Guy's and St Thomas' NHS
NHS Foundation Trust

Transfers of care bundle
5Cs

1. **C**are Home transfer to hospital
2. **C**ommunication
3. **C**oordinate MDT planning
4. **C**hecklist for discharge
5. **C**all to follow up

Why use the transfer of care bundle

- ✓ The bundle sets out best practice for transfers of care between care homes and hospital
- ✓ Using the bundle will enable improved transfers of care and experience for patients / residents

When to use it

- ✓ In care homes, if a resident requires transfer to hospital
- ✓ In hospital, for all care home residents that require transfer to care home

How to use the discharge bundle

- ✓ Follow the 5 steps ensuring each section is completed, guidance is provided

Patient journey – how to use the bundle

1

PATIENT AT CARE HOME

- LAS call required
- **Transfer Form: care home to hospital completed**
- Escort accompanies resident where possible

ATTENDANCE AT EMERGENCY DEPARTMENT

- **Transfer Form: care home to hospital received**
- Diagnosis, intervention and decision made

2

ADMISSION TO MEDICAL ADMISSION WARD

- Patient identified at Board round as a care home resident – bundle triggered
- Coordinator identified

3

TRANSFER TO HAU WARD

- Early coordinate MDT planning for discharge

4

TRANSFER TO CARE HOME

- Completion of **Discharge Checklist**
- No discharge to nursing home after 5pm
- Contact number of senior nurse for queries

5

FOLLOW UP CALL BY HOSPITAL

- Within 24-48 hours by Discharge Coordinator/Senior Nurse

1

DISCHARGE TO CARE HOME

- Complete the **Transfer Form; ED to care home** for any patients being discharged directly from ED
- Advisory leaflet given to patient
- Copy saved in patient notes

TRANSFER OF INFORMATION TO GP

- send relevant information to GP

Guidance Notes

1 CARE HOME TRANSFERS

- Care homes must send relevant documentation with the resident into hospital. The **Transfer Form; care home to hospital** should be used to check that all the relevant documents have been included.
- When the resident is received in hospital, all patient information including current condition must be documented on EPR, either in ED (if patient is not fully admitted) or once they are transferred to a ward. Record any verbal information that may have been received from the care home escort or London Ambulance Service. This is essential in determining the patient's condition on admission.
- All patients should be transferred with the following 3 documents – Transfer Letter, MAR Chart and a Body Map. These should be filed in the patient's medical notes. If a patient is admitted without these 3 documents please speak to the care home contact to request the forms.
- **If** the patient is discharged from the Emergency Department, the **Transfer From; ED to care home** should be completed. **If** the patient is to be admitted, follow steps 2-5.

2 COMMUNICATION

- Once a patient has been admitted to a ward, as soon as they are recognised as a care home resident step 2 of the bundle should be triggered.
- It is important that there is an exchange of information between the hospital and the care home to inform decision making, treatment and intervention within the hospital. Please confirm whether this has occurred and if the patient's current condition has been ascertained.

3 COORDINATED MDT PLANNING

- Professionals/multidisciplinary team must document their discharge plan and agreed date of discharge. Discharge co-ordinator must inform the care home of planned discharge date 2-4 days prior to the agreed date.
- If a pre-assessment by the care home is to be made, it must be arranged and supported by the ward staff, and it should take place 2-4 days prior to the agreed discharge date. The pre-assessment allows the care home to review the patient prior to discharge and assess their needs to ensure a comprehensive care plan is put in place. If the patient is returning to the care home, this pre-assessment will allow them to determine if their needs have changed, and whether they can meet them.
- Please ensure the care home have been informed of and agree with the discharge date of the patient.
- The patient and relatives should be kept well informed of progress and the discharge date. Discharge co-ordinator should ensure they speak to the patient and family when required.

Guidance Notes

3 COORDINATED MDT PLANNING – Continued…

- It is necessary to establish early if a patient requires a HNA, DST or PEACE document prior to discharge. Ensure this is taken into consideration when discussing the discharge date.
- The multidisciplinary team need to determine equipment and any community referrals that are required by the patient on discharge. Please ensure the outcome of this discussion is finalised in time for the discharge date.
- To ensure a smooth discharge process, all medication that is required on discharge should be ordered in plenty of time to allow the patient to be discharged on the agreed date. Any reviews, changes, newly prescribed and stopped medications should be highlighted in the discharge summary.

4 CHECKLIST FOR DISCHARGE

- Please complete the Hospital to Care Home Discharge Checklist to ensure all the relevant documentation has been collated into the discharge pack. The contents of this pack should be discussed with the patient and/or family member/carer to ensure they are familiar with the information included in the pack. This pack should go with the patient to the care home to ensure a comprehensive care plan can be developed.
- The multi-disciplinary team must agree on the final date and time for discharge.
- It is important that the patient is discharged on the day with the correct medication and an accurate list of this is included in the discharge pack.
- Transport is an essential element of the discharge process and should therefore be arranged as soon as the discharge date is known. Transport should be organised for the hours of 9am to 5pm between Monday and Friday.

5 CALL TO FOLLOW UP

- A follow up phone call should be made with the named care home contact (detailed in the Transfer Form – Care Home to Hospital) within 24-48 hours of the discharge. This call should be made by the discharge co-ordinator or lead person.
- This follow up call will establish if a safe discharge has been achieved and if all parties involved are satisfied with the discharge process. If there are any issues raised by the care home this should be fed back to MDT and resolved.
- This follow up call is important to promote continuity of care between the settings and supporting care home staff with developing/ initiating a comprehensive care plan. It call also be used to initiate a discussion on advance care plan and end of life care.

Please ensure a copy of this Discharge Bundle is filed in the patient notes in the hospital and the Discharge Co-ordinator keeps a copy.