

Moving between hospital and your home – what you should expect

Information for the public

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About this information

NICE guidelines provide advice on the care and support that should be offered to people who use health and care services.

This information explains NICE's advice on what adults who are using care services should expect when they are moving to and from hospital and their home. It tells you about the care you should expect and helps you think of questions to ask.

To read the advice itself, see the transition between inpatient hospital settings and community or care home settings for adults with social care needs guideline.

Please note: where we refer to your 'carer' here we mean someone, usually a relative or friend, who helps you in your day-to-day life. This is not the same as someone who provides care professionally or through a voluntary organisation.

Listening to you

You should be in charge of deciding what support you want, and whether you want a family member or carer to help you make these decisions. You should always feel in control and that your privacy and dignity are being respected.

The care you need should reflect what you want and what is important to you. Your care plan is a written record of the care you have agreed to meet your needs, following discussions you have had with people working in health and social care.

This plan – and any other advice or information you are given – should be easy for you to read and understand. People giving you information should also offer to explain it to you.

When you go into hospital

People who are caring for you should explain why you need to go into hospital and how long you are likely to be there. They should talk with you and your family or carer about the types of care on offer.

You should also be told the name of the person who will be your main contact during your hospital stay and how often you can expect to see them.

Questions you or your carer might want to ask

- Who will be involved in my care?
- How long will I be in hospital?

During your hospital stay

You should be made as comfortable as possible. For example, if you have a wheelchair, you should have enough space so that you can move to it from the bed.

You should also be offered help with communication if you need it (including the use of an interpreter). In addition, you should be able to follow your usual daily routines as much as

possible.

Your carer should be made welcome and the hospital should make any necessary adjustments for them.

You should be given the name of the person who will be responsible for coordinating your discharge. They will be the person you and your family or carer will work with to plan your move out of hospital.

Questions you or your carer might want to ask

- Who is the main point of contact for me and my family?
- Will my carer be able to stay?

Getting ready to go home

The person responsible for coordinating your discharge should talk with you about the treatment and care you can be offered when you go home.

You can also talk to them about anything else to do with your move out of hospital. This includes any practical support you may need to carry out daily tasks, such as washing or shopping.

If you are 65 or over, or you have had a stroke, you should be offered something called 'early supported discharge'. This service lets you leave hospital early because health and social care professionals will visit you at home. They should provide you with the same care that you would get in hospital.

Questions you or your carer might want to ask

- When can I discuss what to do if I need more care than I can get from family and friends at home?

- Can you tell me more about home care?
- Who will make sure my carer and family have all the information and support they need ready for when I go home?

When you go home

The day you go home you should be given a summary of everything that you have talked about needing when you get home. It should also include the names of everyone who will provide you with treatment and social care support at home and details of other services that might be able to help you.

Your GP should have a copy of this summary within 24 hours of you leaving hospital.

Any specialist equipment and support you need, for example, bars on the walls of your home to help you move around, should be in place ready for when you go home.

If there is a risk that you may need to go back into hospital within a week of going home, your GP or a nurse working in the community should phone or visit you within 3 days, at the latest, to see how you are.

If you are homeless, you should be offered suitable temporary accommodation and support.

If you are coming to the end of your life, you should be offered the support you need so you can die in a place of your choosing.

Questions you or your carer might want to ask

- Who will care for me at home?
- Where will I go if I'm homeless?

Help for carers

One of the hospital staff should be responsible for giving your carer information and advice so they can provide you with practical support once you get home. This might include advice on ways to help you carry out everyday tasks, like washing, as independently as possible.

Your carer should be offered training. This may happen while you are still in hospital but it might be more useful in your home. Their training and support needs should also be regularly reviewed (at least every 6 months).

Questions your carer might want to ask

- What kind of practical support can I provide?
- What kind of support and training am I entitled to?
- Will this training take place in hospital or at home?
- Are there any organisations that can provide me with support?

What you should expect from people who will look after you

Staff who are caring for you should:

- Make it as easy as possible for you to let them know what you need.
- Offer you information in a way you find easy to understand for example, by speaking to you or giving you information in an easy to understand format such as braille or Easy Read.
- Keep you regularly updated about any changes to the plan for going home.

As soon as you are admitted to hospital

If you rely on health and social care services to support you on a daily basis, all the relevant specialists should check your health and care needs.

If you are 65 or over and rely on health and social care services to support you on a daily basis, you should be cared for in a specialist unit or ward for older people.

If you have had a stroke you should be cared for in a specialist stroke unit.

When you have left hospital

The health and social care team should stay in touch and may visit you. This may include your GP, as well as the people who will offer you ongoing treatment and support, as listed in your discharge plan.

Questions you or your carer might want to ask

- What should I do if my care doesn't match the advice given by NICE?
- How will my communication needs be met?

Where can I go for more information?

- [Age UK](https://www.ageuk.org.uk) (0800 169 6565)
- [British Red Cross](mailto:information@redcross.org.uk) (information@redcross.org.uk)
- [Carers Trust](mailto:support@carers.org) (support@carers.org)
- [Carers UK](mailto:advice@carersuk.org) (advice@carersuk.org)
- [Disability Rights UK](https://www.disabilityrightsuk.org) (personal budgets helpline 0300 555 1525, selfdirectsupport@disabilityrightsuk.org)
- [Independent Age](https://www.independentage.org) (0800 319 6789)

You can also go to [NHS Choices](#) for more information.

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Accreditation

