



Acute-Care Home Interface Project

Final Report

February 2016

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1. Purpose

The Acute-Care Home Interface test took place between December 2014 and June 2015. This final report summarises:

- The problems which prompted the test
- The test and how it was delivered
- The outcomes that have been achieved
- Evidence to demonstrate success
- Lessons learned
- Recommendations

2. Background

The residents of our local care homes are some of our frailest citizens in Southwark and Lambeth with a significant number being discharged from hospital to care homes. In 2014/15, discharge data indicates there were 898 discharges to care homes from King's College Hospital (KING'S COLLEGE HOSPITAL)¹. In 2013/14, this number was at 1062². It should be noted that some of these discharges were to care homes beyond Southwark and Lambeth. Discharging a patient to a care home can be a distressing time for both the patient and their carer/family therefore it is vital that the transfer process in place provides a good discharge for the patient but also provides good lines of communication between the acute setting and the care home.

Partners recognised the need to look at the relationship between the acute trusts and the care homes across both boroughs and the processes in place to transfer the care of the patient from the hospital to the care home. Therefore, they acknowledged the need to design and test an intervention that would address these changes, and so a business case to do this was approved by the SLIC Operations Board in May 2014.

3. What were the problems being addressed?

As part of the process of developing the business case to support the delivery of this intervention, and through an early audit, a number of key issues were identified:

3.1 Admissions and re-admissions

Unfortunately, a high proportion of admissions and re-admissions to hospital are residents in care homes. Of the care homes in Southwark and Lambeth:

- there were 826 admissions to King's College Hospital and Guy's and St Thomas' in 2013/14
- of the 826 admissions, 207 of these were re-admissions within 30 days with an average length of stay of 9 days
- residents can account for over 9% of attendances at the Emergency Department
- residents can account for 13% of admissions in the over 75s³

¹ Business Intelligence Unit, King's College Hospital

² Business Intelligence Unit, King's College Hospital

³ Business Intelligence Unit, King's College Hospital

These admissions and attendances to hospital have a financial implication and it has been reported that on average in 2013/14, the cost of a resident being transferred from the care home to hospital, including a short stay, is £1,185⁴. This cost is based on any emergency incident when a patient requires all emergency procedures/services but doesn't stay within the hospital for more than two days.

Taking into account the 826 admissions to King's College Hospital and Guy's and St Thomas' in 2013/2014, the total cost amounts to £978,810 for all transfers into the acute setting.

The group also recognised that whilst many admissions to hospital from the care homes are appropriate, there are some Emergency Department attendance and admissions that may be inappropriate and result from a lack of confidence in clinical decision making within the nursing home staff for some complex cases, or difficulty in accessing the GP for advice in a timely manner.

3.2 Poor quality transfer of care

It was recognised that the discharge process as it stood was not conducive to delivering a consistently good discharge experience for patients, carer/family, hospital staff or care home staff which in turn had the potential to result in re-admission to hospital.

3.3 Communication between settings

It was recognised that there were gaps in the amount of information shared between the care settings which often led to confusion in both settings, wrong or little information being sent, information being sent to the wrong place and missing documents. This lack of communication often results in care home staff not being able to develop a fully informed care plan for the resident as sufficient information has not been transferred with the patient on discharge.

The initial audit carried out identified instances where care homes were not receiving the appropriate paperwork which would enable them to develop a fully informed care plan. In linking with the point below, it was also found in this audit that quite often GP details would be incorrect or not updated for new care home placements. This meant GPs would not receive the right information or would receive it late.

3.4 Recording of patient information

It was discovered that more often than not, there was a piece of information recorded incorrectly for the patient. Following an audit of information within a ward in King's College Hospital for each patient, Figure 1.1 below demonstrates the amount of information recorded incorrectly:

⁴ National Schedule of Reference Costs 2012-13 for NHS trusts and NHS foundation trusts (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/397487/N_SRC01_2012-13_in_13-14_format.xls)

	Number	%
Name incorrect	9	11%
Address incorrect	11	13%
DOB incorrect	7	9%
Gender incorrect	1	1%
GP details incorrect on EPR	22	27%
No GP on EPR	7	9%
>1 hospital number	14	17%

Figure 1.1 Audit of recording of patient information in King’s College Hospital

Source: Audit of patient information, Julie Whitney, 2014

Recognising these problems, it was agreed that the discharge process from hospital need to be improved as well as the level of communication and information shared between both care settings. As a result, a test was designed to address these problems.

4. Test design & delivery

4.1 What was being tested?

This intervention was to test whether improving the transfers of care processes between the hospital and the care home could improve the discharge experience, improve levels of communication between the acute and the care homes and lead to a reduction in the rates of 30 day readmissions.

This was to not only improve the discharge process from hospital, but focus on the transfer processes from the care homes to emergency departments, ensuring that there is sharing of appropriate information from the home to support Emergency Department staff. The intervention was also to support the development of on-going relationships between the care homes and hospital and encourage routine communication about transfers, as well as build on King’s College Hospital’s internal initiatives such as assigning nurse consultants to act as named contacts with individual homes.

4.2 Expected outcomes

The following outcomes had been agreed as part of the scoping and design phase of the project:

- Improved patient experience for frail older people who have either been transferred to or from Lambeth or Southwark care homes
- Reduced avoidable hospital admissions from residential homes and homes with nursing residents
- Reduced hospital admissions from residential homes and homes with nursing residents.

- Reduced inpatient hospital stays with advance care planning
- Care in the right place for frail older people
- Improved quality of transfer of clinical care
- Optimal communication between hospital and care homes in complex cases
- Improved and coordinated discharge process to ensure right GP is responsible for multidisciplinary care for resident

4.3 *How was the test delivered?*

The test was conducted over a seven month period (Dec 14 to June 15) at King's College Hospital, led by Bose Adegbola, a care home interface practitioner. Following an initial period of consultation with staff in the hospital and care home providers, a transfer of care bundle was designed. This transfer of care bundle was designed to be used for patients being discharged to Southwark and Lambeth care homes; however staff were encouraged to utilise for all discharges to care homes. Initially, the test looked at developing only a discharge checklist, however it was agreed that transfers of care cover a much wider area, therefore leading to the development of an Emergency Department transfer form and a care home transfer form. Together with the discharge checklist, these three documents were embedded into an overall transfer of care bundle.

The following elements of testing were carried out:

- Initially, testing of the "discharge checklist" took place on a Health & Aging Unit (HAU) (Marjorie Warren ward) within King's College Hospital. Following this, testing was expanded to all HAUs and Mary Ray ward. On completion of the testing period, 53 discharges were made using the new bundle
- Testing within the clinical decision unit (CDU) of the Emergency Department of the "ED transfer of care form"
- Testing within a number of the local nursing homes of the "nursing home transfer of care form"

Each element of the test was refined as more was learnt until the final versions of the document and transfer of care process was developed and tested.

During the testing phase and following the launch of the Transfer of Care bundle, work was carried out to collect information to determine whether the project/test objectives have been met. This was done via engagement with hospital and care home staff, retrieving patient records to identify if the information was sent, and paperwork audits on the wards, in the care homes and in the emergency department.

- In addition to this, there was a focus on ensuring medication listing and medication optimisation was carried out on discharge to the care home. This was designed to ensure that when the patient arrived at the care home, staff had clarity of the following:
 - Changes/reviews of medication
 - Cessation of medication
 - New prescriptions

5. Findings

Please note all the following data and findings are from King's College Hospital as this was the location of the test.

5.1 Hospital to Care Home

Between December 2014 and June 2015, there were 469 discharges from across all King's College Hospital to care homes in Southwark and Lambeth (a small number of these were out of borough)⁵. In carrying out this test, 53 of those discharges were part of the sample group – this accounts for 9% of discharges to care homes.

Figure 1.2 illustrates the breakdown of the destination of these 53 discharges:

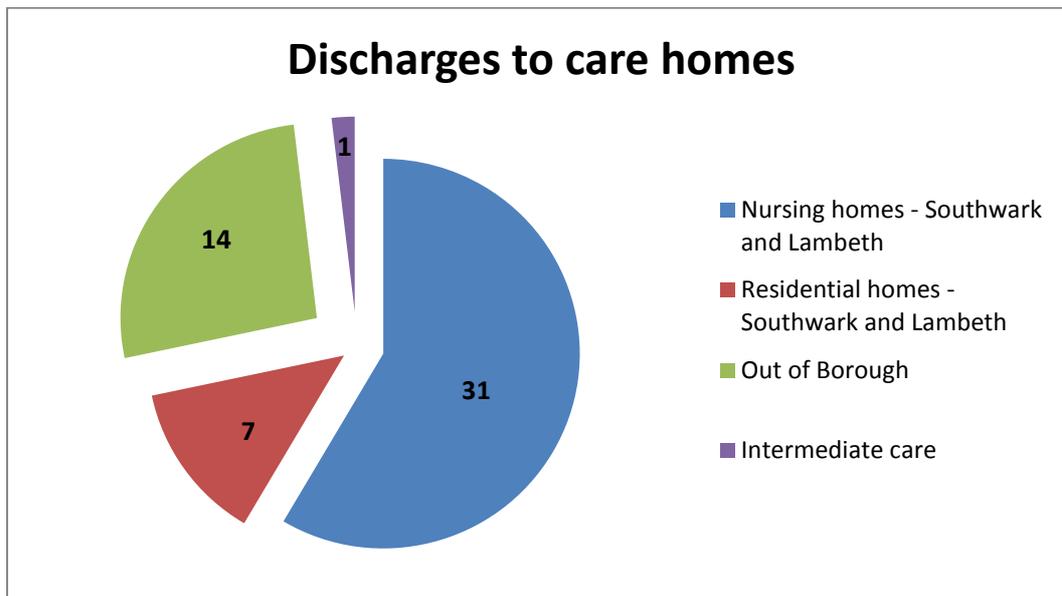


Figure 1.2 Care home destination following discharge

Source: Audit of sample group, Acute-Care Home Interface Test, Aug 2015

These discharges were made from Marjory Warren, Donne, Byron and Mary Ray wards. Initially, the discharge checklist was tested on the Marjory Warren ward and once reiterated it was expanded to include the other wards. When the decision was taken to discharge a patient to a care home, these four wards were asked to utilise the checklist to ensure a smooth transfer of care. Following the development of the transfer of care bundle, the wards were asked to utilise the full bundle which included the checklist.

An audit took place to ascertain what documents were sent with the patient when discharged and also to identify the number of documents found in the care home. Figure 1.3 shows the results of this audit:

⁵ Nursing home discharges, King's College Hospital, April 2013 to August 2015

Documents	Documents sent from hospital	Percentage of discharges	Documents found in care home	Percentage of documents found in the care home
Discharge Checklist (REQUIREMERGENCY DEPARTMENT)	53	100%	45	85%
Transfer letter (REQUIREMERGENCY DEPARTMENT)	53	100%	46	87%
Discharge Summary (REQUIREMERGENCY DEPARTMENT)	50	94%	49	98%
DNAR	11	21%	10	90%
Health NeEmergency Departments Assessment	17	32%	14	82%
Decision Support Tool	5	9%	3	60%
PEACE	14	26%	13	93%
This is me	7	13%	5	71%
Speech and Language Therapist	4	8%	3	75%
Dietician	2	4%	2	100%
Body Map	28	53%	25	43%
MEmergency Departmentication Rev/MAR	47	87%	Not available	Not available

Figure 1.3 Audit of paperwork in KING’S COLLEGE HOSPITAL sent using the discharge checklist (post-test)

Source: Audit of sample group, Acute-Care Home Interface Test, Aug 2015

You will see from Figure 1.3 above, that three documents are highlighted as required documents. It was agreed at the beginning of the test that as a minimum each patient should be discharged with the discharge checklist, a transfer letter and the discharge summary. The other documents are not required and would only be utilised when appropriate for that particular patient. Given that some documents are only completed when appropriate, the data does not capture if the non-required document was appropriate, therefore it has been difficult to conclude if there are gaps in completing the non-required documentation. It should be noted that prior to the test, there was not an audit carried out which would allow for direct comparison.

The data above indicates a 100% use of the discharge checklist, however it should be noted that the 53 discharges as part of this test did not account for all discharges to care homes from the four wards. All other discharges have not been documented here. Please note that the reasons for the difference in numbers sent from the hospital and numbers received in the care home were not explored as part of this test.

In terms of information included on the checklist, it was noted that of the 53 discharges, only 43 included the NHS number of the patient and only 30 included the hospital number.

NHS Number	43	81%
Hospital Number	30	57%

Figure 1.4 Inclusion of NHS and Hospital number

Source: Audit of sample group, Acute-Care Home Interface Test, Aug 2015

In carrying out the audit, it was further noted that of the 53 discharges, 23 follow up calls were carried out and there were 11 onward referrals to community services. These referrals included palliative services, catheter services, cardiac and diabetes.

5.2 PEACE

In figure 1.3, it is noted that of the 53 discharges 14 PEACE documents were completed and sent with the patient to the care home. 13 of these documents could be found at the care home. In carrying out the audit, it was deemed that it would have been appropriate for a further 12 of these discharges to have had a PEACE document completed.

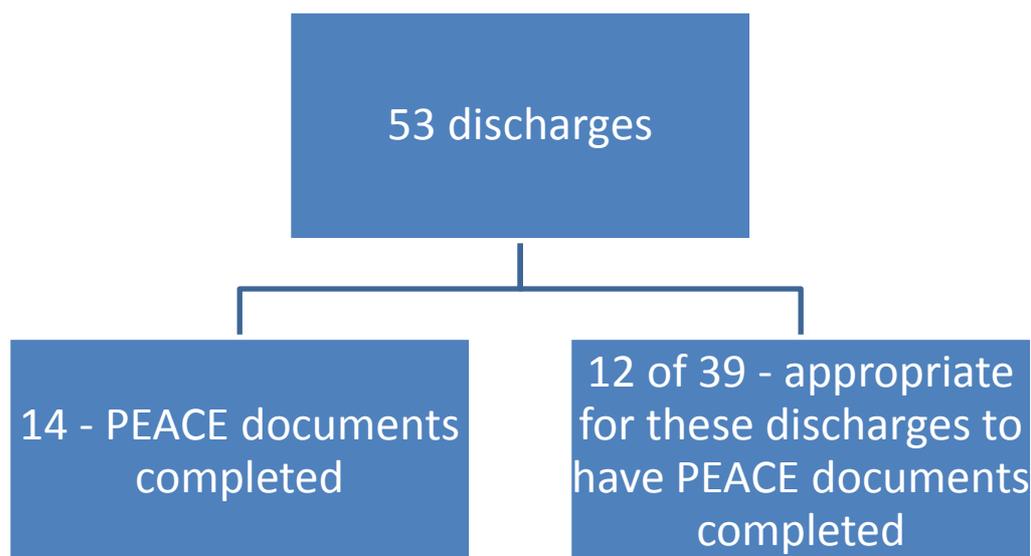


Figure 1.5 PEACE documentation

Source: Audit of sample group, Acute-Care Home Interface Test, Aug 2015

On further exploration of these 12 patients, it can be noted that in the majority of these cases a PEACE document would have been useful for both the patient and the care home staff. It was further demonstrated that in some cases, PEACE was completed but not discharged with the patient or highlighted as required but not followed up in the community.

However, it should be clear that having a PEACE document does not prevent residents receiving hospital care if it is deemed beneficial to the patient and doesn't go against the decisions made in the PEACE document.

Of the 12 that were deemed appropriate for a PEACE document five of these patients died shortly after their hospital admission (NB we are unclear as to the circumstances of their deaths). It should also be noted that three of these 12 patients were re-admitted to hospital. One of these was presented to the Emergency Department four times in the months following their discharge from hospital.

5.3 Readmissions

Following discharge from hospital, five of these 53 patients were re-admitted to hospital on seven separate occasions, however not all of these can be categorised as 30 day readmissions. From data gathered, it is clear that three of these can be classed as 30 day readmissions which converts to a 6% 30 day readmission rate. The table below indicates the comparison of 30 day readmission rates in Southwark and Lambeth across the year and the 53 patients who were part of this test.

	30-Day Readmissions	Emergency Admissions	30-Day Readmission Rate
2013/14 (in Southwark & Lambeth)	136	583	23%
2014/15 (in Southwark & Lambeth)	127	578	22%
Discharge Bundle Intervention (7 months test at KING'S COLLEGE HOSPITAL)	3	Not available	6%

Figure 1.6 30-Day Readmissions for Care Homes: 2013/2014 - 2014/2015

Source: NHS Southwark CCG 2013/14 & 2014/15; audit of sample group at King's College Hospital, Aug 2015

Furthermore, it can be noted that only one of these seven separate readmissions resulted in a full admission to a ward – six of the re-admissions resulted in the patient being discharged from CDU back to the care home.

Below is a case study of one of the patients in the sample group.

Case Study – Mr B

On further exploration of the information collated, one patient had been admitted on several occasions following his original discharge date. Mr B was discharged on 12th January 2015 and within a 3 month period, was re-admitted to hospital a further three times beginning on 21st March 2015 for mild dehydration. On the other occasions, Mr B was admitted on 9th April 2015 and stayed overnight for decreased appetite and withdrawal. Mr B was discharged the next day on 10th April, however was re-admitted on the very same day with depression. Mr B was discharged back to the care home on the same day. Looking at the available information, it is difficult to know if these admissions were appropriate however it can be noted that these transfers happened over a very short period of time with diagnoses of mild dehydration, decreased appetite and depression. Further work is required to understand the reasoning behind this case in particular but also all transfers of care from care homes to hospital.

5.4 Emergency Department to Care Home

Between October 2014 and June 2015, there were 26 presentations to King’s College Hospital Emergency Department from residents in care homes who then utilised the Emergency Department to Care Home checklist when the patient was discharged.

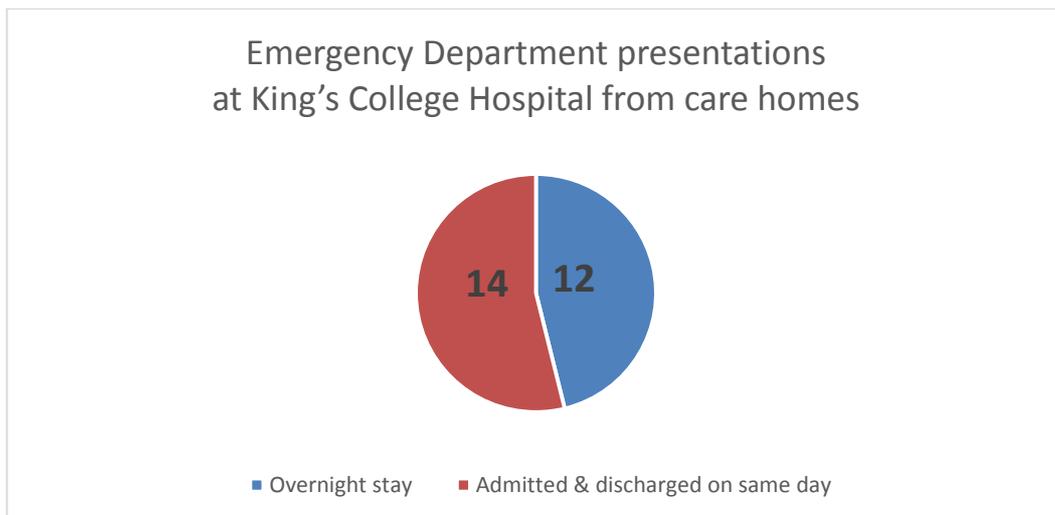


Figure 1.7 Number of presentations to King’s College Hospital Emergency Department

Source: King’s College Hospital Emergency Department Audit of care home presentations, Aug 2015

As indicated above, of the 26 presentations 14 were admitted to the hospital and then discharged on the same day. The reasons for these presentations ranged from falls, catheter issues and dizzy spells. Of these presentations, staff within the Emergency Department suggested that five of these presentations could have been avoidable.

12 of these 26 presentations were admitted and had an overnight stay in the hospital. The data indicates that the majority of these presentations were caused by falls within the care home and catheter issues including UTIs. In looking at the data, staff within the Emergency Department suggested that seven of these presentations were avoidable. It should be noted that two of these presentations were the same resident and it was deemed that both of these presentations could have been avoidable.

In terms of documents accompanying residents when presented to Emergency Department, the data indicates that only two from the 26 presentations were presented with a MAR chart (no other paperwork was indicated). Therefore, 24 presentations were not accompanied with any paperwork.

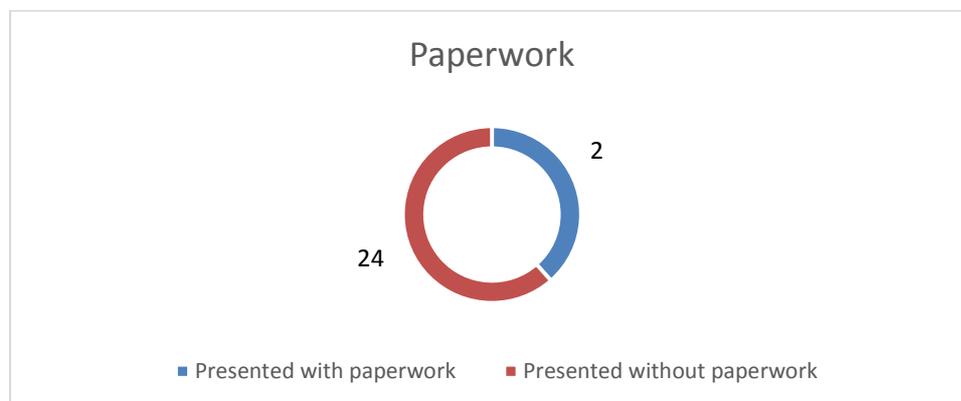


Figure 1.8 Numbers of presentations with or without paperwork

Source: King’s College Hospital Emergency Department audit of care home presentations, Aug 2015

Overall, of the 26 presentations it was deemed by Emergency Department staff that 12 of these could have been avoidable. It could be argued that these presentations are putting pressure on system costs in terms of cost to the care home, LAS cost, workforce cost including Emergency Department staff and costs associated with medical investigations. King’s College Hospital recently identified that the average cost of a 9 day stay for an elderly patient is £4,903 including overheads, staffing costs, medical investigations and medicines (this excludes Emergency Department costs when the patient is first admitted)⁶. This figure specifically relates to Mary Ray ward; however this can be looked upon as an average cost for a typical care home resident admission.

5.5 Care Home to Hospital

As well as addressing discharges from hospital, the Transfer of Care Bundle addressed the transfer of patients from the care home to hospital.

The initial Emergency Department audit in King’s College Hospital carried out in October 2014 highlighted a high level of variation in terms of residents being transferred to hospital with paperwork. The audit showed that only 49.3% were transferred with a medication list and only 13% were definitely accompanied by a member of care home staff⁷. On one particular occasion a safeguarding issue was raised by London Ambulance Service due to the “poor attitude of carers and no information about an unresponsive patient”.

In an audit carried out in King’s College Hospital Emergency Department from 22 June to 22 July 2015, there were 39 presentations from 16 nursing and residential homes from across Southwark and Lambeth⁸. When a patient is transferred from the care home to the hospital, particular documents are expected to accompany the resident in order to ensure staff in the Emergency Department are clear about the patient’s medical history and the current issues. Below is a breakdown of the submission of paperwork:

⁶ BIU, King’s College Hospital, 2015

⁷ King’s College Hospital Emergency Department audit of care home presentations, Karl Mason, Oct 2014

⁸ King’s College Hospital Emergency Department audit of care home presentations, Karl Mason, Aug 2015

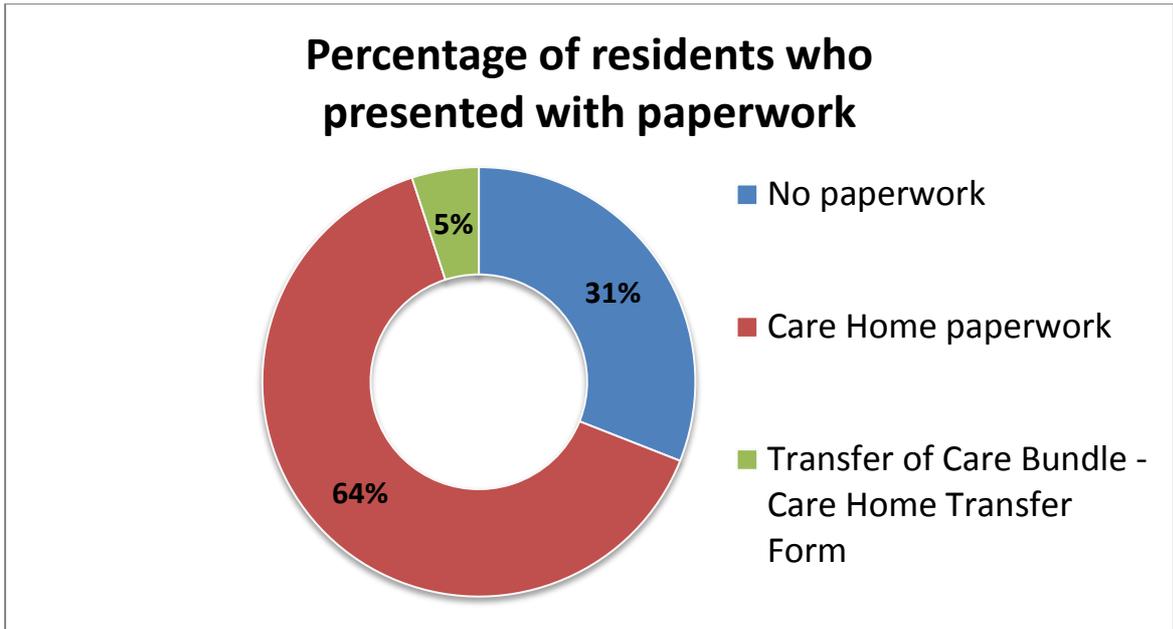


Figure 1.9 Percentage of residents transferred from the care home with paperwork
 Source: King’s College Hospital Emergency Department audit of care home presentations, Aug 2015

As indicated in the graph above, 69% of residents presenting to the Emergency Department were transferred with paperwork. However, it should be noted that only two of the 27 presentations were with the new transfer form developed as part of the Transfer of Care Bundle.

This data can be broken down further to demonstrate the split of nursing and residential homes. Of the 39 presentations to Emergency Department, 69% of these were from nursing homes and 31% from residential homes.

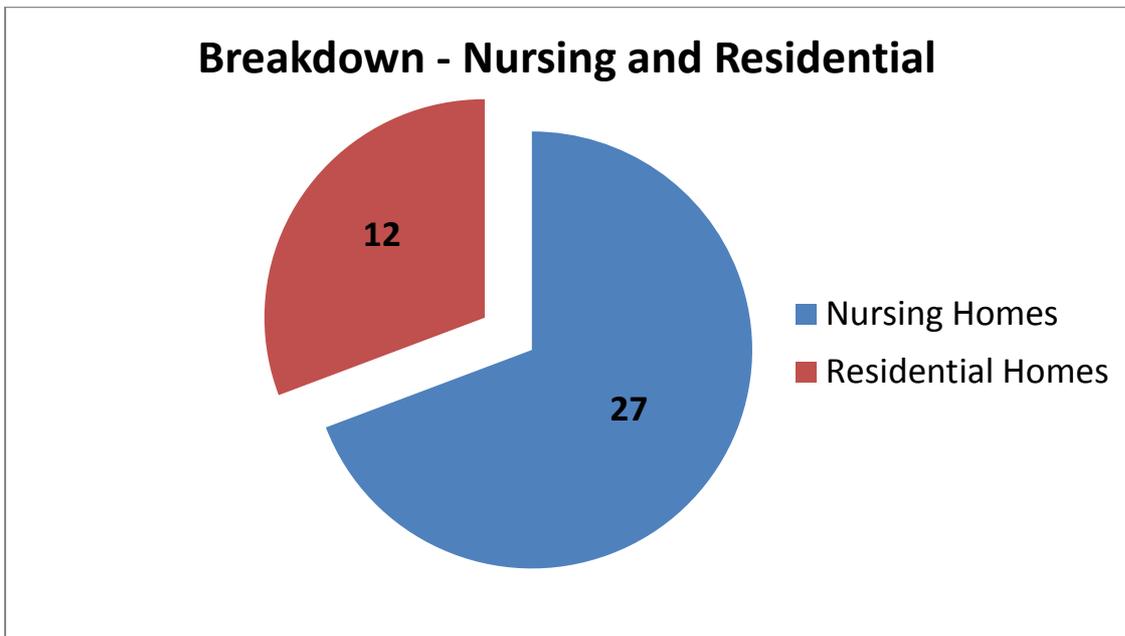


Figure 1.10 Breakdown of Emergency Department presentations from Nursing and Residential Homes
 Source: King’s College Hospital Emergency Department audit of care home presentations, Aug 2015

Furthermore, below is a representation of paperwork submitted from the nursing home sector and residential home sector.

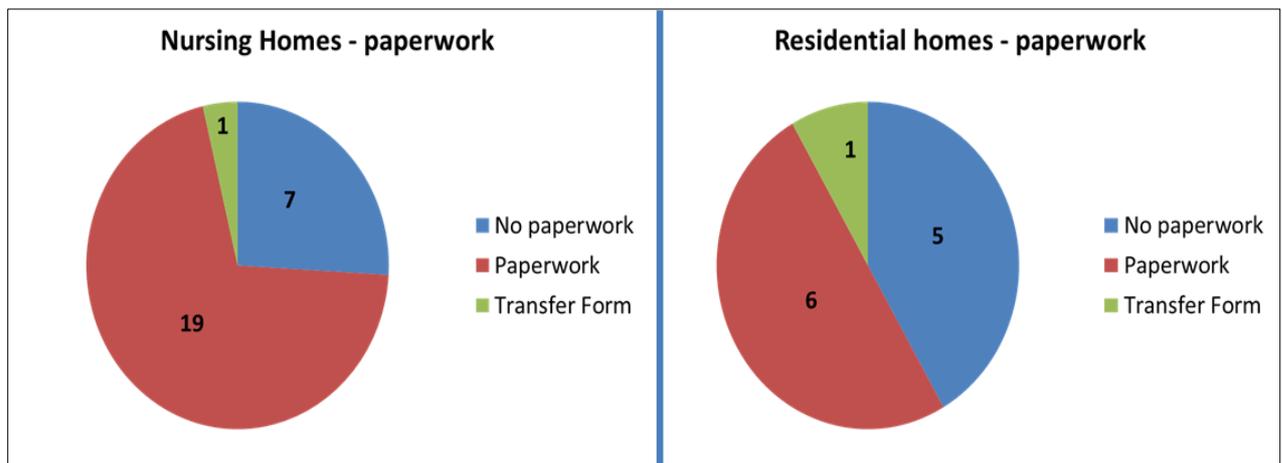


Figure 1.11 Breakdown of paperwork submitted from nursing and residential homes
Source: King’s College Hospital Emergency Department audit of care home presentations, Aug 2015

Appropriateness of the transfers

Whilst not in the scope of the intervention, data was captured on whether presentations to the Emergency Department could be deemed as appropriate. Of these presentations, 82% were admitted to hospital. The remainder were discharged back to the care home from the emergency department. Furthermore, in looking at the details of each presentation, it was deemed (by a member of Emergency Department) that 79% were appropriate presentations. It was deemed that in six of the remaining cases a GP review would have been appropriate first and in two cases a direct referral to a speciality service would have been more appropriate. This should be considered for future recommendations.

6. Staff feedback

Feedback was sought from staff in both the acute setting and in the care homes on the transfer of care bundle. During the testing phase, staff were regularly engaged with to ensure the bundle was fit for purpose. In particular, the Care Home Network meetings were utilised to gain feedback from care home managers. All feedback contributed to iterations of the bundle throughout testing and the final design of the Transfer of Care bundle.

In the acute setting, feedback demonstrated that staff found the information in the bundle acted as a really good prompt which enabled them to carry out an effective discharge to a care home and enabled them to discharge the patient with appropriate medications and dressings.

Staff in both settings felt communication between acutes and care homes had improved as a result of the discharge bundle. Staff feel they have become more familiar with each other which has enabled them to explore queries on the patient/resident efficiently and effectively.

When asked if they felt it added to their workload, the majority of respondents indicated that they did not feel it was additional workload. They felt it was useful and proved to be a useful tool for facilitating a safe discharge for patients to a care home.



7. Outcomes/discussion

As indicated at the beginning of this report, there was a set of expected outcomes. Below demonstrates the extent to which each of these were addressed as part of the intervention.

7.1 *A more structured discharge with all the relevant documents and information on the care and treatment the resident received while in hospital*

The purpose of the bundle is to provide a structure to the discharge of patients to care homes. As well as discharge from the hospital, the project expanded to include a more structured transfer of care process including discharge from Emergency Department and transfer of residents from care homes to hospital. The bundle, checklist and transfer forms provided a way in which hospital/care home staff were advised of the documentation and information that may be required by each care setting when the decision is taken to discharge them to a care home/transfer them to hospital.

These forms can be found by clicking on the following link - bit.ly/2412xLc

As a result, it would seem that more of the right information is being shared with the care home when a patient is discharged enabling the care home staff to be fully aware of the condition of the patient when care is transferred. The data indicates that of the three required documents to be transferred with the patient, there is 100% compliance on the checklist and transfer letter and 94%

compliance on the discharge summary. However, the discharge bundle is not yet being used across all discharges to care homes therefore further work is required to ensure that all discharges are utilising the bundle to allow for a good quality transfer of care.

7.2 Sufficient information to support further planning of individual residents care management

It has always been recognised that care home staff require appropriate information in order to develop a robust care plan for residents within the care home. The discharge bundle includes a core set of documents which are required to develop a core care plan. The checklist further augments this by identifying a number of other documents which should be completed where appropriate and transferred with the patient. This includes occupational therapy, physiotherapy, dietician, body map, information on medication and community referrals. These would all contribute to the development of a robust care plan for residents.

As part of the testing phase, it has proven difficult to understand if staffs believe the increased sharing of information has led to better care planning for residents within the care home.

7.3 Reduced number of re-admissions from care homes to hospital

From the data presented in Figure 1.6, it may be concluded that as part of this intervention 30 day re-admissions are at a much lower level than the overall rate across Southwark and Lambeth. The rate of 30 day re-admissions within this intervention was 6% as opposed to 22% across Southwark and Lambeth. Further work will be required to analyse this data in terms of reasons why patients attend the Emergency Department and whether they are appropriate transfers.

7.4 Reduced avoidable hospital admissions from residential homes and homes with nursing residents

Unfortunately, due to the lack of available data it has been difficult to understand and demonstrate the impact the Transfers of Care bundle has had on avoidable hospital admissions.

7.5 Improved quality of transfer of clinical care

Feedback was sought from staff on the transfer of care form and demonstrated that staff found the information in the bundle acted as a good prompt which enabled them to carry out an effective and safe discharge to the care home. This also enabled them to discharge the patient with adequate medications and dressings thus enabling the care home to deliver the most relevant care.

7.6 Improved communication between hospital and care home staff, including ensuring the right GP received the correct information.

Development of the Transfer of Care Bundle was carried out with the intention of ensuring the lines of communication between hospital staff and care home staffs, including the GP, were more open and transparent. Each checklist and transfer form was designed with space to include hospital ward information, care home information, GP details and lead consultant. This ensures that each care setting has details and information they can utilise to contact staff who would have information pertinent to the care of the patient/resident.

The discharge bundle checklist was also designed to ensure follow up calls were carried out by hospital staff when a patient was discharged. The checklist included a number of questions to be asked to ensure the care home staff had the right and relevant information which could be utilised to develop a robust care plan for their resident.

In developing the discharge bundle, staff from across the care home sector and staff in the hospital worked closely together to design and agree what information was to be included in the bundle. Their input to the design of the bundle was invaluable and ensured the bundle had all the relevant information which enabled them to carry out their role to the highest level. This process facilitated improved communication between the two groups of staff.

8. Unintended outcomes

Following on from the development and implementation of the Transfer of Care Bundle, the staff at King's College Hospital developed a medication form for discharge which identified any changes to medications/or cessation of medication for patients which could be discharged with the patient to the care home. This has proved to be beneficial to care home staff as it is not easily identified which of the resident's medications have been stopped, changed or reviewed.

Furthermore, following discussions with care home staff and hospital staff, it was agreed to develop and distribute resource packs for both care settings. These resource packs hold essential information for each setting when transferring a resident/patient. Information and documents in the resource pack includes the Transfer of Care Bundle, PEACE documentation, DNACPR form and guidance, This is me, Directory of Services available in the community, key hospital contacts and a list of care homes in Southwark and Lambeth. These resource packs have been distributed to all wards at King's College Hospital. The Care Home Support Team distributed the resource packs to care homes in Southwark and Lambeth.

9. Conclusion

Overall, where the Transfer of Care Bundle is being used, evidence suggests that the discharge process has been enhanced by the implementation of the bundle and it is believed that there has been a positive impact on the processes, staff and the patients. The bundle has also led to an improvement in patient and staff experience. However, the Transfer of Care Bundle is not being universally utilised within the hospital setting.

Furthermore, there is evidence to demonstrate that the bundle is having a positive effect on outcomes in particular on 30 day re-admissions. Despite the small sample group, the number of 30 day re-admissions in the group is dramatically smaller than the average across Southwark and Lambeth.

The development and implementation of this bundle has also led to changes in relationships between staff across different care settings. Trust and co-operation between staff in the hospital and care homes has improved leading to better information sharing and better relationships. Staff reported increased confidence in discharging patients to care homes due to the Transfer of Care Bundle acting as a prompt.

Engaging with staff in both the acute setting and in the care homes has been invaluable to this project. In particular, design of the bundle benefitted from input and feedback from the Care Home Network. Their input was invaluable in ensuring the bundle was fit for purpose in all settings.

Developing this Transfer of Care Bundle has not been without its challenges. Given the nature of the bundle, it has proved difficult to effectively monitor and measure the impact of the various elements of the bundle and attribute any significant changes to this one intervention. The sheer number of older people being discharged to care homes has made it challenging to measure the numbers discharged using the bundle.

As a result of the implementation of the bundle, King’s College Hospital staff are now more aware of the information which should be transferred with the patient when being discharged to a care home. The audit data indicated that not all the information was being transferred with the patient however staff have indicated that the transfer of care bundle now acts as a prompt for this information and will be more likely to include the information when patients are transferred in the future.

10. Lessons learned

Question	Lessons
What worked well?	<ul style="list-style-type: none"> • Interagency working between hospital and care homes that enabled trust to be built between staff in the different settings • Facilitation from CCG/SLIC forums with care home providers, this enabled a joint forum to design and develop together • Input from Care Homes Support Team in promoting interagency working • Having a dedicated interface worker to lead the work during design, testing and implementation
What didn’t work so well?	<ul style="list-style-type: none"> • Getting buy in and local leadership to own the test (i.e. nurses on the wards and discharge staff) • Achieving balance in this project between development of care home transfer bundle (a process) and evaluating the outcomes of community PEACE • Use of a predominantly paper based process which is not yet linked to electronic records or ward ware • There was a minimal level of engagement with GPs from project staff, therefore general practice have found it difficult to see the benefits of the project
What could have been done differently?	<ul style="list-style-type: none"> • Development of a true baseline prior to the project starting • Identifying and engaging champions early in the project • A focus on patient outcomes that explored the impact of advance care planning • Communication between care providers on care planning, patient experience and carer satisfaction • Patient feedback should have been captured more effectively and more regularly to feed into the design and development process • Appropriateness of admissions should have been within the scope of the project • A better focus on ownership and gaining universal buy in from staff at the beginning of the project

11. Recommendations

Each hospital and the Care Home Network to consider and agree the following recommendations:

ACUTE SETTING

Recommendation	Owner
Transfer of Care Bundle should be implemented across all wards in Kings College Hospital – King’s College Hospital staff to consider how this is spread across the hospital to ensure all patients discharged to a care home are using the Bundle. Consider what training is required and how to raise awareness.	Nicky Hayes (King’s College Hospital)
Improve the discharge of patients from the Emergency Department back to the care home by engaging with staff in Emergency Department around the Transfer of Care Bundle and raise awareness of the Emergency Department Transfer Form.	Nicky Hayes/Jane Tippett (King’s College Hospital)
To ensure a consistent approach across Southwark and Lambeth, the Transfer of Care Bundle should be utilised across King’s College Hospital and Guy’s and St Thomas’. Agree with Guy’s and St Thomas’ the process to implement the Transfer of Care Bundle in their wards.	Nicky Hayes (King’s College Hospital)/GSTT
It is clear that in some cases GP contact details are still not correct when a patient is discharged - King’s College Hospital to consider how to find a solution to this issue to ensure all details are correct at time of discharge.	Nicky Hayes/Sue Bowler (King’s College Hospital)
The Transfer of Care Bundle is currently a paper based process – King’s College Hospital to develop a longer-term solution that will ensure this process is integrated with IT systems within the Trust.	Nicky Hayes (King’s College Hospital)
Set out clear guidance on the supply of dressings and other similar equipment as part of the discharge process to care homes, this should include what items and the number of days’ supply.	Rose O’Keeffe (King’s College Hospital)

CARE HOMES

Recommendation	Owner
Care home network should explore their role in how they can drive forward the improvement in relationships between care home staff and staff in the hospital including encouraging the use of the Transfer of Care Bundle when residents are transferred to hospital.	Care Home Network (Kate Moriarty-Baker and Jen Burgess)
Work with community and acute colleagues to explore advanced care planning and how care home staff can ensure comprehensive plans are put in place for their elderly residents.	Nicky Hayes/Julie Whitney (King’s College Hospital)
Care home network to explore the reasons why residents are presenting to Emergency Department and look at resolutions to this issue , including considering commissioned services in the community that would help to prevent transfer to hospital	Care Home Network (Kate Moriarty-Baker and Jen Burgess)
Develop linkages with the falls prevention work in the community to decrease the risk of residents falling in the care home	Julie Whitney (King’s College Hospital)/Care Homes
Care homes to explore further linkages to other community services which would enable them to prevent future transfers to hospital	Care Home Network (Kate Moriarty-Baker and Jen Burgess)/Care Homes

PEACE

Recommendation	Owner
Raise awareness of PEACE amongst hospital staff (in particular when new staff start/junior docs when they move) to ensure that it is completed for those patients, where appropriate. King's College Hospital to explore the potential to include in the induction process for new staff.	Nicky Hayes/Julie Whitney
Further development and evaluation of the impact of community PEACE including impact on hospital admissions and attendances.	Nicky Hayes/Julie Whitney

WHOLE SYSTEM

Recommendation	Owner
Develop the following interventions to continue to build relationships between staff in the acute setting and staff in the care home: <ul style="list-style-type: none">• Twinning Project• Resource pack (completed December 2015)• Interface role	Nicky Hayes/ Stacey Hood SLIC Nicky Hayes (King's College Hospital)
GP Federations and community services to explore their role in admission avoidance for residents in care homes.	Southwark and Lambeth CCGs