Settling into the first week at home

A discharge plan gets its first test at home. After a meal, a trip to the bathroom or the first medicine dose, note anything that was harder than expected and tell your care team.

When you or a loved one leaves an acute care hospital, nursing and rehabilitation center or a long-term acute care (LTAC) hospital, recovery does not end. In many ways, it begins – whether you are going to another care setting or home.

Many studies have shown that the period after hospital discharge, or the transition between acute care and a less intense level of care, represents one of the times when the patient is most vulnerable.1

A family conference gives the patient, the people they choose and the care team time to review progress together. Ask what help will be needed in the next setting and which decisions remain open.

There are several important ways you can take an active role in making sure your or a loved one's discharge is not an end, but a step toward further recovery and meeting your personal objectives at the next level of care.

Plan for Leaving in Advance

- Ask your case manager what discharge resources are available. Name the practical obstacles, such as equipment, transportation or overnight help, while there is still time to address them.
- Make sure you know as much as you can about your or your loved one's illness.
- Know what medicines you will be taking and ask about how or if they might interact with medicine you were taking before you were hospitalized (or herbal medications or supplements you might have been taking). What are the possible side effects of the medication and how can those be managed?
- If you are going home, ask if you will need to make accommodations in your home for your conditions – will you need a ramp for a wheelchair? Should you remove rugs or be careful around pets that may jump?
- Make sure you have a clear plan for how you will get to your follow-up appointments if you cannot drive yourself. Ask about agencies in the community that might be able to help.
- If you are going to a skilled nursing facility, utilize information about what to look for in making your choice.
- If a family member is going to serve as a caregiver, does that person understand the demands of the position and feel prepared to undertake it?
- Understand how your information will be conveyed to the next care setting.

For a practical discharge checklist, use Medicare's planning guide to write down medicines, appointments, equipment and who to call with questions about returning home. https://www.medicare.gov/publications/11376-your-discharge-planning-checklist.pdf

Maintain Realistic Expectations

It's common for patients or their family members to expect a full return to their pre-hospital selves after a health event. However, this is sometimes not possible, and not maintaining realistic expectations about recovery can lead to disappointment and depression.

At minimum, many patients will need to make lifestyle changes to prevent the kind of event that precipitated the hospitalization from happening again. These changes may include dietary or exercise modifications. At the other end of the spectrum, many patients require extensive additional treatment, monitoring or rehabilitation. Before leaving the hospital, make sure you understand the extent of improvement that is expected to take place, and what further therapy or treatment is needed to ensure the best outcome.

Know the Pitfalls So You Can Avoid Them

Here are some of the largest challenges patients experience after leaving a medical facility:

- Medication errors (incorrect dosing, missing dosages or mixing medications that should not be mixed)
- Establishing an appropriate caregiver- Is a family member able to provide the right level of care or do you need home health services?- Is another inpatient setting needed as you move through lower levels of care?
- How will care be paid?- Does your insurance and/or Medicare cover the cost of your care?
- Did you ask the right questions?- Some patients have concerns that they are not ready for discharge. This may be valid, or it may just be nervousness about what's to come. If you have concerns, ask the hospital staff.

Patients and their loved ones can be important participants in this team process with the goal of excellent outcomes.

A safe transition depends on communication between the people leaving and receiving care. Confirm who will review each pending result, who will arrange follow-up and how to get help outside office hours.

Using the tips in this article can help you prepare for leaving a medical facility, maintain realistic expectations for your transition and know potential challenges you may face so you can create a plan to prevent them.

For questions about a possible stay, call Lakeview Admissions at (262) 534-8509. During a stay, ask the bedside nurse who can help with your question.

Study cited in the earlier article • The Seamless Transfer-of-Care Protocol, a randomized controlled trial of an electronic transfer-of-care communication tool. BMC Health Services Research, 2012, volume 12, article 414. https://doi.org/10.1186/1472-6963-12-414

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