scie social care institute for excellence

NICE National Institute for Health and Care Excellence

QUICK GUIDE

Moving between hospital and home, including care homes

A quick guide for registered managers of care homes and home care

*First, start with the person. They are your common cause. Second, ask yourself how do we help this person get back to where they want to be?**

*Right place, right time. Better transfers of care: a call to action (NHS providers)

When people with care and support needs transfer into and out of hospital, good communication and integrated services are essential.

Without this, people can experience:

- Unmet care and support needs
- Avoidable hospital readmissions
- Avoidable admissions to care homes
- Delayed transfers of care

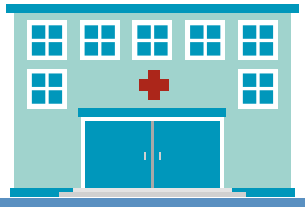
Registered managers and their teams have an important role to play as part of the community-based team supporting people transferring in and out of hospital.

What you can do

Before admission

Think about who might be at risk of hospital admission and support them to make a care plan in case this happens

Make sure you are familiar with the hospital's discharge planning protocols and processes



During hospital stay

Keep in touch with the hospital team and share any information that might affect discharge planning

Work with the discharge coordinator to help develop the discharge plan

At admission

Make sure the admitting team have all the information they need about the person. This might include:

- Care plans, including any preferred routines, and advance care plans
- Communication and accessibility needs
- Current medicines
- Triggers to behavioural issues
- Family, including carers and next of kin
- Housing issues
- Preferred places of care

After discharge

Keep in touch with people who are supported at home and make sure they know how to contact your service if they need to

Red bag scheme: one example of how to make sure the person takes and brings back everything they need. The red bag might include:

- Personal belongings
- Medicines
- 'This is me'
- Current care plan
- Discharge summary

Developed by Sutton Homes of Care Vanguard (A NICE shared learning example)

You may be able to participate in a similar scheme run by your local authority or CCG.

What you can expect from the hospital team

Discharge planning principles

- People experience continuity of care
- Decisions about long-term care are only made after a crisis is resolved
- Discharges are planned and coordinated, despite any pressure on beds

Discharge planning from the point of admission

- Assess the person's current and ongoing health and social care needs.
- Refer to existing care plans
- Select a hospital-based team according to the person's assessed needs.

A copy of the discharge plan which should include:

- Details about the person's condition
- Information about medicines
- Contact information for after discharge
- Arrangements for social and health care support, including family support
- Details of other useful services.

Contact from a named discharge coordinator, who should:

- Agree a discharge plan with the person and the community-based team
- Arrange follow-up care and any specialist equipment and support
- Agree the plan for ongoing treatment and support with the community team and maintain regular contact with them.

What you should expect after discharge

People who need end-of-life care or have complex needs should have details of who to contact in case problems with medicines or equipment occur within 24 hours of discharge.

If a person is at risk of readmission, the GP or community-based nurse will telephone or visit them 24–72 hours after discharge.

Further information

Transition between inpatient hospital settings and community or care home settings for adults with social care needs – NICE guideline

Transition between inpatient hospital settings and community or care home settings for adults with social care needs – NICE quality standard

Quick guide: improving hospital discharge into the care sector – NHS England

Hospital Transfer Pathway (Red bag) and **The red bag pathway from a resident's perspective** – Sutton Homes of Care Vanguard You Tube films

Safely Home: What happens when people leave hospitals and care settings? – Healthwatch

This is me – Alzheimer's Society

Effective healthcare for older people living in care homes – British Geriatric Society

This content has been co-produced by NICE and SCIE and is based on NICE's guideline and quality standard on transition between inpatient hospital settings and community or care home settings for adults with social care needs.

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