

How to make referrals or contact the Home from Hospital Service

We work closely with the Hospital discharge teams, occupational therapists and social workers to identify eligible patients who can benefit from the service who can be referred into the service through a number of routes:

- ◆ Hospital discharge or as part of a period of reablement
- ◆ GPs , social services or community health services.
- ◆ Integrated health and social care projects
- ◆ Self-referral or family referral

By phone: 020 8442 7651

Contact: Marcelle or Catherine
Referral Coordinators

By email: homefromhospital@bridgerenewaltrust.org.uk

In person: The Bridge Renewal Trust
Laurel's Healthy Living Centre
256 St Ann's Road
Tottenham
London N15 5AZ

www.bridgerenewaltrust.org.uk

Time: 10am—5pm (Daily)
FREE SERVICE

FREE

HOME FROM HOSPITAL SERVICE



About our service

The Home from Hospital service provides practical and emotional support to patients aged 18 years old and over to return home safely from hospital on discharge. We accompany the patient home and provide up to three home visits for up to four weeks after discharge to prevent unnecessary re-admissions.

Who we can help

We can help people due to be discharged from hospitals who meet the following criteria:

- Resident of Haringey and aged 18 or over
- Requiring discharge from Whittington or North Middlesex Hospitals
- Give consent or have been determined that it is in the patient's best interests to access the service
- Would benefit from practical support at home but not including personal hygiene, domestic cleaning or laundry
- Home and social situation deemed not at risk
- Able to be safe at home alone with this service
- No longer requiring acute medical care
- Money available for basic amenities (food, transport, fuel)
- At risk of hospital readmission within four weeks of discharge if no support is currently provided
- At risk of hospital admission at the point of receiving medical treatment at Hospital Accident & Emergency Service
- Worried about returning home and / or live alone and have no apparent support from family or friends

Who we cannot help

- Not Haringey resident
- Children and adults under the age of 18 years
- People with complex needs

What you will get from us

The service encourages patients to regain their independence on returning home, by providing social practical personalised support from staff and trained volunteers who will:

- Accompany patients home following hospital discharge.
- Provide three home visits within four weeks after hospital discharge.
- Supporting patients to collect pension / benefits / prescriptions.
- Practical assistance with essential food shopping .
- Assistance with contacting appropriate services to ensure residents feel safe and well with access to amenities – heating, lighting and hot water.
- Practical assistance with checking and topping up gas/electricity and paying bills.
- 'Check and chat service' – telephone calls for the first 4 weeks following discharge from hospital to check how patients are settling back in the community.
- Provide information and signposting or referrals to local community activities and local services.
- Help with making and accessing GP appointments and other health and social care appointments.
- Practical assistance with accumulated posts, completion of forms, letter writing and posting.

What we do not provide

- **Personal care**
- **Financial support including handling of patient's credit or debit cards by staff.**
- **Support to meet complex needs**