

Why do we need HAL?

HAL addresses patients' needs for logistical support at time of hospital discharge.

HAL helps remove barriers to getting home.

HAL ensures that patients in need don't leave the supportive environment of the hospital to find themselves struggling on their own.

HAL eliminates the "cold turkey" on supports that patients sometimes experience—going home is instead a "warm and welcome" experience.

HAL connects patients and family caregivers to the Community Support Service agencies that can provide additional, and if necessary, ongoing assistance to help seniors live safely and independently at home.

HAL is a referral-based service for seniors who will benefit from assistance with the logistics of the transition from hospital to home.

For more information or to make a referral please contact:

**Telephone:
613-476-0270**

**Toll free:
1-877-340-4CSS
(4277)**

www.4css.org

Regionally managed by The Prince Edward County
Community Care for Seniors Association

Funded by:



**For help
getting home
and
settling in**

*Offering safe, manageable and
positive transition from hospital to
home for seniors in need.*

**Toll Free #:
1-877-340-4CSS (4277)**



What is Home At Last (HAL)?

A program enabling smooth transition from hospital to home and supporting linkages to community.

A two-part service to assist seniors to travel home and settle in after a hospital stay.

The HAL program facilitates a return to home that is welcoming with support and reassurance from a HAL Personal Support Worker (PSW) or home support worker.

HAL workers escort patients from the hospital and assist them with settling in at home. Services include picking up food and medications on the way home, assisting with light laundry, readying sitting/sleeping area, and clarifying any discharge instructions.

HAL offers an immediate link to the **Community Support Services** that are available early on, following a hospital stay, and later as needed. Contact is made with a **Community Support Services** agency within 48 hours of settling in at home.

How is service determined?

A member of the hospital Care Team will discuss the program with patients/caregivers who fit the criteria at time of discharge planning.

The HAL program is designed for patients who are:

- able to communicate their needs to the HAL worker during the escorted transition to home;
- require minimal assistance with transfer;
- and are not infectious.

A HAL team member will follow up with the patient at home. Support is available for up to seven days if necessary, or for just a few hours, depending on the needs and preferences of the patient and where appropriate, the family caregiver.

The HAL program makes a referral to the appropriate **Community Support Service** agency.

What does the HAL program ask the patient/client to do?

- Be dressed, packed and ready to go home at the agreed-upon discharge time.
- Have house keys available or know where to pick them up.
- Communicate needs and preferences to the HAL worker throughout the transition to home.
- Have enough money for any needed groceries and/or medications to be picked up on the way home.
- Transfer in and out of vehicle, and into home, with minimal assistance.
- Participate in a brief evaluation survey with a HAL team member after receiving the service.