UW Medicine
UNIVERSITY OF WASHINGTON MEDICAL CENTER

Your Hospital Stay at UWMC

About your care team and getting ready for discharge

This handout explains who will be caring for you during your stay at UWMC. It includes a "discharge checklist" to help you prepare to leave the hospital.

Who is on my care team, and what will they do?

While you are in the hospital, your care team will include medical staff, consultants, unit staff, and allied health professionals. Your care team will:

- Provide your care during your stay
- Make sure you know what the goals are for your stay
- Prepare you for your next steps when you leave the hospital

Your attending doctor will direct your care.

Your Medical Team

The medical providers listed below are your main care team. They will visit you every day and create your plan of care:

- An **attending doctor** (*attending physician*) directs and monitors your care. This doctor also oversees and trains resident doctors.
- **Resident doctors** have graduated from medical school and are licensed to practice medicine. Your resident doctor will work with your attending doctor to help make decisions about your care. You may receive care from an *intern* (who is in their first year of training), a *senior resident*, or a *chief resident*.
- A **medical student** works closely with a resident to learn about caring for patients in the hospital.
- **Registered nurses** provide your nursing care while you are in the hospital. You will meet many nurses during your stay.
- **Advanced practice providers** (APPs) have received advanced training and may help manage your care. Your APPs may be nurse practitioners or physician assistants.

UWMC Patient Care Services
1959 N.E. Pacific St., Seattle, WA 98195

A patient services specialist is one of many people on your unit team.

Consultants

Consultants are specialists who work with your main care team when you have certain health concerns. For example, your care team might consult with a *hepatologist* on liver issues, a *cardiologist* on heart issues, or a *pulmonologist* on lung issues. There are also consulting teams, such as the Palliative Care Team, that may provide an extra layer of support for patients with serious illness.

If your care team calls in consultants, they will visit you one at a time. Please be patient if a consultant asks the same questions that the medical providers on your main care team have asked. Consultants need to gather their information directly from you.

After a consultant visits you, they will talk with your medical team. They may suggest additions or changes to your plan of care.

Unit Team

- A **patient care technician (PCT)** helps your nurse with your care. A PCT may take your vital signs (such as pulse, temperature, and blood pressure), help you bathe, or take you for a walk on the unit.
- A **charge nurse** oversees the nursing staff for your unit. This nurse is responsible for making sure you are receiving excellent care. There is a charge nurse on every unit for every shift.
- A **patient services specialist (PSS)** coordinates and oversees clerical work at the front desk on the unit. A PSS can answer basic questions and validate parking.

Allied Health Professionals

These staff members may also visit you while you are in the hospital:

- **Pharmacists** teach doctors, nurses, and patients about the uses, doses, and effects of medicines.
- **Dietitians** assess your dietary needs. They will explain any changes you need to make in your diet when you go home.
- **Therapists** include physical, occupational, and speech therapists. These staff will assess your ability to move, do daily tasks, and swallow or speak. They then work with you to help improve these abilities.
- **Respiratory therapists** assess your breathing. They may provide therapy to help improve your breathing.
- **Social workers** can help find resources to ensure that the practical and emotional needs of you and your family are met while you are in the hospital. They can also help you prepare for discharge.
- **Spiritual care providers** offer respectful spiritual and emotional care to people of all faiths and beliefs.

Your care team will advise you on where to go after you leave the hospital.

Where will I go after I leave the hospital?

Your care team will assess you every day. Based on their findings, these are some of the places they may advise you to go after discharge:

- Home (self-care)
- Home with support services
- Skilled nursing facility (SNF)
- Inpatient rehabilitation hospital (IPR)
- Assisted living facility (ALF)
- Adult family home (AFH)
- Hospice

Please know that **your discharge plan may change at any time,** based on your clinical condition or new information.

Home (Self-care)

To take care of yourself at home after discharge, you must either:

- Be able to do ALL of the tasks listed below; or
- Have a reliable caregiver who can help whenever needed

To go home without support services, you must be able to do these tasks:

❑ Move and get around by yourself

❑ Feed yourself

❑ Bathe and dress yourself, go to the toilet, and do all other self-care

❑ Take care of your wounds and drains by yourself, if you have them

❑ Plan your meals, go shopping, manage your money, clean the house, do the laundry, and do other chores

❑ Manage your medicines by yourself

If you cannot do all these tasks by yourself or do not have a reliable caregiver, we will work with you before discharge to get the care you need. This may be in your home or in a care facility.

Home with Support Services

You may need support from a Home Health Care Agency for nursing or therapy services. The fees for these services may be covered by your insurance if you are "home bound." This means that either:

- Your care team advises you not to leave home because of your health condition; or
- You would need a lot of help to leave your home for any reason

If your care team tells you that you can go "home with support," you may also need to set up other services such as meal programs or paid caregivers. Ask your social worker for more information.

Skilled Nursing Facility (SNF)

A skilled nursing facility provides patients with skilled medical care, such as general physical therapy, occupational therapy, speech therapy, general wound care, and *intravenous* (IV) antibiotics. Many patients who no longer need hospital care go to a SNF before going home.

Inpatient Rehabilitation Hospital (IPR)

Patients who have a major injury, have a disease that makes them very weak, or have had a certain type of surgery may be moved to a special rehabilitation (rehab) facility when they leave the hospital. These facilities are for patients who need an intensive rehab program. Patients must be able to take part in therapy 3 hours a day.

Assisted Living Facility (ALF)

An assisted living facility is an option for adults who need only a little help with daily living and care. This special housing allows a person to be independent, but it can provide support services for an extra fee.

Adult Family Home (AFH)

Adult family homes offer a smaller, home-like setting for adults who cannot live by themselves or in an ALF. These homes offer care around the clock. They include food services and help with daily living tasks.

Hospice

When a patient is expected to live for only 6 months or less, their doctors may advise hospice care. The goal of hospice is to provide the best possible quality of life for as long as possible. Even if someone lives longer than 6 months, they can stay on hospice care.

Hospice is usually provided in the patient's home, but some patients need around-the-clock care in a hospice facility.

You can choose to leave hospice care at any time.

Discharge Day

My doctor expects me to be able to leave the hospital:

Day _____

Date _____

Time _____

Questions?

Your questions are important. Call your doctor or healthcare provider if you have questions or concerns.

_____

_____

How can I help prepare for discharge?

Your care team will talk with you often about your discharge plan. To help you be ready, we are providing a "Discharge Checklist" for you to use. Please use this checklist to help you plan for your care after you leave the hospital and share it with a family member or your caregiver.

Remember: Your discharge plans may change at any time, based on your condition or new information. Be sure to tell your care team about any changes in your plans for rides and caregiver support.

Discharge Checklist

At Least 2 Days Before Discharge

I asked my care team:

- ❑ Where will I go when I'm discharged – my home, a skilled nursing facility, or somewhere else?_____
- ❑ If I'm not going home, how long can I expect to stay there?_____
- ❑ How will I get where I'm going? Do I need to arrange a ride? (If so, UWMC social workers can help with this.) _____
- ❑ What kind of care support will I need, such as friends, family, hired caregivers, or a home health service? _____
- ❑ What supplies and equipment will I need? _____
- ❑ Do I need to see my primary care provider and/or a specialist? _____

  If so, when? _____

1 to 2 Days Before Discharge

- ❑ I talked with my care team about any final tests or procedures I will need before I leave the hospital.
- ❑ My discharge location is ready for me.
- ❑ My ride is arranged.
- ❑ My caregivers are ready for me. They know my discharge plans.

Discharge Day

I talked with my care team about:

- ❑ Any discharge medicines, how to take them, and where to get them.
- ❑ How I use my new medical equipment and devices, if needed.
- ❑ What signs and symptoms I should watch for, and when I should call my doctor or nurse.
- ❑ The best phone numbers to use to reach my doctor or nurse, and what times of day to call. (See your discharge paperwork for these numbers.)

Published PFES: 2019
Clinician Review: 08/2019
Reprints on Health Online: https://healthonline.washington.edu

UWMC Patient Care Services
1959 N.E. Pacific St., Seattle, WA 98195