Care Home Envelope

CARE HOME / HOSPITAL TRANSFER DOCUMENTATION

CARE HOME: This document must go into Royal Berkshire Hospital with the resident.

ROYAL BERKSHIRE HOSPITAL: This document is to be kept with patient's notes, completed and return to care home with patient on discharge

Patients Name……

DOB…… NHS NUMBER ☐☐☐ ☐☐☐ ☐☐☐☐

Name of Care home: ……

Address of Care home: ……

Telephone number: ……

Patient in Residential Care (no nursing care) ☐ Nursing Care ☐

DNACPR (purple form) in place? YES ☐ NO ☐

Advance Care Plan in place? YES ☐ NO ☐

GENERAL PATIENT INFORMATION

Please ensure that this form is completed in full for every resident that is transferred to Hospital or Care Home.

PERSONAL DETAILS			
Resident/Patient Full Name		Date of Birth	
Preferred Name		NHS Number (if known)	
Care Home Name/Unit (if applicable)		Care Home Contact Name (if applicable)	
Care Home Telephone No. (if applicable)		Current care received within Home: (if applicable)	Resident care ☐ Nursing Care ☐ Dementia ☐ (Please tick)
Next of Kin (NOK) Name		NOK relationship	
NOK Telephone No.		NOK aware of transfer	YES / NO
GP Name		GP Practice	

Permission given by resident / Patient / Power of Attorney for Hospital to discuss care with Care Home	YES / NO	Hospital confirm permission on transfer (if applicable)	YES / NO

Resident Transfer Form- CARE HOME TO HOSPITAL

Please ensure this form (and pages 1&2) are completed in full for every resident that is transferred to hospital indicating their normal presentation.

Date of admission			Time of admission
Who decided to admit? Ambulance ☐	GP ☐	OOH GP ☐ Other ……	Were RRATs team involved: YES / NO

REQUIRED INFORMATION TO BE SENT WITH RESIDENT INTO HOSPITAL	Attached with Transfer Form	Comments/Details
DNACPR (purple) Form	YES / NO	If yes, it must be the original
Advanced Care Plan	YES / NO	If Yes, it can be a copy
Medication (MAR)Chart	YES / NO	
Any Allergies/Intolerances?	YES / NO	Details:
Is the resident on Palliative Care or End of Life pathway?	YES / NO	
All About Me booklet	YES / NO	
Any current Safeguarding issues?	YES / NO	Details:
Is a DoLs in place?	YES / NO	Details:
Skin Damage (Please attach body map if skin damage is in more than one area)	YES / NO	Location: Category: 1 2 3 4 (please circle)

MOBILITY (normally–before being unwell)	How much help do they need? Please tick appropriate…				Equipment Used/Details
Bed	Indep ☐	AO1 ☐ AO2 ☐	Unable ☐ Bedbound ☐		
Chair Type of chair: ……....	Indep ☐	AO1 ☐ AO2 ☐	Unable to sit out in chair ☐		
Mobility	Indep ☐	AO1 ☐ AO2 ☐	Unable ☐		
CONTINENCE (normally –before being unwell)					
Toileting Please tick appropriate for day and night.	Day Indep ☐ AO1 ☐ AO2 ☐	Night Indep ☐ AO1 ☐ AO2 ☐	Day Incontinent ☐ Pads ☐ Catheter ☐ Stoma / Ileostomy bag ☐	Night Incontinent ☐ Pads ☐ Catheter ☐	**If** Incontinent: Urine ☐ Bowels ☐ Both ☐

COGNITION **(normally –before being unwell)**	**YES / NO**	**Details:**
Cognitively Impaired?	YES / NO	
Has there been a recent deterioration in Cognition?	YES / NO	
Does the resident tend to wander?	YES / NO	
COMMUNICATION **(normally –before being unwell)**		
Any speech impairment	YES / NO	
Does the resident have a hearing impairment? Do they wear hearing aids?	YES / NO	Left Ear ☐ Right Ear ☐ ☐
Visual Impairment Do they wear Glasses? Are they registered blind?	 YES / NO YES / NO	For Distance ☐ Reading only ☐
EATING, DRINKING AND NUTRITION **(normally –before being unwell)**		
Does the patient wear dentures?	YES / NO	Top ☐ Bottom ☐
Is the resident on a special diet?	YES / NO	Details: Puree☐ Soft☐Vegetarian☐ Gluten free ☐ Diabetic ☐ Coeliac ☐ Other ☐……..
Is the resident taking nutritional supplements?	YES / NO	
Do they have any swallowing difficulties	YES / NO	

SPECIAL ITEMS	
Description of particular item sent in with resident to hospital, which needs to return to care home. E.g. hair wig, prosthetic leg etc. YES / NO	Details:

ASSESSMENT COMPLETION	
Is the resident or their representative aware they can be provided a copy of the transfer information?	YES ☐ NO ☐
Staff Member Completing form: **NAME:** **SIGNATURE:** **DATE:** **Telephone Number:**	

Patient Transfer Form- HOSPITAL TO CARE HOME

Please ensure this form (and pages 1&2) are completed in full for every patient that is transferred to a care home.

REQUIRED INFORMATION TO BE SENT WITH PATIENT BACK TO CARE HOME	Attached with Transfer Form	Comments/Details
DNACPR (purple) Form	YES / NO	If yes, it must be the original
Discharge Summary / EDL	YES / NO	
TTO's including any allergies	YES / NO	This must include detailed instruction on when and how to take
Advanced Care Plan	YES / NO	If Yes, it can be a copy
All About Me booklet	YES / NO	
Is the resident on Palliative Care or End of Life pathway?	YES / NO	
Skin Damage (Please attach body map if skin damage is in more than one area)	YES / NO	Location: Category: 1 2 3 4 (please circle)

DISCHARGE DETAILS	
Diagnosis / Treatment Details	**Medication**
Current infections e.g. MRSA:	Any changes to medication on this admission YES / NO……Details Details of referrals or follow-up appointments made:

MOBILITY TODAY	What is the resident's mobility and transfer TODAY? Please tick appropriate…			Equipment Used/Details
Has the patient had Physio/OT input whilst in hospital	YES / NO	Details:		
Bed	Indep ☐	AO1 ☐ AO2 ☐	Unable ☐ Bedbound ☐	
Chair Type of chair:	Indep ☐	AO1 ☐ AO2 ☐	Unable to sit out in chair ☐	
Mobility	Indep ☐	AO1 ☐ AO2 ☐	Unable ☐	
Please list equipment to be sent with patient back to the care home:	Details:			
CONTINENCE TODAY:				

Is continence the same as prior to admission? If not, please detail why?	Yes / No Details If new to wearing pads, has referral for supply been made to continence service? Yes / No	If there is a new cathether please give reason why inserted and date due for renewal / TWOC: Date for renewal……TWOC:……..

Toileting Please tick appropriate for day and night.	Day	Night	Day	Night	**If** Incontinent:
	Indep ☐ AO1 ☐ AO2 ☐	Indep ☐ AO1 ☐ AO2 ☐	Incontinent ☐ Pads ☐ Catheter ☐ Stoma / Ileostomy bag ☐	Incontinent ☐ Pads ☐ Catheter ☐	Urine ☐ Bowels ☐ Both ☐

COMMUNICATION TODAY		
Any speech impairment	YES / NO	
Does the resident have a hearing impairment? Do they wear hearing aids? **Are hearing aids with patient on discharge?**	YES / NO YES / NO YES / NO	Left Ear☐ Right Ear ☐
Visual Impairment Do they wear Glasses? **Are all glasses with patient on discharge?** Are they registered blind?	 YES / NO YES / NO YES / NO	For Distance ☐ Reading only ☐
EATING, DRINKING AND NUTRITION		
Does the patient wear dentures? **Are dentures with patient on discharge?**	YES / NO YES / NO	Top ☐ Bottom ☐
Is the resident on a special diet?	YES / NO	Details: Puree☐ Soft☐Vegetarian☐ Gluten free ☐ Diabetic ☐ Coeliac ☐ Other ☐……..
Do they have any swallowing difficulties	YES / NO	
SPECIAL ITEMS		
Any special item sent in with resident to hospital has been returned on discharge (see page 4) YES / NO	Details:	

ASSESSMENT COMPLETION	
Is the resident or their representative aware they can be provided a copy of the transfer information?	YES ☐ NO ☐
Staff Member Completing form: **NAME:** **SIGNATURE:** **DATE:** **Telephone number & Ext:**	

PLEASE ENSURE THIS FORM IS RETURNED WITH THE PATIENT ON TRANSFER BACK TO CARE HOME AND A COPY KEPT IN THE MEDICAL NOTES