BRENT CARERS CENTRE

To improve the lives of the carers of Brent

Hospital discharge planning advice

Are you a Carer?

Many people looking after someone do not recognise themselves as Carers.

You are a Carer if you provide, or intend to provide, practical and / or emotional support to a relative, friend or neighbour who is disabled, ill or frail. Their disability could be a physical disability, a hearing or sight loss, learning difficulty or mental health problem, or they could be frail due to old age.

Or you may be the parent of a child with a disability or illness.You may be a child or young person who spends a lot of time helping someone who is disabled or ill, for example, one of your parents or a brother or sister.

You might have been caring for some time or started caring more recently. Either way it is likely that you are caring out of love, friendship or duty.

Caring will not always be easy emotionally or physically. Caring can have a major effect on your emotions, time, relationships and everyday life, and you have needs of your own that shouldn't take second place to your caring responsibilities.

Services are available to help and support you, as well as the person you are caring for to cope with any distress you may be experiencing and to help with any practical problems that you might incur.

How we can help

Brent Carers are an independant, well-established charity with over 4,000 Carers currently registered with us.

We provide information, advice and support to Carers across Brent.

Contents

This leaflet is to provide the 'carer' with information about the discharge from hospital process. When your cared for person is being discharged from hospital it can be a very distressing and confusing time.

It may be you are becoming a carer for the first time. Or if you were caring for that person before, you may now face changes to your caring role.

At the Hospital

It is essential that you identify yourself to a member of staff on the ward as 'the carer' as soon as your cared for person is admitted to hospital. This may be more important if your cared for person lives alone, or you are not the next of kin. It will enable the staff to recognise you and include you in the planning for the discharge process.

As soon as people are admitted to hospital a process of planning should begin to identify the services and support they may need when they leave. By the time they leave hospital a clear discharge plan should be in place.

The planning process should ensure that when people leave hospital they and, with their permission, you as their carer, know about the following:

Their medical condition

This should include information on treatment, medication and future medical appointments.

Services and Support

This should include information on the services that have been agreed and that will be in place for the person returning home e.g. community nurse and home care. It should also include information on local points of contact and if needed specialist information e.g. Brent Carers and other support organisations.

Patient Advice and Liaison Team (PALS)

If you feel concerned about lack of communication with the hospital staff regarding discharge or have any other concerns that are not resolved by talking to the hospital staff you should contact PALS they provide the following service:

- Advice and support to you as a carer, and your cared for person
- Listen to your suggestions, queries and concerns
- Help sort out problems on your behalf
- Provide information about NHS services
- Put you in touch with interpreters and other services

Professionals Involved

The following professionals will be involved in the discharge process:

NAMED NURSE – the contact person while the patient is in hospital who will oversee the discharge planning process

PHARMACIST – will dispense the medication to take home and provide information on changes in medication.

CONSULTANT – will decide when the patient is well enough to go home and what medical care should be provided. The GP will be notified of any change in treatment and medication. Outpatients appointments will be arranged

The following professionals may be involved in the Discharge Process:

The **HOSPITAL SOCIAL WORKER** will communicate with you and your cared for person. They can explain the services that are available. The social worker will assess the services that need to be put in place at home. The assessment should be person centred meaning that the cared for person's needs are paramount and not restricted to current services that are available. The new word for describing this process is 'Personalisation'. If your cared for person has complicated needs a meeting with the relevant professionals involved in their care may be held. You can, as the carer request such a meeting and can attend if you wish to give some input into the discharge plan, the hospital social worker will help you with this.

The **PHYSIOTHERAPIST** works with people to help them regain lost movement, improve mobility and to maintain safe independence in activities at home e.g. getting in and out of bed and using stairs. If you are worried about movement and handling and feel this might be an issue when your cared for person is discharged you should speak to the physiotherapist in the hospital before discharge takes place, the named nurse should help with this.

The **OCCUPATIONAL THERAPIST** works closely with the social worker and aims to help the patient be as independent as possible in everyday tasks such as bathing and cooking. They will offer aids and adaptations to the home. The occupational therapist will also be helpful with movement and handling issues and provide equipment such as hoists in the home if required.

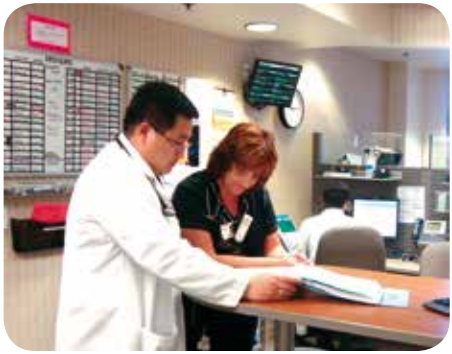
The **CONTINENCE ADVISOR** can offer information and advice about managing bowel and bladder problems and will ensure that the most appropriate incontinence products are available where necessary. Initially you will receive these products via the district nurse. They will contact the continence advisor if necessary or you can

phone the Continence Coordinator to make an appointment at the clinic. Please phone: 020 8795 6454.

The **COMMUNITY OR DISTRICT NURSE** will visit people requiring nursing care at home e.g. dressing wounds, complicated medication, injections etc. On their first visit they will assess the person's needs and make a plan of the nursing care required, this will include how often they will visit. Referral should be made from the named nurse in hospital before discharge. The GP can also make a referral to the community nurse. The community nurse can make referrals to all the above professionals.

If you are unhappy with the services provided by the Primary Care Team after discharge you can contact PALS at the PCT.

Questions to ask yourself before discharge



Did I and/or the person I am caring for have input into the Discharge Plan?

If not, speak to the named nurse or hospital social worker.

Does the person I am caring for and, with their permission, do I, as their carer, have information about?

- Medication
- Medical condition
- Future appointments
- Primary care contacts

If this information has not been provided speak to the named nurse.

Does the person I am caring for and, with their permission, do I, as their carer, have information on the services they will receive on leaving hospital?

If not speak to the named nurse or hospital social worker.

The person you care for may have to pay towards the services provided. Has this been discussed?

If not, speak to the hospital social worker about a financial assessment. Brent Carers or Citizens Advice can also offer support in relation to the assessment.

You should be asked if you are able and willing to provide care for your cared for person especially if you are to be expected to do so when they return home.

If not, speak to the hospital social worker before they are discharged.

Services at Home

Once your cared for person is at home the Plan will be sent to them and to you, with their consent, for you to sign and return. You will be given the phone number of the hospital social worker should you require any further assistance and they will review the Plan approximately six weeks after discharge.

After this period you will be referred to the community social worker should you require any further input from Social Services.

It may be that your cared for person requires intermediate care or 'Reablement' this is undertaken at home, this period is normally 6 weeks for extra care and rehabilitation.

More input from Health and Social Care may be needed in these early weeks. No extra payment should be made for these services during this intermediate care period.

Brent CCG are planning to develop this intermediate care stage further to enable earlier discharge from hospital or in some cases to avoid hospital admission all together, referrals would then be made from the GP, other members of the Primary Care Team or the Accident and Emergency Departments.

In the near future it will be possible for your cared for person to employ a 'Broker' who will organise their personal budget enabling them to meet their individual needs, with 'person centred planning', e.g. the cost of two visits to a day centre each week will be calculated then another activity, which the person would prefer, could replace that at the same cost. We believe these 'Brokers' will be employed by voluntary organisations e.g. Age UK.

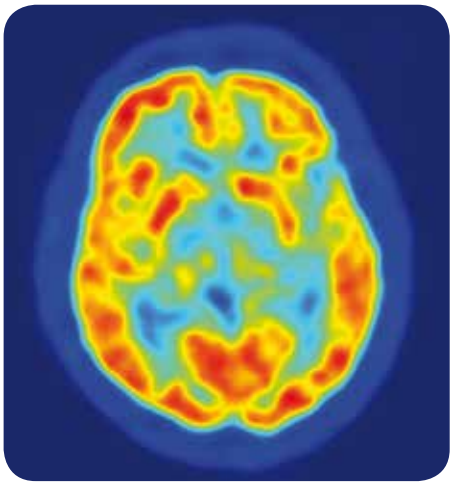
Caring for someone with Mental Health Issues

If you care for someone with mental health issues they are likely to be under the care of The Central and North West London NHS Foundation Trust (CNWL).

Involving yourself as the carer early on in the discharge planning process again applies and using the check list above on page 7.

CNWL have a Mental Health Intermediate Care Team.

This service is a multi-professional team which works to promote the mental health of older adults in Brent intermediate care services.



The team consists of a clinical psychologist, occupational therapists, mental health nurse rehabilitation support workers, a researcher and an administrator.

The Team provides:

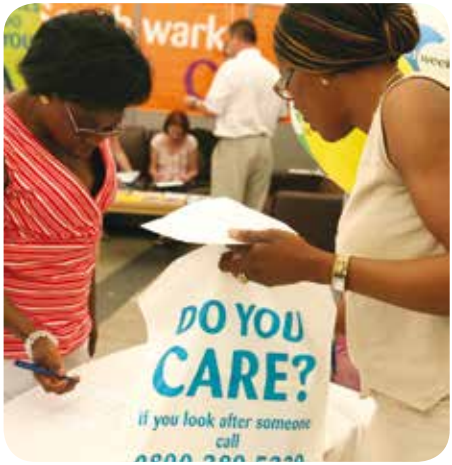
Timely rehabilitation services to maximise functional independence and metal health with a view to avoiding unnecessary long-term and institutional care.

Advice and information to service users and carers

Joint working to help in specialist assessments of service users with goal oriented interventions via agreed care programmes.

Support for Carers

When you become a carer or your caring situation changes, you may find that your life changes in all sorts of ways. You may have to spend more and more time supporting the person you care for. You may have to give up work. You may have to learn new skills. You may have to change the way you view your life.



You are entitled to a Carer's Assessment by a Social Worker if you have problems accessing one you can contact Brent Carers.

Once you are registered with Brent Carers you will be eligible for all our services to support you in your caring role.

Contact numbers

NHS Brent PALS
Tel: 020 8795 6771
email pals@brentpct.nhs.uk

NHS England - London Region complaints team
Tel: 020 3350 4500
email: NWLCSU.
CBLondonComplaints@nhs.net

Brent Carers
Tel: 020 8795 6240
email info@brentcarerscentre.org.uk

Become a member of Brent Carers

Brent Carers is an organisation run by and for Carers. We also seek to increase recognition of Carers invaluable contribution and to influence policy to recognise the needs and contributions of Carers.

You DO NOT have to be a member to receive our services.

Brent Carers is a charity and a company limited by guarantee. Carers and other individuals in Brent interested in our work can become members of the company. Being a member of the company, unless you are under the age of 18, gives you the right to:

- Vote at any general meeting held by Brent Carers
- Nominate members to stand for election to the Board of Trustees
- Be nominated to stand for election to the Board of Trustees

All members can help to shape our policies that should benefit Carers in Brent. We wish to encourage as many people to join our organisation and support the needs of Carers in Brent.

All members are obliged to abide by the rules set out in our governing document (Memorandum and Articles of Association). Under company law the names of members are maintained on a register kept at our offices unless this would place the member at risk. The register is regularly updated and can be inspected at our offices.

If you would like to join Brent Carers please complete and return the tear off form and return it to us.

Application to become a member

Name ..... Status: Current Carer

Address ..... Former Carer

..... Other

.....

Post code .....

Telephone .....

Email .....

I agree to abide by the rules of Brent Carers and wish to receive a summary of the rules (please tick) ☐

Signature ..... Date .....

Print name .....

You will receive a membership card.

Hospital Discharge Planning Advice
Printed September 2013

Tel: 020 8795 6240

Web: www.brentcarerscentre.org.uk

Address: Brent Carers Centre, 116 Chaplin Road, Wembley, HA0 4UZ

Registered Charity number 1066691

Company Limited by Guarantee 3354038

BRENT CARERS CENTRE
To improve the lives of the carers of Brent

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