Sutton Homes of Care Vanguard Programme

Kings Fund: Better Transfers of Care for Older People

The Hospital Transfer Pathway

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An overview

INTEGRATED CARE
1. Health and Wellbeing Rounds in Nursing Homes
2. Health and Wellbeing Rounds in Residential Homes
3. Hospital Transfer Pathway
4. Care Home Support Team (link nurses; end of life care nurses, pharmacists)
5. Champion Roles
6. Dementia Support (DeAR-GP & training films)
7. Socialisation Initiatives (Silver Line Letters, Music Mirrors)

CARE STAFF EDUCATION AND TRAINING
8. Training Packages (E-learning modules, bespoke training)
9. Resource packages (posters, reference cards, films)
10. Care Home Forums
11. Annual Conference
12. Access Course Volunteers/Students in Care Homes
13. Student Nurse Training in Care Homes

QUALITY ASSURANCE AND SAFETY
14. Joint Intelligence Group
15. Quality Dashboard
16. NHS.net e-mails
17. Care Home Policy Package (standardised policies)
18. Engagement Channels with Residents, Families and Carers (cake cuppa chat)

SUTTON HOMES OF CARE
NEW CARE MODEL
The magic of Red Bag

- 2 or 3 per home depending on size and need
- Serial number to track
- Space for name tag on front
- Spacious inside to hold change of clothes and personal items
- Separate compartment inside to hold glasses and visual aids, dentures, hearing aids and other personal aids
- Sleeve on side to hold paperwork (securely fastened with velcro)
- Includes a set of cleaning instructions

Openhouse Products
sales@openhouseproducts.com
Price: £49.26 + VAT
The standardised paperwork

- CARES Handover Process
- Older Persons Assessment Form
  - For baseline information
- CARES Escalation Record
  - To capture the acute episode
- This is Me
  (or equivalent)
- MAR Sheet
The actual handover

C: Concerns  S: Situation
A: Actions   B: Background
R: Response  A: Assessment
E: Examination R: Recommendation
S: Shared Information

Most important things we need to know:
• What is happening to the resident now?
• What has changed from previously?
Training film and poster

https://www.youtube.com/watch?v=XoYZPmULHE
How we achieved this (1/2)

- Corridor conversations with partners revealed there were several issues with the admission/discharge of residents

- Set up a meeting (task and finish group) with all partners involved in care provided
  - Care homes
  - Local hospital
  - Ambulance service
  - CCG

- Held “no-blame” conversations to discuss all issues in detail

- Collaboratively proposed solutions to overcome these issues

- Continued to work together to implement the pathway
## Issues identified

- No standard paperwork
- Lost documents
- Loss of residents’ belongings
- Medicines disappear
- No system in place to track residents through the hospital
- Care homes find it difficult to get information from hospitals
- Care homes receive lots of phone calls about the residents’ clinical ‘situation’
- Poor communication between hospitals and care homes on discharge
- Residents staying in hospital for longer periods than necessary

## Solutions proposed

- Transfer bag
- Standard paperwork to assist ambulance staff and A&E staff
- Baseline information about the resident
- Better communication between care homes and hospitals at all points of the resident’s journey
- Senior staff from care homes to visit residents in hospital within 48 hours of admission
Advantages for care homes (1/3)

- **Saves you time**
  - Baseline information would be up to date, only need to complete the **current episode**, i.e. why they are going to hospital
  - Smoother handover to ambulance
  - Less time spent on phone with hospital
    - During admission because they have all the necessary information
    - After discharge because they have included updated **clinical information and TTOs**

- **Enhances resident experience**
  - Personal aids available to resident and a change of clothes to come home in
  - Less likely to lose property and personal aids
  - Treated with dignity and respect due to information required e.g. ‘this is me’
  - Identified as a care home resident and the appropriate steps can be taken by all hospital staff

- **Enhances continuity of care** during admission and after discharge

- **Resident comes home quicker** instead of an unnecessary long stay

- Opens lines of **communication** resulting in much better working relationships with hospital staff
Advantages for ambulance (2/3)

- Smoother handover from care home, and to hospital
- Standardised paperwork between care homes easier to use
- More informed clinical decisions
- Residents property contained
- Better relationship with care homes
Advantages for hospital (3/3)

- **Time saved**

- **Informed clinical decisions**

- **Good communication** between care home and hospital

- **Patient-centred care** as documents highlight needs, wishes and risks (e.g. DOLs, CMC).

- **Better relationships** with care homes

- **Smoother discharge process**
Demonstrable impact to date

- 179 residents of care homes have been tracked through our local hospital in the last nine months

- Average length of stay with a bag was 13.4 days, compared to 17.4 days without a bag

Residents with a Red Bag spent 4 days less in hospital than those without a Red Bag

Note: Data kindly collected by Integration and Transformation Team and Oder People Nurses at our local hospital
“Patient can be aggressive but tips included about talking to him about his wife and has been so much easier to care for him. Might usually take 2 hours to find out this information and sometimes might never find out!”

“I didn’t know the patient was on thickener [for drinks] until I looked through the Red Bag”

“A good organised comprehensive approach enabling clinicians to obtain a complete picture, especially in cognitive impairment.”

“Definitely helpful for the acute take”
Supports best practice

- Standard documentation enhances clinical decision making
- Improves residents’ experience
- Supports collaborative working and communication
- Aids early discharge and involves care homes in discharge planning

National guidance

- NICE Guideline 27: Transition between inpatient hospital settings and community or care home settings for adults with social care needs
- NICE quality standard [QS120] Medicines optimisation
- CQUIN Indicator N2: Reduction in Emergency Admissions.
Great care for our residents

Perspectives
A care home resident:  https://youtu.be/MP03jUtBXmA
A care home manager: https://www.youtube.com/watch?v=aOmd00dE6ml
A care home resident: [https://youtu.be/MP03jUtBXmA]

A care home manager: [https://www.youtube.com/watch?v=aOmd00dE6mI]

VANGUARD
NHS SUTTON CCG
A care home resident: [link to video]

A care home manager: [link to video]
Great care is a partnership