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 / NA  Has 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 / No  Is there a named **IMCA** or **Advocate**? Yes / No  If yes, provide a name and contact details:  Are there any **ongoing safeguarding** concerns? Yes / No  Comments / 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 / No  Details (include reason for insertion and date due for change) OR attach catheter passport:  Does the patient have **faecal incontinence**? Yes / No  Has the patient been using **continence products** whilst in hospital? Yes / No  Details:  Have you provided a **supply of continence products**? Yes / No / Not required | | | | | | | | | |
| **Falls and mobility** | | | | | | | | | |
| Is the patient at **risk of falls**? Yes / No  If 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 / No  If 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/No  Details:  **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 / No  If yes please give details, including any pressure care aids required and management plan:  Are there any **other wounds**? Yes / No  If 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 / No  Details:  Is the patient currently being **risk-fed**? Yes / No | | | | | | | | | |
| Any **weight loss/gain** whilst in hospital? Yes / No / Unsure  If 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 / No  Please 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: | | | | | |