Good Practice Guidance N: Admission of residents from care homes to hospital

Key Points

- 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 out patient appointments.
- When information is supplied with a resident moving into hospital this will improve care.
- The NHS Oxfordshire Care Home Admission Alert form (or similar) 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 all of the residents' current medication with them into hospital, including medicines packed in a monitored dosage system.

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.

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, unified Do Not Attempt Cardiopulmonary Resuscitation (uDNACPR), Child and Young Persons Advanced Care Planning document (ACP) (for under 18 years) 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.

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, uncommunicated 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.

Hospital Admissions Procedure

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

- Planned admissions
- Unplanned admissions
- Out patient hospital appointments

The admissions procedure should include:

- The information that should be sent with the resident – see below. An Oxfordshire Care Home Admissions Alert template has been developed to assist with this information and can be adapted by a care home to meet its own needs.
- Who is responsible for ensuring the Oxfordshire Care Home Admissions Alert template or equivalent is completed and that all relevant information such as copies of the MAR charts are included.
- Please send all of your residents' current medication with them into

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hospital, including medicines packed in an MDS.
- All medicines such as inhalers, eye drops, insulin, GTN sprays, other injections etc, should be sent with the resident to hospital.
- How the resident will get to hospital and if required, who will accompany them.
- Where in 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.

Information Required by the Hospital
The following information should be included with a resident when they are admitted to hospital. This information is important for hospital staff to ensure the best care for the resident.

- Complete resident details:
    - full name
    - date of birth
    - GP
    - GP practice
    - NHS number
    - Next of Kin details
    - Date and reason for admission
- Care home details including a contact name and number
- Name and contact number of community pharmacy who usually supplies the residents medicines
- Details of all other illnesses / medical history
- Any other information that will improve the care of your resident while they are in hospital. This might include any mobility issues, including equipment they use and whether this has been sent with the resident; details around cognition, i.e. whether the resident has dementia (ensure any behaviour management strategies are clearly communicated); information around continence issues; in this section you could include whether he/she uses incontinence pads or a catheter and when for example the catheter is due to be changed; if your resident needs any extra support with eating and drinking e.g. has swallowing difficulties or is on nutritional supplements (please also

include a recent weight here); any tissue viability issues, including details of any wounds and the last section is to note any support that your resident might need with communication, sight or hearing.

- A complete list of medicines the resident is currently taking :
  - Ideally this should be a complete copy of the MAR chart(s) clearly numbered so the hospital know they have all of the MAR sheets, i.e. “sheet 1 of 3” etc.
  - It is important to ensure the MAR charts sent are:
    - The most up-to-date version
    - Contain all of the resident’s current medicines
    - The administration section of the MAR chart needs to be included and be the most up-to-date one
    - Any medicines the resident no longer takes have been clearly crossed out
  - If it is not possible to copy the MAR chart, then list:
    - Drug name
    - Strength
    - Formulations (i.e. tablets, capsules, liquid, cream etc)
    - Complete dosage instructions for each drug as it appears on the MAR chart
    - When the resident took their last dose
- Ensure any medicines that are being taken short term are also included e.g. antibiotics and where known include the reason for taking for the short term medicine.
- Ensure any medicines that are being taken on a periodical frequency such as vitamin b12 injections, depot injections are also included with the frequency and date of last dose given.
- If a District Nurse administers any of the residents medicines state which ones.
- A list of any ‘over the counter’ medicines the resident is taking (i.e. ones that haven’t been prescribed by the doctor). Include:
  - Any medicines bought for the resident
  - Herbal medicines
  - Homeopathic medicines
  - Vitamins and supplements
- Any known allergies, including medicine allergies/medicines the resident hasn’t tolerated (for example due to side effects).
- Any known or suspected infections.
- Resuscitation status/documentation i.e. “Do Not Attempt Cardiopulmonary Resuscitation" (uDNACPR) form or Child and Young Persons Advanced Care Planning (ACP) document if one exists.
- If the resident has a Learning Disability, ensure their Health Action Plan is sent and also complete a Hospital Passport. For further information on the Health Action Plan and Hospital Passport contact the Community Learning Disability Teams:
  - Oxford City: 01865 323357
  - South: 01865 897974

  - North: 01295257727
- If the resident is on the Gold Standards Framework Register (GSF) / End of Life Care Register.
- Integrated Care Pathway (ICP) and Advance Cape Plan (ACP) if in place.

It is important the above 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.

An Oxfordshire Care Home Admissions Alert template form has been developed which care homes can use should their resident be admitted to hospital that contains the above information.

Administration of Medicines by District Nurses

When a resident is admitted to hospital and is receiving district nursing care, it is important to notify the district nursing team as soon as possible, after the admission, that this has occurred. When a resident is discharged from hospital, ward staff may not be aware that district nurse teams are involved in care and need to know when the resident will be back in the care home. It would therefore be beneficial if for items administered by district nurse e.g. insulin this could be annotated on the medicines chart so the hospital is aware that district nursing teams need to be notified of the residents discharge.

It is also recommended that once the care home is notified a resident is to be discharged from hospital, they also contact the district nursing team if the district nurses are required to administer medicines, change dressings etc.

Further information

- Further information on managing medicines in care homes is available in Outcome 9 of the CQC Essential Standards of Quality and Safety.

- Further information on The handling of medicines in Social Care' can also be found on the Royal Pharmaceutical Society website: www.rpharms.com

- The Nursing and Midwifery Council (NMC) provides guidance and advice on a number of topics which is available on their website; www.nmc-uk.org including;
  - The code: Standards of conduct, performance and ethics for nurses and midwives
  - Standards for medicines management

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- The National Patient Safety Agency also contains safety alerts related to medicines; http://npsa.nhs.uk/

The above links are made available solely to indicate their potential usefulness to users. The user must use their own judgment to determine the accuracy and relevance of the information they contain.

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