Hospital-to-Home Transition Checklist — *Steps for Smooth Discharge Planning*

Evidence shows that structured transitional care interventions — for example, the Care Transitions Intervention (CTI) and the Transitional Care Model (TCM) — reduce readmissions and improve outcomes when they include home visits, medication reconciliation, caregiver activation, and planned follow-up contacts. Families who participate in structured transition processes report a better understanding of care plans and fewer avoidable returns to the hospital.

Goals of a Family-Centered Transition Checklist

The check below aims to:

1. Reduce preventable complications and 30-day readmissions.
2. Ensure safe medication use and reconciliation.
3. Empower family caregivers with the information and tools they need.
4. Provide simple process measures for families

Aricares Alliance

The Hospital-to-Home Transition Checklist (Family Version)

Use this checklist as a printable guide for families. Mark items as **Completed (✓)** or **Pending (—)** and add notes.

A. Before Discharge (while still in hospital)

S/N	Guide	Check	Notes
1	**Identify a transition lead** (assign a family member or caregiver who will be the primary point of contact).	☐	
2	**Request a written discharge summary** (diagnosis, hospital course, red-flag symptoms, pending tests, and contact information from the discharging clinician).	☐	
3	**Confirm follow-up appointments** (primary care and specialist appointments scheduled within 7 days - note date/time & phone)	☐	
4	**Obtain a complete medication list** (include medication name, dose, frequency, indication, and whether it is new, changed, or stopped. Ask pharmacist to review).	☐	
5	**Arrange home services/equipment** (confirm orders for home health, home PT/OT, oxygen, supplies, or durable medical equipment and expected delivery date).	☐	
6	**Discuss mobility and fall risk** (ask for a mobility plan and equipment recommendations, e.g., walker, cane, etc.).	☐	
7	**Verify discharge transportation and immediate home readiness** (a safe place to rest, bathroom access, etc.,).	☐	
8	**Get emergency instructions** (who to call for urgent symptoms, and where to go if worsening occurs).	☐	

B. First 48 Hours After Arrival Home

Schedule a transition visit (in-person or telehealth) within 24–48 hours with the care team. Tasks:

S/N	Guide	Check	Notes
1	Confirm identity and role of the care team	☐	
2	Perform medication reconciliation and set up pill organizers.	☐	
3	Check vital signs and basic functional status (mobility, eating, toilet use).	☐	
4	Verify equipment and supplies are present and working.	☐	
5	Perform a quick home safety check (pathways, rugs, lighting).	☐	

C. Follow-Up Schedule (recommended)

S/N	Guide	Check	Notes
1	**Day 3:** phone or telehealth — symptom check, medication adherence, confirm follow-up appointment.	☐	
2	**Day 7:** in-person nurse visit or telehealth for high-risk patients — reassess vitals, wound status, and mobility.	☐	
3	**Day 14:** phone check for symptom trends and caregiver burden.	☐	
4	**Day 30:** comprehensive review of progress, medication changes, and next steps (rehab, long-term planning).	☐	

D. Medication Safety Actions

S/N	Guide	Check	Notes
1	Master medication list: keep a single current list (paper and electronic) with pictures when possible. AHRQ	☐	
2	Pharmacy coordination: confirm prescriptions have been filled and pharmacies deliver or are accessible.	☐	
3	Monitor for adverse effects: dizziness, confusion, rash, breathing issues — escalate if present.	☐	

E. Education & Support

S/N	Guide	Check	Notes
1	Know red flags: breathing trouble, chest pain, severe dizziness, inability to eat/drink, new confusion.	☐	
2	Learn specific tasks: wound care, feeding tube care, transfers (use stepwise training with return demonstration).	☐	
3	Keep written quick-reference sheets (med list, emergency numbers, who to call by problem).	☐	
4	Identify respite resources: local caregiver support or short-term services to prevent burnout.	☐	

F. Home Safety, Documentation and Communication Tools

S/N	Guide	Check	Notes
1	Install bathroom grab bars, bedside lamp, remove loose rugs, secure cords, ensure good lighting in stairs, install non-slip mats. Address each high-risk room with targeted actions.	☐	
2	Keep Care binder or digital folder: discharge summary, med list, care plan, equipment receipts, clinician contact list.	☐	
3	Keep Daily care log: vital signs, intake/output, medications given, symptoms, and clinician messages.	☐	
4	Keep Escalation log: when symptoms began, who was called, and outcomes — useful if readmission occurs.	☐	

Families and small agencies can track basic metrics to know if the transition process is working.