



Care1 

Hospital 2 Home: A guide for Health Care Professionals

Care1 offers a comprehensive discharge service for people with complex clinical care requirements looking to discharge from 'Hospital 2 Home'.



How we deliver a seamless Hospital 2 Home experience

Our aim is to work with you – their trusted healthcare partner – to support clients and their families to have the best transition to home experience possible.

Our specialised Care1 Hospital Transition Team work closely with your client, their family and the hospital's discharge team to create a smooth transition from Hospital 2 Home. The Care1 transition team maintains weekly in-

person or online meetings with all stakeholders to ensure all transitions are clinically safe and supportive. And aside from the practicalities, we understand that this transition can be daunting for everyone involved, so we're here to help. Whether you're a discharge planner, treating team member, case manager or other member of a client's care team, we will work with you to design the best transition program possible, based on 10 key steps.

Our 10 key steps for a better transition from Hospital 2 Home



1. Making contact

The first step is to initiate the discharge process by contacting the Care1 Hospital Transition Team on **1300 422 731** or emailing **services@care1.com.au** or via our online Hospital 2 Home referral form. We will be in touch within 24 hours to set up a meeting with the client and their discharge team to establish the next steps.



3. Agreements

Once we have all the details, a Service Agreement and Consent Form will be provided for the client and their family to review and sign before the discharge plan commences.

This ensures all parties are comfortable and aligned with the plan, timing and any other factors that need to be considered.



5. Accommodation

If the client is not transitioning back to home, Care1 can assist in arranging temporary or long-term accommodation, as well as any required support services. This may include a transition to an NDIS funded SDA property.

Care1 has relationships with many housing providers in NSW, QLD and the ACT, and can work with clients and their families to find the best solution for all parties.



2. Transition planning as a team

The Care1 Hospital Transition Team will collaborate with all key members of the hospital treating team, case managers, support coordinators, and family members to collect comprehensive patient details, assess specific clinical needs, and determine a realistic discharge timeline and plan. The initial assessment will consider things like care requirements, any funding needs (including any application processes), and housing requirements.



4. Documentation for Discharge

Relevant clinical documentation, including medical and allied health reports, behaviour support plans, medication authorities, equipment needs and client or family requests are completed as part of the Hospital 2 Home discharge process.

This information forms the basis of our commitment to person-centred and safe discharge practices.



6. Team Selection

Arguably the most important step in the process, we are committed to matching every client with a suitable team of highly skilled support staff and/or nurses, based on their qualifications and clinical experience. Support staff providing clinically complex care are always provided with 'clinical oversight' delivered by Care1 Registered Nursing staff.



7. Support Worker Introduction

Our commitment to finding the right team of support staff for every client means we offer the opportunity for parties to meet and ensure compatibility in terms of skills, personality, and interests.



9. Discharge Readiness

In the lead up to discharge, the Carel Hospital Transition Team collaborates with the client, their family, case manager, hospital discharge and treating teams through regular meetings to ensure a safe, smooth, and effective transition.

Carel staff can even provide care in the hospital prior to discharge to ensure all stakeholders are confident of the level of competence of each team member, and to allow the support team and carer to become familiar with each other.

It is important to note that all safety considerations and clinical requirements for home-based support will be addressed prior to discharge – this includes ensuring equipment is delivered and working, to ensure the most seamless experience possible.



8. Clinical Training

All support staff allocated to this program undergo specialised, client-specific training at the hospital. Training may include medication management, catheter or bowel care, ventilator management, enteral feeding management and behaviour support strategies.



10. Coming Home

The client is discharged home and home-based care and support services commence immediately. Carel can even assist with arranging transportation from Hospital 2 Home if required.

A note on post-discharge

To ensure a seamless discharge, the Carel Hospital Transition Team maintain weekly in-person or online meetings with all stakeholders. This process ensures the clients transition is clinically safe, efficient, and supported at all times. Monthly or quarterly meetings are also organised with the client as well as their family post discharge to minimise the possibility of readmission.

Need more information?

We're always happy to discuss ways in which we can better support you. Please contact us for more information:

 **1300 422 731**

 **services@carel.com.au**

 **www.carel.com.au**

