Hospital

a guide to staying safe

by Terry Lynch

The Centre for Welfare Reform

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Foreword

by Simon Duffy

Hospital is dangerous. It may be a necessary danger, but it is still dangerous. It is dangerous of course because it is full of people who are sick; but it is also dangerous because it is full of caring, but very busy people, who are using drugs, surgeries and other complex and risky treatments to make people better. Busy people are easily distracted, they make rapid judgements, they make mistakes and sometimes they lose sight of the very people they are there to help.

What makes this guide from Terry Lynch so important is that it doesn't blame - it focuses on creating practical solutions to keep people safe. It is obviously relevant to older Americans. Terry describes the extra challenges they face in hospital and in the US Medicare system, which funds most of this care. However all of his advice is also relevant to older people in other healthcare systems. All healthcare systems ration, all healthcare systems are under pressure and all healthcare professionals are busy and liable to make the mistakes that Terry describes.

In fact Terry's guide is useful to anyone, of any age, but especially to those of us who may be a little bit different from the norm: people with an intellectual disability, people with a physical disability, people with a mental health problem, people who don't communicate like others or people who may be upset, poor or in trouble. Hospital is dangerous for everyone, but it is particularly dangerous for people who are not fully valued or understood. As I say, hospital is dangerous - go in prepared.

This guide is also useful to professionals who work in hospital settings. This is not an attack on them - quite the opposite. It is a recognition of the natural forces at work in hospital settings. Professionals need to think about how they can work in partnership with people, their families and the wider community to make hospitals safer. This is not a job they can do alone - and Terry's guide is a perfect tool for building the right kind of trusting partnership between professionals and citizens.

This guide also has important policy implications. Too often the system tends to treat entry into hospital (always the most expensive system) as the end of other support systems. The system, in the face of all the facts, tends to assume that hospital is safe and that it cannot afford to continue to offer people on-going practical support or even income support when they are in hospital. This is a dangerous and potentially very expensive mistake. It is the community, including paid community supports, that keep people safe in hospital and ensure they can safely return home with a lower risk of readmission. We need to ensure that systems of self-directed support can move with people into hospital and can help manage a safe transition home.

Please share this guide and follow its advice for yourself and for those you love.

Introduction

The battleground: take nothing for granted

I was my mother's housemate, caregiver and advocate for 10 years. She (Leila Lynch) and I spent months in hospitals due to various crises stemming from her challenging medical conditions such as congestive heart failure and osteoporosis. Those experiences highlighted a destructive and often deadly gap in publicly funded long-term care services in the United States - the hospitalization black hole.

During the many weeks my mother spent in hospitals at various times, we learned to see them as "battlegrounds." Hospitals are where I helped her fight for her life. Our battles were frequently more difficult than they might have been because of mistakes, and misguided actions, that conspired with her illnesses to threaten her life. Our supportive services stopped at the hospital door (frequently the emergency room entrance). In my more cynical moments I would tell anyone who would listen that it felt as though we were being dismissed with: "Good luck in there. We hope you survive, return home, and don't cost us more money."

Hospital stays can be hazardous for anyone. The hazards become more daunting as we age, particularly for medically fragile older patients such as my mother who are incapable of managing their own care due to dementia or to "delirium" – otherwise known as "sudden confusion" as discussed below. My mother did survive each hospital stay and return home "at no additional cost." The keys: her indomitable spirit, my increasingly effective advocacy and the skilled support of some of the finest people I have known: the nurses, aides, rehabilitation specialists and other staff that helped my mother live to 89 and also looked out for me.

Our story eventually became an early model of self-determination for older adults and I had learned that skilled navigation of the hospital rapids was an essential building block. There are, fortunately, various relatively uncomplicated opportunities for supporting and empowering older adults to manage and benefit from hospital stays in spite of the hazards confronting them. None is more urgent than being with them as much as possible. The emphasis is on as much as possible.

Key Message

Don't leave a vulnerable person alone

I was giving a presentation to healthcare and social services professionals. The topic: avoiding unnecessary life changes resulting in older adults' loss of independence. I call these unnecessary changes the "quantum leap" – for instance, a "leap" from home to nursing home.

An audience member raised her hand and said: "I see quantum leaps all the time. I am a hospital nurse." She told us that many older people enter her hospital with illnesses or injuries from which they could recover. "They don't because they have no one to help them get back on their feet and return home."

The nurse offering this valuable perspective could have spoken for at least an hour on the difficulties associated with helping an older patient, and others, to make it out of the hospital alive and in better condition than when they were admitted.

A report by an United States healthcare advocacy organization, Healthgrades, Inc., found that there were over 700,000 "patient safety events" affecting 667,828 Medicare beneficiaries from 2007 through 2009. These events resulted in 79,670 patient deaths and cost the Medicare program nearly $7.3 billion. (Patient Safety in American Hospitals March 2011.)

The Context

The pressure of 'limited resources'

I fear that the current accelerated reductions in Medicare reimbursements to United States hospitals, associated with national deficit reduction, will increase the hazards underlying the kinds of "safety events" that generate these shocking statistics.

I was on a panel at a local meeting of the American Association of University Women. Our topic was healthcare and I was there to talk about Medicare. A participant asked me whether I thought we would soon see the rationing of medical care. I told her it was already here and illustrated it with this story:

DNR - do not resuscitate

During one of my mother's multiple hospitalizations, a nurse obtained a middle-of-the night "Do Not Resuscitate" (DNR) consent while Leila was overdosed on Demerol (a strong painkiller) and engaged in a sudden post-admission battle with congestive heart failure (CHF). The DNR was neither ethical nor legal, given my mother's confused state and that nurses are not authorized to obtain these decisions in any circumstance. Fortunately, I was Leila's agent under her Healthcare Power of Attorney delegation and had the DNR reversed once I was informed about it - five hours later.

Leila's doctor's treatment for CHF worked. One reason: he switched her to another, less potent painkiller and she was enabled to rejoin the battle. The next day I had a chance to ask several nurses, together, about the DNR. None of them seemed shocked or upset. They told me they had too often seen older patients brought back from the brink of death only to linger in a "vegetative state."

Leila had not been to her hair salon in the days before she was hospitalized. As she lay in her hospital bed, without makeup, pale, ill and disoriented, I could see how she might be mistaken for a patient who had "had it" and was ready to die. "Old, sick, crippled and confused... Who would want to go on like that?"

I told our audience it was obvious that this was not the first time there had been an illegal DNR on that unit. Medicare reimburses hospitals at flat rates for hundreds of service categories and, often, the reimbursement amount does not cover the full costs of patient care. I said that ongoing care for a patient suspended between life and death most likely poses a particularly thorny fiscal problem that can lead to questionable decision-making involving a patient's "best interest."

At the end of the panel session, a participant identified herself as a hospital administrator and asked another panel member a question. After the session, I asked the administrator why she hadn't challenged my story. "Terry, that's the least of it." I asked her about the worst of it. She smiled wanly and went on to a more innocuous topic.

This story illustrates several perils particular to the treatment of older people that can contribute to "resource conservation" practices awaiting them in United States hospitals. Among them:

- devaluation and depersonalization related to age and frailty
- uninformed judgment of quality of life and what makes life worth living
- The "institutionalization" of some hospital staff - good people whose values and perspective have been distorted in what can be a dehumanizing environment. Fortunately this experience with nursing staff was an exception among our various hospital experiences and these women turned out to be valuable allies once they got to know my mother as "Leila".
- medication overdose mistakes, common in the treatment not only of older people but people of all ages who have been hospitalized
- failure to communicate an emergency situation to the person's healthcare agent

I told a friend who was a hospital administrator in Milwaukee that, had my mom died due to the illegal DNR order, I would have gone to the local district attorney with a negligent homicide complaint against the hospital. He said he was glad that Leila and I had not been in his hospital. I asked whether he thought that Medicare reimbursement practices sometimes contributed to violations of older adults' best interests. He paused and then said, "Probably."

I "interviewed" a physician with an excellent reputation to get an idea of how he approached the treatment of Medicare patients. One of my questions: would he provide my mother with the same aggressive care he gave younger patients if her general health warranted this treatment? His answer: "It would depend on available resources." At least he was honest.

Strategies

For maximizing successful outcomes

1. Have an Advance Directive

When Leila was ill or in pain due to an injury, she was usually too confused to guide decisions regarding her healthcare. We set up a legal arrangement that enabled me to make decisions for her in those circumstances. In the United States, Health Care Power of Attorney (Health Care POA) is categorized as an "Advance Directive."

Leila's POA described specifically how she would like to be cared for in a variety of health crises. For instance, she did not want her life prolonged by emergency care or artificial life supports should she be terminally ill or in a "persistent vegetative state." Leila specified her wishes in a conversation with me guided by a discussion booklet provided by a local hospital.

The POA also empowered me to make treatment decisions in any situation for which my mother had not provided specific directions. She trusted that I would always ask: "What would Leila do if she was capable of making these decisions?" regardless of how difficult emotionally it would be for me to follow her wishes.

The other common Advance Directive is known as a Living Will, which instructs physicians on a patient's wishes in instances in which the patient is suffering from a terminal medical condition and is unable to provide informed consent regarding diagnostic and treatment options.

An Advance Directive should be seen as much more than "something to consider."

2. Have others there to look out for you

It is hard to overdo reminding patients, family and friends of this critical strategy. The likelihood of doing well in the hospital increases when you have friends and family with you as much as possible. This is especially true if you are having trouble

managing your own care. Key questions you and they should keep in mind during the initial stages of your hospitalization include:

- What is the preliminary diagnosis of the problem that hospitalized you?
- What tests are planned, if any? What is the reason for each?
- What treatment(s) has the doctor ordered, if any?
- Do the nurses and other doctors know what tests have been ordered/ treatments planned? Share this information. Do not assume they have read your records.
- If you are prescribed medications, what is the purpose of each?
- If you were taking medications at home, is each prescribed for your hospital stay? If not, why not?
- What can you do to stay as strong as possible during the hospital stay-- such as getting out of bed, walking in your room and in the hallways? Are there exercises you can do while you are in bed or sitting in the chair in your room?

3. Don't accept "old" as the only reason for anything

How well you do in the hospital depends on many things but none more important than never accepting "old":

- as a diagnosis - **always** ask for a diagnosis.
- as a reason for not treating your medical problems as they would be treated for a younger person.

4. Work on building relationships

Treat doctors, nurses and other staff with respect. It not only is the "right" thing to do. It can improve your quality of care and staff may be more likely to go out of their way for you. Do things to remind hospital staff of who you are, what your life is outside the hospital. Sometimes in the rush of hospital life it can be easy for doctors and staff to think of you more in terms of your illness or other medical problem. Just having a few personal photographs in your room, for instance of your home, family members or even a pet, can make a difference in how you are seen by hospital staff.

5. Be an active partner

Doctors, nurses, nurses' aides and other hospital staff are there to help you recover from your illness or injury and return home. You are the "customer." Don't hesitate to ask questions, make suggestions, and even complain. You deserve to be treated with respect and given the best possible care.

Being organized is likely to improve your quality of care. Keep a notebook. Keep track of as much of what has been done for you and planned for you as you can. You need to stay on top of your diagnoses, what tests you have had, what tests or procedures have been planned, what doctors have seen you and when, and your medication orders.

Be ready to tell doctors and nurses any or all of this information. Never assume anyone has told anyone else anything. For instance, if a doctor orders an x-ray and you have it done, put it in your notebook making a note of the date, what the x-ray was for and which doctor ordered it.

6. Have your personal advocates watch for delirium.

Older patients, particularly those with memory loss, are at risk of becoming suddenly confused once they enter the hospital. Delirium can be caused by illness, surgery, drug reactions, low blood pressure and low levels of oxygen in the blood. Infections of the urinary tract (UTI's) are a common cause. Just being in the hospital can cause delirium.

Making sure that an older person is alone as little as possible can help to prevent and limit the impact of delirium. Keep circumstances as familiar as possible. Bring comforting possessions from home, such as photographs, a favorite bathrobe. If the person has a vision or hearing problem, make sure hospital staff and physicians know this. Of course, treating the medical problem that brought the patient to the hospital is at the heart of the matter.

7. Make sure the things you need are where you can reach them

These things must be where you can get to them when you are in your hospital bed or the chair in your room and unless you remind the aides it often won't happen. They include:

- Call button-- the button you press that tell nurses and aides that you need some kind of help.
- The cord to the overhead light
- Telephone
- Water glass
- Glasses
- Hand sanitizer

8. Never take anything for granted

For example don't assume:

- the doctor who comes to see you has read your records or talked with other doctors responsible for your care; or even whether
- the doctor does not have you confused with another patient

It's possible that a doctor or nurse will make a mistake and plan to do tests or treatments for you that should actually be done for another patient.

9. Mine the hospital gold

I found a wealth of information during Leila's hospital stays by observing specialists and asking them questions. I told friends that some days I felt that I was going to school in the hospital. For instance, the physicians and therapists who specialized in rehabilitation medicine did not accept "old" as a reason for giving up. They saw my

mother's strengths and potential, not just her injuries and illnesses. With each new instructive experience, I became a better advocate for my mother.

No hospital staff were more important to Leila's wellbeing and my state of mind than the nurses who cared for her. Once I realized how difficult a hospital stay can be, I kept a journal. One entry summed up what the nurses meant to us: "Hospital nurses - our great information resource, my mom's advocates, my therapists."

Common Hazards

Risks and hazards you should look out for:

Doctors, nurses, nurses' aides and even visitors sometimes accidentally do things that make patients sicker and even cause their death. What follows are some additional tips on avoiding these common, particularly harmful and sometimes deadly mistakes.

1. Mistakes with medications

"Medication errors" are a dangerous and common hazard in hospitals.

Questions to keep in mind:

- Are there medications you were taking at home that have not been ordered for your hospital stay? Make sure this is not a mistake. Leila's sister, "Diane", fell and was hospitalized. She had been taking a diuretic medication to treat high blood pressure. (Diuretics flush excess water and salt from the body, lowering blood pressure.) Diane gained weight during her hospital stay. After she returned home, she continued to gain weight, and saw her physician. He found that she had retained a large amount of fluid and that her blood pressure was very high. Her diuretic had not been ordered for her hospital stay or for her return home.
- Why has the doctor ordered a particular medication? What are the potential negative side effects? Is the medication safe to take along with the others you are taking or that have been prescribed for you?
- Are you allergic to any of the prescribed medications? In one of my mother's first hospital stays, her physician didn't pay careful attention to her chart. He overlooked a note and ordered a medication that had made her very ill several years before. Fortunately, I was there to intervene.
- At what times during the day and night are you supposed to be given the medication? It is essential for a medication to be given to the patient on schedule.

- Has the nurse who is giving you the medication checked to be sure that you are the patient for whom it has been prescribed? The nurse must check your wristband first and should ask you for your name and birthdate. For family members or other advocates: if there is a change for the worse after the patient starts new medications, be sure this is not the cause.

2. Infections

Hospital infections can be very hard to treat and can be deadly. Hospitals are required to maintain comprehensive infection control procedures. Ask about these procedures. Let doctors, nurses and aides know that you are concerned about preventing a hospital-acquired infection. No one will be insulted if you ask what the procedures are for ensuring that physicians, nurses and aides wash their hands as they move from patient to patient.

Steps to prevent infections include:

- Keep your hands clean. Make sure that anyone who touches you or anything that you will touch has first used a hand sanitizer or washed their hands with soap and water. (Simply washing your hands may not offer effective protection against all bacteria that endanger hospital patients. Discuss ideal protective steps with your physician or nurse.)
- Visitors should wash their hands before entering your room. There should be a hand sanitizer near the door. Wash your hands after touching anything that a visitor has brought to you.
- Avoid shaking hands.
- Visitors should stay away if they are ill. If anyone who visits you has a cold or any other kind of illness, ask them to wear a special mask provided by the hospital.
- Use disinfectant wipes to keep surfaces clean, especially anything that you are likely to touch.
- Wash your hands before you eat anything. Hospitals can be careless about making sure patients' hands are kept clean.
- If you have had surgery, make sure that the surgical site is kept clean.

- Limit the use of catheters and be vigilant about keeping them from infecting you. A catheter is a tube that is inserted into your urinary tract to help you urinate when it is not possible to urinate normally. Catheters are a common cause of infections of the urinary tract (UTI's). UTI's often cause more serious infections. Tell your physician you would rather not have a catheter unless it is absolutely necessary. Ask every day if it may be removed and, if not, be sure everything is being done to prevent infection.

3. Pressure sores

Pressure sores or ulcers are skin breakdowns that can cause serious medical problems. They are commonly found on patients who are unable to move on their own. Ask the nurses or aides about the prevention plan and then be sure it is followed.

Prevention steps should include:

- Checking wherever moisture collects.
- Replacing wet or damp gowns/other clothing and sheets.
- Checking bony areas, including ears, back of the head, knees, heels, elbows, hip bones, tail bone.
- Having staff move you on a regular schedule whether you are in bed or in a chair.
- Moving around on your own as much as possible whether you are in bed or in a chair.
- Checking on the at-risk areas every day.

Pressure sores are high-risk problems for many people outside the hospital as well. I and my mother's aides followed many of these steps daily and she was mindful about moving around in bed and when she was sitting.

4. Injuries from falls

Falling accidents injure many patients. Risk factors include: confusion, balance problems, poor muscle strength, fatigue, low blood pressure, dizziness and problems with vision. New medications might cause balance problems and/or confusion.

To avoid falls:

- Is the call button in easy reach?
- Is there a movement sensor on the mattress that indicates when you might be standing?
- Are you wearing non-slip footwear?
- Does the plan of care include assistance with walking to the bathroom until it is clear that you can do it without help?
- Is it easy to call staff for help from the bathroom?
- Does the care plan include helping you walk as much as possible?
- Are tripping hazards out of the way?

5. Blood clots

Blood clots are blockages in your arteries or veins. At-risk patients include those with a history of clotting and patients who are obese, have diabetes, spinal cord or other serious injuries. People who have had hip, knee, abdominal or pelvic surgery are also at risk.

Some common methods for clot prevention include:

- Treating the patient with blood thinners
- Using pulsating stockings for patients when they are in bed or sitting
- Assisting the patient to walk as much as possible

There should be a written care plan for preventing clotting while in the hospital and after discharge.

6. Harm related to surgery

Be sure that:

- You have been tested to see whether you "carry" harmful bacteria that can infect the site where you will have surgery
- You have been bathed in anti-bacterial soap prior to surgery

- You are not allergic to the anaesthetic to be used in your surgical procedure
- You have been given a pre-surgery antibiotic unless the physician has a reason for not doing it.
- The surgeons and nurses know who you are. Have them check your wristband.
- The surgeons and nurses know exactly what surgical procedure is to be done and on what part of the body. For instance, if they are to operate on your left leg be sure that they were not planning on surgery on the right leg.
- You have someone with you after surgery if it is at all possible.

7. Diagnostic and treatment errors

Be there from the start

I was living in Washington. DC. My aunt called me. Leila had injured her back and was in the hospital. My aunt was with her so I thought it would be fine if I waited until the weekend. I arrived to learn that the cause of my mother's pain was a fractured hip. Leila had been on muscle relaxants for several days before the fracture was diagnosed and was barely in touch with reality. After successful surgery she was even more disoriented. During the rest of her hospital stay either my aunt or I had to be with her at mealtimes. We would put the food in her mouth and tell her when to chew.

Leila's doctor told me that her hip was healing well. The urgent question was whether she would recover from the medications' assault on her senses. Fortunately, she did. But I hadn't yet learned the most important lessons:

- *Be there from the start.*
- *Mistakes are likely, not rare*
- *Even relatively "harmless" mistakes in hospitals can generate lasting consequences for frail elders*

Instances such as these highlight that patients require a level of assistance which hospitals cannot/do not provide

Again, be there from the start

Several years later my mother fell and fractured a wrist and her pelvis. We were now together in Wisconsin but I was away on business. There had been a two-hour homecare gap and that is when she had fallen. Leila contacted neighbors using her emergency response call button. I was not around for the first two days of the hospitalization which proved to be one of the most significant mistakes I made during our time together. Her physicians missed the pelvic fracture and had her in physical therapy-- walking. On the phone, she told me she was in agony. No one listened to her, including her son.

When I finally got to the hospital an orthopedic surgeon had found the pelvic fracture.

He said it was lucky it was stable. In those situations it is not unusual for a clot to travel to a lung, with serious consequences, death being one of them. I asked him why he had taken the pelvic x-ray. "Your mother told me she hurt."

Lessons learned include:

- *Be there from the start!! Or have a smart and assertive surrogate on the job until you can get there.*
- *Don't assume accuracy of diagnosis; and*
- *Don't treat a confused older person as a second class citizen who does not have the right to be heard, taken seriously and direct his/her own care.*

Instances such as these highlight the importance of questioning providers' decisions. This can be difficult in any circumstance and particularly in crisis situations. We must do it, nevertheless.

Speaking Out

Challenging professionals is difficult but it is essential

There are many nuances to self-advocacy in institutional environments. Here are situations in which the patient or patient's advocate might be inclined to say "I'll just let this one go."

My friend "Maureen" was hospitalized with congestive heart failure. On the second day, they were ready to "wean" her off oxygen. She was taken by a nurses' aide to get an x-ray. The aide was instructed to keep her on oxygen on the way down and back. They would start oxygen reduction when she and Maureen returned. The aide didn't follow directions. As a consequence, Maureen's blood oxygen level had fallen. The weaning process had to be postponed until the next day.

Maureen told me: "I thought about saying something. Now I wish I had."

Ask questions

I was hospitalized (through the ER) due to dizziness. They ran various tests. The hospital physician decided to order another test for the next morning. The next morning, I asked a nurse about the test the doctor had ordered. "What test? There is nothing in the records." I assured her the doctor had told me she would order a test. She reluctantly called the doctor, who admitted she had forgotten and had the nurse set it up. It contributed to beneficial treatment decisions (which included balance therapy).

I wondered later how many others in my situation might have thought the doctor had changed her mind... or might have just been relieved they were spared another uncomfortable experience on a hard table... and how many times these kinds of omissions produce unfortunate outcomes.

Challenge decisions

Another time, I was in the hospital with minor cardiac difficulties. I stayed overnight and was scheduled for an a.m. angiogram and probable stent placement. I was being given IV nitrates to open my arteries and keep me safe until I received treatment. I started to experience pain that could have been artery-related or heartburn-related. The nurse called the physician in charge. He told her to try heartburn medications and if they didn't work she should then increase the nitrate dosage.

A former intensive care hospital nurse was visiting me. We exchanged frowns. I asked my nurse why they were not increasing the nitrate dosage first. If I was experiencing heart-related pain, I, and they, would not want to find it out the hard way. My friend reinforced the sentiment. The nurse nodded and reversed the order. My discomfort subsided.

If I had expired, as they say in hospital land, this would probably not have been reported as a hospital error. How many situations like these - where important decisions defy common sense and go unchallenged, injure or kill hospital patients?

Avoiding Decline

A hospital trip should not lead to an inevitable decline

There are various studies on harmful aspects of even relatively short hospitalizations that are not counted in the accidental harm data. Older patients, particularly those hospitalized in an already weakened state, are at high risk for returning home permanently more dependent on medical and long-term care services.

Older people can experience functional decline in a very short time. The focus of care usually is treating the primary medical problem(s) requiring hospitalization and discharging the patient as soon as possible. Little attention is paid to maintaining strength and mobility or to "vulnerability to hospital- associated complications" such as delirium, pressure ulcers, infections and adverse drug reactions. My mother's experience with potentially life-changing cognitive problems, related to inappropriately prescribed muscle relaxants, is a prime example.

I and Leila were fortunate that I could do much of my work "on site" when she was hospitalized. I also was able to bring our personal care workers into the hospital to help her when I was not there. We would help her walk and move around as much as possible. We were often with her at mealtime. Hospital dieticians created tasty high-octane puddings that my mother ate between meals. Friends and neighbors visited her.

This kind of support was essential to helping Leila remain as strong and engaged in life as possible. She suffered delirium twice, but switching pain medications and reducing dosage was the key in one instance and just giving her lots of attention and keeping life as "normal" as possible helped somewhat in the other. (The muscle relaxant episode.) Getting Leila back home was the ultimate solution.

Several times I asked hospital physicians to order respiratory therapy even though Leila was not there primarily for breathing problems. We worked on helping her maintain as much lung capacity as possible at home. Why not professional assistance in the hospital?

Recent research underscores my mother's good fortune.—The findings show that delirium is more intractable in many instances than we had realized. It frequently has long-lasting post-hospitalization impact.

Hospitals focused on improving geriatric care develop functional capacity maintenance plans at admission, with significant and hopeful results post-discharge.

Getting Home Safely

Be prepared, be very prepared

Many Medicare patients do not do well after leaving the hospital. Approximately 20% return to the hospital (are re-admitted) within 30 days, often because of problems that could have been avoided with careful planning and by following the plan once they went home.

Projects focused on reducing readmissions have found that simply following up with the patient post-discharge can sharply reduce re-admissions. One or two phone conversations can make the difference.

1. Commonalities among 30 day re-hospitalizations

- Limited in-home care
- Failure to keep medical appointments
- Medications errors at and after discharge
- Poor communication with doctors
- Misunderstanding of doctor conversations
- The previous admission was through the ER
- Delirium (often related to hospital stays)
- Increased functional dependence while in the hospital
- Dementia
- Lack of social supports at home
- Living alone
- Lack of transportation
- Depression
- Cultural differences
- Failure to follow the hospital care plan
- Poor care plan

2. Keys to getting discharge planning right

Hospitals are required to give you a discharge plan to take with you. If you are not given one, remind a nurse or aide that it still needs to be done. Before you leave, a nurse or social worker is required to read through the plan with you. Do not leave until this planning conversation occurs and until you understand it. Again, it is ideal to have a friend or family member with you for this discussion.

Whether or not the plan covers the following questions, be sure you know the answers before leaving the hospital.

While you were in the hospital

- What were the medical problems that caused your hospital stay?
- What treatments did you receive?
- What medications were you taking?
- Are there concerns about your health that are related to your time in the hospital (for instance loss of muscle strength?)

For when you return home

- What are the health problems for which you need care and what are the treatments you are to receive for each? Do these treatments cover problems that began during the hospital stay (again, for instance, loss of muscle strength)?
- Has a follow-up appointment with a physician been scheduled?
- What warning signs could indicate complications related to your treatment, medical condition or specifically to your hospital stay, such as a hospital-acquired infection?
- What should you do when you notice these signs? Go to the emergency room? Call a physician?
- Are there activities you should avoid or be especially careful with at home?
- What is the best diet to follow? Are there fluid restrictions?
- If you do not drive who can you call to get you to medical appointments?

Medications

- What medications will you be taking after you are discharged?
- What is the purpose of each? Can you be certain that there will be little chance of harmful interactions or side effects?
- Are you allergic to any of the prescribed medications?
- Has the hospital sent the prescriptions to the pharmacy that is most convenient for you?
- If you will not be taking some of the medications you were taking at home before you were hospitalized, is this an error?
- If some of your medications require periodic testing, what is the plan to make sure that happens?

Be sure you have a list of these prescribed medications and a list of those you were taking in the hospital.

In-home help

If you are going to need help when you get home:

- Is homecare set up for you?
- What kind of help has been planned? Does it include physical therapy? If not, why not?
- If you are going to need immediate assistance, has that been set up?
- What is the agency?
- What is the schedule?
- Who is the person to contact and what is the telephone number?
- Who is going to make sure that help is provided as soon as you get home?
- If you are going to need medical equipment when you get home, has that been planned for?
- What other kinds of supplies or personal items might you need when you get home? Are they covered by Medicare?

At home, call your physician if you are having problems that concern you. Be sure to keep the medical appointments that were set up for you. Patients who do not keep these appointments are likely to have to return to the hospital.

Make sure you get all the help you need, if at all possible.

A "successful hospitalization" may be more difficult the next time around.

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The author of this book is an American hence the terminology and the spelling used is American.

About the Author

Terry Lynch

Terry Lynch is the owner of Strategies for Independent Aging LLC, located in Racine, Wisconsin, USA. Terry has been a Fellow of The Centre for Welfare Reform since 2010. His unique strategies for supporting, personalizing and protecting the rights of older people are presented in his ground-breaking book *But I Don't Want Eldercare!* His powerful essay *Keep the Flame Burning* and other material are published by The Centre for Welfare Reform.

Terry has been promoting the independent living cause since 1977, when he served as Assistant to the Director of the White House Conference on Individuals with Disabilities. He then managed a federal government disability rights program and had a key role in the establishment of the National Disability Rights Network.

Terry returned to Wisconsin in 1985 to begin his consulting and speaking business. He soon began living his work. For 10 years Terry helped his mother remain at home, in control of a meaningful life, overcoming challenging medical problems and a life-changing memory disorder. His writing and his work in the self-determination movement are founded on this illuminating personal experience, as well as his work with other families.

Terry is a founding member of In Control Wisconsin and is Chair of the Wisconsin Board on Aging and Long-term Care. He is assisting The Management Group with designing and implementing an older adult empowerment initiative within Wisconsin's IRIS program. The IRIS mission is to empower older adults and adults with disabilities to create meaningful lives in their communities.

Terry can be contacted through his Strategies for Independent Aging LLC website: www.agingindependence.com and via facebook: Terry Lynch Aging Strategies

The Centre for Welfare Reform

The Centre for Welfare Reform is an independent research and development network. Its aim is to transform the current welfare state so that it supports citizenship, family and community. It works by developing and sharing social innovations and influencing government and society to achieve necessary reforms. To find out more go to www.centreforwelfarereform.org

We produce a monthly email newsletter, if you would like to subscribe to the list please visit: bit.ly/CfWR-subscribe

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About TMG

Over the last 30 years, The Management Group, Inc. (TMG) has led the vanguard of community-based long term care self-determination movements in the United States. By partnering directly with citizens, advocates, the Wisconsin Department of Health Services, and the National Center for Self-Determination, TMG helped implement the innovative Wisconsin IRIS (Include, Respect, I Self-Direct) program. IRIS offers the option for elderly and disabled Wisconsin citizens to manage a personal budget and self-direct the supports and services that are essential to achieving a meaningful life and valued social roles.

TMG's Mission "Empowering People to Create Meaningful Lives in Their Communites" defines and drives the company's work to develop and implement sustainable programs rooted in the core principles of community living and self-determination.

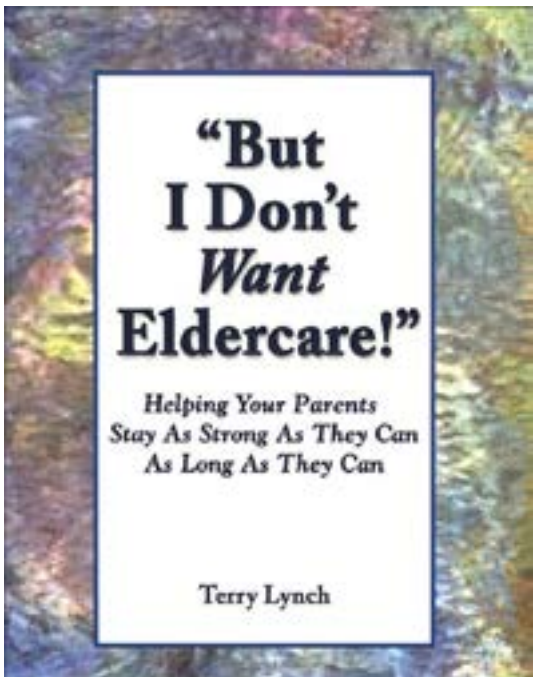
TMG's goal is to deliver on the promise of its mission by centering all its activities around the:

Mission: In order to empower people to create meaningful lives in their communities, TMG has a responsibility to Inform, Inspire, and Innovate through its core values – Learning, Inclusion, and Empowerment.

Method: TMG's role is to be a partner with each person in IRIS, by first seeking to understand each person's goals, abilities, and strengths and then illuminating the pathways towards achieving those goals. TMG understands that life is a journey, not a destination, and we travel alongside people, every step of the way.

Measure: TMG measures its success by working with each person to make the best possible use of all their assets and strengths to achieve the life they seek.

Find out more about TMG www.tmg-wis.com



This book tackles head on the powerful myths and discriminatory attitudes that underlie one of the unspoken moral disasters of contemporary life: that so many older people die, before their time, cut off from their family and their homes, unhappy and alone.

But I Don't Want Eldercare! is the recipient of a 2010 Caregiver Friendly Award and the JPX Media International Book Award in the category of Health and Aging.

Available in paperback or for your Kindle HERE

The Centre for Welfare Reform