Professional-to-professional handover of care

Scottish Palliative Care Guidelines

Healthcare Improvement Scotland

Introduction

When caring for people with palliative care needs, it is essential that relevant clinical information is shared within and across care settings in a timely manner. This enables care professionals (working in and out of hours) to deliver person-centred care aligned to existing care plans, patient preference and disease trajectory.

Information required for effective professional-to-professional handover

Diagnosis:

- relevant medical diagnoses including any future treatment options, and
- patient and carer understanding of diagnosis and prognosis.

Medications:

- All current medications prescribed regularly and ‘as required’, including ‘just in case’ medication and oxygen.
- Details of why medication has been started, stopped or amended while in hospital and recommended timeframes for medication review, such as, if patient on steroids.

Social context

Where relevant, include information on:

- equipment in the home
- formal care provision
- risks within the home that visiting health professionals need to be aware of, and
- practical advice on entering the property.

Future care planning

Information which may include:

- wishes regarding medical care, this may be referred to as a treatment escalation plan (TEP) or “ceiling of care” and future admissions to hospital or hospice
- preferred place of care and death
- existence of documents such as do not attempt cardiopulmonary resuscitation (DNACPR) form

- power of attorney (and whether this relates to welfare and/or financial powers),
- adults with incapacity
- guardianship, and
- clinical guidance on appropriate levels of treatment available to the personal in future.

Professional handover from and within the community setting

Key information summary

The key information summary (KIS) is a shared electronic summary record where palliative care information can be documented and amended using the "special notes" by the patient's GP. The creation of a KIS should be offered for all patients with palliative care needs.

It the GP's responsibility to create or update an electronic KIS for the person as required, as all other users have read only access, and are unable to do so.

Important: Since October 2023, explicit consent is no longer required for the creation or sharing of a KIS. The legal basis for processing is established under data protection law for the provision of direct care. key information summary – removal of explicit consent – change to consent model

If any community-based health or social care professional becomes aware of a change in a person's preferences for future care, they should take the responsibility for contacting the GP to request an update to the KIS.

The KIS can be viewed by:

NHS 24; GP out-of-hours services; Scottish Ambulance Service; secondary care (including, hospital emergency departments or admissions units); other community health and social care services (including third sector hospices).

The KIS should highlight key information that is important to the person. This includes any relevant needs or wishes related to end of life care, regarding their social, emotional, psychological, communication, spiritual, cultural and religious practices. Information extracted from GP records that may be relevant to add to the KIS includes:

- patient and carer details
- patient's own GP and nurse
- patient medical condition:
    - main diagnosis

    - other relevant issues
- current care arrangements:
    - syringe pump at home
    - catheter and continence products at home
    - moving and handling equipment at home
- patient and carer awareness of condition:
    - understanding of diagnosis and prognosis
- advice for out-of-hours care:
    - care plan agreed
    - preferred place of care
    - should GP be contacted out of hours? (if yes, contact details)
    - resuscitation status agreed (if yes, status)
    - will GP sign death certificate in normal circumstances?
    - additional useful out-of-hours information
- the Future Care Planning documents (formally referred to as an “Anticipatory Care Plan” or “ACP”) are not visible to all out of hours providers unless the details are also added in special notes section of the KIS.

If a patient has any of the following documents, it is important to note what has been discussed or decided, and where these documents are located:

- DNACPR
- recommended summary plan for emergency care and treatment (ReSPECT)
- child and young people acute deterioration management (CYPADM)
- power of attorney or guardianship, and
- other future care planning documentation.

The emergency care summary (ECS) is available for all patients, even if a KIS has not been released and provides information on:

- allergies and drug reactions
- current drugs and doses
- additional drugs available at home, including injectable medication. Important: the dose on ECS reflects the dose at the time these were issued. This may differ from the dose now in use, which can be obtained from the community drug administration chart.
- date of issue of prescription.

If there is a need to expedite the issuing of a death certificate it should be highlighted, along with and relevant details of how this is to be done.

If a particular professional involved in a person's care does not have the systems access required to routinely review clinical notes, reasonable efforts should be made

by other professionals involved in that person's care to share the most important information by other secure means. The KIS is one such example.

Many district nursing teams use separate notes systems such as the multidisciplinary information system (MiDIS) or Morse community electronic patient record system to document key information or alerts. These systems do not automatically populate or replace the KIS and it remains important that a person's preferences for future care is highlighted and up to date within the KIS as well.

Some patients will be at a high risk of requiring out-of-hours GP or nursing services. This may be because of severe distress or crisis events such as catastrophic bleeding, loss of airway, or seizure. Where healthcare professionals recognise this, it is good practice to ensure direct handover processes are in place. This may be calling to speak with the duty healthcare professional or sending a direct email outlining the immediate issues.

Professional handover on discharge from hospice or hospital

Immediate discharge letter

When a patient is discharged from secondary care to a community setting, an immediate discharge letter (IDL), or similar written handover document, should be shared promptly with the person's GP and, where appropriate, with the person.

On occasion, it may be decided that an IDL should not be given to the person directly. This could be due to lack of capacity or risk of unacceptable psychological harm. In such circumstances, consider sharing it with someone who has the patient's consent to be involved in their care. This could be the next of kin or someone with legally appointed guardianship or welfare power of attorney.

Additional handover considerations on discharge from hospice or hospital

When patients are discharged from secondary care to the community urgently for care in the last hours or days of life, please refer to the rapid transfer home in last days of life guideline.

- **Consider contacting GP surgery to alert them to the planned discharge in advance.** It may be helpful to highlight key information within IDL and discuss any content relevant to completing an electronic palliative care summary (ePCS)/KIS [see sections on KIS and IDL]. Request for the patient to be added to their palliative care register and for ePCS/KIS to be updated.
- If a person has specific or anticipated nursing needs, there should be a **direct nursing handover to district nursing and/or other community nursing teams**.

- District nursing and/or other community nursing teams should be informed if a patient is being discharged home at end of life, including whether they have a supply of ‘just in case’ medications.
- When issuing “just in case” medication, supply water for injection and the accompanying community drug kardex required for safe administration.
- Ensure an adequate supply of current medication is provided on discharge.
- Share any information that visiting health professionals need to be aware of when visiting the home, such as details of any risks within the home environment; key code number for door; presence of a locked box.