Let's get you home

NHS
University Hospitals Sussex
NHS Foundation Trust

Patient Discharge Handbook

Preparing for leaving hospital

My name

My expected date of discharge (EDD)

Key people involved in my discharge plan:

Name of main carer / relative / friend

Contact Number

A patient and carer information leaflet

What is this handbook for?

While you are here, the hospital staff will make sure you get the best possible care. Before your treatment comes to an end they will need to work with you and others caring for you to help plan your safe return home. We understand that you may be worried about going home, especially if you have been in hospital for a while. This handbook will help you plan how you leave hospital.

- It explains the different services you may need and the arrangements that can be made to support you when you leave.
- Use this handbook to note the services arranged for you and any concerns you may have, or issues you may need to discuss.
- Please keep it with you in hospital and take it home when you go.

How will my return home be planned by the team looking after me?

We will involve you and keep you informed

We will talk with you as soon as possible about when we think you might be able to go home. We will discuss whether anyone else, such as family members or a partner, needs to be involved in any decisions. If you have any questions, we will do our best to answer them.

We will assess your strengths and needs

We will talk with you about what is working well at home and whether you need any more support to remain healthy and independent. We can then make sure that you receive the care and support you need in the best place whilst further assessments are carried out. This helps you recover and remain well.

We will prepare you to leave hospital

When you are discharged home, it is important to us that you will be safe and able to manage. If we feel that you would benefit from further assessment at home to ensure you have the support you need, we will refer you to Community Services who will assess your needs in your home and identify the support you need. We call this Discharge to Assess or D2A.
The community services will support you while this assessment is completed, and if it is identified that you need further support to remain safe at home, you will be referred to the appropriate service, e.g.

- **Responsive services**
- **Community nursing**
- **Carers support service**
- **Voluntary services**
- **Community therapy**
- **Adult Social Care**

If we think that you need one or more of these services, this will be discussed with you and the people supporting you.

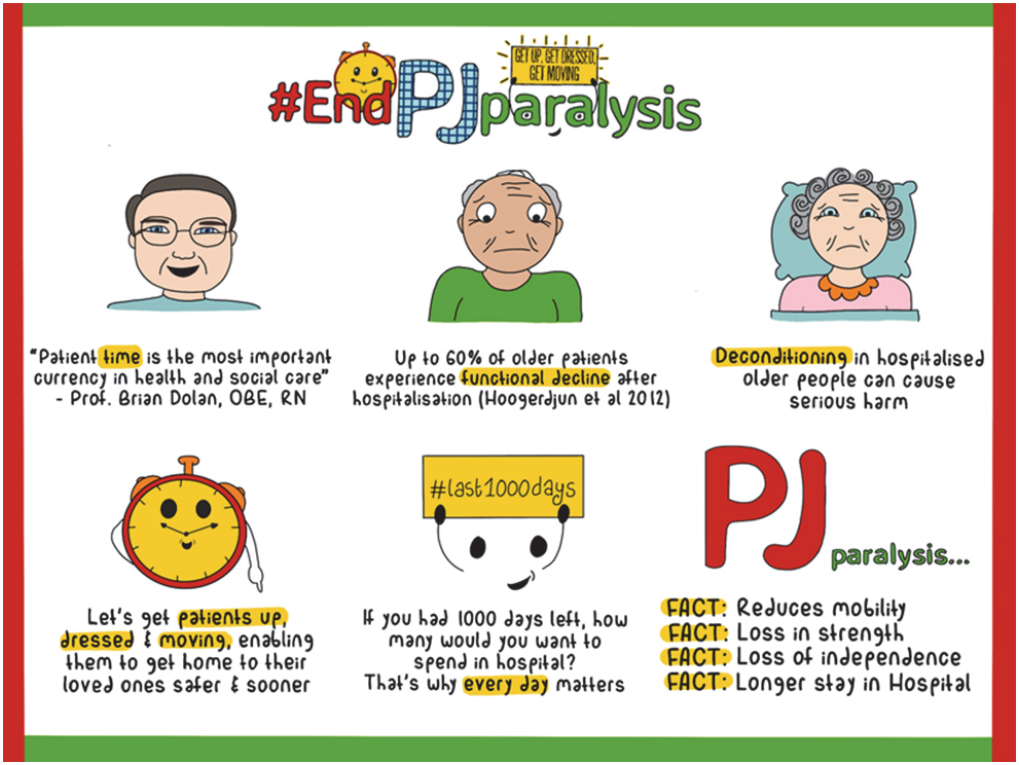
Let's keep you moving

We will look at what you were able to do before you came into hospital to make sure we understand how best to support and encourage you to keep moving; within your safe space – please remember social distancing and regularly wash your hands. Please tick the relevant boxes below. Ask your carer/relative/friend or member staff to assist you to if necessary.

 I have had a full assessment to help understand how I normally move about? ☐	 The hospital has discussed potential challenges that may stop me from being able to get out of bed? ☐	 I wear glasses ☐ I wear a hearing aid? ☐
 I have right equipment to help me move about at home? ☐	 I can walk to the toilet? ☐	 I can sit out of bed? ☐
 I can eat and drink unassisted? ☐	 I can wash and dress myself. ☐	 I change position regularly in the bed or chair ☐

Remember

We want our patients to get up, get dressed and keep active!
This will help them to reduce the risk of getting weaker (deconditioning), maintain muscle strength, improve mood, improve appetite, improve sleep, reduce the risk of constipation and also falls.
Put simply – you are at your best when you are up and dressed! We can help support you to keep you moving, in or out of bed in hospital. If you're able, try to get out of bed especially for meals, get yourself dressed and go for a walk on the ward every day. It will help you to maint maintain your muscle tone, your independence and help you get home.



Planning Your Discharge Checklist

Whilst in hospital please use this list to consider asking about the following and note the answer:

When I get home can I...	Yes	No
Take a bath?		
Have a shower?		
Climb stairs or steps?		
Lift heavy objects?		
Take walks or exercise?		
Resume sexual activities?		
Return to work?		
Drive a car?		
Do other activities		
When I get home, will I need to think about...	**Yes**	**No**
Someone to stay with me?		
Help me to get to the toilet?		
Help with shopping or preparing meals?		
Help me do the housework or gardening?		
Help to walk up my path to my front door?		
Help with my medicines?		
Help to communicate?		
Help to swallow safely?		
My family / friend or carer to be taught how to care for me?		
Will I have continence issues?		
What have I been referred for?	**Yes**	**No**
Community nurse?		
Home care service? Hospital at home, IV therapy team.		
Occupational therapist?		
Physiotherapist?		
Package of Care? Carers		
Dieticians		
Equipment?		
Other?		

What happens on the day I leave hospital?

Please ask a relative or friend to make sure your home is ready for your return, with the heating turned on and some food available. Please ensure you have your own clothes to travel home in and your keys.

Transport

You will need to arrange your own transport to collect you from hospital (except in exceptional circumstances). Please ask a relative or friend to collect you, or we can help you call a taxi. Hospital transport is available only for people who have a medical problem that prevents them from using a car, taxi or public transport (please note that we can only transport one small bag of essential belongings: other possessions must be taken home by family or friends).

Medicines

If you are given medication to take home, the Nurse will explain the instructions to you. Medications you brought into hospital will be returned to you providing it is safe and appropriate to do so.

Discharge Lounge

Patients usually move to the discharge lounge before they leave hospital. It can take several hours for transport and medications to be organised, but you will be well cared for while you wait. The lounge has access to facilities including refreshments, newspapers and a television.

Discharge Summary

A letter giving details of your hospital admission and medications that you have been sent home with will be sent to your GP. You will be given a copy to share with any health or social care professional visiting you. You should get repeat prescriptions from your GP surgery.

Going Home Day checklist

A checklist of things that you can do on your last days in hospital which will help you to feel prepared for your return home.

Day before you leave hospital	
Ask family or friends to bring in clothes for you	
Have your house keys to hand	
Ask for valuables to be returned	
Ask about any dressings, syringes etc. to take home	
Make a note of contact names and numbers for services arranged on the front page of this booklet.	
Ask for details of outpatient or follow up appointments	
Ask if there is any information and support for my carer or family on how to care for me, leaflets?	
Check on transport arrangements to get home	
Ask for information about any special diet (Food as Treatment leaflet)	
Check if the heating been turned on at home	
Check if there is food at home	
Day of discharge	
Ask for a medical certificate (fit note) if requested by your employer	
Ask about medications I must take and instructions for their use	
You may be moved to the Discharge Unit to wait for your medications or transport home.	
Ask for discharge summary letter for your GP	

Thinking about the future

We know that planning for the future in advance can reduce the stress of dealing with a situation when it arises, and makes it more likely that the outcome reflects your wishes. Please tell us if you would like to discuss any aspect of your future care. This might include:

- Considering your overall goals and wishes for your treatment and care.
- Practical things including any adaptations to be made at home.
- Signpost to community support groups for ongoing information and advice.

Some people would like support to express their wishes about certain treatments or types of care they would not want to have, such as major surgery, or cardiopulmonary resuscitation. We can support you with this and document them formally so these can be shared more easily by all those involved in your care. One way we can do this is through something called advance and anticipatory care planning. An example of this is the national ReSPECT process: **www.resus.org.uk/respect/**
There are also many opportunities and supporting organisations in the community who can help you maintain your health, social and support networks, and prevent some future illness or problems. Please speak to your local GP or local council about these.

What if I am ready to leave hospital but still needing on-going support?

If you are medically fit to leave hospital but we feel you need more support than you had previously at home the nursing staff will refer you for ongoing support. This may be provided in your own home or at an alternative care setting. This will be discussed with you and those important to you. This includes:

Intermediate reablement and rehabilitation at home and in other community settings

If your recovery is not complete you may be referred to a multidisciplinary team who can provide physiotherapy, occupational therapy, community psychiatric nursing, social work and nursing support in your own home or in a community hospital.

Community hospital

If your medical condition has stabilised but your recovery is not complete, you may be transferred to a rehabilitation hospital (community hospital) or care home with rehabilitation professionals.

We will always consider the service closest to your home, but it may not always be possible to place you there. You will be expected to transfer to the first available bed, but we will talk to you and those supporting you about this.

Care homes (residential homes and nursing homes)

If, after assessing your needs and talking with you and those supporting you, your needs can only be met in a care home setting, Health and Adult Social Care or the hospital discharge team can give you advice and support.

While we will try to avoid making long-term decisions about your care in hospital, we can help you and your family identify a preferred care home. If the home you choose does not have a vacancy, we can help you arrange an interim placement.

Will I need to pay for my care?

Provision of Care in your own Home

If it appears that you have longer-term care and support needs, Brighton and Hove City Council's Health and Adult Social Care can offer you an assessment, which will determine the level of care and support you require. This may take place following your assessment at home, in hospital or in a community hospital or a Care Home setting.

Health and Adult Social Care can either give you information and advice or, if required link you in to other appropriate services.

Health and Adult Social Care staff will talk to you about which services are chargeable. You will need to complete a financial assessment form and any charges will apply from the start of the service.

A package of care and rehabilitation may also be provided by the NHS. This is subject to assessment by the team on the ward.

NHS Continuing Healthcare

If you have a high level of health or care needs the ward team involved in your care may complete an NHS Continuing Healthcare assessment. NHS Continuing Healthcare is a package of services arranged and funded by the NHS for people outside of hospital with complex continuing health needs. These services can be provided in your own home or in a care home with or without nursing. This assessment can also take place in the community.

NHS-Funded nursing care

People with lower nursing needs who require a care home with nursing may be eligible for a weekly contribution towards registered nursing care. Your ward team can advise you on this.

For more information please ask for the leaflet: NHS continuing healthcare and NHS-funding nursing care - public information booklet. It is also available at this link: http://bit.ly/NHSfund

What if I have housing issues?

When you are admitted to hospital it is important to consider whether you will have accommodation to return to.

Please consider:

- If your home may be unsuitable for your medical needs.
- Whether a long term stay in hospital may have an effect on your rent payments and tenancy.
- If you have nowhere permanent to stay.

Please tell your ward nurse if you have housing issues. There is a Homeless Team in the hospital who will provide advice and guidance. The ward can refer you to them, or they can be reached on 07884195417 if you would like to contact them yourself.

What if I have problems with my memory?

At BSUH NHS Trust we actively encourage the use of the 'This is Me' document on all wards. This document encourages patients who have memory or cognitive impairment and the people who are supporting them to tell us information about them and their routine that will make the person's stay a more positive experience and prevent any unnecessary stresses or anxiety. If you are not sure if a 'This is Me' document is in use, and would like one to be, please speak to a member of the nursing staff.

If you are concerned your memory or thinking is affected please talk to your doctor or nurse who can refer on to the dementia specialist nurses.

What if I have been told I need a community nurse and they don't arrive?

Often you will be provided with the direct contact details of the community nursing team (in some areas also called Integrated Primary Care Teams) while you are on the ward. If you have this, contact this number directly.
If you can't get through, please contact the relevant Community Nursing team based on where you live:

Brighton and Hove: 01273 242117 - select option 2, and then select option 1-4 based on your area

West Sussex:

One Call Coastal (Burgess Hill, Crawley, Ditchling, East Grinstead, Hassocks, Haywards Heath, Horsham, Hurstpierpoint): 01293 228311

One Call Coastal (Chichester, Bognor, Midhurst, Worthing, Littlehampton, Shoreham, Lancing, Storrington, Steyning and Pulborough): 01903 254789

East Sussex:

Lewes Community Nursing Team: 01273 666489

Crowborough Community Nursing Team: 01892 337242

Havens Community Nursing Team: 01273 575490 (Peacehaven & Newhaven)

Heathfield/Uckfield Community Nursing Team: 01435 865379

What if my home care does not arrive?

Contact your care provider directly in the first instance, but if they are unavailable:

If you are a resident of Brighton and Hove contact Access Point: 01273 295555

If you a resident of West Sussex contact CarePoint: 01243 642121

If you are a resident of East Sussex contact Adult Social Care: 0345 60 80 191

What medication will I have when I leave hospital?

The hospital pharmacy will usually give you at least 14 days supply of your medication if needed. You must contact your GP surgery for further medications. If you are receiving artificial feeding you will be given up to five days supply of the feed and further supplies will be delivered to your home.

What if my recovery is not going as expected?

Contact your own GP or community nursing team who will assess the situation.

What if I fall and I can't get up?

Dial 999 and ambulance staff, who are trained to move patients, will able to support your transfer to safety.

A-Z Glossary

Care Home

Care home is a broad term which includes both nursing homes (clinical nursing facilities on site) and residential homes (no clinical nursing on site). Nursing homes are most appropriate for individuals who have the highest level of health and care needs. Some care homes have both residential and nursing components within them.

Carer

A person who provides unpaid support to a partner, family member, friend or neighbour who is ill, struggling or disabled and could not manage without this help. The amount and nature of this support varies depending on the situation. Many people don't realise they are a carer or identify as one and can miss out on useful support. A carer is also anyone who is impacted by living with someone who has health and care needs.

Care Worker

A person who is paid to support someone who is ill, struggling or disabled and could not manage without this help.

Discharge / Hospital Discharge

The process of leaving hospital and ensuring an efficient and safe transfer to an alternative place in a manner which best meets the individual's needs.

Discharge Lounge
The lounge where patients wait once they have been discharged from the ward, and before transportation home. This is where any final tasks to support discharge can be completed in a comfortable setting away from the ward.

Estimated Date of Discharge (EDD)
The anticipated date the multidisciplinary team, the patient, and those important to them plan for the patient to leave the hospital.

Health and Adult Social Care
The department in your local Council responsible for the delivery of social and care services, and who work closely with the NHS to do this.

Key Worker
A discharge coordinator, social worker or nurse on the ward is allocated as the first point of contact for the patient and their family, friend or carer. This is the person who can provide advice and answer questions regarding the patient's time in hospital and the process for leaving hospital including any support that will be provided after leaving hospital (discharge).

Medically Fit / Medically Ready for Discharge
These are terms used when medical doctors have assessed the patient no longer requires to be in an acute hospital from a medical health point of view, and the patient's condition is stable enough to make an accurate assessment of ongoing care to support discharge planning.

Multi-disciplinary Team (MDT)
Many professions make up the health and care team and the MDT is how these individuals work to bring their collective expertise together, so that shared decision making with patients and carers considers the whole range of perspectives.

Reablement and Rehabilitation
Reablement is a short and intensive service, which is offered to those with increased support needs who are recovering from an illness or injury, enables relearning the skills required to keep them safe, independent and closer to home.

Therapist
A broad term describing a range of allied health professionals such as occupational therapists, physiotherapists, psychological therapists, and speech and language therapists.

Hospital contact details

Royal Sussex County Hospital
Eastern Road, Brighton BN2 5BE
01273 696955

Princess Royal Hospital
Lewes Road,
Haywards Heath RH16 4EX
01444 441881

Royal Alexandra Children's Hospital
Eastern Road, Brighton BN2 5BE
01273 696955

Our Website: www.bsuh.nhs.uk
NHS 111

Sussex Eye Hospital
Eastern Road, Brighton BN2 5BE
01273 696955

Park Centre for Breast Care
177 Preston Road, Brighton BN1 6AG
01273 664773

Sussex Orthopaedic Treatment Centre
Lewes Road,
Haywards Heath RH16 4EX
01444 441881

Hospital discharge contact details

Discharge Team
Royal Sussex County Hospital: 01273 696955 Ext. 67885
Princess Royal Hospital: 01444 441881. Ask for **'Bleep 6107'** via main switchboard

Medicines
If you have any questions or concerns about your medicines, or wish to speak to someone about them, you can contact the Medicines Information Pharmacy team on **01444 454388** or **bsuh.medicines.information@nhs.net.** They are open Monday to Friday 9am-5pm.

How did we do?

We hope that the service we provide helps you get better as quickly as possible. We strive to improve the quality of our care and welcome all comments, both good and bad, from patients, families, carers and visitors.

Wherever possible we suggest that you speak to the Nurse in Charge of the Ward. They will listen and try to sort out the problem straight away for you.

Alternatively, you may wish to speak to our Patient Advice Liaison Service (PALS):

- **Royal Sussex County Hospital:** 01273 696955 Ext. 64511 or 64973. bsuh.pals@nhs.net
- **Princess Royal Hospital:** 01444 441881 Ext. 68678 bsuh.pals@nhs.net

You can provide positive feedback for our staff by emailing **bsuh.thankyou@nhs.net**

Brighton and Sussex University Hospitals Charity making it better

Did you know we have our own dedicated charity?
Find out more about us and how to donate and make a difference:
www.bsuh.nhs.uk/charity
Telephone: 01273 664708

WE VALUE YOUR FEEDBACK

Please help us improve our services

You may be contacted by Text or Automated Phone Message

Your response is free, anonymous and really appreciated!

If you don't wish to take part please tell a member of staff or simply reply STOP when you received the message

For more information, please visit:
www.nhs.uk/friendsandfamily

Thank you

Notes on planning your discharge

Please use this page to write down any notes or questions you / the patient would like to discuss.

Date	Notes / Questions

This leaflet is intended for patients receiving care in Brighton & Hove or Haywards Heath

Disclaimer
The information in this leaflet is for guidance purposes only and is in no way intended to replace professional clinical advice by a qualified practitioner.

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