Discharge from Hospital

Information for Patients
**Introduction**

This information has been produced to help you plan your discharge from hospital. The information in this leaflet is intended mainly for residents of the South Eastern HSC Trust area.

It explains the different services you may require and the arrangements that can be made for your care should you need it when you leave hospital. Your ward team will start to arrange your discharge from the day you come into hospital. This will ensure you have a well-planned move from hospital to home. Should you know of anything that may influence your ability to go home please let your nurse know as early as possible.

**Planning to go home**

Following the initial assessment process, you will be given an estimated date for your discharge (EDD). This estimated date of discharge will be reviewed every day. If you don’t know the date, just ask a member of staff. This will help guide you and your relatives/carers as to how long you will be in hospital. This by no means implies that your treatment will be rushed; you will not be discharged until the medical team treating you has decided that you are well enough to leave.

Once you have recovered from your illness and no longer need the services of the acute hospital, it is important that your discharge home, or your transfer to intermediate care services is arranged as speedily as possible. This is in your own best interests and also helps to ensure that beds in acute hospitals are available for people who need medical care. Many people arrange the care they need themselves, by getting help from friends or family. If you are unable to go to your own home without support, a member at the Social Work and Intermediate Care Team will work with you to assess your needs, and will discuss this with you and your family so that appropriate services can be identified and put in place.
Community Health and Social Care Services

You may need support from community services such as home care, district nursing and equipment.

If you require nursing treatment after your discharge, such as for the removal of stitches or change of dressings, the ward staff will contact the district nursing service to make the necessary arrangements or you can make an appointment with the Practice Nurse at your GP’s surgery.

Other appropriate therapies may be provided in the community, for example: -

- Physiotherapy
- Occupational therapy
- Speech and language therapy
- Dietician.

Carers and Discharge from Hospital

Discharge from hospital offers Health and Social Care Trusts a valuable opportunity to identify carers and to help put in place the contacts and services that will support and sustain them in their caring role.

Carers may not ever have thought of themselves as ‘carers’ before. In fact, many will still not identify themselves as carers. But if someone you care for has been in hospital and that person will not be able to manage at home without your help, then they are a carer.

We will involve carers in the discharge planning as early as possible providing information and advice to help them in their caring role, including their right to a carer’s assessment of their needs.
Intermediate Care

Intermediate Care is a range of specialist community based services, which act as a bridge between hospital and home, enabling people with complex needs to be discharged safely and appropriately from hospital.

A team of skilled and experienced staff provides intermediate care services. This includes care from:

- Occupational therapists
- Nurses
- Physiotherapists
- Speech and language therapists
- Social workers
- Rehabilitation assistants
- Care assistants.

Intermediate Care services are delivered in a range of settings including:

- At home with the community rehabilitation service
- At home with the community stroke rehabilitation service
- In specially arranged short-term residential or nursing home places. These are utilised for patients who need further time for recovering and care planning for the future
- Short-term home care services, including the Bryson House Home from Hospital Service
- At home with short term home care service.

The Social Work and Intermediate Care Team will discuss with you whether any of these services might be beneficial, and will make intermediate care arrangements with you.
Moving to a care home

The decision to move to a care home is sometimes made in hospital, perhaps after a number of admissions or a period of illness. It is important that life changing decisions like moving to a care home, are made carefully, and making such decisions during a hospital stay may not always be the best time to do so.

If it has been agreed that moving to a care home is the best decision for you, you and your family will be consulted about your preferences for a particular home or type of home. If there is not a vacancy in the home of your choice you will be asked to move to an alternative care home place whilst you are waiting for a place in your chosen home to become available.

It is not possible to remain in hospital while awaiting the home of your choice.

Community Hospitals

There are two Community hospitals within the South Eastern Health and Social Care Trust, one based in Bangor and the other in Newtownards. These inpatient wards are under the medical remit of local GPs.

Once your clinical condition no longer requires you to remain in an acute hospital bed, you may be asked to transfer to one of the community hospitals as part of your treatment plan. Your care will be handed over to the GP, until you are well enough to return home.
**Charges for services**

Home care and intermediate care services are mainly free of charge. This includes short-term admissions to care homes following discharge from hospital. There are some exceptions to this, which your Social Worker will explain fully to you.

Once a patient’s assessment and rehabilitation is completed and it has been agreed that a care home placement is needed in the long term, a financial assessment is required and the patient will be required to make the appropriate financial contribution. The Care Manager will provide a verbal and written explanation of the regulations and the charges involved.

**Medicines to take home**

When you go home you will be given 28 days medication and the nurses on the ward will explain this to you. If you brought any medication with you this can be returned to you providing it is safe and appropriate to do so. Your GP will receive a letter containing information about your hospital stay and your prescribed medication. Further repeat prescriptions should be obtained from your GP surgery and you should make arrangements to see your GP before your prescription runs out.
Transport

On the day of your discharge you will be expected to leave the ward before 10.00 am.

Most patients are expected to go home using private transport so you will need to make arrangements for someone to pick you up from the ward. If you are unable to make your own travel arrangements, please inform the hospital staff as soon as possible after you are admitted and you will be advised of alternative transport arrangements, including public and subsidised transport.

An ambulance can only be provided if you meet specific medical needs. If ambulance transport is necessary every effort will be made to ensure that ambulance transfers are arranged at a reasonable time of the day.

If you have any additional questions regarding your discharge arrangements just ask any member of staff and they will be happy to help.

Checklist

During your hospital admission, the ward nurses will help you prepare for your discharge from hospital. Please include your family, carers and friends when making these arrangements and talk to them well in advance. Some of the things you may wish to talk about are:-

• Is transport arranged for when I am ready to go home?
• Will the house be warm enough when I get home?
• Do people know I am coming home?
• Have I sufficient food in the house?
• Do I need to arrange to get some shopping delivered?
• Is the key available to gain access to the house?
• Are any services I might need organised?
To contact the Hospital Social Work Departments, phone:-

Ulster, Ards and Bangor Hospitals - Social Work & Intermediate Care
(028) 9048 4511

Lagan Valley Hospital - Social Work & Intermediate Care
(028) 9266 5141

Downe Hospital - Social Work & Intermediate Care
(028) 4461 3311