate well and make my needs known. I have occasional difficulty with word finding but given time I can communicate what I mean. I may struggle to understand what others are saying if I am anxious.  |
| Seeing/hearing: (problems with sight or hearing) | Wears Glasses as poor eyesight. Hard of hearing, bilateral hearing aids. I may forget to wear these or remove them. Staff speak clearly to help me hear.  |
| How you know I am in pain | I am able to let you know if I am in pain. |
| Risk of choking, Dysphagia (eating, drinking and swallowing) | No increased choking risk. Normal diet and fluids.  |
| Assistance required with eating and drinking (food cut up, aids) | Yes. I require prompts and sometimes assistance to ensure I eat and drink well. I can become uncoordinated with cutlery or attempt to put my food in my drink. I may need meat cutting up for me before I can eat it.  |
| Support with moving and handling: (equipment I use such as pressure relief, walking aids etc) | I am able to mobilise independently. I use a rollater frame but may need prompts to remember to use this. I am at high risk of falls so require supervision when I am mobilising. I am able to transfer independently. |
| How I keep safe: (Bed rails, support with challenging behaviour) | I am at high risk of falls which increases at night if I get up out of bed so have a sensor mat in place. I can become anxious about my son and his safety so may need support and reassurance.  |
| Personal care needs: (Assistance with dressing, washing, etc) | I require support and prompts from staff with washing and dressing. This is to help as I can be unsteady and also to sequence tasks.  |
| How I use the toilet: (Continence aids, help to get to toilet) | I am continent however occasionally experience episodes of acute onset loose bowels and may need support. I may need help to locate the toilet. |
| Sleeping: (sleep pattern/routine) | I may become unsettled in a new environment and get up regularly throughout the night needing reassurance.  |
| My Skin integrity: (current issues/how often I need to be repositioned) | No current concerns with skin integrity. Able to reposition self. Previously have had diabetic ulcer on my foot.  |

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| **My Likes and Dislikes** |

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| Likes: for example - what makes me less anxious, things I like to doe.g. watching TV, reading, music, routines.Dislikes: for example – is there anything that triggers a change in my behaviour? e.g. , medical interventions such as taking blood, noise, certain foods, strangers, physical touch. |
| Things I likePlease do this:I am very sociable and like to chat with others and be around other people. I enjoy sweet foods and when eating I like to be with others in the dining room. I like to talk about my family and I am very proud of my son and two grandsons. I used to work at the Nestle factory where I met my husband Jim who passed away in 1999. I am a very proficient knitter and worked in a wool shop when I left school. I am a practicing Christian – Catholic. I enjoy hand massages and having my nails painted.  |  | Things I don’t likeDon’t do this: I do not like being alone or not being able to find someone. I can become anxious about world events on the news and may believe my son has been harmed so need reassurance. I do not like feeling unsafe and falling but need reminders to use my mobility frame. I can experience dizziness if I stand too quickly.  |

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| Variance Sheet (to be completed by hospital staff) |
| Reference number | Details of change/s and signature |
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