James Paget University Hospitals NHS
NHS Foundation Trust

Norfolk County Council

Suffolk County Council

Preparing for Discharge

Name (printed).....

Ward.....

Expected date of discharge.....

Date leaflet issued.....

Documented issue of leaflet in patient record by:

Signature.....

Print.....

Date.....

Information for Patients and Carers

Introduction

We would like to welcome you to our hospital and to assure you that we will explain and involve you in all aspects of your care and treatment throughout your stay.

When the doctor considers you to be well enough to leave hospital, you will be offered the help and advice you need in a safe and timely way. This leaflet is designed to provide information on how, together, we will plan for your discharge from hospital.

When can I go home?

When you are admitted, we will help you to begin planning for your return home and will inform you of your 'expected date of discharge'. This is the date when, based on your treatment and improvement to your health, we think you will be well enough to leave. This is to help you prepare. If you are not sure of your 'expected date of discharge' please ask your nurse.

What should I do to plan for my discharge?

- Remind the person collecting you to bring clothes for you to go home in.
- Make sure you have your door key.
- Make sure everything is ready for you at home. For example, you have enough food and drink or the heating is on.
- Make sure you inform ward staff if you require any medical certificates.
- If you require a follow up appointment, make sure you know the time and date of your appointment.
- Make sure you have a copy of your discharge arrangements.
- Please take all your personal belongings with you when you leave.

We try to ensure that patients are discharged as soon as the doctor states they are medically well enough to leave hospital.

Many will be ready to leave by 11am. Please ensure you have someone available to collect you. If your transport is delayed you may be asked to wait in the discharge lounge until you are collected.

Discharge Assessments

As part of your discharge planning, you will receive assessments from various health care professionals to establish your care needs and what support services you may require. Throughout the assessment process, every effort will be made to ensure we meet your preferences on what you want to happen next. These assessments will identify your level of need and what support or funding, if any, you will require on discharge. This may result in one of the following pathways.

Planning your Discharge: Returning Home

You may need the help of Adult Social Services to plan your return home. With your consent, ward staff will contact the hospital social services team. Your social worker, therapists and the medical team will then assess your care needs. Any needs and options will be discussed with you and with your agreement, your family, carer or representative can be involved. The assessment will consider how to help you:

- Return home to live independently with support services/ reablement.
- Return home after short-term rehabilitation or care at another hospital/ care accommodation.

Planning your Discharge: Moving to a Care Home

A move to a residential or nursing home may be necessary after you leave hospital. If this needs to be considered, with your consent, ward staff will contact the hospital Social Services Team. Your social worker and hospital team will ensure that:

- Guidance is offered to help you decide on your home of choice.

- If there is no vacancy in your home of choice, we will help you find another suitable home. It is not possible for you to remain in hospital as the beds are needed for patients requiring urgent medical attention.
- For people who are self-funding, you will be provided with any information you require to support you in finding care and assistance to make arrangements as soon as possible. This may involve arranging a move to an available vacancy in a care home until your preferred place becomes available.
- If you are an Adult Social Services funded patient you will be supported throughout your discharge from hospital. Any subsequent moves to a care home will be temporary with a review undertaken after discharge for your long term needs.

We understand that a hospital setting is not the best place to make long term care decisions and will endeavour to provide you with as much support as you require. Charges for home support, residential and nursing homes will be explained to you by your social worker.

Planning your Discharge: Moving to a Community Bed/Home with Support

It may be beneficial to receive your rehabilitation within your own home. This option will be discussed with you if deemed appropriate.

Some people may benefit from a period of rehabilitation before returning home. This could take place in a community bed or NHS-funded nursing home bed.

If you require rehabilitation in a community hospital before going home, you will be transferred to the first available bed in a unit which provides the appropriate care to meet your needs. This may not be the closest unit to where you live. Our priority is to transfer you as soon as possible so you can start the rehabilitation necessary for your recovery. When you are ready to leave the community hospital, you will be supported to return home with the care you need to live safely and independently.

How will I get home?

Hospital transport is reserved for patients with a clinical need. A nurse can assess you to see if you are eligible for hospital transport on discharge. Otherwise, we ask that you make your own arrangements with family, friends or by public transport.

Can you get me a taxi?

If you require a taxi please ask a member of ward staff to book this for you. Please ensure that you have enough money to pay the taxi driver directly.

What if I need a prescription to take home with me?

If you require any prescribed medicines to take home, the hospital will arrange these for you. We will ensure you have enough medication for at least 14 days, if required, or for a short course of therapy (for example an antibiotic to treat infection), the remainder of the course.

Please tell us if you have any medicines at home so that we do not arrange an additional supply. Often, your discharge prescription cannot be finalised until after you have been seen by your doctor and advised that you can go home. The full process from writing your prescription to the medicines being ready on the ward can take up to four hours. Your nurse will be able to give you a more accurate time frame near to the time of discharge.

If you require information about your medicines you can call the **Pharmacy Helpline** between 09:00 and 17:00 Monday to Friday.

01493 452452 and ask for **Pharmacy Helpline**

With your consent, a copy of this leaflet can be given to those helping you. Please do not hesitate to ask your ward nurse or your social services worker if you have any questions about arrangements for leaving hospital.

Useful Contacts

If you are experiencing problems or have concerns about how you will cope once you have been discharged please contact your GP surgery.

- **Your local GP** If you are registered with a local GP, they will be able to assist you with most medical concerns post discharge.
- **Crossroads Care East Anglia**, a range of services for carers, tailor made to the individual situation.

  01362 691708
- **British Red Cross Home from Hospital**, free short term support such as shopping, befriending and rebuilding confidence. Red Cross are based in the hospital from Monday to Friday 9am-4:30pm

  01493 452080
- Red Cross Equipment Loans, East Coast Community Access, a service offering loans on equipment such as commodes and wheelchairs.

  01493 809977
- **NHS 111**, if you feel you need medical support but it is not a 999 emergency.

  111
- **Norfolk County Council and Suffolk County Council Adult Community Services** provide a wide range of information and services to enable you to stay in your home independently. These include adaptations to your home, support for carers and access to a range of government funded services.

  0344 8008020 **www.norfolk.gov.uk**

  0808 8004005 **www.suffolk.gov.uk**

- **Care and Repair Service**, support with repairs and adaptions for over 60s living in their own home.

  Staying Put, Great Yarmouth Borough 01493 846190

  Broadland 01603 430514

  Suffolk Care and Repair 0800 1217711

- **Age UK**, free, confidential advice and advocacy service covering a range of issues from moving into a care home to claiming benefits. Age UK are based in the hospital on Tuesdays, Wednesdays and Thursdays from 2pm- 6pm.

  01603 787111 www.ageuknorfolk.org.uk

  01473 351234 www.ageuksuffolk.org.uk

Concerns and Questions

If at any time during your stay you have concerns or questions relating to your discharge or would like further explanation of this leaflet, please ask a nurse or doctor at your earliest opportunity.

Suggestions, Complaints and Compliment

Your feedback helps us to make improvements to the way we provide your care.

We endeavour to provide an excellent service at all times, but should you have any concerns please raise these with the nurse in charge/ matron on duty.

If they cannot resolve your concern, please contact our Patient Advice and Liaison Service (PALS) on 01493 453240 or email us at pals@jpaget.nhs.uk to discuss your concerns.

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01493 452452

Information contained in this leaflet is correct at time of going to print.

Feedback

We want your visit to be as comfortable as possible. Please talk to the person in charge if you have any concerns. If the ward/department staff are unable to resolve your concern, please ask for our Patient Advice and Liaison (PALS) information. Please be assured that raising a concern will not impact on your care. **Before you leave the hospital you will be asked to complete a Friends and Family Test feedback card.** Providing your feedback is vital in helping to transform NHS services and to support patient choice.

Trust Values

Courtesy and respect
- A welcoming and positive attitude
- Polite, friendly and interested in people
- Value and respect people as individuals

So people feel **welcome**

Attentively kind and helpful
- Look out for dignity, privacy & humanity
- Attentive, responsive & take time to help
- Visible presence of staff to provide care

So people feel **cared for**

Responsive communication
- Listen to people & answer their questions
- Keep people clearly informed
- Involve people

So people feel **in control**

Effective and professional
- Safe, knowledgeable and reassuring
- Effective care / services from joined up teams
- Organised and timely, looking to improve

So people feel **safe**

IN TRAN communication for all

The hospital can arrange for an interpreter or person to sign to assist you in communicating effectively with staff during your stay. Please let us know.

For a large print version of this leaflet, contact PALS 01493 453240

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Review Date: September 2019
GE 2 version 1