NHS
University Hospitals of Liverpool
Group

Going home discharge information for patients, their families and carers

Transfer of Care Hub

Welcome to our hospitals

We want to get you back to the place, people and things you love the most as soon as possible.

We will work with you and your loved ones to respond to your needs and provide you with safe, timely and effective care to ensure your experience with us is the best that it can be.

Our aim is to get you from Hospital to Home, soon.

This information leaflet is designed to provide patients with information about our hospital 'Discharge to Assess' processes and what patients can expect when deemed to no longer require a hospital bed.

About discharge

Once you are well enough, you will be discharged from hospital – this simply means that the professionals looking after you feel that you no longer need to stay in hospital and will be able to continue your recovery at home or a place of safety whilst awaiting ongoing assessments in the community if required.

Many hospital discharges are straight forward and require little or no change to a person's lifestyle, home environment and/or care needs. However, some patients may go through significant changes after an accident or period of illness, and may require additional help once they leave hospital.

Why do we plan discharges early?

Staying in hospital for longer than is necessary can increase your risk of infection and reduce your independence, making your recovery period longer. This is why we need to plan your discharge either before you are admitted or within 24 hours of admission. Our dedicated Transfer of Care team will introduce themselves to you when you are admitted onto our wards.

They are there to support and ascertain information around your previous needs and abilities prior to your admission. Our aim is to get you fit enough to go home as soon as possible so that you can complete your recovery promptly and comfortably in an environment you are familiar with.

When you are admitted to hospital you will be given an expected date of discharge (EDD) which will be reviewed according to your needs and wellbeing. We'll keep you informed of any changes to this date so you can help us make plans for your discharge. With your consent, we will involve you and your family/carer as much as possible when planning your discharge.

Discharge plan checklist

We will consider:

- What your needs were before admission
- What your wishes are now
- The views of your family/carers
- What is the least restrictive option for you?
- Possible changes to your needs following admission, and the level of recovery we expect you to achieve.
- Your home environment (for example stairs within the property, the location of the bedroom and toilet, and so on)
- Any equipment or home adaptation needs
- Social care needs.
- Need and eligibility will be considered following the Discharge to Assess ethos for care packages, continued nursing care and/or other services.
- Changes in medications and/or how they are given.
- Transport needs
- Any vulnerability, including age, frailty, terminal illness, learning disability and mental health problems.
- Infection control.

What is the role of the Transfer of Care Team?

The role of the Transfer of Care Team is to facilitate the 'Discharge to Assess' process. The Discharge to Assess process simply means no long-term decisions are made in hospital about what you may need with assessments being completed in the most appropriate setting for you. For most people, this will be home.

The Transfer of Care Hub manage the discharges of all patients in hospital who may require some Health and/or Social Care Support to achieve a safe and timely discharge. It is a multidisciplinary team of Hospital and Community Health and Social Care professionals who will work with you to recommend an appropriate discharge pathway to ensure you are receiving the right care in the right place at the right time.

It is important to remember that all staff, patients and their families/carers play a part in ensuring a smooth and efficient discharge. If you have any questions or concerns about discharge, please speak to your dedicated Discharge Facilitator or the ward nurse who will support you throughout your admission.

What will happen on the day of discharge?

On the day of discharge you will be asked to have breakfast and be ready to leave the ward soon after. The Trust standard is for patients to leave the ward by 9am if possible, to help accommodate patients waiting for admission. If you are waiting for blood results, x-ray results or other interventions, your discharge may happen later in the day. If this is the case, you will be moved to the Discharge Lounge where staff will continue to care for you.

The Discharge Lounge is staffed throughout the day with nurses and Health Care Assistants to look after you during the last few hours of your stay in hospital. The Discharge Lounge provides a nice environment for you to wait for medications, family, a taxi or (if appropriate) hospital transport.

Your medicines

If you will be continuing to take medications that you brought with you from home, these will be returned to you just before you leave the ward.

In some cases, you will need new medications to take home. These should be prescribed by a doctor, checked by a pharmacist and supplied to the ward the day before your discharge date. If this does not happen, please speak to your ward team, as the late arrival of your medicines may delay your discharge.

If you need your medications to be organised in a monitored dosage system (blister pack), the pharmacy department usually need to give notice to your community pharmacist for them to prepare it.

It is therefore important that your needs are discussed with the ward staff well in advance of your discharge date to avoid any delay.

On the day of discharge your medications will be discussed with you, and we will explain how they should be taken, as well as any common side effects that you should be aware of.

You should make an appointment with your GP as soon as possible after leaving hospital to obtain a further supply of any prescribed medications (if needed).

Your GP will also receive an update from the ward giving a brief outline of your admission, any investigations and findings, any further follow-up arranged or any interventions required by the GP.

If you need additional information about your medications, you can contact your local pharmacist for a medicines check-up and review.

Going home

Wherever possible you should organise your own transport to get home. We recommend that you discuss this with the ward staff to ensure family, friends or a taxi collect you at an appropriate time. You will be able to leave the hospital as soon as you have received all the supplies and paperwork required for a safe discharge.

Hospital transport is not available to all patients and the ward staff will only consider arranging this for patients who are eligible. If you require hospital transport, this will be pre-booked for you. However, waiting times can be lengthy, which can be particularly exhausting for patients. For this reason, we encourage families to collect their relatives from hospital wherever possible.

Will I have a follow-up appointment?

Depending on why you were admitted to hospital, you may be offered a follow-up consultation by telephone to ensure that you are managing well at home. Some patients may require home visits from other services for support with interventions such as administering therapies or removing surgical drains/ stitches. The hospital will normally arrange this for you prior to discharge.

If you have had an operation or are under a specialist team, you may be given details about how to contact them directly for advice after you have been discharged.

If you are terminally ill or require palliative care, the hospital will ensure that you are fast-tracked to the most appropriate team as required.

Patient checklist: The 48 hours leading to discharge

- If you live on your own, ensure arrangements have been made to turn on the heating (if necessary) and stock up on food and drinks
- Finalise any transport arrangements with relatives, friends or carers
- Remove all belongings from your hospital bedside table and cabinet, and ensure no valuables are left in the safe
- Make sure you have any medications or nutritional drinks belonging to you from the ward fridge.
- Have suitable clothing for your discharge – this means weather-appropriate, comfortable clothing and shoes
- Check that you have your house keys or make alternative arrangements
- If you have a 'yellow book', ensure your coagulation time has been checked and that the book has been returned to you before you leave
- If you are going home with anticoagulant therapy, ensure you are given a sharps box for your needles and syringes
- If you are on insulin, ensure your dose has been optimised and that your medication prescription has been updated prior to discharge
- Ensure you have all the equipment and/or dressings you need
- Ensure you receive your discharge letter and any other relevant paperwork
- Ask your ward team for any written information leaflets that may help you to manage your recovery at home, and for contact details of any relevant services.

Managing your recovery and follow-up: Patient reminder checklist:

Patient reminder checklist:

- Be aware of signs of health deterioration and how to manage them. Ask your nurse before you leave hospital if you are unsure
- If you are admitted regularly to hospital for the same health issue, please ensure you are referred to a specialist service to help you self-manage your condition
- Make an appointment with your GP to review your discharge letter and medications list (if needed)
- Contact your local pharmacist if you need more advice regarding your medications
- Ensure you have made a note in your calendar of any follow-up appointments or investigations booked for you
- If you have not heard back from the hospital regarding future appointments, contact the relevant department to ensure this is corrected as soon as possible
- Ensure that your cannula has been removed
- If you have a new catheter on discharge, ensure you have been given a supply of day and night bags and a catheter passport.

How is a complex discharge managed?

If your wellbeing has significantly changed, you may need extra help to return home. In some cases, it may not be appropriate for you to return home straight away following discharge. If this is the case, the discharge can be more complex and it will involve a larger team to find an appropriate solution.

The ward will discuss this with you and, with your consent, make a referral to the Transfer of Care Team.

A social care package may be arranged for you if you need it. These are services delivered by your local Social Services team to help you manage in a dignified and comfortable manner after discharge. The package may include help with personal care needs, such as washing and dressing, and meal preparation where you are unable to manage this yourself.

If you are unable to manage at home with a social care package you may be offered a temporary placement in a residential care home. If this is the first time you are going to a care home some basic assessments will have to be completed to ensure that:

- You agree to a temporary move to a residential home
- Your current level of need can be met by a care home that has vacancies
- You are well enough to leave hospital and continue your recovery elsewhere
- You are aware of the possible financial implications for you following the completion of any assessment within the care home.

There may be a cost associated with care provided after your discharge. Someone will fully explain and provide additional supporting information regarding all of the funding requirements if this applies to you.

If you have serious health needs but do not wish to live in a nursing home, consideration will be given to other options. You and/or your family will be fully involved in these discussions.

If you are at the end of your life, you will be offered a number of options according to your needs and wishes.

What if I already live in a care home?

If you were living in a care home prior to admission, and your needs are unchanged following your hospital stay, you will return to your care home. The hospital will contact your care home before discharging you to let them know your date of discharge.

You must continue paying for your care home (whether you are self-funding or someone else is paying for your care) whilst you are in hospital.

If you wish to change care home this should be arranged with your current care home provider once you have been discharged.

If your needs have significantly changed or you are no longer able to immediately return to your own home or care home, the hospital staff and other services will help with the assessment process required to identify a more suitable temporary placement so any longer-term needs can be assessed.

You and/or your family will be involved in this process to ensure your voice and preferences are heard.

What if I already have a care package?

If your needs have not changed:

- **Social Services-funded** – Our Transfer of Care team will discuss whether a care package can restart on discharge and keep you informed of any changes that may be needed.
- **Self-funded care** packages will re-start once the care agency has been informed of your discharge date. The care agency usually requires at least a few hours' notice, so we advise that you contact them as soon as you are informed of your discharge date.

What other services are available?

A discharge pathway recommendation will be made by the Transfer of Care team following information gathering and discussions with the ward staff, yourself and your friends/ family. If it is identified you require further support on discharge it may be suggested you are supported by one of the following services:

Home First (also known as 'Independence and Reablement')

Home First services across Liverpool, Sefton and Knowsley are provided by both health and social care services and vary depending on the local authority you are under. Our Transfer of Care team will be able to explain what services are available in your area and which may be best for your ongoing care needs.

Home First is a service that completes an assessment within your own environment to determine your ongoing care, rehabilitation and/or equipment needs following on from your hospital stay. On discharge from hospital, you will be met at home by a member of the Home First team who will assess your ability to carry out day-to-day functions and prescribe any care or equipment that may make things easier for you.

They will also complete any onward referrals to teams who will assist you to continue your recovery at home. This initiative has close links with Social Services and you will be followed up by a member of their team within threev days of hospital discharge.

Rehabilitation

If you are not back to your normal level of ability, it may be suggested you have some further rehabilitation. This may either be as an inpatient or within your own home.

- **Bed-based services** – Bed-based services provide rehabilitation in community hospitals or care home settings with the support of a multidisciplinary team. These beds are identified for patients who may have higher needs requiring more input.
- **Home-based services** – rehabilitation input within your own home (or care home). This may be delivered by Early Supported Discharge (ESD) or our Community Neighbourhood/Enhanced Primary Care teams. They will visit you on discharge from hospital and work towards achieving your goals and regaining your independence.

Specialist services

If you suffer from complex or long-term health conditions and are at risk of frequent hospital re-admissions, you may be referred to other services such as:

- Rapid Response
- Community Frailty services
- Heart Failure services
- Diabetes services
- Tissue Viability services
- Falls service
- Memory clinics.

Home from Hospital service

Some patients may only need temporary day-to-day help with activities such as shopping, housekeeping and so on. Age UK offer this kind of service and can give you practical support and assistance. There may be other voluntary sector organisations in your area who can also support you when you return. Our teams can discuss options as they plan your discharge with you.

Notes

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Review date: September 2028