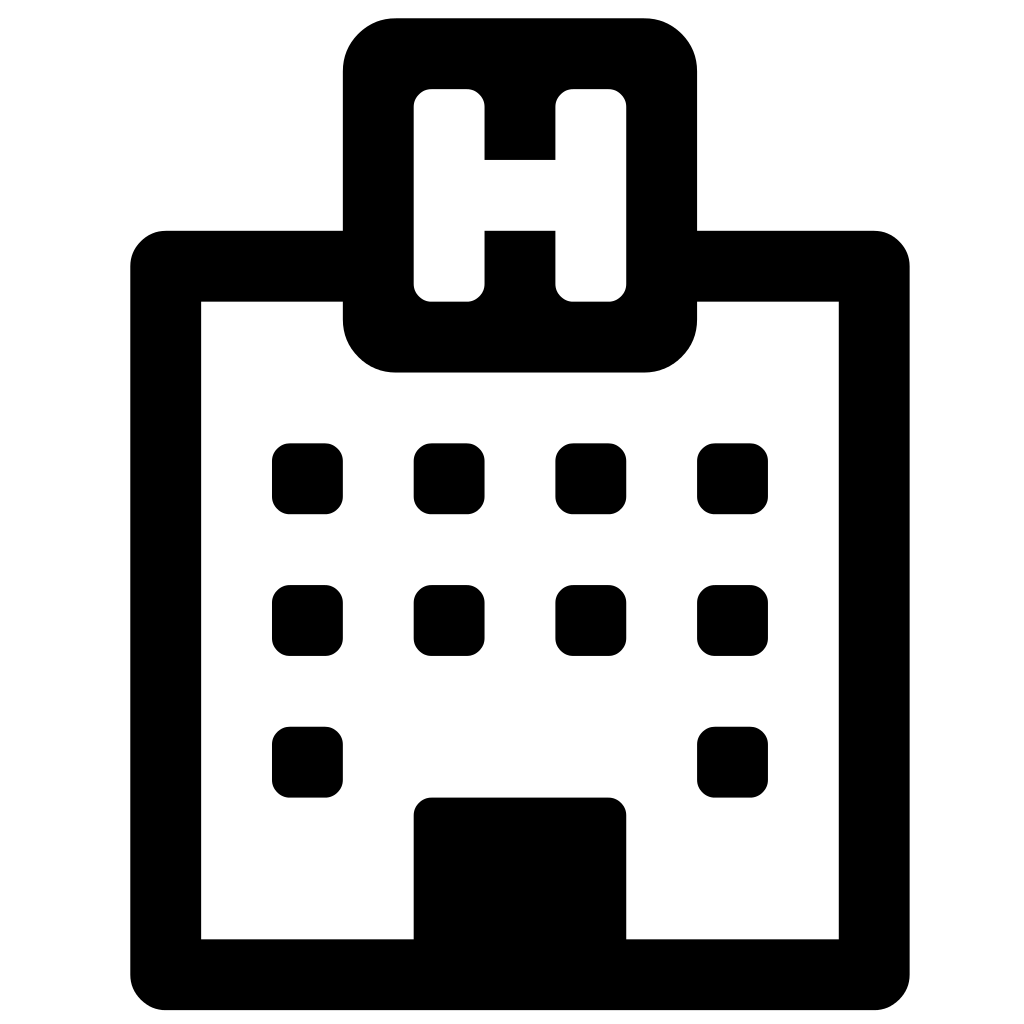
**This is my Trusted Transfer of Care Document**

**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

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  Lasting Power of Attorney (LPA) Included No

Copy of current MAR Chart  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 do  e.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 like  Please 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 like  Don’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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