Transfer Form: Care Home to Hospital

Please ensure that this checklist is completed (with required attachments) for every patient who is transferred to an Emergency Department. Please refer to the guidance notes over the page when completing this form.

Resident/Patient's Name:		**Date of Birth:**	
NHS Number:		**Hospital Number:**	

Care Home Name:		**Named Nurse:**	
Care Home Number:		**Fax Number:**	

Date of Transfer:		**GP Practice:**	
GP Name:		**GP contact number:**	

Next of Kin details:	

REQUIRED INFORMATION		**YES**	**NO**	**COMMENTS**
1	**Transfer Letter**			
2	**Medication (MAR) Chart**			
3	**Skin damage/pressure ulcer plan – Body Map**			
ADDITIONAL INFORMATION (if applicable to the patient)				
4	**Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) – original copy or photocopy**			
5	**PEACE document**			
6	**This is me/my preferences/other**			
7	**Other**			

FURTHER INFORMATION	**YES**	**NO**
Is there a DoLS in place?		
Does the resident have a Co-ordinate My Care (CMC) record?		

Signature: _____ **Designation:** _____

FOR THE ATTENTION OF THE EMERGENCY DEPARTMENT:

If a resident is discharged from the Emergency Department back to the care home, please complete the 'Emergency Dept to Care Homes Transfer Form'. This form sets out for the care home what actions took place in the department, diagnosis and changes to medications and/or treatments.

GUIDANCE NOTES

This transfer form is designed to standardise the process of transfer of care between the nursing and residential homes in Southwark and Lambeth and the hospital setting. This guidance sets out best practice in terms of what information is shared with the hospital when a patient is presented to the Emergency Department. If the documentation is not available at the time of admission, please forward the information as soon as it is available.

PATIENT INFORMATION: Please insert the correct data of the resident including the named nurse at the care home and the resident's GP name and number. This information enables hospital staff to access past medical notes and interventions and will also enable staff to send the discharge summary to the right GP when the resident is discharged.

REQUIRED INFORMATION

1. **Transfer letter:** Please complete the transfer letter and ensure the care needs of the resident at the time of transfer are detailed here. This document, which is care home specific, must include the following:
    a. Clinical presentation, diagnosis and current condition
    b. Capability of the resident including current status of the resident and regular day to day activities
    c. Continence care/Catheter Passport
    d. Behaviour
    e. Cognition status
2. **Medication (MAR) Chart:** Please include the most **up to date** version of the MAR Chart. This document details the prescription of medication by the resident's GP and administration of medication by the nurse, including frequency and how it's administered. This will help to inform hospital staff of the resident's current medications.
3. **Skin damage/pressure ulcer plan and body map:** Please document the current skin condition and illustrate this on the body map, this completed body map should be transferred with the patient. The most up-to-date pressure ulcer plan (wound care plan) should be included to give clear evidence of previous activities, management and further plan for the wound. Please also include a copy of the patch record chart if used. Both these documents will ensure the hospital staff are well aware of any problems prior to admission.

ADDITIONAL INFORMATION

4. **DNACPR form:** If there is a DNACPR in place for the resident (evidence of a medical decision for the resident not to be considered for resuscitation), the original copy or a photocopy of the form should be sent on transfer of the resident to the hospital. It will be reviewed in the hospital prior to discharge and returned with the patient.
5. **PEACE document:** If a resident has a PEACE document in place, transfer to hospital must be considered carefully within the context of the resident's stated preferences. If the decision is taken to transfer the patient to the hospital, please ensure this document is transferred with them. This will allow hospital staff to review the document and update any further decisions for advance care planning on discharge.
6. **This is me/my preferences/other:** This document is fundamental in the management of residents with significant cognitive impairment and with communication difficulties. The document expresses their wishes and preferences which will inform professionals on how to manage their care in any setting. If a resident has a This is me/my preferences document, or care homes own person centre profile, please send with the resident when transferred to hospital.
7. **Other:** Please include any other documents you think need to be included when transferring the resident.

FURTHER INFORMATION

1. Please indicate if there is a DOLS in place.
2. Please indicate if the resident has a Co-ordinate My Care (CMC) record in place.

PLEASE ENSURE A COPY OF THIS FORM IS SENT WITH THE RESIDENT ON TRANSFER TO THE HOSPITAL AND A COPY IS KEPT BY THE CARE HOME.

Version 2.2 (October 2015)