

# Discharge Planning What Happens Next?

Information for Patients, Families, Carers and Staff



## What is this leaflet for?

This leaflet aims to help you understand your stay in hospital.  
It contains information on:

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**If you require any assistance with information contained in this leaflet please  
contact a member of the ward team.**

## Section 1: What is Discharge Planning?

As soon as you are admitted to hospital, planning should begin to find out what services and support you may need when you leave. By the time you leave hospital a clear discharge plan should be in place.

This planning process should make sure that when you leave hospital you and with your permission anyone involved in your future care, know about your medical condition and services and support available.

### Your Medical Condition

This will include any information on treatment, medication and future health appointments. It may also include the names of persons including GPs, Hospital Doctor and contact details for the hospital ward. This information will be included in your discharge letter (a copy of which will also be sent to your GP).

### Services and Support

This will include information on any services currently in place as well as any agreed changes that will be put in place for your return home, based on assessments completed by the ward team for example; home support and community nurse. It will also include information on local points of contact and sources of specialist information (such as Parkinson's Disease Society, local Carers centres etc).

### How is a Discharge Plan Developed?

The plan will be developed following a completed assessment by the ward team and in full discussion with yourself and family/carer, if you require support on discharge or if your care and support needs have changed. Discharge planning will be vital to make sure the right support and services are put in place.

### Who Develops the Plan?

#### **Nursing staff:**

Main contact person while you are in hospital, who oversees the care provided and the plans for leaving hospital (this may also be performed by another member of the health profession).

#### **Hospital Doctor:**

Decides what medical care should be provided and decided when you are well enough to be discharged from hospital.

#### **Hospital Pharmacist:**

Provides the medication required for you and information on when and how it should be taken. In some cases the hospital pharmacist may contact your community pharmacist to provide information on any changes to your medicines or give supply details.

### Others who may be involved (this list is not exhaustive):

- Physiotherapist.
- Occupational therapist.
- Specialist nurses
- Social worker.
- Speech and language therapist.
- Dietician.
- Continence advisers.
- Community care worker.

## Section 2: After Leaving Hospital-Services in your Community

This sections contains information about community services and who provide them. It is divided into three main areas:-

- Community care/social services.
- Primary health care
- Services provided by the voluntary sector.

### Community care/social services

If you require help from social services to manage at home, this can be arranged before you are discharged from hospital. With your permission, an assessment of how you manage your daily activities will be carried out on the hospital by an Occupational Therapist and may also involve a Social Worker. Their recommendations will be passed to Social Services who may be able to provide the following:-

- Equipment, adaptations and transport.
- Help with shopping.
- Respite care/short breaks.
- Sitter services/care attendants.
- Finance and benefits
- Domestic tasks.
- Day care services.
- Help with personal care such as bathing and dressing.
- Help with meals.
- Supported accommodation.

Assistance with personal care is provided free of charge for people over 65, however you may be charged for some of the other services following a financial assessment. The local authority review the services provided and adjust accordingly depending on your needs.

### General Practitioner (GP)

Your GP will provide ongoing medical care and advice following your discharge from hospital. Your GP will receive information from the hospital doctor and nursing staff about your medical needs and this will include a copy of your Discharge Plan. They can refer you back to the hospital consultant if required as well as refer you to other services you may need.

With your permission they will also be able to answer any questions your carer may have on medical matters following your discharge.

## Community Nursing Team

District Nurses (DN) work with other health care professionals including statutory, voluntary and private agencies.

Referrals are taken from all sources but they can only take referrals for patients who have a nursing need that requires the assessment of a qualified nurse and some form of nursing care. The DN will assess, plan, provide and evaluate nursing care to meet the needs of the patient and carers in the community.

- It is important that the DN is involved as soon as possible, especially for patients who have complex care and/or palliative care needs.
- Following admission to hospital, communication between the district nurse and receiving ward or discharge coordinator will alert staff to the care the patient was receiving at home.

## Community Psychiatric Nurse (CPN)

Community psychiatric nurses are trained to work with people with mental health problems. They offer support to the patient and their families and carers. Your GP will refer you to this service if required or arranged as part of the discharge plan. There are also CPNs specific for older people.

## Other members of the team

This may include learning disability nurse, complex care/specialist nursing services.

## Voluntary Sector

A wide range of services are provided by voluntary or charitable organisations.

Some of the services that you can receive through community care may be provided by the voluntary sector include:

- Information and support.
- Sitter and respite services.
- Counselling.
- Advocacy
- Lunch clubs.
- Support groups.
- Day care.
- Specialist support/information on particular conditions.
- Training for carers.

If you would like more information, carers' centres are often the best starting point (see page 12 for contact numbers).

### Section 3: Being a Carer-Support for Carers

If you help or support a relative, friend or neighbour, who is elderly, ill or disabled who could not manage at home without your help **you are a carer.**

**However, most people who give their help to someone who needs it do not see themselves as a Carer and as a result they may be missing out on the financial, practical and emotional support that is available to them.**

Caring can be rewarding, but it can be difficult too. Carers often perform physical tasks such as lifting or assisting the person they care for to get around. They may also provide a great deal of emotional support, and help to ensure the person they care for stays safe.

**Please tell the staff of the hospital if you have a carer or if you are a carer.**

NHS Forth Valley, working with the Princess Royal Trust Carers Centres, provides the following support for carers:

- **Information and support.**
- **Signposting to access benefits and services.**
- **Someone to talk to.**
- **On-going information and support when the person you care for goes home.**
- **Help with carer assessment.**

**See page 12 for contact details.**

### Section 4: Finances-Costs and Benefits

There may be financial costs for the services you receive but you may also qualify for financial help and benefits. Information can be sought from page 12.

### Section 5: Moving to a Care Home

If it has been necessary following an assessment that you have to be discharged to a Care Home then the most appropriate member of staff will give you a leaflet 'Moving from Hospital to Care Home' which they will discuss with you. This will give you all the information required.

### Section 6: NHS Continuing Care

In order to receive NHS Continuing Healthcare, you need to be assessed as eligible. The assessment itself is carried out by a multi-disciplinary team (MDT), led by a clinician, using national criteria to ensure consistency across Scotland and across age groups.

## Section 7: NHS Appeals Process

### Can I appeal against the consultant's decision?

Yes. If you do not agree with the decision to discharge then you can appeal or may ask an advocate or relative to appeal on your behalf. Care in the community may not be appropriate for everybody. It is important to note that NHS care need not always be provided in a hospital setting. The appeal outcome will be binding on all parties.

### The appeal process.

There is a procedure, which gives you, the patient, the right to appeal if you do not accept your consultant's decision that you are fit to be discharged from NHS inpatient care.

### Who should I contact if I want to appeal?

- Consultant.
- Ward sister.
- Director of Public Health or lead Telephone Number.

## Section 8: Useful Contact Numbers

Citizens Advice Scotland (CAS) [www.cas.org.uk](http://www.cas.org.uk)

|   |               |
|---|---------------|
| Alloa:                                  | 01259 723880  |
| Denny:                                  | 01324 823118  |
| Falkirk:                                | 01324 611244  |
| Grangemouth/Bo'ness:                    | 01324 483467  |
| Stirling:                               | 01786 470239  |
| Falkirk Council Benefits Helpline:      | 01324 501404  |
| Falkirk Council Social Work Department: | 01324 504123  |
| Stirling Social Work Team:              | 01786 471177  |
| Clackmannan Social Work                 | 01786 471177  |
| Hospital Social Work Team:              | 01324 616039  |
| Palliative Care Team:                   |               |
| Advocacy Services:                      |               |
| Age Concern:                            | 0845 125 9732 |
| Alzheimer's Scotland:                   | 0808 808 3000 |
| Falkirk Carers Centre                   | 01324 611510  |
| Stirling Carers Centre                  | 01786 447003  |
| Alloa Carers Centre                     | 01259 219288  |

NHS Forth Valley Advocacy Service

You can obtain the service of an interpreter or have this document translated in your own language by contacting the interpreting services on 0845 130 1170. These services are available free of charge.

ਤੁਸੀਂ, 0845 130 1170 ਤੇ ਦੁਭਾਸ਼ੀਆ ਸੇਵਾਵਾਂ (interpreting services) ਨੂੰ ਸੰਪਰਕ ਕਰਕੇ ਇਕ ਦੁਭਾਸ਼ੀਏ ਦੀ ਸੇਵਾ ਜਾਂ ਇਸ ਦਸਤਾਵੇਜ਼ ਦਾ ਆਪਣੀ ਬੋਲੀ ਵਿਚ ਅਨੁਵਾਦ ਲੈ ਸਕਦੇ ਹੋ। ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ।

آپ 0845 130 1170 پر انٹرنیٹ پر سروس سے رابطہ کر کے کسی مترجم کی خدمات حاصل کر سکتے ہیں یا اس دستاویز کا ترجمہ اپنی زبان میں کرا سکتے ہیں۔ یہ خدمات مفت دستیاب ہے۔

您可以通過撥打翻譯服務熱綫 0845 130 1170 取得翻譯員服務或得到此文件的翻譯版本。 這些服務都是免費的。

Galite prasyti vertejo paslaugu arba gauti sita dokumenta isversta I jusu kalba kreipdamiesi I musu vertimo paslaugu biura skambindami 0845 130 1170. Sitos paslaugos yra nemokamos.

يمكنك الحصول على خدمة الترجمة الفورية أو القيام بترجمة هذه الوثيقة إلى لغتك الأصلية عن طريق الإتصال بخدمات الترجمة الفورية على رقم 0845 130 1170. هذه الخدمات متاحة مجاناً بدون أى مقابل مادي.

Dzwoniąc do biura tłumaczeń pod numer 0845 130 1170 możecie Państwo prosić o tłumacza albo otrzymać ten dokument przetłumaczony na wasz język ojczysty. Powyżej wymienione usługi są darmowe.

**If you, or someone you know, would like this in an alternative format, such as audiotape or large print then please phone us free on 0800 456033, fax your request to 01786 470984 or email us at [FV-UHB.yourhealthservice.nhs.net](mailto:FV-UHB.yourhealthservice.nhs.net)**

#### **SMOKING IS NOT PERMITTED ON NHS FORTH VALLEY PREMISES**

This includes corridors, doorways, car parks & any of our grounds. If you do smoke on NHS premises you may be liable to prosecution and a fine.



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