**Going home**

**Discharge information for patients**



****

**A welcome from the chief executive**

Welcome to St. George’s Hospital. We hope to make your hospital experience as pleasant and comfortable as possible. By living out our core values, our staff aim to ensure that all patients feel safe, respected and informed whilst in our care. We promise to listen to you and your needs, and to deliver excellent and timely services with kindness and empathy.

This information leaflet is part of a set of leaflets designed to provide patients with information about our hospitals. The four leaflets that make up this series are:

* General information booklet
* Your hospital appointment – Our outpatient services
* Your hospital stay – Our inpatient services
* **Going home – Discharge information for patients**

If you would like to read other leaflets from this series please ask a member of staff or visit the patient information pages on our website.

**About discharge**

Once you are well enough, you will be discharged from hospital – this simply means that the doctors and nurses feel that you no longer need to stay in hospital, and will be able to cope at home.

Many hospital discharges are straight forward and require little or no change to the patient’s lifestyle, home environment and 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 aim is to get you fit enough to go home as soon as possible so that you can recover sooner.

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 will involve you and your family/carer as much as possible when planning your discharge.

**Discharge plan checklist**

**We will consider:**

* what your needs are before admission
* 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 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 issues.

**What are discharge coordinators?**

The role of a discharge coordinator is to facilitate the discharge process, particularly when it comes to more complex cases. The role of a discharge coordinator can vary depending on their particular speciality and/or the wards they cover.

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 nurse.

**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 11am 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 on in the day. However, it is still important that you are ready to leave in the morning, as you will normally be transferred from the ward to the departure lounge, providing you are well enough.

The departure lounge is located on the ground floor of Grosvenor Wing, opposite M&S. It is staffed throughout the day with nurses and carers to look after you during the last few hours of your stay in hospital. The departure lounge also provides a nice environment for you to wait for medications, family, a taxi or (if appropriate) hospital transport. If you wish to find out more about the departure lounge, you can ask for a leaflet or visit the lounge between 8.30am and 9pm, Monday to Friday.

Departure lounge staff are also happy to come and introduce themselves to you on the evening before your discharge – some patients feel that this helps them to feel more at ease.

**Your medicines**

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

If you attended a pre-admission assessment you may also have been asked to purchase some over-the-counter pain relief or other medications in preparation for your discharge.

In some cases you will need new medications to take home. These should be signed off by a doctor and checked by a pharmacist 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 needs 48hours notice 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.

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 watch out for. For more information, you can also refer to the leaflet, **You and your medicines**, which staff can give you upon request.

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 update your medical notes and ensure that your medications are reviewed. 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. We aim to have these prepared the day before your planned discharge date to avoid any delay.

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 collect their relatives from hospital wherever possible.

**Patient checklist: The 48hours 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.
* If you are in receipt of a care package, alert your care agency 48hours before your planned discharge to ensure adequate cover when you get home.
* Remove all belongings from your hospital bedside table/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 and comfortable clothing.
* 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.

**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 the hospital 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.

**Am I at risk of deep vein thrombosis (DVT) / pulmonary embolism (PE)?**

DVT occurs when a blood clot forms in a deep vein, usually in the leg, leading to partial or complete blockage of a vein. If the clot breaks off and travels to the lungs it can block important lung arteries, causing a PE.

Your risk of developing DVT increases:

* if your leg is immobilised by a cast
* if you have had surgery or a fracture, particularly to your hip or leg
* with age (if you are over 60 years old)
* if you have a medical illness, such as heart or chest disease, cancer or are undergoing cancer treatments
* in pregnancy or if you have recently given birth
* if you are immobile
* with hormone treatment, including the contraceptive pill or hormone replacement therapy (HRT)
* if you have a personal or family history of DVT or PE
* with dehydration
* if you are overweight, with a body mass index (BMI) greater than 30kg/m2.

Common signs of DVT or PE include:

* hotness
* pain
* tenderness and swelling (often in the calf)
* breathlessness
* chest pain
* collapse.

You should seek medical advice immediately if you develop symptoms of DVT or PE – early treatment can save lives.

**How can I reduce my risk?**

You can reduce your risk of developing DVT or PE by:

* drinking plenty of water and staying well-hydrated
* being as mobile as possible and exercising your legs
* maintaining a healthy body weight.

Some patients are advised to continue wearing anti-thrombosis stockings or given treatment until they have returned to their normal level of mobility. If you have been given treatment to continue at home it is important to complete the full course. Remove stockings if they cause discomfort or skin damage and tell your GP.

If you have any questions about blood clots, please contact the thrombosis team on 020 8725 1332 (Monday to Friday 9am to 5pm).

**Managing your recovery and follow-up**

**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.

**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 quite complex and it will involve a larger team to find an appropriate solution.

A **social care package** may be arranged for you. 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 any aspect of personal care, such as washing and dressing
* provision of disability equipment and home adaptations, such as fitting a grab rail.

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

* you are happy to move to a residential home
* you are well enough to live in a residential home
* it has been decided who will pay for your living at the residential home.

A residential home placement is either self-funded (paid by the patient) or paid for by Social Services. This will depend on your circumstances.

If your needs cannot be met in a residential home you may need a **nursing home placement**. The process of placement in a nursing home can be complex and the source of funding for your nursing care will need to be considered.

Nursing home placements can be funded in three ways:

1. **Self-funded** – This means that you (the patient) or your family pay for the nursing home cost. The hospital can provide further advice to identify the right home for you.
2. **NHS Continuing Care** – This happens when the clinical commissioning group (CCG) pays in full for your nursing home placement. Some paperwork will have to be completed to ensure this is the right choice of care for you. Your GP registration will determine who your funding CCG is (for example, if you have a GP in Wandsworth this would usually be funded by Wandsworth CCG).
3. **NHS-funded nursing care** – This is where the NHS pays a fixed contribution to your nursing care. This currently (for 2015/16) equates to a standard rate of £112 per week.

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. Care home staff may wish to visit you at the hospital to ensure you are well enough to return to the home.

You must continue paying for your care home (whether you are self-funding or someone else is paying for your care) while you are in hospital. Giving notice to your care home will most likely delay your discharge from hospital, and so is not in your best interests. If you wish to change care home this should be arranged with your current care home once you have been discharged.

If your needs have significantly changed, the hospital staff and other services will help with the paperwork required to help you identify your future needs. 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 care support packages will re-start when you are discharged. The hospital will inform your care provider of the date and time you will be back at home.
* 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 your discharge has been arranged.

If your needs have changed since you came into hospital, you may need short-term (no more than six weeks’) extra help at home (home enablement services) on top of your existing care package. A full assessment will be arranged if this is required

If your condition has deteriorated significantly, you may require an assessment and more paperwork to determine your future needs and to establish who would pay for your care.

**What other services are available to me?**

**In-reach services**

These small teams come from the community health services, but they are based at the hospital. They work alongside discharge coordinators and ward staff to help avoid discharge delays. They are mostly involved with helping services to identify suitable places for rehabilitation.

**Intermediate care services**

St George’s cares for patients from a wide catchment area. This means that we have to work with many different Social Services offices, community services and other hospitals, as well as private and voluntary services.

Intermediate Care services (ICT) are amongst the most commonly used services. These are rehabilitation services which can be offered as:

* **home-based services**, whereyou are offered rehabilitation input at your own home (or care home). These are usually used for patients that can walk with the help of a walking frame/stick, either with or without assistance.
* **bed-based services**, which are reserved for patients requiring more intense input (for example, patients who are unsteady on their feet). Bed-based services provide rehabilitation in community hospitals or care homes with the support of a therapist.

**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 services
* respiratory services
* heart failure services
* diabetes services
* tissue viability services
* falls clinics
* 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 Wandsworth offers this kind of help to patients aged 60+ who are living in the Wandsworth borough. The service is provided by trained volunteers who can give you practical support and assistance for up to six weeks after returning home from hospital.

For further information, please contact **Age UK Wandsworth** on **020 8877 8940** or visit www.ageuk.org.uk/wandsworth/our-services/

**Equipment services**

If you require a walking stick or walking frame, it will be provided during your initial rehabilitation at the hospital.

If you require a wheelchair, we will refer you to the wheelchair service for further assessment of your needs.

There is a wide range of other equipment that may help you to manage at home. This might include adjustable beds or pressure-relieving equipment. The service that provides this equipment will differ depending on where you live.

If you return home following discharge and realise that you need equipment to help you move around safely, you can contact your local community services by calling 111.

**Notes**

**What should I do if…**

* **My district nurse/therapist/other healthcare professional has not turned up?** Contact 111 and they will get you in touch with your local community nurses.
* **My district nurse does not know what equipment I have been discharged with?** Ensure you have a relevant contact number for the ward/hospital to pass on to the district nurse for advice.
* **I need equipment in my home (for example, a commode)?** Your community services team can help. The NHS 111 advisors will put you in touch with the right community services team.
* **My discharge letter is missing?** Contact the ward and ask them to send you one immediately.
* **I have been discharged without my medicines?** You can try a few things:

1. If the medication is important, contact the ward immediately to check if it can be sent to you by taxi.
2. Take your discharge letter and medications list to a local pharmacy, where you may be issued with an emergency supply.
3. Contact your GP for an emergency prescription.

* **I am diabetic and unsure about my insulin dose?**

If you have just been discharged, contact the hospital and ask to speak to the discharge coordinator or on-call pharmacist to check your prescribed insulin dose. If you have been at home for a few days, contact your district nurse via the NHS 111 service.

* **I need a sharps bin for disposal of syringes/needles?** Contact your community nurses or specialist nurses (diabetes nurse, for example) via 111. They will be able to arrange this for you and advise you on how to correctly dispose of your needles.
* **I have needs relating to my medications (a blister pack or medications advice, for example)?** Please contact your local pharmacy. The pharmacist can give you free medications advice, arrange medications delivery and, if required, provide a blister pack to help you take your medications safely.

**Notes**

**Notes**

**For more information leaflets on conditions, procedures, treatments and services offered at our hospitals, please visit www.stgeorges.nhs.uk**

**Additional services**

**Patient Advice and Liaison Service (PALS)**

PALS can offer you on-the-spot advice and information when you have comments or concerns about our services or the care you have received. You can visit the PALS office between 9am and 5pm, Monday to Friday in the main corridor between Grosvenor and Lanesborough Wing (near the lift foyer).

**Tel:** 020 8725 2453

**Email:** pals@stgeorges.nhs.uk

**NHS Choices**

NHS Choices provides online information and guidance on all aspects of health and healthcare, to help you make decisions about your health.

**Web:** www.nhs.uk

**NHS 111**

You can call 111 when you need medical help fast but it is not a 999 emergency. NHS 111 is available 24 hours a day, 365 days a year. Calls are free from landlines and mobile phones.

**Tel:** 111

 [](https://www.stgeorgeshospitalcharity.org.uk/)

**Reference:** TWD\_WEL(d)\_01 **Published:** January 2016 **Review date:** January 2018