Let's Get You Home

Sleep in your own bed...

have a nap in your favourite chair...

eat at your own table

Home is the best place to recover, the best place to decide on your next steps – away from a busy hospital and unfamiliar settings and people.

We can help you get home by setting you up with the support you need to be independent for as long as possible.

Take charge of your discharge...

fraserhealth

Better health.
Best in health care.

Fraser Health has many supports in place in the community to help those with chronic conditions to stay well at home and avoid coming to hospital.

But sometimes you cannot avoid admission to hospital. Seniors will likely recover more slowly than younger people. Evidence shows that leaving hospital as soon as possible and recuperating at home with home supports and community services is better than waiting in hospital to fully regain your strength before returning home.

On the following pages, we have provided some advice to help you and your family participate in planning your return home as soon as possible after a hospital stay.

If you have questions, please ask any member of your health care team.

Marjorie's Story

'Marjorie' is a lively 80-year-old with a history of rheumatoid arthritis who lived on her own with her pet cat. One day she had a stroke at home. She had the Lifeline service and was able to call for help and an ambulance took her to the Emergency department of a nearby hospital. Her daughter 'Sara' was called and arrived right away.

The health care team treated Marjorie in Emergency until she was stable and she waited for a bed on a ward. After two weeks, Marjorie was medically stable but the stroke had left her with the use of only one hand and arm.

Sara wondered if Marjorie should go to a residential care facility. She worried about how her mother could stay at home alone. But Marjorie insisted she wanted to go home. Her care team knew she would need a lot of help to get around as well as to prepare meals. But they assured Sara that

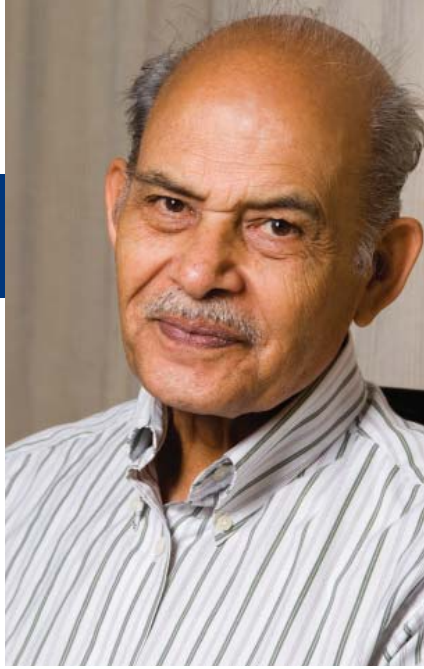
Marjorie could be cared for at home where her quality of life would be highest.

Preparations began and the community team went into action. The community rehabilitation staff did a home assessment for adaptive devices to help Marjorie transfer on and off the toilet and move throughout her home. Marjorie would also be attending an outpatient rehab program.

Marjorie was discharged home after a two-week hospital stay. She was thrilled to be in her own home and see her cat again. A community health worker would come to her house every day to assist her with bathing, grooming and dressing. And a community case manager would provide other assistance to Marjorie and Sara as needed. Home support services would be adjusted regularly based on Marjorie's level of recovery, her care needs and caregiver support plans.

Marjorie was able to live at home for two more years until she could no longer manage safely. She was assessed at home for publicly funded residential care and her daughter helped move her and sell her home and belongings according to plans they had made together.

Take charge of your discharge



Sometimes you cannot avoid admission to hospital. When you are admitted, the health care team will work with you and your family to begin planning for your discharge. They will be checking your progress every day and will provide an estimated date of discharge.

We know that the longer a senior stays in a hospital bed, the more likely it is that he or she may:

- lose the ability to walk as well as before
- fall in the unfamiliar setting
- lose the ability to think as well as before
- lose general muscle tone, strength and energy
- acquire an infection more easily

Therefore, your goal should be to go home as soon as your health care team assures you that the acute phase of your illness is over. Regaining your strength and energy may take longer, especially if you are a senior and have chronic conditions.

Depending on why you were admitted to hospital in the first place, you may be unable to regain your previous level of function. But that doesn't mean that you can't go home.

Returning home as soon as possible with the appropriate supports in place gives you the best chance to regain your strength and independence, even if you are not yet able to care entirely for yourself.

Sometimes you may need to be sure your health care team and your family understand that you *do* want to return home. Ask your health care team about plans to discharge you, and when you can go home. **Let your nurse know that you want to go home to recover.** You know what you can manage and how being at home to recover as fully as possible is best for you.

You may first need to spend some time in a rehabilitation or convalescent care unit to regain a bit more function before you return home. You will plan with your health care team how to address your ongoing medical and rehabilitation needs, either in another hospital unit, or at home.

By talking to you and your family, we'll start making arrangements so everything is ready for your discharge home. You'll be supported by a knowledgeable team of coordinators called the Home Health Liaisons or Quick Response Case Managers who understand how to match your needs to resources in the community.

Housing Choices

Home with support, moving to other types of housing with supports, or residential care?

We know that most people want to stay living in their own homes for as long as possible.

And the health care system is listening. Fraser Health is building more services in the community to help older adults stay healthy, stay out of hospital and stay at home.

When you were admitted to hospital, it may have appeared to your doctor that you would need to be placed in a residential care facility after you were well enough to leave hospital. However, once your medical problem has been taken care of, it may turn out that you don't need to go to residential care. Even if you require some ongoing care, you can go home with support and access to community services. Our Home Health Liaisons or Quick Response Case Managers will work with you to ensure you have the home support you need to live at home longer before considering placement in assisted living or residential care.

Ideally, you will find you are able to manage safely and can avoid the need for assisted living or residential care indefinitely.

Sometimes, the best option for you may be a residential care facility. If your doctor and care team believe that you will be unable to care for yourself at home, even with home support in place, you will be assessed for placement in residential care or an assisted living residence while you are still in hospital. However, most times you will be able to wait at home for the assessment. (See page 15)

Getting ready to go home

As soon as you no longer need to be in the hospital, you will be discharged. The Home Health Liaison or Quick Response Case Manager will assist you to arrange for home support and/or community services, such as activity programs or meal programs, as needed.

Those who choose to go to a private-pay residential care facility will also be supported to return home to make those arrangements.

Once you are back home, your local Home Health office will check in with you by phone within the week. A Home Health professional will be assigned to help you and your family to manage your care so you can live as independently as possible.

If your care needs are long term, you may be assigned a Home Health Case Manager who will help to link you with other community or

Home Health services as required and can adjust your level of support if your condition changes.

If your Case Manager believes remaining at home is unsafe for you, and you agree, you will then be assessed for publicly funded assisted living or residential care options in your community.

Based on our experience, family members who try to manage all of their loved one's needs without assistance from community support services can easily become exhausted and unable to provide further care. If caregivers receive assistance, they can extend the time that they can provide support to their loved one. The longer they can do that, the longer that loved one is able to stay at home. Care provided by family members is not a substitute for formal home support.

What kind of support is available?

- Regular visits by a community health worker to provide personal care such as bathing, toileting, grooming, or dressing and helping you manage your medications, if necessary
- Assistance with caring for post-surgery wounds by a nurse in a community clinic or, if necessary, at home
- Visits by a community health worker to give a break to family members who may be providing some of your care

- Physiotherapists and occupational therapists to provide short-term rehabilitation services plus home safety assessment and education
- Referral to a day program in the community, where a variety of activities take place in a group setting and where program workers can monitor the mental and physical status of participants
- Continuing rehabilitation through day programs, outpatient services, or referral to private clinics in the community
- Visits from your own support networks of family, friends and neighbours
- Referral to United Way's Better at Home program that helps seniors with simple day to day tasks
- Referral to meal programs such as Meals on Wheels, frozen meal delivery programs
- Referral to the Red Cross equipment loan program
- Private housekeeping services (Yellow Pages, Internet, bulletin boards at local seniors' centres)
- Lifeline Program for 24-hour personal emergency response system
- Referral to 2-1-1 to access community, social or government services in your area

How much do Home Health care services cost?

Depending on your income, there may be a charge for home support services supplied by Fraser Health or one of its affiliated agencies. There are provisions in place to request a temporary rate reduction if the home support rate assessed for you poses a serious financial hardship. There are no charges for professional services, such as nursing, occupational therapy, case management or rehabilitation therapy provided by Fraser Health.

Home support may be provided on either a short term, or long term basis:

- Short-Term Care services provide home support when there is a time-limited need for it – for example, after knee surgery to help with personal care, or when a client is at the end of life. There is no charge for this service. If your care needs become chronic and require ongoing home support, you will need long-term care service.

- Long-Term Care services provide home support for clients with ongoing care needs and may be subject to a charge. Client costs are based on client/spousal income and calculated as a per-day-of-service home support rate. Some clients with high charges may choose to purchase home support care privately as it can cost less than paying the assessed home support rate. Low-income clients will pay nothing.

The day arrives: Going home

When your doctor thinks you are getting close to being able to be discharged home, let your health care team and the Home Health Liaison or Quick Response Case Manager know what supports you can access to help you go home. For example, is your next door neighbour willing to pick up your groceries? Can a family member stop by to help you prepare a meal?

The sooner we get started making arrangements, the sooner you will be able to go home, once your doctor discharges you, with the necessary supports all in place.

Ask your health care team for a daily progress report. You have a right to know the plan and when you can go home.

You may be discharged at any time of the day or early evening. Hospital staff will try to give your family as much notice as possible of your projected discharge date. As soon as your physician writes the discharge order, please call your family and pack your belongings. We are not able to delay discharge times as we must immediately prepare your bed for another patient.

If family or friends are unable to take you home that day, some other options, which involve cost, include:

- Taxis
- HandyDART (advance booking required: 604-575-6600)
- Medivan (in some areas only; wheelchair accessible: 1-877-222-2031).

You may ask your nurse or a family member to help with arrangements if you are unable to do it.

Waiting at home for residential care assessment

Why is waiting at home better than waiting in hospital?

- Reduces the risk of falling in an unfamiliar setting or losing muscle strength or mobility due to spending time in a hospital bed
- Lowers the risk of acquiring an infection
- Gives you more time to recover from your hospitalization and ensures you are in the best frame of mind to make major life decisions, such as moving to residential care. These are decisions you do not want to regret by making them when you're not feeling your best
- Gives you time to put your affairs in order, sell your home, distribute your belongings to relatives and friends, before moving, if that's what is right for you

IMPORTANT: Do not change your living arrangements (such as selling your home or giving up your rental apartment) until you are sure that you will be assessed as suitable for assisted living or residential care.

Welcome Home: what now?

1. **Reconnect with your neighbours** and friends so they can support you at home as much as they are able, in both big and small ways
2. If you were registered with Home Health and had a Case Manager before going into hospital, **reconnect** with him or her
3. **Follow up with your family doctor**, by appointment or by telephone, about your recent hospitalization and your needs now that you are home
4. **Take all your current medications** to your next doctor's appointment along with any directions you received from the hospital at the time of discharge
5. **Inform your pharmacist** of your most recent medication list
6. **Call your doctor's office or dial 8-1-1** to speak to a Registered Nurse if you experience any new symptoms or recurrence of the problems that sent you to the hospital
7. Be patient with yourself as you slowly regain your strength and mobility
8. **Enjoy sleeping in your own bed!**

Ongoing care

Initial visits by a community nurse may take place in your home and ongoing visits at our clinics, if that is most appropriate. If you have not been contacted by Home Health within one week, or your condition has changed and you are concerned, please contact the Home Health Unit in your area. Numbers are listed below.

Abbotsford
103-34194 Marshall Rd
Ph: 604-556-5000

Agassiz
7243 Pioneer Avenue
Ph: 604-793-7160

Burnaby
400-4946 Canada Way
Ph: 604-918-7447

Chilliwack
45470 Menholm Rd.
Ph: 604-702-4800

Hope
1275A - 7th Avenue
Ph: 604-860-7747

Langley
101-20651 - 56 Avenue
Ph: 604-532-6500

Maple Ridge
400-11762 Laity Street
Ph: 604-476-7100

Mission
2nd Floor, 7298 Hurd Street
Ph: 604-814-5520

Newton
1009-7495 132 Street
Ph: 604-572-5340

New West
218-610 6th Street
Ph: 604-777-6700

South Delta/Ladner
4470 Clarence Taylor Cres., Delta
Ph: 604-952-3552

Surrey and North Delta
Gateway Station Tower
1500-13401 108 Avenue, Surrey
Ph: 604-953-4950

Tri-Cities
6- 2601 Lougheed Hwy., Coquitlam
Ph: 604-777-7300

White Rock
15476 Vine Street
Ph: 604-541-6800

> **“Returning home as soon as possible with the appropriate supports in place gives you the best chance to regain your strength and independence, even if you are not yet able to care entirely for yourself.”**

fraserhealth Better health. Best in health care.

www.fraserhealth.ca

This information does not replace the advice given to you by your healthcare provider.

Catalogue #432050 (July 2016)
To order: patienteduc.fraserhealth.ca