South Warwickshire NHS
NHS Foundation Trust

Patient Information

Leaving Hospital

Transfer of Care Services

Introduction

Your Hospital

Welcome to South Warwickshire NHS Foundation Trust where our aim is to make your stay in Warwick Hospital as comfortable as possible. The length of time you spend here will depend on your clinical condition.

You were admitted to hospital on ……and your Estimated Discharge Date (EDD) is ……..This date may change as it is dependent on your clinical condition and will be reviewed daily.

The Right Place for Your Care

- Warwick Hospital is an Acute Hospital Trust. This means that it is a hospital that provides consultant led services within the National Health Service.

- Acute care is for patients who require emergency, medical or surgical Services, that can only be provided within a hospital environment and the Acute Trust provides care for patients who require this level of care.

- When your acute treatment has been completed, you will need to be transferred from hospital to more appropriate services and facilities that are available to you.

Leaving Hospital

- You will be discharged from hospital when your consultant led multi-disciplinary team decide that you are clinically ready to leave and that you no longer require an acute hospital bed.

- The majority of our patients will go home from hospital without the need for additional support. However, in some cases, you may need some extra support to enable you to regain your independence or your previous level of ability.

- There are appropriate services and facilities available to you outside of the acute hospital setting when you no longer require this type of hospital care. Your hospital team will assess with you, and if appropriate, your family or carers, your level of need when you are ready to leave hospital and determine with you the service most suitable for you.

- We will give you specific information on the service we have assessed as the most appropriate to support you on your discharge from the acute hospital.

We fully support you in your discharge from hospital. Here are some of the reasons it is important:

1. You are able to regain your independence or previous level of ability as soon as possible.

2. You may find it harder to return home the longer you stay in hospital and lose confidence in your own ability to be independent.

3. We acknowledge that the process of assessing your needs may often happen during a crisis situation when you are still recuperating from an acute episode of your condition, or for example, an operation, when your functional ability is low. This has often led to large care packages being put in place in the past without fully exploring with you the opportunities that might be available to you, including working with you to improve your functional ability and i independence. We will aim to look at appropriate services during your assessment so that, as far as possible, you remain as independent as possible whilst remaining safe on your discharge from hospital.

4. Although we work hard in hospital to ensure that you receive the highest standards of care, there is a risk of acquiring infections. Leaving hospital as soon as you are clinically ready means this is less likely and reduces the risk of complications.

5. You will appreciate that acute beds are needed for people who are very unwell and delays in your discharge may result in patients waiting in the Emergency Department (A&E) for a bed to become available. In some cases people awaiting surgery, both urgent and non-urgent, may have their operations cancelled if a bed is not available.

Your Multi-Disciplinary Team

- The multi-disciplinary team in charge of your care during your stay in hospital often includes your consultant team, ward nurses, discharge co-ordinators, social workers, occupational therapists and physiotherapists. This team will begin to plan your discharge from hospital and the appropriate services you may need as soon as you are admitted.

- This team of professional experts will explain their key roles to you if they are involved in your hospital care.

Our Commitment to You

- Patients will receive the right treatment, at the right place and by the right professional.

- We place a high priority on keeping your stay in an acute hospital bed to a minimum.

- Once your consultant-led team assess that you are clinically ready for discharge, we will aim to move you from hospital on the same day.

- We will aim to discharge you from hospital before lunch on the day you leave.

- If you require transport, we will arrange this for you. You may be moved to the discharge lounge, where you can wait for your transport. The lounge is a comfortable area where you can watch television, read papers and be provided with refreshments (including breakfast and light lunch).

When You Leave Hospital

Below are examples of services you may require when you leave hospital:

1. Intermediate Care - Community Emergency Response Team (CERT)

This is the urgent response service from Intermediate Care. This is a team of registered nurses, occupational therapists, physiotherapists and support workers who will support your discharge from hospital by assessing your current needs in your own home. They will provide you with an individual care plan for up to 72 hours and will signpost or refer you to other services, if required. CERT works closely with other community health agencies, Warwickshire County Council and third sector organisations, such as Age UK; to provide a planned transfer of your care should you be assessed as having on-going needs.

2. Routine Intermediate Care

This particular service within the Intermediate Care service will assist you in achieving short-term rehabilitation goals within the comfort of your own home for a period of up to 6 weeks. This service provides occupational therapy and physiotherapy and further referrals to other services as necessary.

3. Reablement

This is the promoting independence service within Warwickshire County Council. Reablement is a free service for up to 6 weeks and takes place in your own home. An occupational therapist or Reablement assessment officer will create a Reablement Support Plan with you that identify goals and aims that will assist you to maximise your independence. Reablement workers will help you to achieve your goals and aims. Once your independence levels have been achieved, you will, hopefully, require no on-going support. If you do require support, you will receive a further needs and financial assessment.

4. Package of Care

When you return home, you may require some long-term help with your personal care and daily tasks. If so, you will be referred to a hospital social worker who will visit you on the ward and complete an assessment of your needs. Your named social worker will take into account the review made by the medical, nursing and therapy staff. If you receive a long-term care package when you leave, you may have to make a contribution to the cost of this service. This will involve a financial assessment. Your social worker will be able to explain any charges you may need to pay.

5. Temporary nursing care or residential care placement

In some circumstances, you may not be able to return home immediately on your discharge from hospital. To ensure that the assessment of your care needs is accurate and appropriate for you, the continuation of this assessment may take place in a more suitable environment, such as a community based bed which is outside the acute hospital setting.

The multi-disciplinary team may assess that you require a short period of bed-based residential or nursing care.

This is for a period of assessment, while you are receiving rehabilitation, or you are waiting for longer term residential or nursing care placement, or awaiting a package of care to commence, in order to return home.

During your stay in one of these beds, you will receive continuity with planning your future care, as a case worker (a Discharge Co-ordinator or Therapist from South Warwickshire NHS Foundation Trust) and/or social worker will visit you to assess your progress to help you return home or to find appropriate longer term residential or nursing home accommodation.

This temporary placement will give both you and your family the time to make important longer term decisions in a more appropriate environment.

If you no longer require consultant led care and there is a delay in the start of your package of care or preferred community based placement, you cannot choose to remain in an acute hospital bed. You will be transferred to a bed outside the acute hospital setting (within 48 hours) whilst this is arranged.

We will only transfer you when the appropriate placement has been identified and confirmed.

Summary

The Acute Trust understands that patients, when leaving hospital, sometimes need time, with their families or carers if appropriate, to make choices which can be life-changing.

Your hospital works in partnership with Warwickshire County Council to provide services which give you the time to help you make these choices in a more suitable environment.

You cannot choose to remain in an acute hospital bed when you no longer need this level of care. You will be discharged from hospital when your consultant assesses you as no longer requiring acute hospital care. We will aim to transfer you from hospital to a more appropriate environment within 48 hours.

Your safe and timely transfer will also allow new patients who need acute hospital treatment to be admitted without avoidable delay.

Please note: that we will always try our best to involve nominated members of your family, carers or friends in your future care.

However, the absence of family members due to holiday, work commitments, etc, does not mean that decisions regarding your discharge from hospital will be on hold until your family is available.

If an advocate is required to support you with your future care provision, your hospital will arrange this for you.

We hope that this approach to your acute hospital discharge and future care is satisfactory.

Please be assured that our aim is to deliver the care that is most appropriate for all our patients' needs and in the most appropriate environment.

This information is fully supported and endorsed by:

South Warwickshire NHS Foundation Trust (SWFT)
Warwickshire County Council (WCC)
South Warwickshire Clinical Commissioning Group (SWCCG)

For more information, please contact:

Your Discharge Co-ordinator……

Contact Details……..

Your Ward Manager ……Ext……...

Alternatively, you may contact the Discharge Planning Team Manager on extension **8048** or the hospital social care team on extension **4178**.