Jane's Home Care

FAMILY PLANNING RESOURCE

Going Home from the Hospital

A family checklist for a safe discharge. The first days home are when the most goes wrong, and when good preparation makes the biggest difference.

Why the first week matters

About one in five older adults discharged from a hospital ends up readmitted within 30 days, and many of those returns are preventable. The most common causes are missed medication changes, skipped follow-up appointments, and homes that were not ready for a person with new limitations. This checklist walks through each one before it becomes a problem.

A TIP FROM OUR CARE TEAM

Designate one family member as the discharge point person. When information passes through several people, medication changes and appointment times are the first things lost.

At the hospital, while the team is in the room

Understand the plan

- [ ] What was treated, in plain words, and what recovery should look like week by week
- [ ] A printed discharge summary, read aloud with a nurse before signing anything
- [ ] What activities are limited: driving, stairs, lifting, bathing, being alone
- [ ] Whether home health, physical therapy, or equipment was ordered, and who arranges it
- [ ] The direct phone number for questions after discharge, and the hours it is answered

Sort out the medications

- [ ] A complete written medication list: what is new, what changed dose, what stopped
- [ ] Ask specifically: should any pills already at home no longer be taken?
- [ ] New prescriptions sent to the pharmacy, and confirmation they are in stock
- [ ] First doses: what needs to be taken tonight, and with or without food
- [ ] Side effects worth a phone call versus side effects that are expected

Lock in the follow-up

- [ ] Follow-up appointment booked before leaving, ideally within 7 days
- [ ] Transportation to that appointment arranged, not assumed
- [ ] Test results still pending, and who will call with them

Plan the ride home

- [ ] Who is driving, and who helps from the car to the door
- [ ] Comfortable clothes brought to the hospital for the trip
- [ ] Prescriptions picked up on the way, not the next day

> **Do not be rushed**
>
> Discharge day is busy for hospital staff, but you are allowed to slow it down. If an instruction is unclear, ask again. If going home that day feels unsafe, say so to the discharge planner. These conversations are far easier in the hospital than from the kitchen table at 9pm.

COMING HOME

Getting the house ready

Before arrival

- [ ] Clear walking paths: rugs up, cords tucked, clutter moved
- [ ] Bed plan settled. If stairs are now hard, set up a first-floor sleeping space
- [ ] Bathroom checked: night light, non-slip mat, grab bars if ordered
- [ ] Groceries and easy meals stocked for at least the first three days
- [ ] Medical equipment delivered and tested before it is needed
- [ ] Phone, charger, water, and call list reachable from the bed or main chair

The first 72 hours

- [ ] Someone present or checking in on a set schedule, especially overnight
- [ ] New medication routine started exactly as written, with times noted
- [ ] Warning-signs list (page 4) posted where everyone can see it
- [ ] Eating, drinking, and bathroom patterns watched and noted
- [ ] Pain managed well enough to move, eat, and sleep
- [ ] Follow-up appointment confirmed on the calendar with transportation

The honest conversation about help

Most families plan the ride home and the first night. The harder question is the second week, when the casseroles stop and everyone goes back to work. Before discharge, agree on who covers mornings, evenings, errands, and nights, and decide what happens if recovery is slower than expected. Writing it down prevents the most common outcome: one person quietly absorbing all of it.

TRANSITIONAL SUPPORT

This is exactly the gap our Transitional Support service exists for: short-term, flexible care during recovery, from a few hours a day to awake overnight shifts, with a nurse practitioner led team watching for the problems this checklist describes. Care can begin within 24 hours of your call.

WATCH FOR TROUBLE

Warning signs, posted where everyone can see them

Call 911 now

- Chest pain or pressure
- Trouble breathing
- Face drooping, arm weakness, or slurred speech
- Sudden confusion or hard to wake up
- Heavy bleeding, or a fall with a head strike

Call the doctor today

- Fever over 100.4, or shaking chills
- A surgical wound that is redder, warmer, or draining
- New or worsening pain not helped by prescribed medication
- Not eating, drinking, or urinating normally
- New swelling in the legs, or sudden weight gain
- Any new medication side effect

Numbers to post next to this list

HOSPITAL DISCHARGE LINE

FAMILY POINT PERSON

PRIMARY DOCTOR

HOME HEALTH OR THERAPY AGENCY

PHARMACY

JANE'S HOME CARE

(559) 296-2189, answered by a person

FROM OUR CARE TEAM

Recovering at home should not be a solo project

Jane's Home Care is a nurse practitioner led home care agency serving Fresno, Clovis, and the surrounding Central Valley. We provide transitional support after hospital stays, from short daily visits to 24-hour care. Discharge planners and families can reach us seven days a week.

Call (559) 296-2189 or build your own care plan at **janeshomecare.com/care-plan**