

1.1 Your discharge plan and personal recovery passport

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Patient and family education: use your own discharge instructions and clinical team. Do not change medicines, fluid limits, feeding, weight-bearing or exercise restrictions from this lesson. Assistant-prepared translations; independent clinical and native-language proofreading pending.

- Explain the discharge diagnosis and remaining uncertainties.
- Assign an owner and contact plan to pending results and appointments.
- Build a passport and practise teach-back.

Your discharge passport

1. What happened and what changed

2. Who reviews results and when

3. What to do and whom to contact

Keep it updated; the clinician's written plan governs.

Start with one understandable plan

Going home is a change in who provides care; it does not always mean that recovery is complete. This free lesson helps you turn discharge papers into practical instructions. Your treating team's written plan takes priority over general education here. If two instructions conflict, ask the hospital or responsible clinician to resolve the difference. You do not need to understand every medical abbreviation before asking for help.

Choose a person you trust to join the discussion, if you wish. Ask for explanations in your preferred language, large print, or another accessible format. Tell staff about hearing, vision, memory, reading, or communication needs. A caregiver can write notes while you listen. The patient should remain involved in decisions as much as they want and can manage.

Read the story of your hospital stay

Find your name, hospital number, admission and discharge dates, diagnosis, procedures, allergies, and discharge clinician. Ask: “What brought me into hospital? What was found? What treatment did I receive? What is still uncertain?” A working diagnosis can change when further information arrives. A test being performed does not mean that its result is already available. Ask which symptoms may be expected and which changes need help.

Keep the discharge summary, current prescription, test reports, wound or device instructions, and referral letters together. A photograph can be a useful backup, but keep a readable paper copy where possible. Share copies with the clinician taking over care. Carry them to appointments. Avoid posting documents containing personal health information in public groups.

Close the loop on tests and appointments

Write down each pending result, including a biopsy, culture, scan report, or blood test if relevant. For each, record who will review it, when it is expected, how you will receive it, and whom to contact if it has not arrived. “Nobody called” is not confirmation that a result is normal. If responsibility is unclear, ask the discharging team to name the clinician or service that will follow it up.

Record every follow-up visit: date, time, location, purpose, documents, and preparation that the clinic specifically requests. Clarify whether you must book it yourself. Do not stop medicines or fast for a test unless the responsible service instructs you to. Plan transport, accompaniment, cost, mobility support, and time away from work. If attendance is difficult, contact the service to discuss alternatives and urgency rather than silently missing the visit.

Make a personal discharge passport

Use one page or notebook with these fields: my main health problem; what changed in hospital; current medicines and allergies; pending tests with owner and expected date; next appointments; wound, device, food and movement instructions; warning signs; daytime and after-hours contacts; chosen caregiver and practical support. Add the date of the latest update. This passport is a communication aid, not an independent prescription or diagnosis.

Write three questions you still need answered. Examples are: “Who checks my dressing?”, “How do I obtain the next prescription?”, and “Whom do I call on a holiday?” Record the answer and the name of the person who gave it. Ask about necessary equipment and home help before attempting tasks that you cannot safely manage. If food, housing, money, or caregiver availability threatens the plan, tell the team; these are care needs, not personal failures.

Practise with a case

Mina returns home after treatment for an infection. Her papers mention a pending culture, but there is no clear follow-up owner. Her son adds this to the passport and calls the ward to identify the responsible clinician and expected contact date. They also confirm the clinic location and transport. They do not change treatment after reading an unfamiliar laboratory term online.

Teach-back and a final check

Explain aloud: “I was in hospital because... My next step is... This result is pending and this person will check it... If I become worse, I will...” Ask your clinician to correct anything unclear. Teach-back checks how clearly the plan was explained; it is not an examination of you. Before ending the conversation, make sure you can find your papers, medicines, contacts, and appointment details. This lesson supports communication; it cannot promise faster recovery or prevent every return to hospital.

Check your understanding

A report is pending and no one has called. What is safest?

1. Assume it is normal
2. Ask the named service; clarify who will review it
3. Cancel follow-up

Ask the named service; clarify who will review it

No call does not establish a normal result. Confirm the reviewer and contact plan.

Sources

<https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/redtool3.html>

<https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/redtool3a.html>

<https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/redtool5.html>

<https://www.nhs.uk/nhs-services/hospitals/going-into-hospital/being-discharged-from-hospital/>