

Discharge Planning

Adapted from <https://www.caregiver.org/hospital-discharge-planning-guide-families-and-caregivers>

A trip to the hospital can be an intimidating and stressful event for patients and their families. As a caregiver, you will be focused on your family members medical care and treatment, and so will the hospital staff. You may be thinking about what happens when your care recipient leaves the hospital and whether or not you are prepared for what comes next. You cannot assume that the hospital staff are thinking along those lines. Understand early on that you, the caregiver, may not be on the hospital staff's radar but you need to make sure when things calm down and stabilize that you start inquiring about next steps.

The way in which the transition from hospital, back to home, a rehab centre or other facility, is handled is critical to the health and well-being of both the patient and you, the caregiver.

Patients, family caregivers, and healthcare providers all play roles in maintaining the health of the patient after discharge. And although discharge planning should be a significant part of the overall care plan, there is a surprising lack of consistency in both the process and quality of discharge planning across the healthcare system.

Discharge planning is an inconsistent process that can vary from hospital to hospital. Who does it, when it is done, how it is done, what kind of follow-up is mandated, and whether caregivers are assessed for their ability to provide care, and included in discharge/transition discussions are all elements that differ from setting to setting.

Despite its benefits, which clearly increase the well-being of patients and caregivers, discharge/transition planning is often not given the attention it deserves, and indeed, ineffectual planning often serves to add to a patients and caregivers stress.

This document will look at the process of discharge in more detail by explaining some important elements, and providing caregivers with checklists to help ensure the best care for a loved one is achieved. If you are a caregiver, new to the role or not, you play an essential role in this discharge process: you are and will need to be the advocate for the patient and for yourself.

What Is Discharge Planning?

Discharge planning is “a process used to decide what a patient needs for a smooth move from one level of care to another.” The doctor is the one who will authorize a patients release from the hospital, but the actual process of discharge planning may be completed by a social worker, a discharge planning nurse, nurse, etc. Ideally, and especially for the most complicated medical conditions, discharge planning is done with a team approach.

In general, the basics of a discharge plan are:

- **Evaluation** of the patient by qualified personnel
- **Discussion** with the patient, caregiver and family
- **Planning** for homecoming or transfer to another care facility
- **Determining** what caregiver training or other support is needed
- **Referrals** to government home care programs and services, private home care agencies and/or appropriate support organizations in the community
- **Arranging** for follow-up appointments or tests

The discussion needs to include the physical condition of your family member both before and after hospitalization to better understand and assess the new needs of the patient; details of the types of care that will be required; and whether discharge will be to a facility or back to home. It also should include information on whether the patient's condition is likely to improve; what activities he or she might need help with; information on medications and diet; what extra equipment might be needed, such as a wheelchair, hospital bed, commode, or oxygen; who will handle meal preparation, transportation and chores; and possibly a referral for a government home care assessment.

Why Is Good Discharge Planning So Important?

Effective discharge planning can decrease the chances that your loved one is readmitted to the hospital, and can also help in recovery, ensure medications are prescribed and given correctly, and adequately prepare you, the caregiver, to take over your loved one's care. Having a comprehensive after care plan can also reduce the stress you, as the caregiver may be feeling as you prepare to provide possibly new or more complicated care.

Not all hospitals are successful at discharge planning. However, considering that patients are released from hospitals "quicker and sicker" than in the past, makes the importance of comprehensive discharge planning and after care preparations even more critical for the patient and the family caregivers.

Even simple measures can help immensely. For example, you should be provided a telephone number(s) accessible 24 hours a day, perhaps 8-1-1, for care information should problems arise once you return home. A follow-up appointment to see the doctor should be arranged before your loved one leaves the hospital as well as referrals for specialists or other treatments deemed necessary. Since errors with medications are frequent and potentially dangerous, a thorough review of all medications should be an essential part of discharge planning. Medications need to be "reconciled," that is, the pre-hospitalization medications compared with the post-discharge list to see that there are no duplications, omissions, or harmful side effects.

The Caregiver's Role in the Discharge Process

The discharge staff will not be familiar with all aspects of your loved ones situation. As caregiver, you are the expert in regards to your loved ones history. While you may not be a medical expert, if you've been a caregiver for a long time, you certainly know a lot about the patient and about your own abilities to provide care and a safe home setting.

The discharge planners should discuss with you your willingness and ability to provide care. You may have physical, financial, or other limitations that affect your caregiving capabilities. You may have other obligations such as a job or childcare that impact the time you have available. ***It is extremely important to tell hospital discharge staff about any and all limitations***

Some of the care your loved one requires might be quite complicated. It is essential that you get any training you need in special care techniques, such as wound, feeding tube or catheter care, procedures for a ventilator, or transferring someone from bed to chair, before you leave the hospital. Don't allow the staff to assume that you are aware of and/or comfortable performing such tasks. If needed, nursing services should be arranged with the VON before discharge.

If your loved one has memory problems caused by dementia, stroke, or another disorder, discharge planning becomes more complicated, and **you** will need to be a part of all discharge discussions and assessments. You may need to remind the staff about special care and communication techniques needed by your loved one. Even without impaired memory, older people often have hearing or vision problems or are disoriented when they are in the hospital, so that these conversations are difficult to comprehend. They may need your help and you need to be included in all care conversations.

If you or your family member is more comfortable speaking in a language other than English, an interpreter should be provided for discussions on after care and discharge. Written materials must be provided in your language as well. Studies have shown that numerous, and sometimes dangerous, errors can be made in home care when language is not taken into account at discharge.

Because people are in a hurry to leave the hospital or facility, it is easy to forget what questions to ask. We suggest you keep the questions summarized below with you, and request that the discharge planner take the time to review them with you.

Getting Help at Home

Listed below are common care responsibilities you may be handling for your family member after he or she returns home:

- Personal care: bathing, eating, dressing, toileting
- Household care: cooking, cleaning, laundry, shopping
- Healthcare: medication management, physicians appointments, physical therapy, wound treatment, injections, medical equipment and techniques
- Emotional care: companionship, meaningful activities, and conversation.

Once home, community organizations may be able to help with services such as transportation, meals, support groups, counselling, and possibly a break from your care responsibilities to allow you to rest and take care of yourself. Finding those services can take some time and several phone calls. The discharge planner should be familiar with these community supports, but if not, the staff at [Caregivers Nova Scotia](#) can assist you with access to this information.

Family and friends also might assist you with home care. If you need to hire paid in-home help, you have some decisions to make. Unfortunately, if you are not made aware before discharge that this additional home support is required you may not have enough time to engage the right provider for you and your loved ones needs. Many caregivers end up back at home and struggling to access home support services after the fact. This lag in time can create many stressful moments that need not have occurred with proper planning. This is another good reason discharge planning should start early—as the caregiver, you'll have time to research your options while your loved one is cared for in the hospital.

If home care is required and the patient is eligible the discharge planner should help you connect with Continuing Care. Continuing Care will complete a thorough assessment of the patient while in hospital and organize the care they need and qualify for before leaving hospital. You, the caregiver, should be on hand during this assessment so that you have input into the discussion, clearly understand the process and what services will be put in place to help both you and the patient once you return home. A Caregivers Nova Scotia, Caregiver Support Coordinator can help make sure you have access to all the program options that you should be aware of before leaving hospital.

Think about both your needs as a caregiver and the needs of the person you are caring for, including language and cultural background.

Discharge to a Facility

If the patient is being discharged to a rehab facility or nursing home, effective transition planning should ensure continuity of care, clarify the current state of the patients health and capabilities, review medications, and if applicable, help you select the facility to which your loved one is to be released.

Too often, however, choosing a facility can be a source of stress for families. You may have very little time and little information on which to base your decision. You might simply be given a list of facilities, and asked to choose one or you may have to accept the placement offered to you if the patient needs to be placed immediately.

Convenience is a factor to consider—you need to be able to easily get to the facility—but the quality of care is very important, and you may have to sacrifice your convenience for the sake of better care. The list of questions below will give you direction as you start your search for a facility.

Paying for Care After Discharge

If you have private insurance you should investigate what services they may cover. If something is determined by the doctor to be “medically necessary,” you may be able to get coverage for certain skilled care or equipment. Keep careful records of your conversations with insurance providers.

What if You Feel It’s Too Early for Discharge?

If you don’t agree that your loved one is ready for discharge, *you should discuss your fears, concerns* and reservations with the physician and discharge planner. There may be things that the hospital staff can do to help relieve your fears. Don't wait until you get home and feel overwhelmed and panicked. Speak up; the staff should be there to help support you as you prepare to take on this role.

Some Basic Questions for Caregivers to Ask

Questions about the illness:

- What is it and what can I expect?
- What should I watch out for?
- Will we get home care and will a nurse or therapist come to our home to work with my relative? Who pays for this service?
- How do I get advice about care, danger signs, a phone number for someone to talk to, and follow-up medical appointments?
- Have I been given information either verbally or in writing that I understand and can refer to?

- Do we need special instructions because my relative has Alzheimer's or memory loss?

What kind of care is needed?

- Bathing
- Dressing
- Eating (are there diet restrictions, e.g., soft foods only? Certain foods not allowed?)
- Personal hygiene
- Grooming
- Toileting
- Transfer (moving from bed to chair)
- Mobility (includes walking)
- Medications
- Managing symptoms (e.g., pain or nausea)
- Special equipment
- Coordinating the patient's medical care
- Transportation
- Household chores
- Taking care of finances

Questions when my relative is being discharged home:*

- How do we manage stairs?
- Will we need a ramp, handrails, grab bars?
- Are hazards such as area rugs and electric cords out of the way?
- Will we need equipment such as hospital bed, shower chair, commode, oxygen tank? Where do I get this equipment?
- Who pays for these items?
- Will we need supplies such as adult diapers, disposable gloves, skin care items? Where do I get these items?
- Will insurance/MSI pay for these?
- Do I need to hire additional help? What help might be provided to me through Continuing Care? How do I arrange for this care?

Questions about training:

- Are there special care techniques I need to learn about such as changing dressings, helping someone swallow a pill, giving injections, using special equipment?
- Have I been trained in or shown transfer skills and ways to prevent falls?
- Do I know how to turn someone in bed so he or she doesn't get bedsores?
- Who will train me?
- When will they train me?
- Can I begin the training in the hospital?

Questions when discharge is to a rehab facility or nursing home:

- How long is my relative expected to remain in the facility?
- Who will select the facility?
- Is the facility clean, well kept, quiet, a comfortable temperature?
- Does the facility have experience working with families of my culture/language?
- Does the staff speak our language?
- Is the food culturally appropriate?
- Is the building safe (smoke detectors, sprinkler system, marked exits)?
- Is the location convenient? Do I have transportation to get there?

For longer stays:

- How many staff are on duty at any given time?
- What is the staff turnover rate?
- Is there a social worker? Is there a family council?
- Do residents have safe access to the outdoors?
- Are there special facilities/programs for dementia patients?
- Are there means for families to interact with staff?
- Is the staff welcoming to families?
- What types of services will I be responsible to pay for?
- What do I do if I have an issue with staff/facility policies etc.?

Questions about medications:

- Why is this medicine prescribed? How does it work? How long will the medicine have to be taken?
- How will we know that the medicine is effective?
- Will this medicine interact with other medications? Prescription and nonprescription? Or herbal preparations that my relative is taking now?
- Should this medicine be taken with food? Are there any foods or beverages to avoid?
- Can this medicine be chewed, crushed, dissolved, or mixed with other medicines?
- What possible problems might I experience with the medicine? At what point should I report these problems?
- Will the insurance program pay for this medicine? Is there a less expensive alternative?
- Does the pharmacy provide special services such as home delivery, online refills, or medication review and counseling?

Questions about follow-up care:

- What health professionals will my family member need to see?
- Have these appointments been made? If not, whom should I call to make these appointments?
- Where will the appointment be? In an office, at home, somewhere else?
- What transportation arrangements need to be made?

- How will our regular doctor learn what happened in the hospital or rehab facility?
- Whom can I call with treatment questions? Is someone available 24 hours a day and on weekends?

Questions about finding help in the community:

- What agencies are available to help me with transportation or meals?
- What is adult day program and how do I find out about it?
- What public benefits is my relative eligible for, such as home care or Veterans Affairs services?
- Where do I start to look for such care?

Questions about my needs as a caregiver:

- Will someone come to my home to do an assessment to see if we need home modifications?
- What services will help me care for myself?
- Does my family member require help at night and if so, how will I get enough sleep?
- Are there things that are scary or uncomfortable for me to do, e.g., changing a diaper, wound care?
- What medical conditions and limitations do I have that make providing this care difficult?
- Where can I find counseling and support groups?
- How can I get a leave from my job to provide care?
- How can I get a respite (break) from care responsibilities to take care of my own healthcare and other needs?

*You viewed this article on the Caregivers Nova Scotia website www.CaregiversNS.org. For more information, contact us toll-free at 1.877.488.7338.