GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Planning your Discharge from Hospital
What happens next?

A guide for patients, families and carers

What is discharge planning?

Discharge planning is a process that helps to identify the services and support that you may need when you leave hospital. Planning will start when, or soon after, you are admitted to hospital.

We will assist you in planning your discharge from hospital if required. Shortly after you are admitted, a ward nurse will ask you about your home circumstances/environment and the support you already receive or may need on discharge. It is important that you tell the nurse as soon as possible about anything that might make your return home difficult.

If you tell us that you think you might need social care support or we think you might need social care support we will ask your permission to refer you to the Adult Social services Department in the geographical area in which you live.

The hospital discharge planning process will help to make sure that the right support is available in the community to help you before you leave hospital.

How are my needs assessed?

A multi-disciplinary team of health and social care professionals will assess your needs and discuss the results with you, your family or friends, where appropriate, before developing a discharge plan with you. As part of the assessment process you may be moved to another NHS facility, or even your own home or a care home, for further assessment or rehabilitation. This will ensure that you are given the best opportunity to recover and return to your permanent residence with the support you need.

The multi-disciplinary team may be made up of a range of different professionals, including the following:-

- Doctor
- Nurse
- Discharge co-ordinator
- Pharmacist
- Occupational therapist
- Physiotherapist
- Dietician
- Social worker

Why can't I stay in hospital?

You were admitted to hospital for specific medical or surgical care and treatment. These treatments are now completed and your doctor has assessed that you are medically fit to leave hospital. Remaining in hospital any longer is not in your best interests and could increase your health risks and decrease your independence.

Examples of post discharge support available

When you are discharged home it is important to all of us that you will be safe and your independence is maximised where able. Some people require no extra help on discharge however others may need some support. Through multi-disciplinary assessments we will help to assess your needs and identify what you need help with.

We may be able to help you access a range of services to support you on your return home including:-

- District nurses
- Reablement
- Age Cymru
- Packages of care
- In-patient rehabilitation
- Step down assessment beds
- Residential or Nursing care
- Meals on wheels
- Day centre'

District Nursing Services

District nurses are qualified nurses who have the ability to assess and treat your health needs at home. They work closely with your GP to support your care at home. They provide holistic nursing care to house bound adults or by reason of their diagnosis, are best supported in their own environment by the skills and expertise of the District nursing service.

Reablement

There are occasions when your medical or surgical condition has become stable but your recovery is not complete and there is still an opportunity for you to regain more independence. Ideally we would aim to discharge you home with our reablement team in order for this to continue in your own home environment. If you have been assessed as safe for your rehabilitation programme to continue at home, the nurses will support your discharge by working with the reablement team who will support you at home with a short term support plan; with the aim of improving your independence. The Reablement team may work with you for up to 6 weeks (Free of charge) although the duration is dependent upon your personalised programme. At the end of the programme we hope you will have achieved your goals and independence however the team will work with you to identify any further support that you may need.

Age Cymru

Age Cymru can be accessed if you are aged over 50 and require a lower level of short term intervention in order to safely support you back in your own home environment. You would be quite independent on discharge, though following assessment by nurses and therapists would be deemed as being able to benefit from this level of support.

Packages of care

A social worker will work with you, your family and friends to determine if a care package is required. They will work with you to determine what you can do for yourself, what you can do together and what care providers can do. A full assessment of your needs will identify what is required, how often and when. The assessment may identify other important social factors which you may need help with.

The social worker will, upon agreement, arrange for appropriate care at home and explain the financial arrangements attached to this. A care plan will be completed and the care agency providing the care will follow the plan to ensure the identified needs can be met. The social worker will negotiate with care providers to agree call times that you determine appropriate. These call times may not necessarily be your preferred times initially however these can be adjusted following discharge and will not be a cause to delay your discharge.

If you were already receiving a package of care prior to admission and the medical and/or therapy team determine that your needs can continue to be safely met at home then your discharge will be arranged with a restart of this original package of care.

In-patient rehabilitation

Some patients who are stable for discharge and their recovery is not complete require a higher level of support than can be initially and safely met in your own home. In order to progress to this level of safety a period of inpatient rehabilitation may be required.

You will be assessed by a physiotherapist and / or a discharge liaison nurse who will advise as to whether in-patient rehab is the most appropriate environment to continue safely meeting your needs. Whilst awaiting transfer to a Community hospital you will continue to receive physiotherapy and if you improve to a level that you are now assessed as safe for discharge home with reablement support then your discharge arrangements will change to the most appropriate pathway. This change of pathway may also occur following transfer to a Community hospital, as you continue to improve you may then be discharged to finalise the remainder of your rehabilitation programme in your own home.

Our Community hospitals are:-

- Ysbyty Aneurin Bevan – Ebbw Vale
- Ysbyty Ystrad Fawr – Ystrad Mynach
- Rhymney Resource Centre – Rhymney
- Chepstow Community Hospital – Chepstow
- Monnow Vale Hospital – Monmouth
- County Hospital – Pontypool
- St. Woolos Hospital – Newport

We will endeavour to try and transfer you to your local Community Hospital however this is not always possible. It is important that you are transferred to the most appropriate environment and therefore when you have been discharged from your Consultants care in the acute hospital it may be necessary to transfer you to a Community hospital that is best equipped to meet your needs and will support the next steps in your discharge planning process.

Step down beds

We have access to assessment beds in some of the residential homes across the five localities:

- Red Rose – Ebbw Vale in Blaenau Gwent Locality
- Lys Glyn Coed – Ebbw Vale in Blaenau Gwent Locality
- Llys Nanty Medd - Blaina in Blaenau Gwent Locality
- Ty Clyd – Bargoed in Caerphilly Locality
- Ty Iscoed – Newbridge in Caerphilly Locality
- Severn View – Chepstow in Monmouthshire Locality
- Parklands – Malpas in Newport Locality
- Plas-Y-Garn – Pontypool in Torfaen Locality

These beds are utilised as an extension to our in-patient rehabilitation beds and provide an opportunity to conduct further assessments away from the hospital environment. This enables a longer period of assessment which may be required in order to determine and finalise the most appropriate discharge arrangements. The environment provides opportunities to recuperate in a friendly and safe environment with additional help and support where needed.

Residential or Nursing care

In exceptional circumstances some people do require a long term placement in a residential or nursing home immediately on their discharge from hospital. NHS and Adult social services professionals will carry out the appropriate assessments which will identify the kind of suitable environment for you and support you and if appropriate your family to identify a preferred care home as quickly as possible.

If your preferred home has no immediate vacancies then you will be expected to transfer to an interim placement (Care home) as required by the Aneurin Bevan University Health Board Choice of Accommodation Policy.

Transport arrangements

It is expected that people will make their own travel arrangements when they leave hospital. Please arrange for a relative or friend to collect you from hospital. Hospital transport is available only for those people who have a medical problem that prevents them from using a car, taxi or public transport.

"This document is available in Welsh /
Mae'r ddogfen hon ar gael yn Gymraeg".