



TheKey to Going Home

Your Hospital-to-Home Transition Guide



Going Home Is a Transition, Not a Finish Line

Going home is an important milestone, but it is also a high-risk transition.

In the hospital, nearly every aspect of care is monitored and supported. At home, that structure changes quickly. Medications may be new, strength may be reduced, routines disrupted, and families may suddenly be responsible for noticing changes that once would have been caught by a clinical team. The first days home can have an outsized impact on recovery, safety, and the likelihood of returning to the hospital.

It is common, not a sign that something is going wrong, for someone to come home weaker, more tired, less confident, or temporarily more confused than they were before hospitalization. The task of the first days and weeks home is to treat that as the expected starting point and rebuild from there deliberately, rather than waiting for things to simply return to normal on their own.

Readmission Risk: What the Evidence Shows

1 in 8

readmitted within 30 days

1 in 4

within 180 days

For older adults, the weeks after discharge are a vulnerable period. In a 2024 national study of community-living adults age 65 and older after major surgery, nearly 1 in 8 were readmitted within 30 days, and more than 1 in 4 within 180 days. Risk was even higher among people living with frailty or probable dementia.

What drives an avoidable setback is often not a single dramatic event, but a series of smaller gaps after discharge: confusion about medications, missed follow-up care, unmanaged symptoms, reduced mobility, falls, poor nutrition or hydration, or a change in thinking or function that is not recognized early.

Every section of this guide is designed to help families **close one of those gaps**, by knowing what to watch for, what to track, and when to ask for help.

This guide helps you:

- Prepare the home before discharge
- Know what to watch for in the first days home
- Rebuild the everyday foundations recovery depends on
- Track what matters, without turning recovery into a full time data collection project
- Recognize when a change warrants a call, and when it warrants urgent care
- Walk into the follow up visit with the information the clinical team actually needs

The Balanced Care Method®

Recovery at home is shaped by more than any one task or symptom. Eating well can support strength. Better sleep can make movement, thinking, and mood easier. Staying connected and returning to familiar routines can help someone feel more like themselves again. TheKey's Balanced Care Method® brings these pieces together across six foundations (Nutrition & Hydration, Sleep, Movement, Cognitive Health, Social Connection, and Joy & Purpose) so recovery supports the whole person, not just the condition that brought them to the hospital.

Jencks, S. F., Williams, M. V., & Coleman, E. A. (2009). Rehospitalizations among patients in the Medicare fee-for-service program. *New England Journal of Medicine*, 360(14), 1418–1428.

Joo, J. Y., & Liu, M. F. (2023). Transitional care interventions for supporting frail older adults discharged from hospitals: An umbrella review. *Geriatric Nursing*, 50, 80–89.

01

Before You Leave the Hospital: Your Discharge Checklist

Understand the Plan

- ☐ I understand why the hospitalization occurred
- ☐ I understand what has changed since admission
- ☐ I know what recovery is expected to look like over the next few weeks
- ☐ I have written discharge instructions, not just a verbal summary
- ☐ I know what specific symptoms or changes the care team wants us to watch for

Medications

- ☐ I have one complete, current medication list, not several partial ones
- ☐ I know which medications are new
- ☐ I know which have changed, in dose, frequency, or form
- ☐ I know which have been stopped, and why
- ☐ I understand when and how each medication should be taken
- ☐ I know who to call with a medication question
- ☐ One person is clearly responsible for organizing medications at home

Medication questions I still have:

Follow-Up Care

- ☐ Follow up appointment(s) are actually scheduled, not just recommended
- ☐ I know which specialists need to be seen, and by when
- ☐ I know whether labs, imaging, or other tests need to be repeated
- ☐ Home health (nursing, PT, OT, speech therapy) has been arranged, if ordered
- ☐ I know when the first home health visit is expected

Home Readiness

- ☐ Needed equipment is already in the home and ready to use (walker, wheelchair, hospital bed, shower equipment, transfer equipment)
- ☐ Needed supplies are on hand (wound care, catheter/ostomy supplies, BP cuff, glucose monitor)
- ☐ Someone has been trained on any specialized care, transfers, exercises, or equipment
- ☐ Walking paths are clear and well lit
- ☐ Bathroom safety has been addressed
- ☐ Diet, fluid, activity, swallowing, or weight bearing restrictions are clearly understood

Support

- ☐ One person is responsible for the first day home
- ☐ We know whether the person can safely be left alone, and for how long
- ☐ Transportation to appointments is arranged
- ☐ We have a backup plan if the primary caregiver becomes unavailable
- ☐ We know who to call with questions after discharge, and that this is different from who to call in an emergency

02

The First 24 Hours Home

The first day is not the time to resume normal life. It is the time to establish safety, orientation, and the basics. Everything else follows from getting this part right.

-
- ☐ Fill all new prescriptions
 - ☐ Compare the discharge medication list against what is already in the home
 - ☐ Set aside anything stopped or changed until questions are resolved. Do not guess
 - ☐ Confirm tomorrow's medication schedule
 - ☐ Confirm the first follow up and home health appointments
 - ☐ Make sure mobility equipment is within reach and fitted correctly
 - ☐ Make sure glasses and hearing aids are available and functioning
 - ☐ Prepare food and fluids according to discharge instructions
 - ☐ Clear and light the path between bed, bathroom, and main living area
 - ☐ Post important phone numbers somewhere visible
 - ☐ Review, as a household, which symptoms mean call the clinical team and which mean call 911
 - ☐ Establish today's baseline (see Section 3)
-

03

Know the Starting Point

Recovery is far easier to judge against a known baseline than against a vague sense of normal. Fill this in on day one, while the hospital stay is still fresh, and use it as the reference point for every week that follows.

Before hospitalization

Walking/mobility: ☐ Independent ☐ Used a device ☐ Needed some help
☐ Needed significant help

Bathing/dressing: ☐ Independent ☐ Some help ☐ Significant help

Thinking/communication: ☐ Usual baseline ☐ Some prior cognitive change
☐ Significant cognitive support needed

Eating: ☐ Independent ☐ Needed reminders/help
☐ Significant assistance

Typical sleep: _____

Activities or routines that mattered most: _____

Today, the most noticeable changes are:

1. _____
2. _____
3. _____

Our recovery priorities right now:

- ☐ Safer mobility ☐ Strength/endurance ☐ Eating/drinking ☐ Pain control
- ☐ Sleep ☐ Thinking/alertness ☐ Personal care ☐ Medication routine
- ☐ Returning to meaningful activities
- ☐ Other: _____

04

Know When to Get Help

Start with the discharge team's individualized instructions. They supersede everything general in this guide. As a baseline: when something is meaningfully different from the person's own usual pattern, it is worth acting on, even if it seems minor.

Call 911 or Seek Emergency Care

Signs of stroke. Severe difficulty breathing. Chest pain. Loss of consciousness. Uncontrolled bleeding. A serious fall or injury. Any emergency symptom the discharge team specifically flagged.

Call the Medical Team Promptly

New or worsening confusion. A meaningful change in alertness or behavior. New or worsening shortness of breath. Fever or signs of infection. Repeated vomiting or inability to keep fluids down. Concerning wound changes. Uncontrolled or significantly worsening pain. A fall or repeated near-falls. A sudden decline in mobility or usual functioning. A significant change in eating, drinking, or urine/bowel function.

My care team specifically told me to watch for:

Who to call

Primary clinician:

Phone:

Home health:

Phone:

Specialist:

Phone:

05

Six Foundations of Recovery: The Balanced Care Method®

Recovery is not only about the condition that caused the hospitalization. It is also about rebuilding the everyday systems that hospitalization reliably disrupts, and the evidence behind each of these is specific enough to act on.

01 Nutrition & Hydration

02 Sleep

03 Movement

04 Cognitive Health

05 Social Connection

06 Joy & Purpose

Nutrition & Hydration

Illness, hospitalization, and the medications that come with both routinely blunt appetite and alter taste. Under eating and under drinking in the weeks that follow are a leading, and often overlooked, contributor to weakness, dizziness, constipation, and stalled recovery, not a separate problem from it.

This week:

- ☐ Include a protein source at meals when appropriate
- ☐ Offer smaller, more frequent meals if appetite is low
- ☐ Encourage fluids according to the medical plan
- ☐ Watch for unexpected weight change
- ☐ Report any new chewing or swallowing difficulty
- ☐ Follow prescribed sodium, fluid, carbohydrate, or texture restrictions exactly
- ☐ Other: _____

Pay Particular Attention If

- Heart failure: fluid and sodium limits are often individualized and stricter than general guidance. Follow the specific plan, and track daily weight as an early warning sign.
- Diabetes: appetite changes can destabilize glucose control even when medication doses have not changed.
- Stroke/dysphagia: confirm prescribed food texture and liquid consistency before the first home meal.
- Wounds/surgery: adequate protein and micronutrient intake measurably affects healing time.

Sleep

Hospital sleep is fragmented by design, through vitals checks, noise, and unfamiliar surroundings. That disruption to circadian rhythm does not resolve on its own the moment someone gets home. It has to be actively re-established, and doing so lowers the risk of falls, delirium, and low mood during recovery.

This week:

- ☐ Keep a fairly consistent wake time
- ☐ Get daylight exposure in the morning
- ☐ Encourage appropriate daytime activity
- ☐ Reduce unnecessary nighttime stimulation
- ☐ Note what interrupts sleep: pain, urination, breathing, restlessness, anxiety
- ☐ Raise significant daytime sedation or sleep disruption with the clinical team
- ☐ Other: _____

Movement

Muscle strength declines quickly during bed rest. Older adults can lose a meaningful share of leg strength after just a few days of hospitalization, independent of the illness that caused it. The task now is not to push hard. It is to rebuild consistently, within whatever limits the care team has set.

This week:

- ☐ Follow the PT/OT plan as written
- ☐ Use prescribed mobility equipment, even on good days
- ☐ Increase activity gradually
- ☐ Break activity into shorter periods when needed
- ☐ Track falls and near-falls, not just falls
- ☐ Follow weight bearing or activity restrictions exactly
- ☐ Other: _____

Stop and Seek Guidance For

Chest pain. Significant shortness of breath. Dizziness or fainting. Sudden weakness.
New significant pain. A meaningful decline in walking ability.

Cognitive Health

Thinking often feels less clear after hospitalization, a common and usually temporary consequence of illness, surgery, anesthesia, medication changes, sleep disruption, or delirium. Distinguishing which of these is at play changes what is worth doing about it.

This week:

- ☐ Keep a visible clock and calendar
- ☐ Maintain a simple daily routine
- ☐ Make sure glasses and hearing aids are worn, not just available
- ☐ Encourage conversation and familiar activities
- ☐ Support daytime light exposure and appropriate movement
- ☐ Note any change from the person's own usual thinking or behavior
- ☐ Other: _____

Delirium, Specifically

Delirium is a sudden or fluctuating change in attention and awareness. Clear at one point in the day, markedly confused a few hours later. That fluctuation is the key distinguishing feature: dementia progresses gradually and consistently, while delirium comes on acutely and moves.

Common contributors include infection (a urinary tract infection is a classic, easy to miss trigger), dehydration, constipation or urinary retention, uncontrolled pain, medication effects, poor sleep, sensory impairment, and unfamiliar surroundings. Nearly all of them are identifiable and treatable once suspected.

A sudden change in thinking, alertness, or behavior should never simply be assumed to be dementia or normal aging. Contact the medical team.

Inouye, S. K. (2006). Delirium in older persons. NEJM, 354(11), 1157 to 1165.

Social Connection

Recovery narrows a person's world quickly. Reduced mobility and disrupted routine can isolate someone within days, and isolation independently predicts both depression and readmission.

This week:

- ☐ Ensure at least one meaningful interaction daily
- ☐ Identify someone who can check in regularly
- ☐ Reintroduce familiar routines where possible
- ☐ Include the person in decisions about their own day and care
- ☐ Ask for help before the family reaches the point of being overwhelmed
- ☐ Other: _____

Joy & Purpose

Recovery should not reduce someone's life to a list of medical tasks. Restoring familiar roles, preferences, and small pleasures is what keeps a person oriented to themselves as a person, not just a patient, and it is associated with better engagement in everything else on this list.

This week:

- ☐ Do something enjoyable every day
- ☐ Resume one familiar routine or role
- ☐ Make time for music, a favorite program, time outdoors, cooking, gardening, reading, or another activity that is simply theirs
- ☐ Set one small, personally meaningful goal
- ☐ Other: _____

My goal this week: _____

06

When the Plan Isn't Working

What looks like noncompliance is often information. Before treating resistance as a behavior problem, it is worth asking what it is actually signaling.

If someone doesn't want to exercise, consider:

- ☐ Pain ☐ Fatigue ☐ Fear of falling ☐ Confusion ☐ Low mood
 - ☐ An exercise that feels too difficult ☐ A poor time of day
-

If someone isn't eating or drinking, consider:

- ☐ Nausea ☐ Constipation ☐ Altered taste ☐ Trouble swallowing
 - ☐ Medication side effects ☐ Low mood ☐ Foods they genuinely don't like
-

If someone is refusing help, ask:

- ☐ Are we offering choices?
- ☐ Are we preserving independence where possible?
- ☐ Does the person understand why the help is needed?
- ☐ Could a cognitive change be affecting their awareness of their own needs?
- ☐ Would a different time, approach, person, or routine work better?

07

Who Is Doing What

The transition home almost always involves more than one person. Naming responsibilities explicitly, rather than assuming they will sort themselves out, is what keeps tasks from falling through the cracks. Use the notes column to flag anything that is still unassigned or uncertain.

NEED	PERSON RESPONSIBLE	NOTES / BACKUP
Medications		
Meals/hydration		
Personal care		
Mobility/exercises		
Wound/medical care		
Appointments		
Transportation		
Overnight support		
Daily check-in		
Watching for changes		

If a row is blank, or the person filling it is stretched across too many rows, that is worth addressing before it becomes a gap in care rather than after.

Home Health and Home Care Are Different, Complementary Roles

Home health nurses and therapists deliver skilled services: nursing, physical therapy, occupational therapy, speech therapy. A professional home care caregiver supports the daily implementation of that plan: routines, mobility support, meals, hydration, personal care, engagement, and communication back to the family and care team. Most recoveries rely on both working together.

Your 7-Day Recovery Tracker

Track trends, not perfection. One week of honest, brief daily entries tells a clinician more than a page of detailed but incomplete notes.

	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6	DAY 7
Appetite: Good/Fair/Poor							
Fluids: Good/Fair/Poor*							
Sleep: Good/Fair/Poor							
Pain (0-10)							
Mobility: Better/Same/Worse							
Thinking/alertness: Baseline/Different							
Mood: Good/Okay/Low or worried							
Medications taken as planned? Y/N							
Fall or near-fall? Y/N							
New or worsening symptoms?							

*Follow any prescribed fluid restriction.

Optional clinical measures, only if instructed:

Weight: _____ Blood pressure: _____ Heart rate: _____

Blood glucose: _____ Other: _____

09

What Changed?

END-OF-WEEK REFLECTION

What improved?

What stayed the same?

What became harder?

What surprised us?

What is the person's biggest priority now?

10

Bring This Page to the Follow-Up Visit

This page is designed to be handed directly to the physician or care team. It compresses a week of home observation into what a clinician actually needs in a short visit.

Since coming home

Mobility is: ☐ Better ☐ About the same ☐ Worse

Eating/drinking is: ☐ Better ☐ About the same ☐ Worse

Sleep is: ☐ Better ☐ About the same ☐ Worse

Thinking/alertness is: ☐ At usual baseline ☐ Improving ☐ Different/worse

Pain is: ☐ Controlled ☐ Improving ☐ Still a concern

Mood is: ☐ Good/stable ☐ Some concern ☐ Significant concern

Since discharge there have been:

☐ Medication questions ☐ Missed doses ☐ Falls ☐ Near-falls

☐ New confusion ☐ Appetite/weight concerns ☐ Sleep concerns

☐ Breathing concerns ☐ Wound concerns ☐ New or worsening symptoms

Symptoms or changes I want to bring up today:

1. _____
2. _____
3. _____

Three questions we want answered today:

1. _____
2. _____
3. _____

ONE QUESTION WORTH ASKING DIRECTLY

“Based on where things stand today, what should improve next, and what change would concern you?”

Notes from this visit:

Next steps and follow-up actions:

- ☐ New or changed medication: _____
- ☐ New test, referral, or appointment ordered: _____
- ☐ Next follow-up visit scheduled for: _____
- ☐ Who to call if symptoms change before then: _____
- ☐ Other: _____



The Next 30 Days

Recovery is rarely linear. Some days will be stronger than others, and that is expected, not a warning sign on its own. What matters is the pattern over time.

- Is strength returning?
- Is the person becoming more engaged?
- Is eating or sleeping improving?
- Is thinking returning toward baseline?
- Are meaningful routines coming back?

How TheKey Can Support This Transition

This guide identifies what recovery requires. Consistently providing it, day after day, is often the harder part, especially for families who are also managing work, distance, or their own health.

TheKey's professional caregivers are trained specifically in hospital-to-home recovery: supporting the Balanced Care Method® pillars in this guide, coordinating with home health nursing and therapy, watching for the changes worth reporting, and giving families room to be family again instead of a full-time care team. Support can range from a few hours a day during the highest-risk early weeks to around-the-clock care, and can scale up or down as recovery progresses.

If any row in Section 7 is unfilled, or the first 30 days feel like more than the household can safely cover alone, that is exactly the gap TheKey is built to close.

The goal is not simply to avoid another hospital stay. It is to help someone return to the fullest, safest, and most meaningful life possible at home.