

# Hospital Home

Essential information for:

## *Hospital- based staff*

This leaflet is for hospital-based staff working directly with older people including ward nurses, discharge coordinators, social workers and occupational therapists.

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 often need to draw on housing and community-based services, temporarily or permanently, when they are discharged from hospital. The availability of the right services, and the ability to access them in a timely way, is critical if delayed discharge is to be avoided.

A range of services is available to older people being discharged from hospital that will help to 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 handyman services (see *Factsheet 1*). The suitability of an older person's home environment and availability of practical support is at least as important as their medical and social care, following discharge.

If you are a nurse, occupational therapist, discharge co-ordinator or social worker, you need to know about your older patients' housing and home situation. You need to know who to go to, to make their home safe and to ensure they receive the support they need following discharge to promote their recovery. Solutions need to be included within their care plan and discharge process.



#### CASE STUDY

## British Red Cross

Client A was living in a property that had no cooking facilities, no heating, no hot water and the electricity was not safe. The client cooked on an open fire with an oven attached.

The client was taken into respite whilst waiting for a council property to become ready. A Red Cross case worker and the client's social worker escorted the client to get carpets, furniture, bedding, electrical items etc and helped her to set up her new home and to move into it. The case worker helped the client to set up to pay household bills such as water rates, council tax electricity, rent etc. and showed her how to use electrical items such as a cooker, toaster, washing machine, microwave and the shower. The client had no experience of using such items.

The client's partner had recently passed away so the case worker helped the client build her confidence and re-settle her into a new environment and area and introduced the client to other residents in the complex. The client settled in well.<sup>1</sup>

## Did you know?

- 1) There are a range of serious health risks associated with poor housing (see Factsheet 3). Unsuitable home conditions can directly cause health problems, and hence hospital admissions. If individuals are discharged to unsafe, cold, unsuitable homes they are more likely to return to hospital.**

Many of the health conditions experienced by older people have a causal link to, or are exacerbated by, particular housing conditions. These include heart disease, respiratory conditions, mental ill health, arthritis and rheumatism. This housing/health link becomes more important with age, as people become more prone to trips and falls and more susceptible to cold or damp related health conditions. Poor thermal standards in the homes of older people are a quantifiable contributor to excess winter deaths. Vulnerable people over 75, particularly low income older homeowners, are the group most likely to live in poor housing, with a million occupying non-decent homes<sup>2</sup>.

- 2) It is cost effective for hospital nurses and occupational therapists to take the time to fully assess an older person's home situation before they are discharged.**

A Rapid Emergency Assessment and Care Team (REACT) provides assessments on mobility, activities of daily living, cognition and social support. Over a three month period, 126 admissions were prevented at a saving of £105,000<sup>3</sup>.

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 handyman service carried out the tasks quickly and gave the older person appropriate information and advice. Discharges were timely and to a safe environment.

- 3) A lack of coordination with housing and support agencies during discharge planning is a common cause of delayed discharge.**

There are many community-based agencies that provide significant housing-related services or emotional and practical support to older people returning home following a stay in hospital. If properly embedded into the discharge process they can help to speed up discharge from hospital and prevent readmissions.

# Key actions for nurses, hospital-based occupational therapists and discharge co-ordinators

Some hospitals have appointed dedicated ward-based discharge coordinators, sometimes known as housing options workers. They are familiar with the local housing market and related provision and know who to speak to and work with to facilitate necessary home adaptations and repairs as well as potential housing moves.

## In general

- ② Familiarise yourself with key agencies offering non-statutory housing and support services and enter them onto **Factsheet 1**.

## At admission

- ② Obtain as much information as possible about an individual's housing and home circumstances – and keep this updated.
  - Include questions about an individual's housing and home circumstances as part of wider medical assessments wherever possible. **Checklist 1** contains some sample questions
  - Record details of their landlord, if they are living in social housing or the private rented sector
  - Record details of any home care or self funded help at home.
  - Store this information with the patient's clinical records and update on each hospital admission.

This will enable you to make early judgements about a patient's ability to cope when they return home, and to start any necessary planning in good time. It also provides a picture of factors that might have contributed to hospital admission – such as damp housing, inadequate heating or disrepair.

## Whilst in hospital

- ② **Consider nominating dedicated discharge co-ordinators at ward level.** This individual would have responsibility for liaising with the patient's family, carers and key professionals both inside and outside the hospital to ensure a seamless discharge process. They would have up-to-date knowledge of all services available to:
  - a) Support the patient when they return home and
  - b) Ensure that their housing is safe and meets their needs.
- ② Identify any housing-related barriers that could impede patients' progress towards their goals.

- 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 can help families to make temporary arrangements such as converting a downstairs room into a bedroom. (**See contact list**).
- 2 If patients have complex housing needs, including homes in poor condition, they may need significant repairs, adaptations and/or telecare to enable them to live independently. Factsheet 1 gives details of the types of local agencies that can provide necessary advice and support.
- 2 If the patient is homeless, they will need specialist help to secure suitable accommodation in a timely fashion. You must involve the local authority Housing

Options service and possibly other specialist advice services in the discharge planning process (**see Factsheet 1**).

- 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 a local 'home from hospital' or other relevant service (**see Factsheet 1**) as well as referring them where necessary to local authority community nursing and adult social care for ongoing support.
- 2 **Wherever possible arrange for the occupational therapist to conduct a home visit with the patient before discharge.** This is to check how well they can really cope in their home.

#### CASE STUDY

## Discharging a homeless patient

A diabetic patient, admitted with foot ulcers and who suffered a heart attack whilst on the ward, was living in his car as he was homeless. The discharge coordinator spoke to Knowsley Housing Options before the patient was declared medically fit.

A representative attended the ward and assisted the patient in completing the relevant housing application forms. Once the patient was deemed medically fit, a few days later, he was moved to Duffy Suite to await rehousing. He spent only 4 days there and he was offered and accepted a bungalow, into which he was discharged.

*Whiston Hospital, St Helens*

- ② Establish pathways and a working relationship with key partners such as their local home improvement agency and handyman services (see **Factsheet 1**).

*“The lynchpin was the OT hospital social worker/housing specialist combination ... I do not know what I would have done without them. There were forms that even the housing specialist had never seen.”*

Sister of double amputee who moved into extra care housing<sup>4</sup>

- ② Review progress and implications for the patient’s housing situation on a daily basis.
- ② Signpost older people and their families to places where they can get help and good advice with housing problems.
- ② 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.

**Good occupational therapy risk assessments in hospital can speed up discharge. These should be immediately relayed on to handyman or Care & Repair where minor adaptations, repairs and equipment are needed.<sup>5</sup>**

## At discharge

- ② Make sure you have a clear understanding of what an older patient is going home to and what support and/or home care they’ll receive when they get there.
- ② Include your knowledge about patients’ housing circumstances in your decisions regarding timing of discharge. Complex housing needs can take time to resolve. Some hospitals set up special arrangements with external agencies to speed up the process and reduce discharge delays or unnecessary readmissions.

### CASE STUDY

## Hospital-linked service

Whiston Hospital has formally recognised the importance of the home environment to patients' safety, and to timely discharge.

The Home improvement Agency (HIA) at St Helens Council works with the hospital in various ways to improve the discharge process. For example, HIA employees helped to write the hospital's discharge policy and they take part in quarterly 'discharge' meetings. They have committed to carrying out essential adaptations such as grab rails and access ramps within 2 working days of a request being made, so that patients can be discharged in a safe and timely manner.



- ② Give discharge summaries including reference to housing circumstances to the patient as well as to the GP. This is so that there is good communication should the patient need medical help very soon after going home.
- ② Make sure there are systems in place to capture any personal change of circumstance at the patient's follow-up or planned day or outpatient consultation that may impact on housing.

**Fact:** Sheltered housing scheme managers are frequently not informed when their residents return home from hospital. Many schemes do not now have an on-site scheme manager and residents are not necessarily visited daily. However, if scheme managers are informed about the date and time of a resident's discharge, they will be able to make their home-coming as comfortable as possible and to help them settle back in<sup>6</sup>.

Checklist	YES	NO
Do you routinely collect information about patients' home situations and store that information on hospital records?	<input type="checkbox"/>	<input type="checkbox"/>
Do you update it every time a patient is readmitted to hospital?	<input type="checkbox"/>	<input type="checkbox"/>
Do you consider a patient's housing situation when deciding whether they have simple or complex discharge needs?	<input type="checkbox"/>	<input type="checkbox"/>
Are there any housing-related barriers that will prevent the patient from achieving their clinical goals?	<input type="checkbox"/>	<input type="checkbox"/>
Do you know what's available locally to help with housing related problems?	<input type="checkbox"/>	<input type="checkbox"/>
Have you involved housing-related agencies in discharge and care planning for the patient, rather than leaving it until the discharge day to contact them?	<input type="checkbox"/>	<input type="checkbox"/>
Are housing-related activities and/or home care requirements included in your patient's discharge checklist?	<input type="checkbox"/>	<input type="checkbox"/>
Have you considered all the other local housing options before deciding that the patient needs residential care or a nursing home?	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient have someone at home to meet them when they arrive, to ensure sufficient food and heating is available and help them to settle back in?	<input type="checkbox"/>	<input type="checkbox"/>
Does the senior medical practitioner with overall responsibility for the decision-to-discharge have assurance that the patient is being discharged to a home environment that will aid their recovery and will not be prejudicial to their health?	<input type="checkbox"/>	<input type="checkbox"/>

#### REFERENCES:

- 1 British Red Cross Home from Hospital Service Case study
- 2 Extract from If only I had known; integration of housing help into a hospital setting... Care & Repair England 2012.
- 3 Selly Oak Hospital reported in OTN May 2010 p30.
- 4 Care & Repair England (2012) If only I had known; integration of housing help into a hospital setting.
- 5 Care & Repair England (2012) If only I had known ... An evaluation of the local hospital linked pilot projects
- 6 Information provided by EROSH [www.erosh.co.uk](http://www.erosh.co.uk)



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