

Home from hospital carer support

HOSPITAL DISCHARGE CARER SUPPORT

Roslyn Scott, VOCAL Carer Support Worker

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The aim of this service is to identify and support carers who may be struggling to cope with the additional pressures as they help to look after their family member or friend after discharge from hospital.



The Princess Royal Trust
for Carers

Coming home after a stay in hospital

As soon as people are admitted to hospital a process of planning should begin to find out what services and support they may need when they leave. By the time they leave hospital a clear discharge plan should be in place. Discharge arrangements will vary depending on whether someone is returning home or moving into a care home (for information on moving into a care home from hospital please see the last page of this factsheet). Carers are also entitled to have their views considered and needs assessed. It should not be assumed that family members will be able or willing to provide all the help required.

What is a discharge plan?

This is a planning process which should ensure that when people leave hospital they and, with their permission, you their carer, know about the following:

Their medical condition

This should include information on treatment, medication and future medical appointments. It should also include the names of the person's GP, consultant and named nurse.

Services and support

This should include information on services that have been agreed and that will be in place for the person returning home, for example, home help and community nurse. It should also include information on local points of contact and where needed specialist information eg. local Parkinson's Disease Society, local carers projects.

Who is involved in discharge planning process?

A consultant will decide when a patient is medically fit but the final decision may involve several different people including nurses on the ward, other hospital staff (eg. Physiotherapist, Occupational Therapist), the GP and staff from the Health and Social Care Department. Here is a short list of the key people involved and their role:

Named nurse

They are the main contact person while the patient is in hospital, overseeing the care provided and the plans made for leaving hospital.

The consultant

They decide what medical care should be provided and decide when the patient is well enough to be discharged from hospital.

Pharmacist

They provide the medication required and information on when and how it should be taken. They can contact your community pharmacist to provide information on any changes to the medicines or to give supply details.

Other people can also be involved when requested and when necessary:

Hospital Social Worker

They can explain what services are available and can assess what services need to be put in place at home. They will pass details of your assessment and care plan on to the Hospital Discharge Team (see following section for more details on the team) to follow up when you are discharged from hospital.

Occupational Therapist

Their aim is to help the patient to be as independent as possible in every day tasks such as bathing, dressing, confidence building and linking to the community. They can offer support when particular equipment or adaptations are needed.

Physiotherapist

They work with people to help them regain lost movement, improve mobility and to maintain safe independence in activities such as walking and using the stairs.

Carer Support Worker

There is a Carer Support Worker based at the Royal Infirmary of Edinburgh and St. John's Hospital in Livingston. His name is Keith Lugton and he works with carers when the person they care for is admitted to either of these hospitals. He can provide practical support and advice around carers' assessments and hospital discharge planning and can refer carers to other sources of support following discharge. Keith can be contacted on 07525157358 or email: keith@carers-westlothian.com.

Speech and Language Therapist

They work with adults and children, offering information and advice on communication, speech and language and/or eating, drinking and swallowing difficulties.

Dietician

They can offer information and advice to the patient, and you as their carer, if a special diet is needed.

Incontinence Advisors

They can offer information and advice about managing bowel and bladder problems. You should also contact the Community Nurse at your local health centre for a comprehensive assessment of needs and advice on suitability to receive services such as the Community Laundry Service.

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Checklist before someone leaves hospital

Do you and/or the person you care for have a copy of the discharge plan? Are you aware of date and time of discharge?

Does the person you care for have clothes to go home in, food in the house and transport to get home?

Does the person you care for and, with their permission, you as their carer have information about their medical condition, medication, what the medication is for and how often to take it?

Does the person you care for and, with their permission, you as their carer have information on any specific diets or exercise needed?

Have you (and the person you care for) been told who to contact if you are concerned about their condition when you get home? GPs are advised by the consultant of the date of discharge and told of any care arrangements within 24 hours of the patient leaving hospital.

Do you have information on the services that the person you care for will receive when they return home?

The person you care for may have to pay for some services - has this been discussed?

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Have you received a Carers Assessment ?

Carers are entitled to a carer's assessment and details about the process. For information contact Keith Lugton on 07525157358 (if the person you care for is in Royal Infirmary of Edinburgh or St.John's Hospital, Livingston), Roslyn Scott on 0131 313 6725 or 07508804760 (if you are based in central or west Edinburgh). Otherwise you can contact VOCAL on 0131 622 6666. A carer's assessment is carried out by a social worker.

Has the person you care for been in hospital for more than four weeks?

If they are in receipt of Disability Living Allowance (DLA) or Attendance Allowance (AA) they need to tell the Department for Work and Pensions. After four weeks these benefits (with the exception of the DLA **mobility component**) are stopped. When they return home the DWP needs to be told so their benefits can be reinstated.

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Services and support when you leave hospital

If the hospital thinks that the patient will continue to need care when they get home the hospital social worker will be asked to assess the patient and liaise with the local Health and Social Care Department to decide what services will be required. Services that might be put in place include:

- help with meals
- day care services
- respite/short breaks
- help with shopping and laundry in essential cases
- sitter services/care attendants
- equipment/adaptations
- help with personal care such as bathing and dressing
- supported accommodation

A home visit is sometimes included to assess the home environment. If a home visit is not arranged and you think it would help, you can ask for this to be arranged.

If there were services in place at home before admission, the hospital staff should ensure these services restart when the patient returns home and contact their local social work centre on their behalf. If hospital staff are unaware of existing services then you should approach one of the ward staff to let them know.

If a special piece of equipment is needed (eg. a bath seat or walking frame) this should be supplied before discharge, and both you and the person you care for should be trained on how to use it.

Paying for services

If someone is 65 or over and assessed as needing personal care, they are entitled to it free of charge. Personal care can include help with washing, bathing, toileting, getting in and out of bed, assisting with medication and help with the preparation of meals. Day care, lunch clubs, help with shopping and housework are not personal care tasks and will still have to be paid for. Eligibility for attendance allowance or disability living allowance is not affected if you receive free personal care.

There is a charge for some services however anyone assessed as needing home care following discharge is entitled to a maximum of 28 days free. A financial assessment is carried out by Social Services to work out how much the patient can afford to pay after the 28 days has expired.

There can be some confusion around which services are free and which you still need to pay for. If you have questions related to charges you should discuss this with the hospital social worker who has carried out the initial assessment.

Hospital Discharge Team

If a patient is assessed as needing services and support the hospital social worker will pass the patients care plan on to the Hospital Discharge Team which consists of a Team Co-ordinator, Occupational Therapist, Housing Support Worker, trained care workers and a Carer Support Worker - Roslyn Scott - who covers the central and west areas of Edinburgh.

Once the person you care for is home from hospital, they will receive a visit from the Hospital Discharge Team Co-ordinator who will discuss the services they can provide which can be in place for up to four weeks depending on your needs.

The carer support which Roslyn offers can include providing a listening ear, sourcing information, assisting with benefit queries, making referrals to Social Care Direct and liaising with other professionals within the Social Care departments to address individual issues. Roslyn can be contacted on 0131 313 6725 or 07508804760, her email is roslyn.scott@edinburgh.gov.uk.

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Examples of problems that might arise

The hospital discharge procedure should ensure everything runs smoothly on the day of discharge whether the patient is going home or moving into a care home. However, sometimes things go wrong. Here are some of the problems that may arise and how you can address them:

The hospital thinks that the person you care for is ready to leave but they don't feel they will manage.

It is important to let hospital staff know if you and the person you care for are not happy with the arrangements being made or if you feel there won't be enough support available. A patient should not be pressurised into leaving hospital before an agreed care plan is in place and any services needed are ready to start.

Explain your concerns to the ward staff. If you aren't satisfied with the response try to speak to someone from hospital management. Stress that you are worried that the person you care for won't manage and that the hospital has a responsibility to ensure their needs will be met when they are discharged.

The Hospital Discharge Team have been assisting you for four weeks and are due to terminate their service

If you still need ongoing support, once a suitable level of care has been decided on, a service will be arranged with the Council's Home Care Service or with a Council approved Care at Home agency.

No services have been offered to support the person you care for at home and you think a home help and meals on wheels might help.

If the assessment has not taken place, you should ask for one to be carried out. The local authority is obliged to assess anyone who appears to need services to help them remain in their home. If someone has had an assessment and has not been offered the services, they have a right to challenge the decision. It is worth talking to the hospital staff about this and you can also speak to the social worker who carried out the assessment and ask them why they cannot have the service you think is needed.

Hospital staff are putting pressure on the person you care for to move into a care home but they and their family think they could manage at home with a bit of help.

No-one can be discharged to a care home against their will. If you feel the person you care for could cope at home talk to the social worker who carried out the assessment to discuss services that might help them to cope. You could ask why they have not been offered these services but it is important to be realistic about their capabilities and about the help the local authority and/or you or other relatives may be able or willing to provide. For some people moving into a care home can be the best option. If you and the person you care for are still not happy, you can follow the appeal procedure detailed on the next page.

The person you care for is at home, having been discharged, and can't manage.

This is what the hospital discharge procedure is designed to prevent but sometimes things can go wrong. If you think this might happen make sure you voice your concerns to hospital staff before discharge. At home you can contact Social Care Direct (if living in Edinburgh) on 0131 200 2324 and explain your concerns. The Health and Social Care Department also has a 24 hour phone number which can be contacted on any day of the year. The emergency number for Edinburgh is 0800 731 6969. A Carer Support Worker - Roslyn Scott - is also available to offer support and assistance to carers after hospital discharge. Her contact number is 0131 313 6725 or 07508804760.

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Moving to a care home

An assessment may find that the person you care for won't be able to manage at home even with a lot of help from social services. If this is the case and the consultant advises that they are medically fit to be discharged but hospital care is no longer required, then they may be offered the option of moving to a care home instead of returning home.

Making the move to a care home is a big step and no-one should be rushed into making this decision. If you and the person you care for are concerned you should let the hospital staff know as there may be other possibilities to consider, like sheltered housing. It is natural to have some reservations and most people do. Moving into a care home can be a positive step and may help the person you care for feel more secure and comfortable.

If there is an assessed need the local authority can arrange for a place in a care home. A social worker will try to find a care home that is appropriate. People are usually given the opportunity to visit the care home before they accept a place there and are under no obligation to accept the first place offered. All reservations and concerns should be discussed with the social worker involved.

VOCAL has produced a booklet entitled 'Thinking about Long Term Care' which looks at the emotional aspects of long term care. Free copies can be ordered by calling VOCAL on 0131 622 6666.

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Appeals Procedure

While a patient has a right to refuse discharge to a care home, no-one has a right to stay in hospital indefinitely. Social services have a responsibility to work with patients, their carers, hospital and community based staff to find an acceptable way of meeting the patient's needs.

If you feel that discussions are going nowhere, there is a right of appeal against the clinical decision to discharge someone from continuing NHS care. Information on this procedure is available from hospital staff on request. Once a consultant has decided that a patient can be discharged, the patient has ten days to request a review of the decision by the Director of Public Health. This should be completed within two weeks. There is a right to a second opinion from a consultant in another health board area if it has been decided that discharge should go ahead. Discharge cannot take place during the appeal process.

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