HOME FROM HOSPITAL – BASSETLAW

CLARA TAYLOR – SERVICE MANAGER

KEY SUPPORT AIMS

AIM: Improve health and wellbeing, and reduce (re)admissions.

All support packages are individual but include as a minimum:

- Key contact information (PEP) which aims to divert people away from A&E - providing reassurance they can get help if needed.
- Assisted shopping accompanying individuals to shops supported by nutrition & hydration information/encouragement.
- Targeted 1 to 1 or group 'Move it or Lose it!' exercise sessions or an agreed activity programme to address muscle loss for those with balance/mobility problems.
- Goal setting: 'what do you want to be able to do in 6 weeks?'
- Confidence building & restoring social connections: Support/mentoring with getting back to 'day-to-day tasks' e.g. meeting up with friends and/or joining local social clubs.

SUPPORTING YOUR RECOVERY

(continue)

- Guidance on use of relevant IT: laptop, phone, Tablet to develop communication/ connection.
- Community Transport (charged to older person unless part of funded commissioner offer).

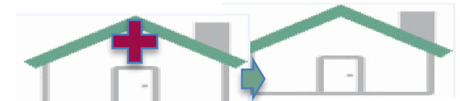
Safe and Well check:

- Includes assessing risks associated with their housing: warmth, risk of falls, overall safety (pre and post discharge).

Active signposting:

- Working with local partners to deliver services (e.g. fitting of aids/ adaptations, benefits check, handyman services, etc); need to ensure all requests are actioned & delivered.

DELIVERY MODEL



Referral

May come from hospital, social care provider or professionals for lonely people aged 50
(please see full criteria as defined by the commissioner)

Home Visit or Ward Visit

The older person will be visited by an official RVS team member either at their home or on-ward

Assessment (of needs)

A assessment will take place to establish the older person's needs & identify current capabilities that can be built upon, achievable goals can be agreed

Support

To build confidence and individual resilience.
This may include hydration/nutrition, assisted shopping, transport (if available), IT guidance, gentle exercise and getting connected with local groups or activities

Connected to a Volunteer

A suitable volunteer will be identified, usually someone local with common interests. Where available a 'Coming Home' pack will also be provided.

Support Plan (including Personal Emergency Plan)

with the older person, develop an action plan to meet their needs and develop their current capabilities and achieve their goals

Progress Review (Re-assess)

Official RVS Team member assesses progress of older person toward meeting needs and goals and developing capabilities. If necessary, amend and agree further goals.

Withdraw Support (As agreed)

Goals achieved and action plan and if necessary active signposting completed. Confirm support withdrawn with older person & referrer (Opportunity to return if needs/situation changes)

REFERRAL PROCESS

Working closely with the community and secondary care partners

Key Criteria:

- Registered to a Bassetlaw GP
- Are vulnerable and at risk of readmission with no or limited care package available
- Are primarily aged 50 years or over, living alone or in a co caring relationship
- Are in or have been recently discharged from hospital

Examples of what we do not include:

- Provision of personal care
- The administering of medicines or involvements in any medical issue

INITIAL ASSESSMENT

To ensure we are meeting the needs of the older person we will carry out an initial assessment, this will normally take place on the ward or in the home of the client.

- Common sense approach to working with the client
- Will take place in the client's own home or on a hospital ward by an official RVS staff member or volunteer.
- Will identify needs of client and current capabilities that can be built upon
- Identify and assess any risks also completing a Safe and Well Check
- Outcome and goal setting

WELCOME HOME HAMPERS

Thanks to funding from Tesco we are working with Bassetlaw Hospital Integrated Discharge Team to provide a 24 hour pack of essential food items to be given to a vulnerable patient upon discharge

- Hospital transport have agreed to carry these items as "medical"
- Hampers for specific dietary needs can be arranged with notice
- Our hampers have been designed to require minimal cooking equipment / ability
- A small amount of hampers are kept on site at the hospital at all times
- Our team arrange for hampers to greet patients as they arrive home when discharged from other hospitals

SUPPORT PLAN

During the initial assessment visit develop a practical Support Plan with the client (led by the older person)

- Typically we will provide support for up to 6-8 weeks
- Will set realistic goals and timescales as well as our plan for withdrawing our support

Support plan will include:

- Personal Emergency Plan
- Programme of basic exercises to build strength
- Guidance on good nutrition/hydration
- Health & Wellbeing questions – health, happiness, confidence, companionship, physical function

ROYAL
VOLUNTARY
SERVICE

PROGRESS REVIEW AND WITHDRAWING SUPPORT

Progress review will be completed ideally with the initial representative who completed the assessment

- Assesses progress of the client towards meeting needs and goals in their support plan
- If necessary further goals will be set and support will be extended or agree to withdraw
- Will also re-ask the Health & Wellbeing questions in the support plan

Withdrawal of support was planned from the start so everybody is prepared. If further support from other organisations or further time limited interventions from us is required this can be agreed.

Follow up call after withdrawal to see how the client is.

LEGACY POST SUPPORT

Personal Emergency Plan (PEP)

- The PEP should be easily available and within reach of the client in their home.

EMERGENCY CONTACT NUMBERS

CONTACTS	CONTACT NO.
NHS 24	111
Police Non Emergency	101
Doctor	
Electricity Supplier	
Gas Leak	0800 111 999
Water Supplier	
Floodline	0345 988 1188
Telephone Provider	
Home Insurance	
Other Insurance	

CONTACTS	CONTACT NO.
Boiler/Central Heating	
Plumber/Handyman	
Food Supplier	
Taxi	
Opticians	
Audiologist	
Vet	
Other	

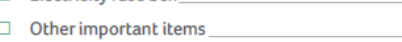
IF YOU HAVE A MOBILE PHONE, KEEP IT CHARGED

BE PREPARED FOR AN EMERGENCY

Complete this card and put it by your phone with a torch handy too.

Make a note below of where the following are:

- ☐ Torches ____
- ☐ First aid kit ____
- ☐ Candles ____
- ☐ Radios ____
- ☐ Batteries (radio & torch) ____
- ☐ Light bulbs ____
- ☐ Portable heating appliances ____
- ☐ Spare blankets ____
- ☐ Hot water bottles ____
- ☐ Mains water stopcock ____
- ☐ Gas Mains tap ____
- ☐ Electricity fuse box ____
- ☐ Other important items ____



LEGACY CONTINUED…

Nutrition & Hydration Handbook

- Hints and tips around choices supported by the Nutrition and Hydration Handbook and associated recipe cards

- The guide covers information on: sarcopenia, osteoporosis, obesity, cognitive health, nutritional supplements and malnutrition.

Active Signposting

- We aim to provide our clients (through practical support) assistance in connecting/reconnecting or engaging/re-engaging with their community however we sometimes will be unable to provide the service/activity required. Therefore important to have a sound understanding of opportunities offered locally and nationally.

PHASE 2 ROLLOUT

- Mobility Volunteers on ward
    - Assist with mobilising the patient – avoiding pyjama Paralysis
    - Compliments the ongoing work of clinical teams
    - Timely discharge
- Community based exercise
    - Keep people active
    - Further reduce readmissions