Guy's and St Thomas' NHS
NHS Foundation Trust

Discharge Checklist from Hospital to Care Homes

GUIDANCE NOTES

Guy's and St Thomas' Hospital (GSTT) is standardising the process of transfer of care between the hospital setting and nursing and residential homes in Southwark and Lambeth. This guidance sets out best practice in terms of what information is shared with the care homes and how to ensure a safe transfer of care for the patient, support a patient centred process and help reduce avoidable readmissions.

The notes below are intended as a guide for hospital staff when preparing a patient to be discharged to a care home. It should be used as part of the discharge bundle and supported by other appropriate GSTT policies or national standards.

The discharge pack should be pulled together as part of the discharge planning process and accompany the patient at the point of discharge so that the care home has one pack of all the required information from which to develop care plans for their residents.

REQUIRED INFORMATION

The following documents must be completed as part of the discharge pack for every patient being discharged to a care home;

1. **Nursing Transfer Letter (required)**: Please complete the Nursing Transfer Letter and ensure the care needs of your patient at the time of transfer are detailed here. This must include all activities of daily living (ADL). Please attach any relevant assessments and/or charts where appropriate. Ensure it includes falls and weight loss during admissions.

2. **Discharge Summary/To Take Away Medication (required):** Summary of medical investigation, new diagnosis and intervention during admission. Any new diagnosis or new prescription developed during each admission should be recorded including a medication list.

   It is the responsibility of the multidisciplinary team, in line with the discharge principles, to ensure discharge summary and transfer letters cover all interventions within the period of admission and further management plan of care on discharge. All other existing guidance regarding discharge must be followed including medication reviews and referral to GP and community team if appropriate. *Before sending the discharge summary please check GP information is up to date.*

ADDITIONAL INFORMATION

The following documents should be included within the discharge pack if they are required;

3. **DNACPR**: If a patient is admitted to hospital acutely unwell, or becomes clinically unstable in their home or other place of care, and they are at foreseeable risk of cardiac or respiratory arrest, a judgement about the likely benefits, burdens and risks of CPR should be made as early as possible. This should be discussed with the patient and/or family. If it is agreed that a DNACPR should be put in place, this must be completed and the **must be sent** with the patient on discharge. If the patient already has a DNACPR in place, this should be reviewed during their admission to hospitals. Once reviewed, the **form must be sent** with the patient on discharge[1].

[1] DNAR- Joint Guidance from the British Medical Association, Resuscitation Council (UK) and the Royal College of Nursing.' 2014

4. **Health Needs Assessment**: A current London Health Needs Assessment must be completed by the ward Multidisciplinary team and approved by the Panel for all new placements. If the patient is being placed in a Care/Nursing Home for the first time, please complete a HNA and include as part of the discharge pack.

   Decision Support Tool: A current Decision Support Tool must be completed by the ward multidisciplinary team and approved by the Panel for all new nursing home placements. If the patient is being placed in a Nursing Home for the first time, please complete a DST and include as part of the discharge pack to the Nursing Home.

5. **PEACE document**: Proactive Elderly Advance Care (PEACE) document must be considered for all transfers to care homes, and completed where applicable. Patients who are on a palliative trajectory should be prioritised for completion of PEACE. You can download the PEACE document from http://gti/clinical/directorates/acutemed/ageing-and-health/policies_and_procedures/policiesandprocedures.aspx or search on GTI .

6. **This is me:** A practical tool for people with dementia which tells staff about their needs, preferences, likes, dislikes and family life and supports the transfer of care of the patient between care settings. If a patient has a diagnosis of Dementia and does not have a This is me document, staff should complete and ensure the document is transferred with the patient. If the patient already has a This is me document, please send with the patient when discharged.

Items 7 to 11: If a new report has been carried out or it has been reviewed for the patient while in hospital, please include in the discharge pack.

12. **Skin protocol/pressure ulcers/body map:** Skin must be assessed by staff on the day of discharge to document the condition of pressure areas, possible bruises or marks on the body, waterlow score and what the possible causes are. The body map must be included in the discharge pack to ensure the Care/Nursing home is well aware of any problems. TVN recommendations should include positioning and dressings. Referral to community TVN should be documented in the Nursing Transfer Letter if not done so already.

13. **Catheter Passport**: If a patient is catheterised during their stay in hospital, a Catheter Passport must be completed and given to the patient as part of the discharge process. The passport should be completed with type of catheter, any known history and infection control measures including antibiotics administered on insertion. If the patient was admitted with a catheter passport please document any changes or problems resolved in the passport and ensure it is given back to the patient.

14. **Other:** Please include any other documents you think need to be included in the discharge pack for the patient.

OTHER INFORMATION

Medication: Medication reconciliation on discharge. Stopped, reviewed, newly prescribed medication and reasons must be indicated on discharge to care home with a review date by the GP. The person responsible for a resident's transfer into a care home should coordinate the accurate listing of all the resident's medicines (medicines reconciliation) as part of a full needs assessment and care plan[2]. A two week stock of medication is advised on discharge. Dressings are given on discretional basis and wound condition. Registered nurse must check current medication with prescribed medication on discharge and be signed by 2 Registered nurses. Medication must be discussed with the patient on discharge.
http://www.nice.org.uk/guidance/sc1

[2] Ref: NICE guidance on managing medicines in Care homes - 1.7 & 1.7.3.