PURPOSE

- To ensure that Access/TCHS Clients are enabled to exit from the service within an anticipated and planned time frame relevant to their care requirements.
- To facilitate Clients to collaborate with Access/TCHS personnel to plan goals that are realistic, achievable and promote the social, psychological, spiritual and physical well being of the Client.
- To ensure a smooth safe transition, with minimum disruption and risk to the Client and significant others during and following the process of discharge, or transfer to another provider.
- To validate the practice of short term goal planning for individual clients as a strategy in assisting the client to remain in his/her own home or to facilitate their return to normal daily living.

1. **SCOPE**
    a. Applicable to all ACC clients referred by any agency whose package of care is accepted by Access/TCHS.
    b. Applicable to private clients who request services from Access/TCHS and whose care and hours requirements are within the scope of what TCHS can provide.

2. **Process**

From time to time clients need to be transferred to another service. The most common reasons for transfer are;

- Client's care is no longer ACC related
- Client moves outside of TCHS geographical distribution area
- Client goes away on holiday to an area TCHS does not cover
- Client goes into permanent care to a Rest home / Hospital setting

Clients who are covered under ACC

1. Nurse notifies office that a client is going away (either on holiday or to permanently) outside of TCHS visiting area
2. If client not going straight way, note is put on visiting schedule with a date when transfer is to take place
3. Nurse completes transfer documents – TCHS referral and summary of care
4. Office puts together all required documents
    - TCHS referral
    - Summary of care –Nursing Intervention – Transfer Template
    - Client information sheet
    - Assessment chart
    - Current treatment plan
    - Current Evaluation Sheet
    - Current Clinical note
    - One page referral acceptance form

5. Administrator to ensure that all required information is on TCHS referral;
    - ACC#,
    - Date of first visit,
    - New visiting address and
    - Package client has been visited under
6. Admin send transfer to new service and call to confirm received
7. Complete transfer spreadsheet
8. Put a note into MY Practice in client's file that transfer has been completed
9. If new provider declines to accept Admin will send referral back to GP for further care

Client who is transferred as NON ACC

1. Decision is made that the clients wound is no longer ACC related or ACC wound is healed and has been discharged. This decision is either made by one of the clinical nurse leaders or ACC through a nursing assessment
2. Note is put into MP about why client is being transferred long with date of final visit, Note put onto task to prompt nurse to complete transfer documents at required time.
3. Date office notified, client name, final visit with us and first visit with new provider
4. Nurse completes transfer documents – TCHS referral and summary of care
5. Office puts together all required documents
    - TCHS referral
    - Summary of care – Nursing Intervention – Transfer Template
    - Client information sheet
    - Assessment chart
    - Current treatment plan
    - Current Evaluation Sheet
    - Current Clinical note
    - One page referral acceptance form
6. Make sure that all required information is on TCHS referral, why this wound has not ACC cover any longer, date of first visit required, visiting address and clients contact details.
7. Send transfer to new service
8. Complete transfer spreadsheet
9. Put a note into MP to note referral has been completed.
10. If referral acceptance page has not been received by the following date, contact new provider and confirm they have received referral.

3. Associated Documents

Template Instructions – under construction 03.05.2021
Transfer Template – under construction 03.05.2021
Discharge Process – Flowchart C 3.6.1