

Hospital Home

Essential information for:

*Community-based
social workers and
occupational
therapists*

This leaflet is for community-based occupational therapists and social workers.

It contains information about how older people's housing and support can be considered as part of the hospital discharge process and is part of a [larger resource pack](#) containing leaflets, factsheets and checklists for different professional sectors involved in the discharge process.

Older people are being discharged from hospital following treatment sooner than in the past. The suitability of their home environment and availability of practical support can make or break their successful and timely discharge and is at least as important as their medical and social care, following discharge.

There are a range of services available to people who are ready to be discharged from hospital that will help ensure that they can return to a home situation that will aid, rather than hinder, their recovery. These range from community-based 'home from hospital' services, to handyperson services that can complement services offered by community-based occupational therapists and social workers (*see Factsheet 1*).



CASE STUDY

Handyperson Services

Handyperson Services provide older and disabled people with much valued practical help with 'odd jobs', small building repairs, minor adaptations such as the installation of grab rails and temporary ramps, as well as offering home safety and energy efficiency checks.

[A National Evaluation of Handyperson Services](#), commissioned by the Department for Communities and Local Government¹, concluded that "They offer an important safety net for older people, and they also enhance the effectiveness of health and social care provision through the delivery of often very simple and very low cost interventions" and that they offer value for money. It was noted that "the work undertaken by handyperson services is related to reducing risks and hazards and improving people's safety and well-being in their homes" and hence supports the preventative agenda.

Did you know?

- ② Housing adaptations can reduce the cost of home care by £1,200 to £29,000 a year².
- ② Ambulatory care-sensitive conditions (ACSCs) currently account for more than one in six emergency hospital admissions in England, costing the NHS £1.42 billion each year. Effective management and treatment could reduce the incidence of hospital admission by 18% (potentially saving £238 million) if all local authorities performed at the level of the best-performing local authorities³.
- ② Nearly 80% of all 30-day emergency readmissions in England follow a previous unplanned stay in a hospital; nearly half return within 7 days of their initial discharge⁴.



Key actions for community-based occupational therapists and social workers

In general

- ② If someone is going into hospital for elective treatment, start planning for hospital discharge prior to admission and take into account an individual's housing circumstances at every stage. Where possible spend time early on to properly understand individuals' housing and support needs.
- ② Many areas have effective 'Home from Hospital' services in place run by voluntary agencies. Familiarise yourself with the key housing and welfare benefit contacts in your local area (*see Factsheet 2*).
- ② Many older people are discharged into care homes, despite an expressed wish to return home. In many cases, such individuals could return home safely if key agencies coordinated their efforts to meet the individuals specific needs. For example, telecare is increasingly used to help people with dementia to live in their own home.

Before admission – for elective stays

- ② If you are already working with an older person before they go into hospital, ensure that you have up to date information about their housing circumstances (*see Checklist 1*).

This will allow you to make early judgements about patients' ability to cope when they return home, and to get a picture of factors that might have contributed to hospital admission – such as damp housing.

- ② Complete the Template for assessing a patient's housing situation and forward this information to the hospital to ensure it reaches personnel dealing with both the individual's clinical care and their discharge planning.
- ② Identify any housing-related barriers that could impede a patient's progress towards their recovery goals and include potential solutions within their Care Plan.
- ② Signpost older people and their families to places where they can get help and good advice with housing problems (*see Factsheet 1*).
- ② If an individual has a rapidly deteriorating condition, and is likely to be entering the terminal phase, there are often housing implications. A variety of agencies (*see Factsheet 1*) help families to make temporary arrangements such as making a downstairs room into a bedroom.

- 2 Discuss patients' housing situations and options with them, their families and carers, so that they can make informed decisions and arrange for necessary works to be carried out in a timely fashion. If they are at the point of having to take significant decisions, for example to move house, provide access to specialists who can help them to consider their options (*see Factsheet 2*). It may be appropriate for the patient to move into temporary accommodation to provide time for suitable accommodation to be secured. This might coincide with a period of reablement and rehabilitation.

Fact: The occupational therapy accident and emergency service at Royal Cornwall Hospital provides seven day cover. This change made increased savings on admission avoidance, and initial screening of patients who had fallen, and increased efficiencies in discharging patients to their homes within 72 hours⁵.

situation and forward to the hospital-based contact to ensure it reaches personnel dealing with both the individual's clinical care and their discharge planning.

Emergency admissions

- 2 If you have worked with the individual previously, and are informed about their emergency admission, transfer any existing information about their housing situation onto the [Template for assessing a patient's housing](#)

Whilst in hospital

- 2 The more that can be planned before admission, the less the chance of delay in discharging the individual. It's preferable to get a ramp in place whilst the individual is in hospital than a week after discharge.

CASE STUDY

Age UK Mid Mersey

Age UK Mid Mersey piloted a hospital discharge service with a focus on housing. An occupational therapist carried out home visits with patients before discharge.

The patients were involved in identifying changes needed, which included moving furniture, repairing trip hazards (such as loose carpets), moving a bed downstairs, fitting grab rails. Age UK's local handyperson service carried out the tasks quickly and gave the older person appropriate information and advice. Discharges were timely and to a safe environment.

② If an older person is a tenant you will need to liaise with the landlord if aids and adaptations are required before discharge. The College of Occupational Therapists and Housing Corporation co-publication Minor Adaptations Without Delay provides practical guidance for housing associations involved in fitting ‘minor adaptations’ for tenants, such as stair rails. It provides technical specifications and examples of good practice. A local home improvement agency should be able to provide advice about aids and adaptations for private tenants and home owners. If there is no home improvement agency in your area, the local authority housing or environmental health department should be able to help (**see Factsheet 1**).

② Liaise with hospital based professionals to achieve a smooth discharge.

② If it appears that an older person is isolated, with no one to help with practical tasks such as walking the dog or helping with gardening, arrange a referral to local ‘home from hospital’ services (**see Factsheet 1**) as well as referring them where necessary to local authority community nursing and adult social care for ongoing support.

Post discharge

② Continue to liaise with local hospital discharge voluntary schemes to ensure a co-ordinated and seamless discharge process.

② If you and your community and hospital-based colleagues take a patient’s housing circumstances into account, and make arrangements in a timely way, there should be no hold-ups due to unsuitable housing. Even with the best laid plans difficulties do sometimes arise so wherever possible check that the patient is returning to a home that will aid their recovery, before the hospital discharges them.

② Where post-discharge day or outpatient consultations are planned, wherever possible check for any changes in the patient’s personal circumstances and any impact on housing that can help facilitate their recovery.

Preventing readmissions:

An independent evaluation of one British Red Cross hospital discharge scheme offering personalised, flexible support found that only 3% of service users were readmitted in the six months following discharge, compared with NHS Trust’s figures showing a 12% readmission rate within 28 days for the same period.

Checklist

YES NO

Have you familiarised yourself with the key housing and welfare benefit contacts in your local area?

Do you routinely collect information about patients' home situations as part of routine health and care assessments? Have you passed this on to the relevant person at the hospital, providing you have permission to do so and the patient's agreement?

Are there any housing-related barriers that will prevent the patient from achieving their health/care goals? **(See Checklist 1)**

Have you involved housing-related agencies operating outside the hospital in discharge and care planning for the patient?

Does the patient and/or their family or carer know and understand all the available housing-related options to help them to recover and live post-discharge? Do they know what it will cost them and have they been given payment options?

Have you considered all the options for helping an older person to live independently, before making a decision to advise them to go into care?

Does the patient have someone to meet and greet them on return home and ensure that they have sufficient food and heating? If not, do you know about local agencies who may be able to provide such a service? **(See Fact Sheet 1).**

REFERENCES:

- 1 Supporting hospital discharge and reducing readmissions: A British Red Cross briefing.
- 2 Heywood F *et al.* Better Outcomes, Lower Costs ODI/DWP 2007.
- 3 Kings Fund. Emergency hospital admissions for ambulatory care-sensitive conditions. April 2012.
- 4 Analysis based on 2009/10 figures. Taken from Sg2 Service kit Reducing 30-Day Emergency Readmissions, June 211.
- 5 OTN May p46.



supported by:

