GOING INTO HOSPITAL

When a loved one goes into or leaves hospital, it can be a daunting time. The Borders Carers Centre Hospital Liaison Worker is there to ensure this transition is as smooth as possible. The Liaison Worker visits the wards and will work with you intensively on a one-to-one basis whilst the person you care for is in hospital, and two weeks after discharge to make sure all the support and services are in place and you are ready, and prepared, to start or continue your caring role. After this time, you will be allocated your own named Carer Liaison Worker who will work with you as long as you require them.

The Hospital Liaison Worker will also support you through any choices or decisions you may need to make regarding residential care homes, or the process of palliative/ end of life care and choices.

Please contact the Borders Carers Centre if you would like to arrange a visit with the Hospital Liaison Worker, or ask the staff on the ward at Borders General Hospital or

in any Borders Community Hospital or Mental Health Unit.

Before discharge you or the person you care for will be given a booklet called 'Leaving Hospital' which has information you may find helpful.

"It was all such a shock when mum had a stroke and I suddenly became a carer. It was really confusing and emotional and I was so grateful when the nurse referred me to the Hospital Liaison Worker"

If the person you care for agrees, staff will discuss all the plans for them leaving hospital, with you. This will include any support that may be needed once they are home. If you have worries about them going home please tell the nursing staff or the Hospital Liaison Worker.

Where possible, you will be given 48 hours notice before the person you care for leaves hospital. Most patients do not require to be in hospital for long and discharge planning should start early after admission to hospital. You may be given an estimated discharge date to keep you informed and allow you to make any arrangements required.

A team of professionals in the hospital will work together to discuss and arrange the discharge process. You should be fully involved in this.

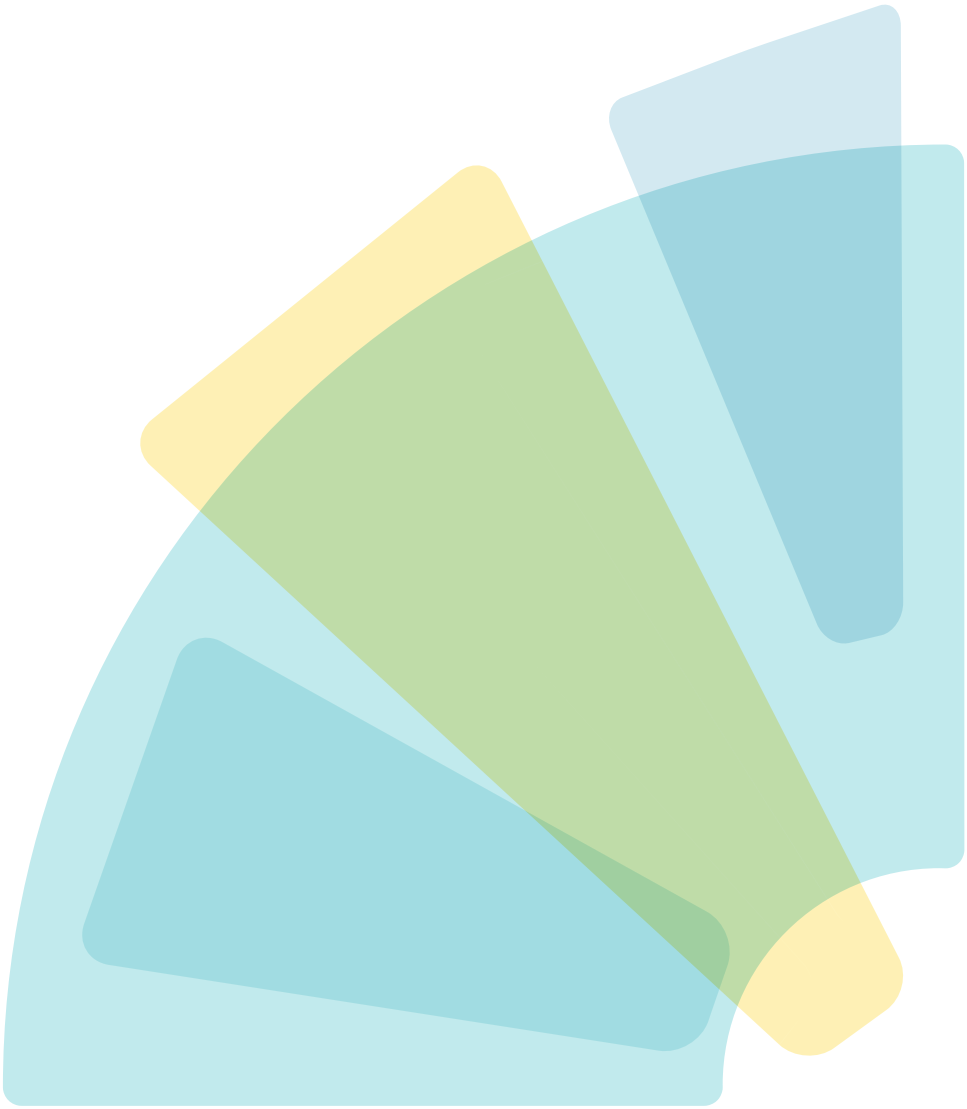
By the time someone leaves hospital they should know:

- how to contact relevant services
- what treatment will be provided

- What services will be provided and when and the cost of these
- how to use any equipment needed
- What, and how, medication will be given

If required, the person you care for may be referred to the Short Term Assessment and Re-ablement Team (START) for assessment of social care needs. This team supports all discharges from both the BGH and local community hospitals by assessing patients to ensure they are able to return home safely. They will provide support at home if required. If it is felt that the risks of returning home are too great, they will work with the patient and their family/carer to find an appropriate alternative.

"It's so important knowing that there is someone to turn to and someone who can take all the practicalities off your hands so that you can get on with the looking after"



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