Hospital Nursing Transfer Checklist and Letter

* To be completed when any patient is being transferred from hospital to a care home or intermediate care bed
* To be included within the **Red Bag** prior to leaving hospital if a patient has one of these

**Wherever possible, this form should be completed electronically and printed. If your hospital does not have this functionality, please use this paper copy.**

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| --- | --- |
| Date of **admission** to hospital: | Date of **transfer (discharge)** from hospital: |
| Patient’s name: | Date of birth: | Gender: | NHS number: | Nursing Transfer Checklist and Letter |
| **Social Worker info (if known):**Name:Contact details: | **Transfer information:**Hospital and Ward name:Ward telephone:Has the NOK been notified? Yes / No / NAHas the Care Home been notified? Yes / No / NA |
| **Care home details**Name:Address:Unit/floor: | **Next of Kin information:**Name:Relationship:Contact details: |
| Is there a current **DOLS** in place? Yes / NoIs there a named **IMCA** or **Advocate**? Yes / NoIf yes, provide a name and contact details:Are there any **ongoing safeguarding** concerns? Yes / NoComments / actions: |
| **Document Checklist** |
| **Required Information:** | **Included?** | **Comments** |
| **Yes** | **No** | **NA** |
| Discharge Notification / Electronic Discharge Letter |  |  |  |  |
| TTA / TTO medication |  |  |  |  |
| DNACPR |  |  |  |  |
| Skin protocol / wound map / body map |  |  |  |  |
| **Also include if available:** | **Yes** | **No** | **NA** | **Comments** |
| PEACE Document |  |  |  |  |
| This is ME |  |  |  |  |
| Occupational Therapy Report |  |  |  |  |
| Physiotherapy Report |  |  |  |  |
| Speech & Language Therapy Report / Care Plan |  |  |  |  |
| Dietician Report |  |  |  |  |
| Mental Health Report |  |  |  |  |
| Catheter Passport |  |  |  |  |
| Other documents? |  |  |  |  |
| Glasses / Dentures / Hearing Aids available? |  |  |  |  |
| **If the patient has been in hospital for > 36 hours please also complete the following 3 pages** |
| **INFORMATION TO SUPPLEMENT THE ABOVE DOCUMENTS** | Nursing Transfer Checklist and Letter |
| **Admission and Diagnosis** |
| **The EDL / Discharge Summary MUST be included with this document**Any additional information regarding admission / diagnosis that the receiving carers should be aware of (e.g. MRSA status, CDT infections, etc)?**Is the patient/carer aware of their diagnosis/prognosis?** Yes / No / Unsure |
| **Medications** |
| Date and time that regular medications/PRNs were **last administered**:……………………………………… |
| **Supplies provided to care home**  |
| Provide details of any **new supplies or equipment** being provided (e.g. respiratory aids, oxygen, IV equipment, PEG feed, etc):Where equipment is not going with patient, what is the **delivery date** (if known):…………………………….. |
| **Personal care and continence** |
| What is the patient’s current ability to **self-care**, including washing/dressing, and any necessary prompts:What is the patient’s **preference regarding washing**?Does the patient have a **catheter**? Yes / NoDetails (include reason for insertion and date due for change) OR attach catheter passport:Does the patient have **faecal incontinence**? Yes / NoHas the patient been using **continence products** whilst in hospital? Yes / NoDetails:Have you provided a **supply of continence products**? Yes / No / Not required |
| **Falls and mobility** |
| Is the patient at **risk of falls**? Yes / NoIf yes, please give details of the falls management plan:Has (s)he required any **assistance or mobility aids** to walk/transfer whilst in hospital? Yes / NoIf yes please specify: |
| **Sensory / communication** | Nursing Transfer Checklist and Letter |
| Are there any **communication** challenges (e.g. dysphasia, language, hearing, etc)?Details:Does the resident use any **sensory aids** (e.g. hearing aid, glasses)? Yes/NoDetails:**Please ensure the patient has all their sensory aids with them when leaving hospital.** |
| **Skin and Wounds** |
| Have you provided a **supply of dressings or other required supplies/equipment**? Yes / No / Not required Where relevant **a copy of the skin protocol / wound map** / body map **MUST** be included with this document**, or complete the section below:**What is the patient’s **Waterlow** score?Are there any **existing pressure ulcer(s)**? Yes / NoIf yes please give details, including any pressure care aids required and management plan:Are there any **other wounds**? Yes / NoIf yes please give details and management plan:Please complete the **body map** below: |
| **Nutrition** | Nursing Transfer Checklist and Letter |
| How has the patient been **eating** e.g. self-fed, needs assistance, enteral-feed?Any food and fluid consistency recommendations e.g. thickened fluids/soft diet? Yes / NoDetails:Is the patient currently being **risk-fed**? Yes / No |
| Any **weight loss/gain** whilst in hospital? Yes / No / UnsureIf Yes, provide details: | **Weight on discharge**: ……………… |
| **Cognition and behaviour** |
| Is the patient experiencing **confusion, depression, anxiety, behavioural disturbance** or other? (Including views about leaving hospital)?Has the patient been demonstrating any **challenging behaviour** whilst in hospital(including resistance to care, wandering, violence & aggression, etc)? Yes / NoPlease give details, including any suspected triggers / successful management techniques: |
| Latest **MMSE**:Latest **AMTS**:Latest **MOCA**: | **CMHT** practitioner contact details (if known): |
| **Any other information / summary of nursing needs:** |
|  |
| **Form completed by:**Name:Qualification: | Signature:Date and Time: |