

# The Hospital Transfer Pathway

## The Red Bag Initiative: Guide to Implementation

## Foreword

The Health Innovation Network, the Academic Health Science Network for South London is working with Boroughs across South London to spread the Hospital Transfer Pathway, developed by Sutton Homes of Care Vanguard. The Hospital Transfer Pathway (red bag initiative) is an innovative example of a pathway redesign to make sure residents living in care homes receive safe and effective treatment should they need to go into hospital in an emergency.

The pathway is designed to support care homes, the ambulance service and the local hospital to meet the requirements of the NICE guidance [NG27] Transition between inpatient hospital settings and community or care home settings for adults with social care.

The pathway is a whole systems approach and success is dependent on the collaborative working of all partners who are involved in the admission/discharge process of a care home resident across the pathway.

Sutton Vanguard launched the pathway to every older people's nursing and residential care home in Sutton in November 2015. A preliminary evaluation has revealed a four day reduction in length of stay for residents with a red bag. It is anticipated that the following savings will be found:

- reduced length of stay for care home residents in hospital through quicker and better assessment, treatment and discharge
- reduced cost of replacing resident's lost belongings such as, dentures, glasses and hearing aids

Contact Don Shenker, Project Manager Dementia [don.shenker@nhs.net](mailto:don.shenker@nhs.net) to discuss implementation of the Hospital Transfer Pathway in your Borough.

## Introducing the 'Red Bag'

The red bag follows a resident on their journey to hospital if they become unwell. It clearly identifies the patient as being a care home resident in hospital. On admission to the accident and emergency department, the hospital system has a red flag to enable a tracking system for the pathway. The Red Bag includes:

- standardised paperwork completed with all relevant clinical information about the resident's general health, any existing medical conditions, medication they are taking, as well as highlighting the current health concern to enable effective treatment. A 'This is me' document to provide clinical staff with background information on an individual's needs, preferences, interests, likes and dislikes to support person-centred care. The paperwork is updated in the hospital and sent back to the care home when the resident is discharged,
- residents personal belongings (such as day of discharge clothes, toiletries and personal aids e.g. glasses, hearing aids, dentures and medication) to ensure nothing is lost or misplaced.

## Principles of the Hospital Transfer Pathway

These are the principles of the Hospital Transfer Pathway:

- Every person who meets the resident knows their personal information (who they are, what their health and social care needs are when they are well, and what their wishes and preferences are)
- Every person who meets the resident knows what the reasons are for them going into hospital
- The resident has a red bag that contains their personal information documents, their medications and their belongings and clothes for travelling home in
- The care home manager or nominated deputy is available to support the resident whilst in the hospital, and visits within 48-72 hours of admission and is involved in the episode of care
- The resident, or if they don't have capacity, their lasting power of attorney or a best interest decision, consents to their personal information being shared between the care home, the hospital and the ambulance service
- The hospital and ambulance service communicate all relevant information about the resident with each other and with the care home

## How it helps

### Advantages for care homes

- All **baseline information** would be up to date and ready to go with ambulance, and you only need to update detail on the **current episode** why they are going to hospital

- There will be a **smoother handover** to ambulance
- **Correct care** can be given immediately if the hospital has accurate and up to date clinical info
- **Less time spent on phone** with hospital because they have all the necessary info in one place
- **Identified as a care home resident** and the appropriate steps can be taken by all hospital staff
- **Personal aids** available to resident and a **change of clothes** to come home in
  - Contained within the bag (and there is a record of this) so less likely they will be misplaced
- Discharged with **updated clinical information** and **medicines** so you know what care was provided in hospital and if their care needs have since changed
- **Discharged in a timely period** instead of an unnecessary long stay
- Opens lines of **communication** resulting in much better working relationships with hospital staff
- **Ensures residents are treated with dignity and respect**

### Advantages for hospitals

- Smoother admission process with baseline information and detail about current episode available
  - Hospital staff do not have to rely on the patient or carer who may not know the patient well.
  - The staff know whether it is likely to require a speciality referral
- Everybody recognises the standardised paperwork and where they need to go to find the info required
- Consent box on paperwork
- Quick informed clinical decisions
  - Therapists don't try to get patients to stand/walk if they have not been able to for some time
  - Multiple invasive tests are not required if there is a comprehensive history
- Less time spent phoning home for info
- More around continuity of care between hospital and care home
- Smoother discharge process if patient is identified as a care home resident
- Good communication between care home and hospital

### Advantages for London Ambulance

- Smoother handover from care home and handover to hospital
  - Quick efficient handover
  - Assurance that clinical information is in place

- Red bag helps identify patient as a care home resident immediately
- Standardised paperwork easier to use
  - Know where to look for information required
- Clinical history and baseline info of patient available, and details about current episode available to make quick informed clinical decisions
- Better relationship with care homes
  - Handovers are not so rushed in an already stressful situation

## Stage 1 Mobilise your stakeholders

Your first steps are to consider who needs to be involved in the project. It is important to engage with senior stakeholders / decision makers from all the relevant organisations in the pathway. They need to be able to act as change agents and influencers to ensure the pathway is embedded and communicated to all their teams. We advise that the following stakeholders be involved from the beginning:

- Directors / Head of Nursing at hospital
- Relevant CCG Commissioner
- CCG clinical lead
- Local authority older people or care home leads
- Care home Managers leads
- Care home support teams (e.g. Link Nurses, pharmacy)
- London Ambulance
- CCG Medicines optimisation
- Data Analyst for performance management

## Stage 2 Meet face to face

To gain an understanding of the existing challenges in your local area for stakeholders involved in a care home resident's journey to hospital and at discharge we recommend a face to face meeting.

### The stakeholders need to

- Review the standardised documentation. Is anything missing?
  - Older Person's Assessment Form (medical history)
  - CARES Escalation Record (incident form – why the resident is going to hospital)
  - Medicine Administration Record sheet (MARS)
  - This is Me booklet
- Discuss how the impact of the project will be measured

- (length of stay, readmission rates etc. information flow between hospital and care home). Consider using patient-centred outcome measures to record patient satisfaction,
  - agree who is responsible for data collection and reporting. Agree the frequency of reporting and evaluation points.
- Agree implementation of the red bag. To include
    - number of care homes (e.g. all of CCG versus a smaller pilot )
    - allocate responsibility to individual to engage and train care homes
    - agree time lines for implementation

## Stage 3 Order the 'Red Bags'

Production of the 'Red Bags' is approximately 6-8 weeks. Once all stakeholders are on board ensure you place an order to minimize delays. Care homes will need between 2 –4 bags depending on the size of the home. The Red Bags cost approximately £38 per bag. See Appendix 2 for information on how to order.

NB: You may wish to recruit care homes BEFORE ordering the Red Bags but be mindful of the 6-8 production time.

**Use the 6-8 weeks delay in production time to complete stages 4-6.**

## Stage 4 Recruit Care Homes

Ideally all nursing and residential care homes across the Borough will participate in the project. This makes it easier for other stakeholders to embed a change in practice. e.g. ambulance staff will know that if transferring a patient from a care home they need to collect the 'Red Bag' and hospital staff will know if the patient is a care home resident they will have a 'Red Bag' that needs to stay with them throughout their stay and at discharge. You will need to:

- Ensure care home staff are fully involved in designing and testing the pathway at every stage
- Support care homes to complete an Older Person's Assessment Form and This is Me booklet for each resident. Allow one hour for a new resident and approximately 20 minutes to update the paperwork for current residents.
- Deliver awareness training to ensure care home managers and staff understand the documentation and how to use the 'Red Bag'

## Stage 5 Embedding and sustaining change

It is important staff across all stakeholders organisations know about the 'Red Bag' and their role in moving the 'Red Bag' through the pathway. See Appendix 1 for the specific responsibility for each stakeholder group.

To guarantee staff are aware of the project and to ensure it becomes embedded into practice, is it advisable to do some promotional work. This is critical to ensuring successful implementation. In Sutton the hospital service improvement team and London Ambulance engagement team were responsible for promotion of the pathway.

The Sutton Vanguard developed a training pack including a short film which can be adapted for local implementation (see appendix 3). Some other effective methods of communication include:

- Lunch and learn sessions
- Roadshows
- Promotion through staff bulletins and screensavers
- Team meeting presentations and discussions
- Promote at existing meetings in place
- Posters

Promoting the project as part of a bigger event may help draw a bigger audience and ensure that more staff are aware of the changes.

Due to staff turnover we recommend continued promotion of the pathway to ensure sustainability.

## Stage 6 Collect baseline data

Collect baseline data against the agreed outcome measures so you can report on and evaluate the impact of the pathway.

## Stage 7 Launch the hospital transfer pathway

Agree and communicate a launch date with all stakeholders. Follow up with key contacts during the first few months to identify and address any implementation issues experienced. Remember to:

- Keep meetings short and action points delivered in quick timescales.
- Keep the project alive by regular updates.
- Make sure you ask for and use feedback from all staff involved to help improve the pathway.

## Stage 8 Evaluation

Evaluate the changes you have made by

- Reviewing results to baseline data
- Undertaking staff surveys to assess whether the 'Red Bag' has addressed concerns with transfer of care, for hospital staff, care homes and ambulance staff and embed the learning to refine the pathway further



## Appendix 1

There are specific requirements of staff at each stage of the red bag journey, as set out below.

### Care home staff

- When an ambulance is called for a resident, the care home staff will ensure that all the correct paperwork is completed and included in the red bag: *Older Persons Assessment Form, CARES Escalation Record, MAR Sheet, This Is Me leaflet, Checklist*
- They will also ensure that the bag includes any medication the person is currently taking together with the personal belongings that they will need in hospital: *Change of clothes for day of discharge, slippers, toiletries, dentures, hearing aid, glasses, reading book, etc.*
- When the ambulance arrives they will make sure that the ambulance personnel take the red bag and know what they are to do with it. If the ambulance staff are unsure, the care home staff will explain the requirements to them.
- The care home staff will complete the red bag checklist and hand it to the ambulance staff.
- The care home manager or a representative will visit the resident in hospital within 48 hours of admittance and discuss their care and future discharge with the hospital staff. They will report to the security office at the hospital and receive a visitors badge upon providing photo identification which will be cross-referenced against an approved list of staff.

### Ambulance staff

- On arriving at the care home, the ambulance staff will receive the red bag from the care home staff and check to ensure that all the paperwork is present and correctly completed.
- On arriving at the hospital, ambulance staff will pass on the red bag to the hospital staff, inform them that the paperwork is complete and discuss any issues arising, and ensure that the hospital staff are aware that the red bag must stay with the patient at all times.
- The ambulance staff will complete the red bag checklist and hand it to the hospital staff.

### Hospital staff: arrival at hospital and stay on ward

- When advised by ambulance staff that a patient is a care home resident, hospital staff will ensure that the red bag is present and complete, and refer to the enclosed paperwork for up-to-date information about the patient.
- Once this paperwork has been reviewed the folder holding the paperwork will be placed inside bag which will remain closed at all times.
- They will ensure that the red bag remains with the patient at all times, keeping it with them in A&E and ensuring that it is placed in their locker or by their bed if they are transferred onto a ward.
- Ward staff will ensure that there is a poster/indicator of the red bag placed in the patient's folder at the end of the patient's bed so that all staff are aware they are a care home resident.

### Hospital staff: discharge

- Hospital staff can identify the patient as a care home resident by the presence of the red bag, allowing them to consider an earlier discharge.
- The discharge should be discussed fully with the care home manager or a representative to ensure that the care home is prepared for the discharge.

- When the patient is ready for discharge, a ward nurse will pack the red bag, ensuring that all the correct paperwork is completed and included: *Older Persons Assessment Form, CARES Escalation Record, a summary of discharge information, This Is Me leaflet, Checklist*
- They will also ensure that the bag contains any medication prescribed by the hospital with clear instructions for care home staff, together with all the personal belongings that came in with the patient (this can be confirmed by referring to the red bag checklist)

The hospital staff will complete the red bag checklist and hand it to the ambulance/patient transport staff.

### **Ambulance/patient transport staff**

- The ambulance/patient transport staff will receive the red bag from the hospital staff and ensure that it stays with the patient at all times.
- On arrival at the care home, they will hand over the red bag to the care home staff.

### **Care home staff**

- When the resident returns from hospital, the care home staff will ensure that the red bag is with the resident and contains all the correct paperwork, medication and personal belongings.
- If anything is missing, they should contact the agreed contact at the hospital.
- Care home staff should clean the bag in accordance with the agreed infection control protocol.
- Care home manager to check all the paperwork and return the checklist to the CCG, together with any feedback.


### **Key points for all staff**

- The red bag must stay with the resident at all times from when they leave the care home until they return
- Patient documentation must be kept securely in the red bag at all times
- Staff should complete the red bag checklist at all stages of the journey to enable accurate tracking and evaluation of the Initiative
- If a red bag is lost, or an unidentified red bag is found, staff should contact the CCG immediately.


## **Appendix 2**

Openhouse Design manufactures the red bag.

Tel: 0151 646 4044. Email: [sales@openhouseproducts.com](mailto:sales@openhouseproducts.com)






# openhouse™



## Vanguard Patient Overnight Bag

CODE	DIMENSIONS (H x W x D)	WEIGHT	PRICE
10-01270	400 x 250 x 200 mm	2KG	£49.26 +VAT

**FEATURES**

- Top grab handle for ease of carrying.
- Clear business card sized window for patient name card.
- Clear document sleeve on rear for patient report form.
- Consecutively numbered for easy identification and security.
- Zip: Openhouse Standard Gun Metal Grey Zip with No. 10 Chain and sliders.
- Piping: Gun Metal Grey PVC Piping  
This is our standard piping that used across all our products, it adds strength and structure and well as protection items contained within the bag.

The Vanguard Patient Overnight Bag has been designed using our latest micrAgard wipe clean fabric with an inner silver micrAgard lining. micrAgard gives the product a high quality, hard wearing and durable feel.

2016				2017				
QTY 1 PRICE	QTY 20	QTY 50	QTY 100	QTY 1 PRICE	QTY 10 5% Off	QTY 25 10% Off	QTY 50 15% Off	QTY 100 20% Off
£44.78	£42.54	£40.30	£38.06	£49.26	£46.80	£44.33	£41.87	£39.41

openhouse design, manufacture and source products for any industry...

Openhouse Products Ltd, 125 Craven Street, Birkenhead, Merseyside, CH41 4BW, UK  
t: +44 (0)151 647 4044 | f: +44 (0)151 647 4048 | e: sales@openhouseproducts.com

An alternative supplier of the red bag is Rescue and Medical. Tel: 0844 576 6868.

## Appendix 3

South East Clinical Support Unit created the training film and poster. These resources can be adapted for local use with the proviso Sutton Vanguard are acknowledged on the resources.

Contact: Samuel Jackson: [Samuel.jackson@nhs.net](mailto:Samuel.jackson@nhs.net) Tel: 03000 424002.

## Resources

For more information about the Sutton Vanguard Hospital Transfer Pathway and watch short films: <http://www.suttonccg.nhs.uk/vanguard/plans/Pages/Hospital-Transfer-Pathway.aspx>

To read the Hospital Transfer Pathway Case Study:  
<http://www.suttonccg.nhs.uk/vanguard/plans/Documents/NHSE%20Case%20study%20-%20Hospital%20Transfer%20Pathway%2027042016%20final.pdf>

To read NICE coverage of the Hospital Transfer Pathway:  
<https://www.nice.org.uk/news/article/using-a-red-bag-approach-to-improve-transition-of-care>

View a film about the Hospital Transfer Pathway from the resident's perspective:  
<https://youtu.be/MP03jUtBXmA>

New Care Models have made a film on working together for better care: sharing the learning from enhanced health in care home vanguards  
<https://www.youtube.com/watch?v=aOmd00dE6mI>