General Considerations for Prevention of Hospital Readmissions for people with CVP Issues checklist

- Is the patient being discharged on a holiday or weekend?
- Is the discharge information clear to the patient? Can they give a return discussion/demonstration?
- Has a caretaker been identified (i.e., family member, friend) to review discharge planning and support the patient at home?
- Is the patient able to return home or will they need a higher level of care to rehab i.e. Transitional Care Unit, Skilled Nursing care?
- If the patient is returning home is home care ordered and scheduled to come promptly i.e. within the next two days?
- If the patient is going home, has preparations been made for transportation and medications and visit with general practitioner been made and arrangements made?
- Is the patient having nutrition issues i.e. losing weight or need to gain weight? Has a dietician/nutritionist been in contact?
- Will the patient have friends/family that can provide food? How will they be nourished? Do they need liquid supplements or easy to eat food, how will that be available?
- Is the patient aware of reasons to call the doctor, nurse practitioner or PA to get in the medical system if they have temperature, yellow secretions, swollen ankles, losing or gaining weight, GI issues, pain etc.
- Is the patient living in poverty? Will they be able to afford food and medication, medical care? If so has a social worker been in contact with resources that are needed?
- Has the team communicated concerns and discharge plans?
- Have the doctors in the hospital and community had communication about the patient, change of meds, condition?
- Have the therapists planned an effective “pass off “ to the next level of care, i.e. PT in hospital call the PT at the rehab or Transitional Care unit or home care therapist?
- Are there provisions for a follow up call or several to the patient who has gone home?
- Are there provisions to follow up with a patient that missed the week follow up with their physician?
- Is there the possibility of a home visit for a high risk patient going home to assess the home situation, food and nourishment and need for therapy at home to regain strength and endurance
- Is the patient cognitively aware and knows who to call, friends, family, healthcare provider and can independently make those calls or have a caretaker that can be contacted and help?
- Is the patient depressed? Many CVP patients have depression often as they were smokers or had risk factors that weren’t addressed and feel guilty for the medical issues they are having?
- How is the family doing? Is the burden of caretaking difficult for them? Do they have support they need? Would a social worker be helpful in identifying resources?

Remember each person is an individual and his/her needs are unique. Try to understand their roles and responsibilities and whether they will be able to fulfill them. See what support the person has and what they may still need. Look particularly at issues of transportation, financial, nutrition and emotional needs of the person and family. Let them see your compassion and concern.