#### Nursing and Residential Care Journal Submission

#### Title: ‘Optimising Working Practices in Nursing and Residential Care Settings in the North East and North Cumbria, UK: An Evaluation of a Hospital Transfer Pathway.

**Authors:**

Yitka Graham, Head of the Helen McCardle Nursing and Care Research Institute, Faculty of Health Sciences and Wellbeing, University of Sunderland

Sarah Keith, Research Assistant, Faculty of Health Sciences and Wellbeing, University of Sunderland

Maria Freeman, Research Associate and Associate Tutor Faculty of Health Sciences and Wellbeing, University of Sunderland

Ken Haggerty, Independent Care Sector Lead for NHS England (North) Care Partnership

Kathryn Dimmock, National Health and Safety Executive, Independent Care Sector Lead, Nursing and Quality Team

Catherine Hayes, Professor of Health Professions, Pedagogy and Scholarship, Faculty of Health Sciences and Wellbeing, University of Sunderland

**Abstract:**

This article provides an insight into how findings from an evaluation of a Hospital Care Transfer Pathway, can be operationalised, with the intention of improving information for staff in nursing and residential care home settings. The article provides information of the evaluation, detailing the RE-AIM methodology that was implemented. The findings of the evaluation revealed the ongoing need for effective communication pathways between residential care setting staff and their counterparts in transfer pathways and the pivotal role of reflection and reflexivity on practice for all healthcare staff. The article incorporates a series of recommendations at its conclusion, that it is hoped can be pragmatically integrated by staff working in nursing and residential care settings.

**Keywords:**

Hospital Transfer Pathway; Red Bag; Care Homes; RE-AIM; Evaluation; Multi-disciplinary healthcare practice

## **Introduction**

This article reports on specific findings of a wider formal evaluation undertaken across the North East and North Cumbria STP, focused on enabling an understanding of the adoption and implementation processes of a multi-centred and multi-disciplinary Hospital Transfer Pathway (HTP) known as the ‘Red Bag’. Ideally, and in accordance with the originally implemented scheme, the Red Bag ought to contain standardised information about the nursing and residential care home resident's general health, any existing medical conditions they have, medication they are taking, as well as highlighting the current health concern which necessitates a hospital visit. The bag also has room for personal belongings (such as clothes for day of discharge, glasses, hearing aid, dentures etc.) and it ought to stay with the patient whilst they are in hospital. When patients are ready to go home, a copy of their discharge summary (which details every aspect of the care they received in hospital) ought to be placed in the red bag so that care home staff have access to this important information when their residents' arrive back home. The approach to hospital transfer facilitates and enables front line ambulance workers to optimally manage the needs of residents in a timely manner. It is worth noting that these are often older vulnerable patients who may have a condition which impacts on their cognitive capacity to articulate their specific needs or who may be physically too ill to be able to communicate with those caring for them. .

The Red Bag also clearly identifies a patient as being a care home resident, which potentially means that it may be possible for the patient to be discharged from hospital more quickly. This is possible since the care home staff can then be engaged in discussions with hospital staff so that a clear mechanism of continuing support for the resident when they are discharged can be operationalised.

A methodological framework called RE-AIM enabled the data analysis to be guided by principles which made it possible to examine the specific impact of an intervention – in this instance the Red Bag. The evaluation revealed both lessons learnt and examples of best practice, all of which have the potential to be further shared and disseminated as part of improving patient care in the context of interprofessional healthcare working.

## **Strategic and Operational Background to the Red Bag Hospital Transfer Pathway**

In 2015, the National Institute for Health and Care Excellence (NICE) introduced guidance on the transfer of patients with social care needs from care homes and community settings to hospital (National Institute for Health and Care Excellence, 2015). The HTP is designed to provide optimal support to care homes, ambulance services and local hospitals, in meeting the recommendations of the NICE guideline NG27 ‘Transition between inpatient hospital settings and community or care homes’.

The HTP, which incorporated the Red Bag, was initially introduced by Sutton Clinical Commissioning Group in 2016 to improve the handover process between care homes and ambulance staff, when residents were admitted to hospital in Sutton. Specific aims of the HTP were to improve communication between staff and minimise time delays in patient transfers. This pertained to paperwork collation, misplacement of or a paucity of personal belongings accompanying the resident to hospital and medical teams being provided only with limited baseline information of a residents’ health, medication, or specific needs. Together, these were recognised as having the potential to contribute to avoidable delays and a lack of effective communication (Sutton Clinical Commissioning Group, 2016).

Principles of the Hospital Transfer Pathway were formally adopted by NHS England with a launch across localities in the North East and North Cumbria in early 2018 characterised by multi-agency collaboration between NHS, local authorities, and private sectors.

## **Evaluation Aim**

The aim of the evaluation was to provide an insight into the processes of the implementation and adoption of the Red Bag Scheme in the HTP across the North East and North Cumbria, establishing how effective this was in practice.

## 

## **Objectives**

Objectives for the study were designed to:

* Understand the experiences of a range of users of the scheme, specifically Care Home Managers, Clinical Commissioning Groups, Hospital Staff, Paramedics, and Local Authority staff.
* Identify areas of best practice for sharing and dissemination with NHS England regional colleagues.
* Identify reasons for gaps in the HTP, in order to provide information as to why these might be apparent and also to recommend strategies for context specific improvements.

Whilst the focus of this article is to provide an insight into the specific findings relevant to nursing and residential care home settings, it is clear to see that the HTP is reliant on effective communication between organisations during handover periods, of which these are an integral part (see Figure 1).

Figure 1: The Hospital Transfer Pathway: Key times for the initiation of communication and transfer of responsibility

### **Geographical Context of the Study**

The localities incorporated into the evaluation process were Darlington, Durham Dales, Easington and Sedgefield, Durham, Hambleton, Richmond and Whitby, Hartlepool and North Tees, Northumberland, North Cumbria, Newcastle/Gateshead, North Tyneside, South Tyneside, Sunderland and South Tees.

# **Methodology and Methods**

We adopted a pragmatic approach to the evaluation of the HTP. Simply explained, we acknowledged the complexity of social world settings and the various layers of opinions and perceptions that are true for all of the individuals, groups and institutions, which were of immediate relevance to our evaluation objectives. We therefore adopted a philosophical approach termed critical realism, which specifically acknowledges all of these factors in any study of social reality (Robson, 2011). In relation to the data sets we collected, it also enabled us to place our findings in the contexts of where information had been collected and could be explained. (Corson, 1991).

We implemented a mixed methods approach which integrated both qualitative and quantitative methods. This meant that we could both qualify and quantify research findings which had been captured at the front line of patient care. We adopted a thematic analytic approach in order to provide a robust, structured analysis of the qualitative data.

In relation to the wide geographical area over which the evaluation took place, a bricolage approach was used. This is a mechanism of using and adapting data collection tools to make meaning and establish understanding by several different approaches.

To more fully understand the sociodynamics of the Red Bag implementation in practice, the researchers attended as many formal and informal meetings across the NHS, local authority and care home settings as was feasibly possible. This allowed engagement with potential participants in their everyday natural working environments, where dynamics of working practice could be further observed and contextually framed in the evaluation report.

Three surveys were designed for each organisation involved in the HTP, pilot tested to ensure questions were fully understood and that they reflected the current context of practice of the HTP implementation. These surveys were administered between November 2018 and February 2019 via purposive and snowball sampling techniques to ensure staff from multi-agency settings were effectively targeted. Data collection formally ceased at the end of April 2019.

An initial scoping exercise revealed care home residents admitted to hospital progressed through a variety of organisational infrastructures which had a correspondingly diverse range of interactions with people, places and processes. We triangulated data findings by subcontracting the North East Ambulance Service (NEAS) to both advise on this phase of the evaluation and also to collect parallel experiential data from paramedics.

A thematic analytic approach was adopted in the data analysis phase of the research. This entailed the identification of specific themes and categories and the generation of codes from them (Denzin and Lincoln, 2011). Final codes were agreed by consensus between the research team, where they were specifically grouped into themes in the context of their relevance to the research questions and interpretation of the social processes in the organisations.

A constant comparative framework was implemented, where data was iteratively compared with other collated data, which facilitated the identification of tacit meaning and actions underlying specific processes (Charmaz, 2014). Consensus on the final confirmed set of themes was agreed collectively between research team members.

## **Overview of the principles of RE-AIM Framework for the evaluation**

The research team adopted a formal framework abbreviated to RE-AIM, and can be seen in Table 1. We mapped out and were guided by this framework in our analysis of the implementation and adoption of the Red Bag. As illustrated in Table 1, the framework consists of five dimensions (reach, effectiveness, adoption, implementation, maintenance) which can be used to illuminate more than just traditional outcomes of whether the scheme worked and was efficient, in that it also enabled the capture of the subtle and often nuanced tacit experiences of healthcare workers (Holtrop, Rabin and Glasgow, 2018).

Table 1 Framework for scoping the evaluation

|  |  |
| --- | --- |
| RE-Aim Dimension | Addresses |
| Reach | Define participants across the organisations involved |
| Effectiveness | Define benefits that are trying to be achieved and identify any negative consequences |
| Adoption | Where is the HTP being applied and who is applying it? |
| Implementation | How consistently is the Red Bag scheme being applied, what are the barriers and enablers and, how will best practice be shared? |
| Maintenance | When did the Red Bag scheme become operational in each locality and what can be shared to inform development of sustainability? |

**Adapted from Holtrop et al (2018)**

These dimensions occur at multiple levels, e.g. service users, surgeries, organisations and communities (Glasgow, Vogt and Boles, 1999) which need to be taken into account when evaluating the success of the locality interventions. The principles of the framework have been used for this evaluation, rather than using it as a prescriptive tool, in line with other evaluations which have used this method (Finch and Donaldson, 2010), as we sought to be guided by induction in keeping with qualitative methodology to allow a wide range of possibilities when evaluating the Red Bag scheme in practice (Sweet et al, 2014).

## **Ethical approval**

Formal ethical approval for this evaluation was granted by the University of Sunderland. For the arm of the evaluation involving the North East Ambulance Service, ethical approval was provided by the Health Research Authority.

**Findings of Direct Relevance to Nursing and Residential Care Home Settings**

Variance in practice was revealed, ranging from identified implementation strategies, processes across organisations e.g. paperwork, what went in the Red Bag, type of Red Bag and other documentation which accompanied the Red Bag. The surveys to care homes elicited 40 responses (as of April 30th 2019). The majority of the responses were from Managers (92.5%, n= 37), Nurses (5%, n=2) and a self-reported Deputy Manager (2.5%, n=1). All respondents were employed full-time on a permanent basis, with 90% (n= 36) working during the day, and 10% (n=4) working at night. When asked if they were aware of the procedures for the transfer of patients to hospital, 95% (n=37) reported they were, and 5% (n=2) said they didn’t know. One form was not completed fully with regard to this question.

When asked to describe the Red Bag scheme, the following in-vivo quotes reflected perceptions of the process in practice (Permission was granted by participants of the evaluation for the sharing of these quotes prior to data collection). Responses ranged from short answers to lengthy descriptions. It was noted that there was greater emphasis on the journey *to* hospital rather than the return to the care home following discharge.

For example, the following quotes:

*‘A safe system of transport of paperwork relevant to the service user’*

*‘Upon transfer, we complete the documentation with the info relating to the reason for admission and the checklist of any accompanying records. Also, overnight clothes, pads etc. go in the Red Bag. The ambulance crew sign off receipt of everything and then again in the hospital. The hospital fill in the return to care home document and continue the tick-list for the accompanying items and the care home then sign it off upon return to the care home’*

Participants were then asked what they felt worked well with the process of transferring residents from care homes, with 36 responding and 4 not answering the question in line with the previous question logic. The following quotes are examples which reflect the respondents’ perspectives:

*The process works well in our care home as our carers have a good knowledge and understanding of the residents who they care for and can pass this information on to hospital staff*

*Having everything in one place for the individual regarding them, person centred*

*Ambulance crew are usually helpful and supportive*

It is noted that 8 of the responses contained negative comments despite the question asking for what had worked well. These were worthy of note and typified by the following quotes:

*The Red Bag works effectively. However we don't always get the Red Bags back especially if a resident has passed away in hospital.*

*The Red Bag scheme works well from our end of the process, however we rarely receive the bag back and if we do, it is often not filled in by the ambulance service or the hospital staff on the wards or A & E*

Respondents were then asked what could be improved in the context of the Red Bag Scheme, with 37 respondents providing comments. The following quotes reflect the main issues articulated:

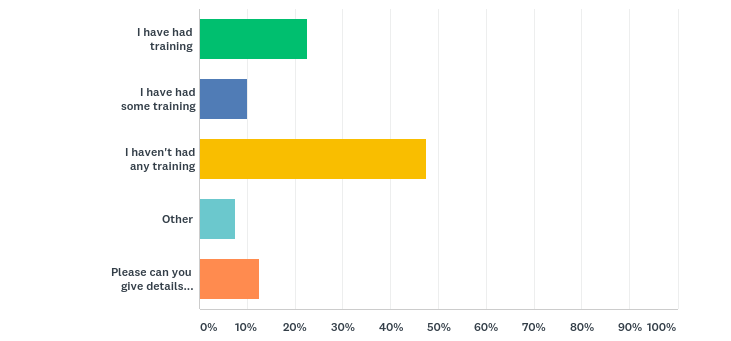
*There is a lack of communication between hospital wards and we find quite often that we receive telephone calls asking for information which we know were handed over to hospital staff. This sometimes happens days after the resident has been admitted…*

*The bag does not always return from the hospital and the home has to chase up the whereabouts of the Red Bag.*

*Some documentation sent previously was not always looked at by hospital staff resulting in lots of telephone calls.*

Participants were asked to state the training they had been given in the transfer of care of residents including the Red Bag Scheme. All participants responded, with nearly half of the respondents (47%, n= 19) reporting not having any formal training in relation to the Hospital Transfer Pathway (see Figure 2).

Figure 2: Respondent reported levels of training in the transfer of care



For the 23% (n= 9) who had training and the 10% (n=4) who stated having some formal training, examples of responses are:

*Documentation to support this initiative & face to face short discussion with representative.*

*I received a visit from a staff member explaining the procedure to me, which I passed onto fellow staff.*

Respondents were then asked about their confidence levels in terms of knowledge and awareness of procedures of transferring residents to hospital with 67% (n= 27) stating they were very confident, 28% (n=11) somewhat confident, 2.5% (n=1) feeling not so confident and 2.55 (n=1) not confident at all.

Participants were then asked what further training they felt was needed, with 29 answering the question and 11 declining to respond. Half the respondents stated they did not have any further training requirements, and the other half typically expressed their training needs as:

*I would like training for staff so they are more aware of the procedure of the bags.*

*Any training is a bonus*

Finally, participants were asked for general comments and suggestions around the transfer of residents in their care. Two thirds (n=28) responded to this question and within this, ten said they did not have any suggestions. The comments and suggestions were framed around improved communication, increasing the number of Red Bags available, ensuring paperwork is completed across the pathway, defining expectations of organisations and reducing overall time taken to complete paperwork.

*The process for our clients being admitted onto a ward can take up to 8 hours and staff need to stay with the client. Would there be a way of looking into the procedure to make this less stressful for the patient who is waiting but also given then information in the bag, should staff be required to stay until ward bed is available if not necessary?*

*Everyone using the Red Bag as standard. The forms that come with the bag could do with being reviewed if some sections are not being completed by some departments.*

Further data from meetings was collected from key staff in Clinical Commissioning Groups (n=6) which was analysed and compared with the findings from the care homes to give further contextual relevance to the findings from care home staff.

In line with the bricolage approach, further data was collected through telephone calls, targeted emails, individual, face to face and small group meetings with key Trust staff and attendance at multi-organisational (CCGs, Local Authority) scheduled meetings where the Red Bag was discussed in routine practice. The face to face meetings were undertaken as informal discussions, rather than as semi-structured interviews in order to facilitate a natural conversation, capture nuances of the organisations and allow the researcher to observe staff in a work environment. It also established a mutual reciprocity between the researcher and staff member(s) as equal partners in the discussions, which is important in qualitative research, to aid the flow of conversation (Charmaz, 2014).

Prompts resulted in in-depth discussion and were deemed useful in practice, these are outlined below as:

1. Please can you tell us how many care homes there are in your locality relative to those who have implemented the scheme?
2. Please can you tell us when the Red Bag was launched and if possible the process that led to the formal launch? (We are aware that this isn’t necessarily a standardised process and we are keen to capture these different approaches.
3. Would you let us know what has worked well with the Red Bag in practice? (for obvious reasons, if we can identify and advocate potential areas of best practice, that would be great)
4. Can you let us know the reflective cycle outcome following implementation of the scheme in practice i.e. what the key lessons learnt are and how this will influence being able to move forward? Are there specific reflections that have taken place on process and practice with the Red Bag?
5. Can you let us know what hasn’t worked as well, and specific issues relating to this, where/if possible? (this will afford us a degree of critical reflexivity in moving forward which we are keen to capture)

Variance in how the Red Bag scheme was implemented in each locality was evident – for example with the timing of the launches, how long the scheme has been in practice, how it has been rolled out (some localities took a phased approach) and two localities in various stages of re-launching the scheme at the time the evaluation was completed. As a result of this, it was difficult to make comparisons between localities as there was insufficient data to provide a retrospective account, however the following typical quotes highlight the findings which are consistent with the data collected from care home staff:

*The care homes having an opportunity to use the Red Bags when a resident is transferred to hospital have been very good in feeding back both good and bad things about their use.*

*The paperwork had been changed accordingly as we have moved along through the process. Some further simplifying could help to reduce time filling in the paperwork.*

*We also had issues raised about the DNACPR forms which are being addressed.*

**Theme 1: Conflicting priorities**

Healthcare service personnel involved in the implementation of the Red Bag initiative as part of the patient care transfer pathway provided an insight into the adoption and potential use of them in the longer term. A salient theme though, were the conflicting priorities of the healthcare professionals implementing the Red Bag scheme. As with any other innovation, resources are evidently an issue in relation to the thorough training and assessment of staff in how to use the Red Bag as a resource in practice, building consensus as to the inherent value of the Red Bag as a product in practice and also advocacy for early adoption and implementation, the number of innovative approaches to longstanding processes often outstrips the resources necessary for their effective implementation. Within this context, it was the severity of the emergency, which ultimately impacted on the capacity of staff to prioritise the Red Bag as an integral part of the patient care pathway, and often also led to the fewest returns of the Red Bags back to residential care settings.  These findings are entirely consistent with extant literature from the field of care, which illuminate the relevance of the population targeted, the health benefits likely to result from implementation and the perception of the intervention as an innovative approach to a relatively routine task, where staff may be resistant to change or not necessarily perceive any benefit to the addition of different or further functional tasks as an integral part of their respective roles (Erdem and Thompson, 2014). This raises important issues in relation to how clear and unambiguous parameters of Red Bag implementation in practice can effectively be traded off against relatively unclear procedural regularity of use and subsequent return in practice. In relation to the everyday implementation of the Red Bag scheme in practice, this has important repercussions for all staff responsible for patient transfer, regardless of their organisational origins. Methods adopted within the study have successfully illuminated, though, the means in which processes might be better facilitated in relation to the situated nature of care and how the delineation between professional roles and contexts might be incorporated for awareness raising in for example, training sessions on implementation of the scheme.  It is also important to acknowledge the relative overlap of themes throughout this analysis. For example, the concept of conflicting priorities is of direct relevance to the attribution of responsibility and the capacity of interprofessional working to accommodate differences in approach of implementation.

**Theme 2: Attributing Responsibility**

Within and between the healthcare organisations taking part in the evaluation, it was evident that the attribution for responsibility was characterised by perceived level of belonging to the organisational hierarchy and this was explicitly linked to the capacity of staff to prioritise the Red Bag as a process in their everyday activities with patients. Staff perceived to work in abstraction from secondary and primary care settings, for example those working in residential care home settings, articulated a clear sense of ownership of the scheme, whereas those healthcare practitioners working in secondary care settings articulated feeling less accountable and less responsible for the Red Bags following handover in practice. This is indicative of the need to improve the interprofessional and interdisciplinary dynamics between staff in different organisational settings but also of the need to improve awareness raising of the knowledge that all staff have, of others in healthcare practice systems which ought to be patient rather than practitioner centric. This has also been reflected in pedagogical literature, reflecting a need for the active consideration of this in the formal training and education of healthcare staff, regardless of their level in the organisational hierarchy (Vereen et al, 2018; Zamjahn, 2018) .  This is a particular issue when paramedics hand over to secondary care contexts in Accident and Emergency services and less so in the context of the interrelational working between front line care staff in residential care settings at the point patients are transferred into paramedic care. Armstrong et al (1982) indicated the evident need for change management to become an integral part of quality improvement where power loci can effectively be limited at the points at which the opportunity for quality improvement may be potentially jeopardised. This is of significance to this study where the Red Bag scheme illuminated the need for staff to perceive the process of implementation as a positive chance to improve the quality of patient centric care that is being engaged with across multi-agency settings.

**Theme 3: Understanding and communicating needs of other organisations**

Participant commentaries revealed the need for a process of ongoing improvement of communication within and between organisations generally and healthcare practitioners, regardless of their level in the organisational hierarchy specifically. Findings from this study highlighted that it is difficult but increasingly important to establish communication channels to support those happening beyond the context of fixed organisational structures, so that patient care transfer pathways can remain open to tacit and responsive change wherever necessary so that optimal provision of patient care pathway transfers can be provided wherever organisational structures permit. This will also serve to highlight the bases of accountability and responsibility within key care settings and how the interprofessional communications underpinning these are pivotal to the potential success of this. This ought not only to be a feature of the ongoing training and education that existing qualified staff receive but a feature of initial education and training programmes for all staff, that highlights the significance of effective collaborative working and how central effective mechanisms of communication are to this.  Reducing the ambiguity of core communication is key to this, from the findings of this study. Central to the understanding of the need for implementation and early adoption is the provision of knowledge of the initiative to be implemented, in this instance the Red Bag transfer pathway. Ensuring equity and parity in the information provided within and between organisations, organisational hierarchies and the staff employed in different healthcare professional groups is paramount to the success of this, as is already well annotated in the published literature (Bokhour et al, 2018). Ensuring this enables all staff working in collaboration with others from differing backgrounds to have an adequate insight and capacity to engage with new initiatives in healthcare practice. Healthcare practitioners have provided findings that clearly broaden understanding of how these problems manifest in practice and as a consequence of this, actions to improve interprofessional working, collaboration, the co-construction of shared knowledge and communication, are now highlighted for address. These are issues raised in contemporary literature surrounding healthcare working relationships in practice ( Moretta Tartaglione, 2018; Rosen et al, 2018 ).    
  
**Theme 4: Challenging perceptions of organisational status as hierarchies of care**

The perceived power balance of organisational hierarchies was perceived as a barrier to the effective implementation of the Red Bag patient care transfer pathway in practice. Longstanding reports of the impact of delineation within and between members of staff in different organisations and settings are evident in published literature (Godin et al, 2008; Gormley,2018; Mitchell, Boyle and Von Stieglitz, 2018). Our findings reveal that this is most apparent in relation to those working in the context of residential care settings, the perceptions of which, by other members of the healthcare professions and in particular secondary care staff do not reflect the expertise of these healthcare professions, despite the fact all that differs in care delivery is context. This is reflective of work already undertaken to investigate the perceived marginality between professional disciplines and contexts and is one which ought to be further developed (Saks, 2015).  
  
**Discussion**

## **Recommendations for organisations**

There is an overarching need for communication to be improved between organisations. Although we acknowledge variation in practice in localities and within the individuals and organisations, the Red Bag is most effective when accompanied by robust processes for communications. The communication breakdowns appear to occur during handover of care home residents from one organisation to another a demonstrated in Figure 1 (see page 6)

There appears to be a disconnect between care homes and NHS Trust staff, the latter who often held care home staff responsible for delays in transfers of care. This may be down to a lack of knowledge about the processes involved and the organisation of care within this setting. Trust staff should have an awareness of how care homes are organised and why certain processes occur, so they are able to better understand the context behind processes, may lead to improved communications between the two organisations which would potentially inform better working practices.

It is recommended that there are meetings between key staff in NHS Trusts and Care Homes to identify and discuss issues relating to care, and work collaboratively to establish mutually beneficial processes and that these processes are piloted and evaluated and are reviewed on a regular basis.

Additionally, both care homes and NHS Trusts need to work with ambulance services to discuss the delays and how collaboration and communication can be improved. It is recommended that the ambulance service is actively involved in discussions and recommendations for forward planning and processes.

The perspectives of the ambulance service staff to date showed that there were variances in practice and interpretation of the Red Bag and highlighted the importance of training and education in the interpretations of hospital transfer pathway, and the need to have clear processes and effective communication between organisations.

**Guidance on mapping to the RE-AIM Framework in localities**

It is suggested that organisations in each locality map their implementation and current status of the HTP against the RE-AIM framework to provide insight and discussion to inform future planning using, and possibly adapting the following framework (below) as a guide:

|  |  |  |
| --- | --- | --- |
| RE-Aim Dimension | Addresses | Areas for discussion |
| Reach | Define participants across the organisations involved | Who is leading the HTP processes in each organisation?  Who else needs to be involved?  How effectively has awareness of the HTP and Red Bags been communicated? |
| Effectiveness | Define benefits that are trying to be achieved and identify any negative consequences | How effective is the Red Bag in the hospital transfer pathway?  What are the identified barriers to success? |
| Adoption | Where is the HTP being applied and who is applying it? | Who/where/how has the Red Bag in the HTP been adopted in practice? |
| Implementation | How consistently is the Red Bag scheme being applied, what are the barriers and enablers? | Within the implementation process: ---What has worked well?  -What areas need to be further developed?  -What are the lessons learnt? |
| Maintenance | What can be shared to inform development of sustainability? | How can best practice be shared:  -Across locality?  -Across organisations?  -What do we need to do to sustain the processes? |

## **Key Lessons learnt from Organisations**

Participants provided lessons learnt from their own practice, which could inform recommendations for implementation and adaptation of the scheme in practice:

1. Paperwork ought to be simplified to reduce the overall time taken to complete it.
2. Focus on the communication and process, this ought to be an area for focus rather than on the Red Bag itself.
3. Having Red Bag screen savers on hospital computers raises awareness of the bag and raises awareness of it in practice, which is needed given the size of NHS Trusts and the potential number of staff who may encounter their use in everyday practice.
4. Communication with all NHS Trust sites who receive admissions and all wards should be informed of Red Bags and the importance of returning the documentation to the bag.
5. Ensure there are asset logs of the bags.
6. Laminate documentation as a master copy to raise awareness with staff, possibly completed correctly as an exemplar to highlight best practice and encourage complete paperwork.
7. Maximise the opportunities to use IT solutions in the process going forward.
8. Have the documentation in a red plastic folder inside the Red Bag, so if it is taken out of the bag, the red folder is a prompt to return it to the Red Bag and reinforces the care home resident status (this has improved the rates of paperwork being returned to the bag on wards)
9. Wrist bands on patient (hospital ID) with matching ones on the Red Bag handle (print out 2 at time of admitting to hospital)
10. Ward handover checklists.
11. Giving care home staff the opportunity to challenge demands from hospital staff, i.e. asking ward staff to look for missing paperwork as opposed to care home having to send it in again. Keeping a list of recurring staff/wards where this is a continuous problem in order to escalate to manage the situation.
12. Reinforcing that the hospital transfer pathway is not about the Red Bag, but about effective communication. The Red Bag should facilitate, not replace communication.

## **‘Top Tips’ for all Interprofessional Working in Partner Organisations**

The findings of the evaluation are summarised into eleven ‘top tips’, which have been framed under the acronym ‘COMMUNICATE’ which underpins the ethos of the Hospital Transfer Pathway:

C Consistent use of the transfer bag across the care pathway is crucial

O Opportunities to participate must be open to everyone

M Messages need to be clear, concise and consistent

M Measuring success is imperative – reflect along the way

U Understanding the importance of handover points is pivotal

N Nurture your champions

I Innovative ideas should be encouraged

C Collaboration is paramount

A Assess the readiness of organisations before you start

T Train staff to understand the process and documentation at the outset

E Ensure the transfer bag stays with the resident throughout their journey

**References**

Armstrong, N., Brewster, L., Tarrant, C., Dixon, R., Willars, J., Power, M., & Dixon-Woods, M. (2018). Taking the heat or taking the temperature? A qualitative study of a large-scale exercise in seeking to measure for improvement, not blame. *Social science & medicine*, *198*, 157-164.

Bokhour, B. G., Fix, G. M., Mueller, N. M., Barker, A. M., Lavela, S. L., Hill, J. N., ... & Lukas, C. V. (2018). How can healthcare organizations implement patient-centered care? Examining a large-scale cultural transformation. *BMC health services research*, *18*(1), 168.

Charmaz, K. (2014). *Constructing grounded theory*. Sage.

Corson, D. (1991). Educational research and Bhaskar's conception of discovery. *Educational Theory*, *41*(2), 189-198.

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2011). *The Sage handbook of qualitative research*. Sage.

Erdem, S., & Thompson, C. (2014). Prioritising health service innovation investments using public preferences: a discrete choice experiment. *BMC health services research*, *14*(1), 360.

Finch, C. F., & Donaldson, A. (2010). A sports setting matrix for understanding the implementation context for community sport. *British Journal of Sports Medicine*, *44*(13), 973-978.

Glasgow, R. E., Vogt, T. M., & Boles, S. M. (1999). Evaluating the public health impact of health promotion interventions: the RE-AIM framework. *American journal of public health*, *89*(9), 1322-1327.

Godin, G., Bélanger-Gravel, A., Eccles, M., & Grimshaw, J. (2008). Healthcare professionals' intentions and behaviours: A systematic review of studies based on social cognitive theories. *Implementation Science*, *3*(1), 36.

Gormley, G. J., Dempster, M., Corry, R., & Brennan, C. (2018). ‘When Right could be so Wrong’. Laterality Errors in Healthcare. *The Ulster medical journal*, *87*(1), 3.

Holtrop, J. S., Rabin, B. A., & Glasgow, R. E. (2018). Qualitative approaches to use of the RE-AIM framework: rationale and methods. *BMC health services research*, *18*(1), 177.

Mitchell, R., Boyle, B., & Von Stieglitz, S. (2019). Professional commitment and team effectiveness: a moderated mediation investigation of cognitive diversity and task conflict. *Journal of Business and Psychology*, *34*(4), 471-483.

Moretta Tartaglione, A., Cavacece, Y., Cassia, F., & Russo, G. (2018). The excellence of patient-centered healthcare: investigating the links between empowerment, co-creation and satisfaction. *The TQM Journal*, *30*(2), 153-167.

Rosen, M. A., DiazGranados, D., Dietz, A. S., Benishek, L. E., Thompson, D., Pronovost, P. J., & Weaver, S. J. (2018). Teamwork in healthcare: Key discoveries enabling safer, high-quality care. *American Psychologist*, *73*(4), 433.

Saks, M. (2015). Inequalities, marginality and the professions. *Current Sociology*, *63*(6), 850-868.

Sweet, S. N., Ginis, K. A. M., Estabrooks, P. A., & Latimer-Cheung, A. E. (2014). Operationalizing the RE-AIM framework to evaluate the impact of multi-sector partnerships. *Implementation Science*, *9*(1), 74.

Vereen, L. G., Yates, C., Hudock, D., Hill, N. R., Jemmett, M., O’Donnell, J., & Knudson, S. (2018). The phenomena of collaborative practice: The impact of interprofessional education. *International Journal for the Advancement of Counselling*, *40*(4), 427-442.

Zamjahn, J. B., Beyer, E. O., Alig, K. L., Mercante, D. E., Carter, K. L., & Gunaldo, T. P. (2018). Increasing awareness of the roles, knowledge, and skills of respiratory therapists through an interprofessional education experience. *Respiratory care*, *63*(5), 510-518.