THE CARE PARTNER PROJECT™

How to Get the Care You Want for the People You Love

PLEASE NOTE:

If your loved one doesn't have any support for recovery at home, it is OK to say:

"This is an unsafe discharge."

The hospital is then required to hold off discharge until support care can be arranged.

CHECKLIST

TRANSITIONING FROM HOSPITAL TO HOME

Take good notes and speak up with questions. You may ask permission to record the discharge conversation on your phone, especially if you explain that you don't want to bother them with a call in case you miss an important detail.

- ☐ Ask for a meeting with a discharge planner early in your loved one's stay, ideally on Day 1.
- ☐ On the day of discharge, be sure to stay with your loved one during the entire discharge conversation. This is no time to get the car—a very common practice!
- ☐ Discuss the home environment for safety equipment that may be needed.
- ☐ Ask when the hospital stay records will be sent to your loved one's main doctor.
- ☐ Confirm follow-up doctor appointments needed (when, with which doctors).
- ☐ Cover driving limitations (if any), and any other limits, like exercise.
- ☐ Record the medications administered the day of discharge, including the time and dose.
- ☐ Ask about signs or symptoms to watch for, when to get medical attention, and if there's a hospital hotline.
- ☐ Find out if skilled care is needed. For example, speech therapy, physical therapy, occupational therapy, wound care.
- ☐ Get specifics on any diet and nutrition needs, including groceries to buy or remove from the home.
- ☐ Ask where to rent or buy any needed medical equipment or supplies. Tip: Many communities have lending programs through churches and senior centers.
- ☐ Ask if your loved one could benefit from electronic monitoring equipment, which reports info directly to the doctor.) Will hospital supply?
- ☐ Find out if follow-up tests are needed or if there are prescriptions to fill.

THE CARE PARTNER PROJECT™

Common Problems and Pitfalls at Discharge

- Discharge instructions are often confusing, incomplete, and shared by hospital staff in a rush.
- Medication instructions can be incorrect, incomplete, or not well understood by the patient or their Care Partners.
- Appointments for follow-up testing or care with the patient's doctors after discharge can fall through the cracks.
- Coordination for care and medical equipment needed following the hospital stay may be spotty or not provided at all.
- The patient may not be ready to leave (e.g., still medically fragile, the home is unsafe, the person is homeless, there is no one available to help the patient get prescriptions filled or assist with daily living needs).
- Infections picked up in the hospital may not show symptoms at discharge but will develop at home.
- The patient may not have enough help or the right kind of help coordinated to support their recovery.
- The patient's home may not be safely set up to accommodate medical equipment or physical limitations.
- Social, welfare, and medical services may not be known, coordinated, or available.
- Daily living activities can be a challenge.
- Getting proper nutrition is a worry.
- Managing responsibilities the patient may have for others may be challenging and cause anxiety.

Symptoms that Warrant Medical Help

☐ Depression, sadness, excessive sleeping, or inability to sleep

☐ Anything that seems unusual about emotions or mental alertness/thinking skills

☐ Any of these signs of infection, blood clots, heart or lung problems *(most hospital infections show up after leaving)*:

- chills
- extreme pain
- fast heartbeat
- shortness of breath
- bulging neck veins
- signs of fluid retention*
- headache/migraine
- diarrhea
- nausea
- fast breathing
- coughing
- swelling in legs or arms
- body aches
- cramps
- no appetite
- blood in urine
- oozing/red sores
- stitches
- open breaks in skin
- bumps
- rash

** puffiness or weight gain of 2+ pounds in 1-2 days*