

Going Home From the Hospital

Questions for you and your caregivers to ask
your care team as you get ready to leave the hospital



Ontario Health
Quality





Why is it important to talk with your hospital care team about your transition from hospital to home?

Going home from the hospital is a major step forward in your health journey, and a lot will change at this point. You'll leave your hospital routine, doctors, and the other people caring for you for care at home that could involve different people, new medication, and new instructions.

Before you leave the hospital, it's important for you and your family to talk to your doctors and other caregivers about your next steps in care. This guide supports those conversations, with questions to ask on:

- Getting a written transition plan
- Your medication
- Home and community care
- Equipment you might need
- Follow-up appointments
- You and your life: changes to your routine at home

If you don't have time to go through the entire guide, **use this checklist as a quick reference to help you ask about each topic before going home.**

Finding out as much as you can before leaving the hospital will prepare you for the next phase of healing and help you avoid complications.



Write it down, or record it

Use this guide when you talk to your care team about your transition plan.

If you can, take notes while you talk to your doctors, nurses, or other care providers about leaving the hospital. Or, ask a friend or family member to take notes for you.

If it's easier, and your care providers agree, record the conversation on your phone.

If you're a caregiver ...

You might have your own questions. And you may want to identify yourself as the patient's caregiver to their hospital care team and make sure that they know and respect your concerns.

- Let them know what your role will be in the patient's care at home
- Let them know if you're not available to provide care once the patient is home, or if you need help



Ask about: getting your written transition plan

While you're still in the hospital, your care team will create a transition plan that supports your move back home when the time is right. This document describes your diagnosis, hospital stay, and treatment, and sets out a plan for the care you need at home. You should get a copy of the plan, which is sometimes known as a patient oriented discharge summary, before you leave. This copy could be printed or electronic.

Ask your hospital care team:

- When will I be sent home? What's the earliest day I should plan for?
- Who is in charge of planning my transition home from the hospital?
- Can I have copy of my transition plan?
- Once I'm at home, who should I contact if I have questions about my transition plan?
- Will I need to change the dressing on a wound, or use new equipment on my own? And if so, who will show me how to do this before I leave the hospital?
- If I have problems, how will I know if I should go to my doctor or to the emergency room?

Tell your hospital care team:

- Who you want to include in decisions about your transition plan (like a family member or friend)
- If you don't have a place to go after leaving the hospital
- If you don't have a ride home
- If you need help getting to the lobby or to your car
- If you might need extra help or changes at home to make things more accessible (for example, if you can't climb stairs)
- If you have any other worries or concerns about leaving the hospital and managing at home



Did you know?

While you're still in hospital, your support goes beyond health care. If you would like an interpreter (so you can understand your doctor's instructions), peer support, religious services, or social workers to help you with transitions, they're available. They will work with you to help you understand your care and what to expect.



Resource: patient oriented discharge summary

The [patient oriented discharge summary \(PODS\)](#) outlines information you should be given when you leave the hospital. If your hospital is not yet using PODS in your discharge discussions, you can download and use this worksheet with your hospital care team. It was co-developed by health care professionals, caregivers, and patients like you.



Did you know?

Going home is part of the healing journey. While in hospital, your body is under extra stress: you might not sleep well, you're in bed longer than usual, and you may be in pain or overwhelmed by repeated tests or questions. It's normal to feel anxious, tired, or unwell, even after you get home. Allow yourself some time to get to feeling better.



Ask about: your medication

Once home, you might need medications. Knowing exactly why, when, and how to take them will keep your recovery on track.



Taking medication safely

The Institute for Safe Medication Practices Canada and other patient safety groups [developed a list of 5 questions](#) you can ask to help take your medications safely:

1. Have any medications been added, stopped, or changed, and why?
2. What medications do I need to keep taking, and why?
3. How do I take my medications, and for how long?
4. How will I know if my medication is working, and what side effects do I watch for?
5. Do I need any tests, and when do I book my next visit?

Ask your doctor, pharmacist, or nurse these questions while you're still in hospital.

You may also want to ask:

- Will I have enough medication to last until I can get to a pharmacy?
- Will I have pain? How should I treat it, and what should I do to manage it?
What should I do if the pain gets worse?

Tell your doctor, pharmacist, or nurse in hospital:

- About any medication you were taking before your hospital stay
- If you're worried about how to pay for medication
- If you can't get to a pharmacy
- If you are worried about managing your medication at home



Ask about: home and community care

Once home, you may need support. Home visits from a nurse, social worker, or someone to help you bathe or prepare meals can help your recovery. Or you might need other health services, like occupational therapy, physiotherapy, or respiratory therapy, either at home or in a community clinic. The more you know about what's available, the more you'll be able to get the help you need.

Ask your hospital care team:

- Will I need home care (such as at-home visits from a nurse or other health care provider) or personal support care (such as help with bathing, dressing, or cooking?) How soon and how often will I receive this help? Who will pay for these services?
- Will I need equipment, such as a hospital bed, shower chair, raised toilet seat, walker, or oxygen tank? How will I get this equipment? Who will pay for it?
- Is a home visit or phone call by a nurse or doctor an option?
- If I have problems getting the right kind of care at home when I need it, who can I call?

Tell your hospital care team:

- Whether you had home or community care services before your hospital stay
- If you need extra help taking care of yourself at home
- Whether someone will be at home to help you
- If you don't think the services offered to you are enough support



Resource: thehealthline.ca

Go to thehealthline.ca to find health and community services in your area that can support your transition, such as medical equipment, supplies, and adult day programs. You'll need to type in your city or postal code to find out what services are in your area.

If you're a caregiver ...

Caring for someone after their hospital stay means that their needs and schedules will overlap with your own. Ask the care team to let you know when the patient will leave hospital and what their care requirements will mean for you. Tell them if you have concerns about managing their care at home.

It's important to be honest with yourself about how much you can do. What are you physically, socially, and emotionally able to do to support the patient? Where do you need extra support or another person to help?

You may also have questions for the patient's hospital care providers, such as:

- What peer support groups for caregivers are available to me?
- Do you know of any workshops, family therapy sessions, or other supports for caregivers?
- Do you know of any day programs or in-home respite care that would help me to take breaks while I am caregiving?



Ask about: follow-up medical care

You might need to check in with your family doctor, hospital clinic, or other health care provider after you get home.

Before you leave the hospital, ask your hospital care team:

- Do I need to follow up with my family doctor or other health care providers once I am home? Can you book an appointment for me or give me the contact number?
- If I need to book the appointment, when should I book it? (For example, within a week, 2 weeks, or a month?)
- If I have trouble getting to this follow-up appointment, can I get help with transportation?
- What if I don't have a family doctor? Can you help me find one for my follow-up care?
- Who can I call if I have other questions or concerns about my recovery?



Ask about: you and your life

Any illness or surgery takes you away from your regular routine. Going home gets you back to familiar surroundings, but things may not get totally back to normal right away.

Ask your hospital care team:

- What symptoms are normal for my health condition? When and who should I call if symptoms aren't normal? (For example, a doctor or other health care professional?)
- How long will it take to get back to my normal routine?
- Will I be able to drive right away?
- Are there any foods I should or shouldn't eat when I get home?
- Should I start or stop certain exercises? Are there any activities I shouldn't do?

Tell your hospital care team:

- If you can't go home for safety or other reasons
- If you don't have some basic items—such as food or heat—that you need at home
- About the important parts of your life, like work or school, that you'd like to get back to



For your reference: the quality standard in brief

The Quality business unit at Ontario Health is committed to helping patients, caregivers, health care providers, and organizations improve the quality of health care in Ontario.

We know that not everyone across the province receives the right care, every time. So, to help address gaps in care, we produce quality standards that outline **what quality care looks like** for specific conditions and situations, such as transitions from hospital to home. Quality standards are based on current best evidence and input from patients, caregivers, and health care providers.

This guide for patients and caregivers accompanies the quality standard on transitions between hospital and home.

If you're interested in the quality standard, below is a summary. To read more, you can download it [here](#).

Information-Sharing on Admission

When a person is admitted to hospital, the hospital shares information about the admission with their primary care and home and community care providers, as well as any relevant specialist physicians, soon after admission via real-time electronic notification. These providers in the community then share all relevant information with the admitting team in a timely manner.

What this means for you

When you are admitted to the hospital, hospital staff should ask you:

- The name of your family doctor or nurse practitioner and any specialists
- The name of any other health care providers you have outside the hospital, such as a home care nurse or therapist, community pharmacist, or other community-based providers

The hospital should let these health care providers know you have been admitted to the hospital and give them information about the care you receive while you are there.

Your family doctor or nurse practitioner and your home or community care provider should share any important information they have about your health with the hospital. This communication will help make sure you receive the best possible care while you are in the hospital and when you leave.

Comprehensive Assessment

People receive a comprehensive assessment of their current and evolving health care and social support needs. This assessment is started early upon admission, and updated regularly throughout the hospital stay, to inform the transition plan and optimize the transition process.

What this means for you

Shortly after you are admitted to the hospital, health care professionals should ask you and your caregivers about:

- Your health
- Your ability to function at home and at school or work
- Any other issues that affect your health

This is called a comprehensive assessment. The people taking care of you in the hospital will use this information to make sure you receive the best possible care while you are in the hospital and after you return home.

Patient, Family, and Caregiver Involvement in Transition Planning

People transitioning from hospital to home are involved in transition planning and developing a written transition plan. If people consent to include them in their circle of care, family members and caregivers are also involved.

What this means for you

Before you leave the hospital, you should be involved in all decisions about your transition from hospital to home. This makes sure that your wishes, needs, and preferences are considered. If you want them to be involved, your family and caregivers can also be part of these decisions.

Patient, Family, and Caregiver Education, Training, and Support

People transitioning from hospital to home, and their families and caregivers, have the information and support they need to manage their health care needs after the hospital stay. Before transitioning from hospital to home, they are offered education and training to manage their health care needs at home, including guidance on community-based resources, medications, and medical equipment.

What this means for you

Before you leave hospital, your health care team should help you and your caregivers learn how to manage your care at home, including how to take medications and use medical equipment. Ask your care team for written instructions.

Please see pages 6 to 9 for more information on medication, home and community care, and follow-up care.

Transition Plans

People transitioning from hospital to home are given a written transition plan, developed by and agreed upon in partnership with the patient, any involved caregivers, the hospital team, and primary care and home and community care providers before leaving hospital. Transition plans are shared with the person's primary care and home and community care providers, and any relevant specialist physicians within 48 hours of discharge.

What this means for you

Your hospital health care providers should include you in decisions about your transition from hospital to home. If you agree, your family and caregivers should also be involved. Your hospital care team should:

- Create a written transition plan (for example, a patient oriented discharge summary) with you that explains everything you need to know about leaving the hospital and your care at home
- Make sure that everyone involved in your care after you leave the hospital is aware of this plan

If you agree, your family and caregivers should also get a written copy. The plan should be easy to read and understand, and your care team should offer to explain it to you.

Please see pages 4 to 9 for more information on getting a transition plan, home and community care, medication, and follow-up care.

Coordinated Transitions

People admitted to hospital have a named health care professional who is responsible for timely transition planning, coordination, and communication. Before people leave hospital, this person ensures an effective transfer of transition plans and information related to people's care.

What this means for you

When you are admitted to the hospital, a health care professional should identify the person who will plan your transition home. This person will work with you and your family and caregivers throughout your hospital stay to make sure you know what will happen and what you need to do when you return home.

Medication Review and Support

People transitioning between hospital and home have medication reviews on admission, before returning home, and once they are home. These reviews include information regarding medication reconciliation, adherence, and optimization, as well as how to use their medications and how to access their medications in the community. People's ability to afford out-of-pocket medication costs are considered, and options are provided for those unable to afford these costs.

What this means for you

When you arrive at the hospital, a health care professional should ask you and your caregivers what medications you are taking.

Before you leave the hospital, they should:

- Talk with you about any changes that have been made to your medications and why, how to take your medications, and any side effects you might experience
- Ask if you have any concerns about paying for your medications and help to find options if you aren't able to afford the cost of your medications

Once you are home again, another health care professional—like your community pharmacist, family doctor or nurse practitioner, or a home care nurse—should talk with you about your medications to make sure they fully understand your medication needs.

Coordinated Follow-Up Medical Care

People transitioning from hospital to home have follow-up medical care with their primary care provider and/or a medical specialist coordinated and booked before leaving hospital. People with no primary care provider are provided with assistance to find one.

What this means for you

Before you leave the hospital, your care team should:

- Arrange any follow-up care you need from your primary care provider or a specialist, or
- Give you clear written instructions and contact information so that you or your caregiver can book this appointment

Please see page 9 for more information on follow-up care.

Appropriate and Timely Support for Home and Community Care

People transitioning from hospital to home are assessed for the type, amount, and appropriate timing of home care and community support services they and their caregivers need. When these services are needed, they are arranged before people leave hospital and are in place when they return home.

What this means for you

If you need health care, personal support care, or assistance from other community support services once you are back home, a care coordinator should work with you and your hospital care providers to plan and arrange the services before you leave the hospital. (These services include things like home visits from a nurse, doctor, or therapist to help with your medical care, help with preparing meals or cleaning, and help with transportation to medical appointments.)

Out-of-Pocket Costs and Limits of Funded Services

People transitioning from hospital to home have their ability to pay for any out-of-pocket health care costs considered by the health care team, and information and alternatives for unaffordable costs are included in transition plans. The health care team explains to people what publicly funded services are available to them and what services they will need to pay for.

What this means for you

Before you leave the hospital, a health care professional should:

- Let you know about any health or community support services you will need once you are home again
- Explain the services and medications that require you to pay all or part of the cost, and options you can explore if you can't afford to pay for some services

What's next?

Remember, everybody is different.

The support you need and the transition plan you develop with your care providers in hospital and in the community will be unique to you.

This conversation guide is only a starting point.

You may have other topics you want to cover with your care providers. It's important to speak to them about any other questions or concerns.

Need more information?

If you have any questions or feedback about this guide, please contact us at qualitystandards@hqontario.ca or 1-866-623-6868.

For more reading on transitions between hospital and home, read the quality standard at:

hqontario.ca/qualitystandards