

Hospital Home

Essential information for:

Sheltered and extra care housing providers

This leaflet is for providers of sheltered and extra care housing.

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.



Sheltered and Extra Care Scheme Managers can assist their residents in various ways to make a smooth and successful transition back home after a stay in hospital. Working with on-site or in-reach care teams, they can also facilitate 'home from hospital' services such as intermediate housing and care in partnership with reablement and rehabilitation services, for people whose clinical treatment has ended but who are not yet ready to return to their home.



CASE STUDY

Supporting transition from hospital to home

Willow Housing and Care, a London-based specialist provider of homes and services for older people, worked with Supporting People commissioners to establish a support service to older people in hospital. They did this after becoming aware that some new residents were coming direct from hospital where they had remained too long because their own home was not suitable for them to return to.

The service helps older people in hospital to make choices about their future housing. If the person wishes to return to their home, Willow Housing and Care arranges for various services such as aids and adaptations, cleaning, moving their bed downstairs, a community alarm and homecare. It provides on-going support for up to six months, linking into other services as appropriate. It helps others to secure alternative accommodation such as in a sheltered or extra care scheme.

The Department of Health's evaluation of the service has shown that for a £41k investment, the service has saved £420k per year in health and social care expenditure through reducing admissions to residential care and readmissions to hospital. Service users have shown high satisfaction with the service, and an increasing number of older people have returned to live independently after a hospital stay.

Did you know?

- ② National Outcomes Frameworks require NHS and Public Health professionals to reduce emergency readmissions within 30 days of discharge from hospital. Adult Social Care professionals are required to reduce permanent admissions to residential and nursing care.
- ② Unsuitable home conditions can directly cause health problems, and hospital admissions. If individuals are discharged to unsafe, cold, unsuitable homes they are more likely to return to hospital.
- ② Some sheltered and extra care schemes are offering intermediate housing with care options, such as short stay accommodation, to support rehabilitation and reablement.
- ② It is estimated that a third of sheltered housing and extra care residents have dementia and are likely to find change to their daily routines and unfamiliar space causes stress and anxiety. It is therefore important to seek to maintain continuity of care and a stable environment as far as possible.



Key messages for providers of sheltered and extra care housing

In general

- 2 **Get to know about local 'Home from Hospital' services:** Familiarise yourself with key agencies offering statutory and non-statutory housing and support services and with what they do (*see Factsheet 1*). Consider how they can assist you in providing your residents with tailored support on leaving hospital.
- 2 **Publicise your service offer:** Make sure that local social and health care professionals know about your service and what you can offer. This might include assistance to your own residents with the process of moving back home, intermediate housing and care facilities you are making available or other types of service you are making available to people returning to their own homes.

Before admission

- 2 **Liaise with your residents and the hospital before planned admissions:** Speak to your residents and their families to let them know what sort of support you or others can offer, before they go into hospital. Make sure the hospital has your contact details and is also aware of any 'Home from Hospital' support services you are making available. Ask the hospital to involve you in the hospital discharge planning process.

Following emergency admission

- 2 **Contact the hospital and family following emergency admissions:** Make sure the hospital has your contact details and is aware at an early stage of any Home from Hospital services that you make available for residents on their return. Ask the hospital to involve you in the hospital discharge planning process.

Whilst in hospital

- 2 If possible, take part in case conferences and needs assessments about your residents. This will enable you to participate more fully in the discharge process and to be better prepared for their return home.
- 2 At the least, ensure that you know when your residents are due to be discharged. Aim to get hold of their discharge date as early as possible so that you can prepare in advance of their return home.

At discharge

- 2 Make sure someone is there to meet and greet your resident, clearly this is only possible if you know when your resident is going to return home. It is particularly important that those

residents who have few family and friends close by have someone to welcome them home, make sure they have sufficient food and warmth and to help them with small 'settling in' tasks. If the scheme manager is unable to be present, a local voluntary agency may be able to field a volunteer who can help.

Fact: Sheltered housing scheme managers are frequently not informed when their residents return home from hospital'.

CASE STUDY

Cleves Cross Grange

Cleves Cross Grange, a sheltered housing scheme in County Durham has two flats which form part of the local Sedgefield Home Assessment and Rehabilitation partnership (SHARP).

One of the flats has been adapted to provide a wide range of equipment and fittings in order to assess individuals for equipment and/or adaptations that they might require in their own home and provide individuals with the opportunity to test equipment and adaptations, including:

- Height adjustable kitchen units and a range of kitchen equipment and appliances
- Flat floor shower and bathing aids
- Hospital style adjustable bed
- Over bed hoist
- Home appliances and equipment

The other flat has been left largely unchanged in order to provide a home-like environment for the purposes of the day-time assessment.



Checklist

YES NO

Do you routinely provide hospitals where your residents are admitted with your contact details, so that they can keep you in touch with discharge planning?

Have you clarified your 'home from hospital' service offer to your residents, their families and the hospital?

Are you involved in case conferences and needs assessments for your residents, while they are in hospital?

Do you make sure that someone is available to meet and greet your resident when they return to their home in the scheme?

Have you considered whether you can offer intermediate care or reablement services to support a resident's recovery or rehabilitation?

Have you made specific provision to support people with dementia in your scheme?



REFERENCES:

1 Information provided by EROSH www.erosh.co.uk



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