Berkshire West 10 Partnership

Good Practice Guidance - Admission of Residents from Care homes to Hospitals and Discharge of residents from hospital to Care Homes

Background

The failure to transfer appropriate information effectively can lead to misinformation, confusion, and the potential for medication errors. This guidance covers information that should be provided to the care home and hospital when a care home resident is admitted or discharged from hospital and what to do if the information is missing.

ADMISSION

Key Points - Admission

- In an emergency situation, transfer to hospital should never be delayed in order to collect all the necessary information.
- Care homes should have a procedure for the admission of a resident to hospital. This should include: planned admissions; unplanned admissions and hospital outpatient appointments.
- When information is supplied with a resident moving into hospital this will improve care.
- The Berkshire West 10 Partnership Resident Transfer Form – Care Home to Hospital should be completed where possible to ensure the hospital receives relevant up to date information to help them care for your resident. This should include personal details for the resident; information which will help the hospital provide personal care and medication details as listed below.
- Care homes staff should send the residents MAR chart with them into hospital. **Care homes do not need to send in medication on admission.**

Types of hospital admissions

A resident may be admitted to hospital either as a planned or unplanned admission:

- A planned admission is when a resident has a planned date for admission to hospital e.g. for a planned operation.
- An unplanned admission is when a resident is transferred to hospital unexpectedly i.e. with no planned date for admission e.g. suspected heart attack.

Whilst there is less time within an unplanned admission it is important that information accompanies the resident wherever possible to assist hospital staff. However, in an emergency situation, transfer to hospital should never be delayed in order to collect all the necessary information.

Care Homes- Reducing unnecessary hospital admissions

Care home staff have a key role in the avoidance of hospital admissions by their residents. Their actions have a direct impact on the maintenance of their residents' health and quality of life. Ensuring a good diet and where possible appropriate exercise, are fundamental to achieving this aim.

In addition, care home staff's **early assessment and detection of health problems**, enabling timely intervention, reduces the need for hospital care. For example: early management of leg ulcers can

prevent serious complications; ensuring adherence to medication, such as drugs for the prevention of osteoporosis, can prevent fracture following a fall; and regular medication reviews can avoid adverse reactions to medicines. (Elderly people tend to take more prescription drugs than other age groups, and research has shown that for every 100 residents in long-term care homes, 10 adverse reactions to medicines happen each month).

Care homes can fulfil their role through the education and training of their staff to provide basic nursing skills, and through close liaison and partnership working with the resident's GP and other community health care professionals, in particular pharmacists, dieticians, podiatrists and physiotherapists.

By early identification of residents nearing the end of their lives care can be planned through the use of Advance Care Plans, Do Not Attempt Cardiopulmonary Resuscitation (DNAR), and the Gold Standards Framework or End of Life Care Register to enable them to stay in the care home at the end of life and avoid an unnecessary and unsettling hospital admission. Medication use can be reviewed and anticipatory drugs prescribed by the GP if required. The care home can contact Pall call service for support and advice on 0300 365 1234.

Care homes will be particularly aware that their residents' health care needs cannot always be equated with their level of dependency: a resident with dementia may be functionally independent yet have major, un-communicated health or nursing needs. Care home staff can therefore help to avoid unnecessary hospital admissions through their awareness and understanding of their residents' behaviours and non-verbal communication, and ensuring early intervention by appropriate health care professionals where necessary.

Care Homes - Hospital Admissions Procedure

Care homes should have a procedure for the admission of a resident to hospital. This should include:

- Planned admissions
- Unplanned admissions
- Outpatient hospital appointments

The admissions procedure should include:

- Completing a Berkshire West 10 Partnership Resident Transfer Form – Care Home to Hospital, has been developed to assist the care homes to send all the information that the hospital require.
- Who is responsible for ensuring the Berkshire West 10 Partnership Resident Transfer Form is completed and that all relevant information such as copies of the MAR charts are included.
- How the resident will get to hospital and if required, who will accompany them.
- Where the care home the resident's admission is documented and who is responsible for documenting this.

In an emergency DO NOT delay admission to hospital to collect the above information. Whist the above information is extremely helpful to hospital staff the residents wellbeing must be the first priority. The most important information for hospital staff in an emergency situation is the residents name and contact number for the care home, so this should be sent with the resident where possible.

All staff should be aware of the procedure and comply with it when an admission of a resident is required.

This form has been developed which care homes can use should their resident be admitted to hospital that contains the above information.

It is important the information is clear, unambiguous and legible. It is also essential that the information is correct at the time of admission and not out of date. Incorrect information can cause as many problems on admission as no information and can lead to inappropriate care. Remember it is unlikely the hospital staff will know your resident and so providing the above information will help them ensure the best care for your resident.

Communication
It is important that information is exchanged on a regular basis between the hospital and the care home to inform decision making, treatment and intervention at the hospital.

The care home staff should call the ward on a regular basis (at least every 2-3 days) to be updated on the progress of their resident and any discharge plans. Information should be able to be shared freely about the resident between the care home and hospital staff. Both the care home and hospital staff need to ensure that any communications are documented in the resident's hospital and care home notes. The ward must ensure that the patient has consented to information being shared with the care home on admission.

Hospital – Ward Admission Procedure
When a patient is admitted to a ward and is recognised as a care home resident the hospital staff should locate the transfer form from the care home to check all relevant information in order to provide best possible care for the patient and to ensure that any equipment/aids that were sent with the patient are still with the patient. The ward staff should then ensure that the form is filed in the medical notes.

If any information is missing contact the care home by phone
Engage with the home on a regular basis (at least every 2-3 days) to update them on their resident's progress and discharge planning.

DISCHARGE

Key Points –Discharge

- When a patient is ready to be discharged from hospital back to a care home, the ward nurse should contact the care home to discuss the discharge and the current supply of medicines.
- On discharge from hospital, The Berkshire West 10 Partnership Resident Transfer Form – Hospital to Care Home should be completed, to ensure the care home receives relevant up to date information to help them care for their resident.
- If a supply of medicine has not been sent but is required, it is essential to contact the ward or the hospital pharmacy immediately for a further supply to ensure required doses are not missed.

Hospital Discharge Process

Communication

When a patient is ready to be discharged from hospital back to a care home, the ward nurse should contact the care home to discuss the discharge and the current supply of medicines. Care homes must be contacted by ward staff 48 hours prior to the residents planned discharge date to inform them of the discharge date. This enables the care homes time to restart any special services for a resident e.g. district nurse visits. For any on-going treatment required following a hospital admission, the hospital will refer the resident to the appropriate community service e.g. District Nursing, Physiotherapy.

If a care home patient, in agreement with the Care Home and Hospital, requires a pre-assessment by the care home, it must be arranged and supported by the ward staff, and it should take place within a reasonable time frame 48 hours prior to the agreed discharge date. The care homes require **up to 48 hours' notice** (Monday to Friday) of the pre-assessment 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/resident 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.

Medication

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.

The Royal Berkshire NHS Foundation Trust (RBFT) is contracted to provide a minimum 14 days' supply of any previous medicine and supply of newly initiated prescriptions on discharge unless this is clinically not appropriate. This includes where appropriate supplies of dressings and appliances.

Documentation

It is necessary to establish early if a patient requires a DNAR or Advanced Care Plan document prior to discharge. Ensure this is taken into consideration when discussing the discharge date.

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 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.

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.

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.

Arrival back at care home

Check that all the information has been received from the hospital

What to do if Information is not sent with the Resident

Transfer Form Missing

If on arrival back to the care home the resident does not have a transfer letter, the care home should contact the ward the patient has been discharged from and ask one of the ward nurses to send this information. The care home needs to ensure that when receiving such information they conform to Information Governance and Data Protection requirements.

The Care home will need to report the incident via the incident reporting process to the Local Authority and discharging hospital.

Medication / Appliances Missing

If a supply of medicine has not been sent but is required, it is essential to contact the ward or the hospital pharmacy immediately for a further supply to ensure required doses are not missed. The discharging ward should then complete an incident form which will ensure that incidents are logged and reviewed.

In an emergency, if medications are not received and you are unable to contact the relevant ward, please contact your GP to ensure that the resident is not without medication.

The Care home will need to report the incident via the incident reporting process to the Local Authority and discharging hospital.

Escalation of queries

If you are unable to get the information from the ward you can contact the following staff for assistance:

Lead Therapist Elderly Care – bleep 047

Claire Manneh, Matron Elderly Care – pager 40424

Theresa Matthews, Matron Elderly Care – pager 40096

Please call the main hospital switchboard on 0118 322 5111.