Southend University Hospital
NHS Foundation Trust

Patient Information Service

Southend University Hospital – Trust-wide

Planning your discharge from hospital

Notice to admitting nurse:
The discharge checklist should be removed from the centre of this booklet during the nursing admission assessment, and filed in the front of the medical notes until discharge. It is completed at discharge and the yellow copy given to the patient.

This booklet provides information to patients and carers on planning for discharge from hospital. It is very important to read carefully, and keep with you in hospital, as it will contain your plan of care when you are ready to leave.

Name of patient.....

Ward.....

Planned date of discharge.....

Named nurse.....

Social worker.....

Rehab team.....

Discharge coordinator.....

Property and valuables

It is recommended that you only bring property and cash essential for your immediate needs into the hospital and that you hand any articles you wish to be kept in safe custody to the ward sister/charge nurse/hospital manager as soon as possible. You will be given a receipt for these. You are responsible for property (including cash) not handed over for safe custody. The Trust accepts no responsibility for the loss of, or damage to, personal property of any kind, in whatever way the loss or damage may occur, unless deposited for safe custody.

Your hospital treatment

Southend University Hospital is a general hospital for people with an acute illness requiring 24 hour care of a consultant. There are a limited number of beds, all in great demand, serving a population of 350,000 people.

No patient has the right to occupy an acute hospital bed once their acute phase of care is over. To do so may prevent the admission of another patient. Your consultant will decide when you no longer require an acute hospital bed and discuss this with you, or if you wish, with your relatives.

Your consultant will decide when your hospital medical treatment has been completed, and you will be declared medically fit when you no longer require the 24 hour care of a hospital doctor.

The rehabilitation team will decide when you are safe enough to transfer from hospital and if any further rehabilitation is necessary they will make a recommendation on your needs. Please ask to discuss this with your nurse.

Where there are concerns over the discharge care arrangements for the patient, an alternative care setting will be found to allow continuing discussion to take place. This will ensure that acute beds are available for patients that need this level of care.

Patients do have the right to refuse any care, or to make their own discharge arrangements.

Planning for your discharge

The ward staff will discuss your expected date of discharge as soon as possible after your admission or at the pre-assessment clinic if this applies to you. This will enable you to plan for your transport home, and clothes to travel in. We will involve your family, friends and carers if you wish.

If you require help on discharge, your nurse may refer to other professionals involved in discharge planning.

Some of these plans take time to put into place, and the assessments outside the hospital setting often provide a truer picture. It is helpful to let your nurse know if you will need assistance as soon as possible and who your main carer is.

Professionals involved in your discharge:

Social care

This may include help with:

- personal care
- home adaptations
- meals
- day centre arrangements
- short breaks away from home
- long term care
- financial advice
- assessment of your carer's needs if necessary.

To access social care you will be asked to provide details of your finances which will include savings. Ask your nurse to refer you to the hospital social worker as soon as possible, as you may be entitled to some help you are not aware of.

Nursing care

A nurse will go through all your medication with you to ensure you have been given sufficient information about your medicines. They will double-check everything you need is present and then complete your discharge checklist.

If you have been assessed as requiring district nursing services for ongoing treatment, this will be arranged prior to your discharge. A nurse will call and assess you at home to plan your care with you. Details will be recorded in the middle of this booklet.

If you are discharged with a urinary catheter, and develop problems, please contact your district nursing service, any time, 24 hours a day on 01702 608250.

Rehabilitation needs

When recovering from an acute illness, further rehabilitation may be recommended from the ward based rehabilitation team. They will discuss this with other professionals involved with your care. This is often called 'Intermediate care' and is free for a defined period of time and can be 'up to' six weeks. This care may **be a combination** of rehabilitation in a 24 hour residential setting and some provided in your own home. Please discuss this with the discharge coordinator or the rehabilitation team. This care is provided by the Clinical Commissioning Group following a referral from the hospital.

Equipment for discharge – If any equipment is necessary for you to return home, delivery will be arranged but we would ask that a friend or relative is available to accept delivery. If there is a problem, please discuss this with the discharge coordinator.

Pharmacy team

Pharmacy staff will carry out checks to ensure you are on the appropriate medication and have adequate supplies after discharge. They support the transfer of important information to your GP on medication changes made during your stay. Pharmacy can be contacted for advice and support related to medicines on **01702 385223**.

Please refer to our *Supporting you with your medicines* leaflet for more details.

Consultant

If you require more information on your medical care, please ask your nurse to arrange an appointment with your doctor or consultant.

Your doctor and nurse caring for you will discuss your expected date of discharge 24 hours in advance so that you can plan your transport home.

Arranging ongoing care following discharge

These plans and assessments will continue after you leave the acute hospital. You may receive care at home or in a residential setting as a temporary measure whilst permanent arrangements are organised. The multi-disciplinary team will assist you.

Information will be provided on temporary arrangements. We would expect decisions on placements to be made as near to possible to your planned discharge date, or within five days where possible.

Funding decisions

Your social worker will discuss financial arrangements on care and placements with you during your hospital stay. You will be asked to complete a financial assessment form to identify access to funding. Please discuss entitlements to contributions with your social worker.

- **Self funding** – You may have sufficient funds to pay for your own care. Your social worker and discharge coordinator will assist you in choosing your care arrangements
- **Social care funding** – You may be entitled to assistance with funding depending on the outcome of your financial assessment
- **Health funding** – All patients leaving hospital are assessed against the new criteria for NHS continuing healthcare and NHS funded nursing care.

NHS continuing healthcare

This is the name given to a package of services arranged and funded by the NHS for people who meet the criteria and have an overall healthcare need. If you wish to have a copy of your NHS CHC checklist, please ask your nurse to provide you with a copy. The checklist is completed electronically but one can be printed for you.

NHS funded nursing care

People with an ongoing need for a registered nurse will receive that care free of charge. This may be at home (from the district nursing service) or in a care home setting (either provided by the

care home itself or by the district nursing service). If the care is provided by the home itself, the NHS makes a payment to the care home to cover the cost of providing the ongoing healthcare.

How are assessments made?

A multi-disciplinary assessment of all care needs will be made with the active involvement of the patient and their carers. A multi-disciplinary team is made up of two or more professionals involved in your care. You and your family/carers will be given the opportunity to add any information that you feel is relevant to any assessments for funding decisions.

Screening – Potential eligibility for funding is assessed using a checklist provided by the Department of Health. This determines whether a full assessment for continuing healthcare is required.

Full assessment – An overall picture of your needs will be undertaken by the multi-disciplinary team involved in your care and assessed against a set of national criteria, using the 11 assessment domains.

Decisions on funding are made at a joint agency panel led by the Clinical Commissioning Group. You will be informed of the decision by letter from the Clinical Commissioning Group, continuing healthcare lead. This is not decided by the hospital.

If you are dissatisfied with the decision, you may have a 'right to a review' by an independent panel. Please ask your discharge coordinator for the contact details of your local health commissioner.

For further information, a Department of Health booklet is available at your request.

Email: dh@prolog.uk.com Tel: **08701 555455**

Possible temporary discharge arrangements

Where there is a delay in discharge from hospital, a short term arrangement for care may be planned in order for the bed to be available for another patient's admission.

- **Temporary placements in a residential setting.**
  A short term place in a residential or nursing home may be arranged by your social worker if the care they are arranging is delayed. A financial assessment will be made for these placements along with a full explanation. This allows for ongoing plans for long term care
- **Step-down beds** are temporary placements in a care home setting managed by the hospital, which enable ongoing plans for discharge to continue in surroundings more comparable to home. It is very important that timely discharge is planned from these beds too. These beds are paid for by the hospital for a short stay. Your discharge coordinator will provide more information. These beds provide ongoing rehabilitation and assessment to decide on your long term care options
- **Collaborative care** – A team of therapists, carers and nurses can provide short term rehabilitation, nursing or personal care. An assessment will be made for long term support in the home environment
- **Intermediate care rehabilitation unit** – provides 24 hour nursing care and rehabilitation for patients who require assistance overnight. The aim is to assist recovery following an acute illness. Ongoing plans for discharge will be undertaken in all these settings, and involve the multi-disciplinary team

- **A named nurse** involved in your admission will work with you to assess the care you need to plan for home. A care plan will be provided for you to ensure you are aware of the plans, and keep you well informed of the **date planned** for you to leave hospital
- **Social worker** – may need to assess and provide the care required, which could include a financial assessment. This will be fully explained to you, along with your options for care
- R**ehabilitation team** – can advise on mobility and equipment needs. They may need to assess your home surroundings
- **Discharge coordinator** – can provide help with all aspects of discharge planning. Please ask to speak to them to discuss any concerns you have about leaving hospital as soon as possible after admission. Their name and contact number will be displayed on the ward

The contact telephone number for the discharge team is: 01702 507129

The Mental Capacity Act 2005

The ability to make decisions in life is called mental capacity. Some people may have difficulties making some decisions either always or some of the time and this may be due to a health problem. A doctor or other trained professional (social worker, nurse etc) will make an assessment of someone's mental capacity in cases where decisions on long term care arrangements or serious medical treatment need to be made.

Discharge checklist

Nurse in charge
24 hours before discharge

PAS label or add details

Name:_____

NHS No.: _____

D.O.B.: _____

- The planning for discharge booklet must be given on admission to the ward.
- The discharging nurse should personally sign the discharge book checklist – this is a legal responsibility. **A copy must be given to the patient.**

Ward:	**Date of discharge:**	
Relatives aware:	Yes	N/A
Document the name of the relative you have liaised with:		
Clothes/Key available for D/C	Yes	N/A
Discharge Summary: With patient ☐ One to temp GP ☐	Yes	N/A
Outpatient appointment: given to patient/to be sent on (please circle)	Yes	N/A
Equipment essential for discharge in place.	Yes	N/A
Transport booked stretcher/chair/relatives collecting (please circle) Discuss access issues with DCO, ie can a stretcher get into the property	Yes	N/A
Home from Hospital team – Consider if patient appears vulnerable or will be alone on returning home, or requires shopping etc. Refer to DCO	Yes	N/A

White copy to be filed in medical notes when completed on discharge
Yellow copy to remain in booklet for patient's information

Medication ready and explained to patient/relative, yellow card completed if appropriate.	Yes	N/A
IV Cannula removed	Yes	N/A
Oxygen is ordered and in place	Yes	N/A
Warfarin – Ensure patient has appointment booked and medication dosed	Yes	N/A
Diabetes (inform discharge lounge)	Yes	N/A
Infections – Use inter-health transfer form to notify ongoing care providers – this form must be used for every patient that has ongoing care provider. Including ambulance service	Yes	N/A
DNAR in place	Yes	N/A

Visits at home after discharge

District nurse (contact number **01702 608250**) • 3 days of dressings ☐ • 1 spare catheter and 5 bags ☐ • 1 weeks supply of continence pads (and continence referral if necessary) ☐	Yes	N/A
Care in place (agency or care home contacted and aware of discharge time) Name of agency/home _____ Contact number for agency/home _____ Start date and time _____ Is there a keysafe: _____ What is the number: _____	Yes	N/A

Other information:
Signature of discharging nurse:

The multi-disciplinary team will involve relatives and carers to assist in making these decisions when necessary. If you have concerns about decisions made around mental capacity, please speak to your doctor or the nurse in charge

The act:

- Recommends the use of independent advocates (IMCA – Independent Mental Capacity Advocate) to assist in making important decisions or act as representatives where there are no relatives or carers who can be consulted
- Encourages people to make lasting powers of attorney that enable a designated person to make decisions about finance, property or healthcare
- Enables people to make advance decisions about treatment.

For further information on the Mental Capacity Act visit: www.guardianship.gov.uk or www.dca.gov.uk/legal-policy/mental-capacity or by post:

Mental Capacity Implementation
Department of Constitutional Affairs, 5th Floor, Steel House,
11 Tothill Street, London, SW1H 9LH
Tel: **020 7210 0037 / 0038**

Transport from hospital

We would expect a family member or friend to collect you from hospital via the discharge lounge, as **hospital transport is for medical need and emergencies only.** *Please do not divert ambulance transport from those who really need it. If there is extreme difficulty please discuss with the nurse.*

A leaflet explaining medical entitlement to transport is available at your request.

The discharge lounge

This lounge provides an area to wait for transport home, whether with family or awaiting hospital transport. A trained nurse will ensure you are cared for. You can expect to transfer to the discharge lounge by 11.00am on your day of discharge to await your family or carer, as your bed will be prepared for another patient.

An information leaflet is available. The staff will be pleased to phone your relatives or friends from the lounge.

- Please ask any questions on treatment, medication, equipment or appointments **prior to leaving the ward**
- Ensure you have clothes to travel in and your door key **before your discharge date.**

Location of the discharge lounge

Ground Floor in the day assessment unit
Enter hospital at old main entrance, ramp access available
Direct dial: **01702 435555 ext 6151**
Free short term parking for collection of patients

How do I choose a care home?

Your social worker or discharge coordinator will help you choose a care home. They can give you a list of vacancies in an area of your choice. Using social care funds may limit you to certain homes, dependent upon price.

If your capital/savings exceed the local authority limits, you may not be entitled to social care funds. Self funding patients may choose any home of their choice. If a care home is chosen with no immediate vacancy, your social worker will discuss interim arrangements to leave hospital. Government guidance is for a multi-disciplinary assessment of your needs. The home manager must assess you to confirm they can provide the necessary care.

Registration of care homes

All care providers must be registered and inspected by the Care Quality Commission (CQC). Homes are categorised by the type of care they provide. Homes can only accept patients within their registration categories, ie patients with a diagnosis of dementia can only access care homes with a dementia registration. CQC provide inspection reports on homes at certain time intervals which are available on the internet.

Some care homes provide care with registered nursing input, and others provide for general personal care only. Please speak to your social worker or discharge coordinator for advice and request a copy of the care services directory.

Information for carers

If you look after or care for a relative/neighbour or friend, young or elderly who is suffering from an illness or disability, then you are a carer. Help is available in your local area.

Southend
Southend Carers Forum
29-31 Alexandra Street, Southend, Essex, SS1 1BW
Helpline: **01702 393933**
Drop-in Centre open Monday to Friday 10.00am to 2.00pm
Email: info@southendcarers.co.uk
Website: www.southendcarers.co.uk

Essex
Essex Carers Grapevine

Castle Point / Rochford
The Tyrrels Centre
39 Seymour Avenue, Thundersley, Essex, SS7 4EX
Tel: **01268 638400**
Email: marion.horsley@essexcc.gov.uk
Website: www.essex.gov.uk

Community social care contact details are:
To refer to social care if the patient is at home or is planning to leave without medical agreement or to give advice to relatives post discharge:

Southend
Community contact: The Civic Centre Department of People
Tel: **01702 215008**
Hospital contact: **01702 435555 ext 7241**
Email: council@southend.gov.uk
Website: www.southend.gov.uk

Essex county
Community contact: Adult social care department:
Tel: **0845 603 7630**
Hospital contact: **01702 385584**
Email: contact@essex.gov.uk
Website: www.essex.gov.uk

Feedback on your experience

We want to know about your experience as our patient. If you think we have done well please let us know. If you think we could have done better, we want to hear about that too.

You can let us know your feedback by completing a comment card on the ward, or let a member of staff know about your experience.

You can also email: patient.experienceteam@southend.nhs.uk
PALS@southend.nhs.uk
By telephone: **01702 385333**

We hope you won't need to complain, but if you do, you can contact the complaints team:

By email: complaints@southend.nhs.uk
By telephone: **01702 435555** ext **5144/6449**

Or by letter addressed FAO the complaints team at the usual hospital address.

Help and advice on any aspect of your care:

Patient Advice and Liaison Service (PALS)
Southend University Hospital, Prittlewell Chase
Westcliff-on-Sea, Essex, SS0 0RY
Tel: **01702 385333**

Patient and relative communication sheet

This page is to remind you to discuss your discharge arrangements with your nurse or doctor. Please ask them:

a) What is going to happen to me today?

b) What is going to happen to me tomorrow?

c) How well do I need to be before I can go home?

d) When can I expect to go home?

What is Power of Attorney (now called Lasting Power of Attorney)

A Lasting Power of Attorney (LPA) is a legal document that lets you (the 'donor') appoint one or more people (known as 'attorneys') to help you make decisions or to make decisions on your behalf if the time comes and you lose mental capacity to make decisions for yourself.

This gives you more control over what happens to you if, for example, you have an accident or an illness and can't make decisions at the time they need to be made (you 'lack mental capacity').

You must be 18 or over and have mental capacity (the ability to make your own decisions) when you make your LPA.

There are two types of LPA, and you can choose to make one type or both. Health and welfare (your daily routine, for example washing, dressing, eating, medical care). Property and financial affairs (managing a bank, paying bills, collecting benefits or a pension.

How to make a Lasting Power of Attorney

- Choose your attorney (you can have more than one)
- Fill in the forms to appoint them as an attorney
- Register your LPA with the Office of the Public Guardian (this can take up to ten weeks)
- It costs £110 to register an LPA unless you get a reduction or exemption.

Help deciding if you should make a Lasting Power of Attorney
Contact the Office of the Public Guardian if you need help.

Office of the Public Guardian
customerservices@publicguardian.gsi.gov.uk
Telephone: **0300 456 0300**
Textphone: **0115 934 2778**
Monday, Tuesday, Thursday, Friday, 9.00am to 5.00pm
Wednesday, 10.00am to 5.00pm.
Find out about call charges.
You can cancel your LPA if you no longer need it or want to make a new one.

What is a living will?

A living will is where you express your wishes about how you want to be treated and cared for in certain situations, in case there comes a time when you lack capacity to make or communicate your decisions.

The term 'living will' doesn't have a legal meaning but usually refers to either an advance decision or an advance statement.

Please refer to Department of Health website or speak to your consultant.

DVT

What is DVT (Deep Vein Thrombosis)?
DVT is a common medical condition that occurs when a thrombus (blood clot) forms in a deep vein, usually in the leg or the pelvis. Patients who have been in hospital are more at risk of developing this condition.

Signs and symptoms of DVT include swelling, pain, calf tenderness and occasionally heat and redness. If you feel you have any of the following symptoms, you need to contact your GP.

While you have been in hospital, you may have been having preventative treatment (prophylaxis) such as an injection of heparin or wearing anti-embolism stockings.

Your treatment may continue whilst you are at home. Pharmacy will give you written information on any medication. If you have to continue wearing anti-embolism stockings, make sure you remove them for bathing, and then replace them without any creases. Once you are mobile there should not be any need to continue wearing stockings.

If you have any queries or problems contact your GP.

Jointly produced by the discharge management team on behalf of:

- Southend University Hospital NHS Foundation Trust
- Southend Clinical Commissioning Group
- Castle Point, Rayleigh & Rochford Clinical Commissioning Group
- Southend Borough Council
- Essex County Council.

Southend University Hospital
NHS Foundation Trust

Patient Information Service

If this leaflet does not answer all of your questions, or if you have any other concerns please contact the discharge management team direct on: **01702 507129**.

www.southend.nhs.uk

For a translated, large print or audio tape version of this document please contact:

Patient Advice & Liaison Service (PALS)
Southend University Hospital NHS Foundation Trust
Prittlewell Chase
Westcliff-on-Sea
Essex, SS0 0RY

Telephone: **01702 385333**
Fax: **01702 508530**
Email: **pals@southend.nhs.uk**

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