

**DISCHARGE
PLANNING
TOOLKIT**

**This toolkit is offered by The Beacon Institute through a grant
from the Maryland Office of Health Care Quality**

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Health Conditions

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DISCHARGE PLANNING TOOLKIT INTRODUCTION

Discharge planning involves a coordinated effort between the patient/resident, caregiving professionals, family members, and community supports. It is intended to smooth the transition from facility care to a home setting, or alternate facility. Increased attention is being focused at discharge processes due to post-discharge complications and re-admissions. According to literature reports:

- 20% of patients experience adverse events within 30 days of discharge from hospitals
- 18% of Medicare patients are readmitted within 30 days of discharge
- 40% of patients > 65 years old experience post-discharge medication errors
- 30% of nursing homes have been found to be non-compliant with the requirements for discharge planning

In November of 2017, new requirements for discharge planning became effective with the implementation of the new Mega Rule. It is important for facilities to review their current discharge planning processes and make revisions as necessary for regulatory compliance and for improved quality. These new requirements place increased emphasis on patient goals and preferences, and preparations to coordinate appropriate supports to meet those goals.

Post-discharge needs are often multi-factorial, and often include education of the resident and family on health conditions, medications, and follow-up care. Support services may involve both clinical and non-clinical services and be directed at not only the patient, but family caregivers as well. Special attention must also be given to assess the readiness of the family to assume the caregiving role and the impact that caregiving will have.

Because of the number and variety of activities that must be carried out, and the number of people/disciplines involved, quality improvement initiatives for discharge planning strongly recommend the use of checklists and tools to assure that all needs have been addressed. The purpose of this toolkit is to provide practical information and resources to facilitate and support facility efforts to meet discharge planning needs.

**SECTION I:
STAFF RESOURCES**

NEW REQUIREMENTS FOR DISCHARGE PLANNING

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483.21(c) (1) Discharge Planning Process

The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners, and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set for at 483.15(b) as applicable, and –

- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident*
- (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect those changes.*
- (iii) Involve the interdisciplinary team, as defined by 483.21 (b) (2) (ii), in the ongoing process of developing the discharge plan*
- (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.*
- (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan*
- (vi) Address the resident's goals of care and treatment preferences.*
- (vii) Document that the resident has been asked about their interest in receiving information regarding returning to the community.*
 - (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.*
 - (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local agencies or other appropriate entities.*
 - (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.*
- (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF (skilled nursing facility), HHA (home health agency), IRF (inpatient rehab facility), or LTCH (long-term care hospital) standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data*

on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.

- (ix) *Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident discharge or transfer.*

Key Points from Interpretive Guidelines for 483.21 (c) (1) Discharge Planning Process

- The discharge care plan is part of the comprehensive care plan and must:
 - Be developed by the interdisciplinary team
 - Involve direct communication with resident (and/or resident's representative)
 - Identify needs that must be addressed prior to discharge (such as education, rehabilitation, caregiver support/education)
 - Be re-evaluated regularly and updated when the resident's needs or goals change
 - Document resident's interest in, and any referrals made to local agencies
 - Identify post-discharge needs (nursing, therapy services, medical equipment, modifications to the home, ADL assistance)
- For residents who want to be discharged to the community
 - Family members, significant others or the resident's representative should be involved in this determination (with the resident's permission), unless the resident is unable to participate in the discharge planning process
 - The nursing home is responsible for making referrals
 - The resident, and if applicable, the resident's representative, should be made aware that the local ombudsman is available to provide information and assist with any transitions from the nursing home.
- For those who want to be discharged to another SNF, HHA, IRF, or LTCH the facility must:
 - Provide assistance in finding an appropriate provider that will meet the resident's needs, goals, and preferences
 - Provide publicly available standardized quality data (such as CMS Nursing Home Compare), and resource use data as available (example – number of residents discharged, preventable infection rates, etc.) and guidance in helping the resident/family understand data

PROCEDURE/CHECKLIST FOR DISCHARGE PLANNING

TASK	DATE	INITIAL	LOCATION OF INFORMATION
Explore/document the resident's interest in receiving information about discharge to the community.			
Determine resident goals & preferences.			
Perform assessment of discharge needs – KNOWLEDGE/MANAGEMENT OF MEDICAL CONDITION			
Perform assessment of discharge needs – MEDICATION KNOWLEDGE AND MANAGEMENT			
Perform assessment of discharge needs – PHYSICAL FUNCTIONING			
Perform assessment of discharge needs – COMPLETION OF IADL tasks			
Perform assessment of discharge needs – HOME MODIFICATIONS			
Perform assessment of discharge needs – MEDICAL EQUIPMENT			
Perform assessment of discharge needs – HOME HEALTH SERVICES			
Perform assessment of discharge needs – NON-CLINICAL HOME SUPPORT SERVICES			
Perform assessment of discharge needs – F/U APPOINTMENTS			
Perform assessment of discharge needs – COMMUNITY SUPPORT			
Determine available capacity and capability of family/caregiver support			
Interdisciplinary discharge plan developed with input of resident and resident representative			
Discharge plan addresses all resident goals and preferences			
Document all referrals and response to referrals			
Provide standardized quality and resource data for SNF, HHA, IRF, LTCH as available.			

DISCHARGE PLANNING CHECKLIST

Resident: _____ Anticipated Date of Discharge:

TASK	DATE COMPLETED	STAFF INITIALS	COMMENTS
5-7 DAYS PRIOR TO DISCHARGE			
Resident/family advised of discharge date.			
Discharge care plan developed.			
Date/time set to review discharge plan with resident/family. (Date/time: _____)			
Arrangement made for interpreter if needed.			
1-2 DAYS PRIOR TO DISCHARGE			
Discharge care plan reviewed with resident/family.			
Perform medication reconciliation for discharge meds & investigate any discrepancies.			
Medication Administration Schedule and medication safety reviewed.			
Written notice for all follow-up appointments provided and reviewed with resident/caregiver.			
Resident and caregiver(s) questions and concerns addressed.			
DAY OF DISCHARGE			
Review discharge plan. Highlight any changes since discharge planning meeting.			
Review final medication list; adjust Medication Administration Schedule as needed.			
Review follow-up appointments.			
Provide contact information for all appointments.			
Provide contact information for continuing care provider.			
Provide contact information for local ombudsman.			

Encourage and address questions.			

ASSESSMENT OF POST-DISCHARGE NEEDS

Resident: _____ **Anticipated Discharge Date:** _____

Consider needs in each of the following areas to identify specific needs to be included in the discharge plan:

Medical Condition:

- _____ Type of care and/or monitoring needed
- _____ Follow-up appointments
- _____ Home health services
- _____ Special equipment and supplies
- _____ Medication management

Physical Function:

- _____ Limitations
- _____ ADL/IADL support needed
- _____ Home modifications needed
- _____ Non-clinical home services needed

Mental Capacity:

- _____ Cognitive function
- _____ Education level/Understanding of condition and care
- _____ Mood/Motivation

Lifestyle:

- _____ Usual daily/weekly routines
- _____ Eating habits/food choices
- _____ Physical activity/exercise
- _____ Impact of condition on lifestyle
- _____ Realistic goals and expectations

Safe Housing:

- _____ Appropriate housing available
- _____ Home caregiver available

Home Environment:

- _____ Suitable housing available
- _____ Modifications for physical functioning/safety

Other:

Caregiver:

- _____ Home caregiver motivated and interested in caregiving role
- _____ Home caregiver availability to meet needs and is physically able to provide care
- _____ Caregiver understands what care/services to be provided
- _____ Caregiver has support system

Transportation:

- _____ Services available

Financial Resources:

- _____ Sufficient for housing and care services

Community Support:

- _____ Social/Emotional/Spiritual support
- _____ Counseling

READMISSION RISK WORKSHEET

Resident: _____ Anticipated Discharge Date:

Review the list below to identify the factors that place the resident at higher risk for readmission to the hospital:

Medical Condition(s)

- _____ Heart Disease
- _____ Lung Disease
- _____ Kidney Disease
- _____ Diabetes
- _____ Cancer
- _____ Stroke

Impaired Function:

- _____ Physical limitations/frailty/deconditioning
- _____ Cognitive impairment

Mental Health

- _____ Depression/anxiety
- _____ Substance abuse

High Risk Medications

- _____ Anticoagulants
- _____ Insulin/oral hypoglycemic agents
- _____ Digoxin
- _____ Narcotics

Other:

- _____ Poor health literacy
- _____ Poor social support
- _____ >1 unplanned hospitalization in last 6 months

*For each risk identified, consider contributing factors and potential complications and include appropriate interventions in discharge planning.

DISCHARGE CARE PLAN

Resident: _____ Anticipated Discharge Date: _____

Discharge Destination: _____

Caregiver(s) by name, relationship, and contact information (if applicable):

Discharge diagnoses:

Medications (provide details on Medication Administration Schedule form):

Care Plan

Goal	Actions to Achieve Goal	Target Date to Achieve	Comments
Resident will be discharged to (location) _____ On _____ (fill in anticipated date/time for discharge)	Discuss resident’s goals and expectations for discharge. Explore available options for placement and services. Identify available caregiver and community supports.		
Resident will validate understanding of condition(s) and post-discharge needs and care before discharge date.	Provide resident/caregiver teaching on medical conditions(s) in a language and level that is understandable. Provide handouts/teaching materials and resources in a		

	<p>language and appropriate level for understanding.</p> <p>Validate resident/caregiver understanding by teach-back or demonstration as appropriate.</p> <p>Set-up schedule for post-discharge appointments. Provide dates/times and all appropriate contact information.</p> <p>Arrange for transportation for follow-up care as needed.</p> <p>Arrange for appropriate in-home services and equipment. Provide contact information for types of services, providers and schedules for home visits and/or deliveries.</p>		
<p>Resident will correctly identify all medications to be taken before discharge date.</p>	<p>Obtain/provide necessary prescriptions.</p> <p>Perform medication reconciliation prior to discharge to verify accuracy of discharge medication list.</p> <p>For each medication, provide written information on reason for use, dose, when to be taken, how to be taken, special precautions, as well as signs/symptoms of adverse reaction or side effect to report to health care provider. Assure information provided is in a language/level resident & caregiver can understand.</p> <p>Have resident teach-back and/or demonstrate medication administration information.</p>		

<p>Resident will validate knowledge of health management in special circumstances by discharge date.</p>	<p>Provide information (in a language and level resident & family can understand) on signs and symptoms that necessitate notification of the health care provider.</p> <p>Provide appropriate information on “sick-day” management.</p> <p>Provide appropriate information on emergency/disaster preparation for health care needs.</p> <p>Provide contact information for necessary supports and services as appropriate.</p>		
<p>Resident will verbalize knowledge of and willingness to try lifestyle modifications to promote and maintain optimal health condition and minimize complications by date of discharge.</p>	<p>Review lifestyle choices and patterns with resident.</p> <p>Review pros/cons of choices related to impact on health and function.</p> <p>Help resident to identify acceptable modifications to choices and patterns to promote improved health outcomes and quality of life.</p>		
<p>Resident/family will verbalize knowledge and understanding of all follow-up care and appointments as of date of discharge.</p>	<p>Provide list of all appointments and referrals with full contact information with discharge instructions.</p> <p>Use teach-back method to assure that resident/family understands all plans for follow-up care.</p>		

BEING SENSITIVE TO CULTURAL DIFFERENCES

Beliefs and practices are influenced by ethnic and religious backgrounds. Sensitivity to differences is essential to giving good care and developing realistic discharge plans. Below are some factors to consider:

Diet

It is useful to ask residents about food preferences. Some groups have rules that restrict the eating of certain foods or require fasting and other practices. To assure residents comply with special diets after discharge, it is important to recommend dietary plans that are compatible with the resident's cultural or religious practices. For example, many Jews will follow a kosher diet which forbids pork and shellfish and meat and milk products being served at the same meal or from the same dish.

Sabbath

Holidays and days of religious observance can vary among cultural groups. For example:

Jews observe their Sabbath from sundown Friday to sundown Saturday and may refuse to engage in procedures during that time; Seventh-Day Adventists observe Saturday as their holy day; and the Islamic faith (Muslims) observe Friday as the Sabbath and may pray five times each day facing toward Mecca.

Views on Health and Illness

Views on health status can be influenced by one's culture. For example, Native Americans believe that a person must be in balance with nature to have good health; Asians believe that illness is the result of an imbalance of the body's negative (yin) and positive (yang) forces.

Some cultures follow special practices related to their health. Asians may use herbs and acupuncture. Hispanics may use special healers, such as Curanderos.

Their cultural background can influence the way people participate in their care. Asian residents, for instance, may be reluctant to express disagreement or discomfort. Likewise, African-American residents may be distrustful of nursing home staff due to a history of prejudicial treatment.

People are individuals and there are differences among people from the same cultural group. This emphasizes the importance of learning about the individual resident and treating their personal values, beliefs, and practices with respect. The websites of the organizations listed below offer useful information to increase your awareness of cultural differences.

Bureau of Indian Affairs <http://www.doi.gov/bureau-indian-affairs.html>

National Asian Pacific Center on Aging <http://www.napca.org>

National Association for Hispanic Elderly <http://www.anppm.org>

National Center on Black Aged <http://www.ncba-aged.org>

National Hispanic Council on Aging <http://www.nhcoa.org>
National Indian Council on Aging <http://www.nicoa.org>
National Resource Center on Native American Aging
<http://www.med.und.nodak.edu/depts/rural/nrcnaa/>
Office of Minority Health Resource Center <http://www.omhrc.gov>
Organization of Chinese Americans <http://www.ocanatl.org>

RESIDENT AND CAREGIVER EDUCATION

Include the resident and any family member(s) who will be involved in the resident's care in the discharge planning process.

Discuss the resident's expected living arrangement, lifestyle, and typical practices after discharge, such as:

- Motivation to comply with medications, diet, and other prescribed treatments
- Typical day and how that can impact meeting care demands
- Factors that have been known or that potentially could interfere with meeting care demands (e.g., needs of other family members, finances, energy, house layout, emotions, memory)

Review the discharge plan and actions to support it:

- Major diagnoses and problems in a language and on a level that the resident and family can understand
- Expected prognosis, level of independence anticipated
- Treatments/care that may be necessary. Demonstrate how to provide treatment.
- Medications to administer (*Handout: [Medication Administration Schedule](#), [Medication Safety](#)*)
- Identify what assistance a resident needs with bathing, dressing, transfer, feeding, and toileting. Demonstrate methods for providing assistance.
- Identify assistive devices that can ease care and how to obtain them (e.g., bedside commode, feeding utensils)
- Special assistance that may be needed, caregiving tips (e.g., how to break down instructions for a person with dementia, planning care activities in relation to administration of analgesic)
- Emotional and spiritual needs
- Infection prevention techniques (*Handout: [Tips for Preventing Infections](#)*)
- Potential risks/complications and how to prevent and identify them (*Handout: [For Family Members: Recognizing Potential Problems](#)*)
- Follow up care/appointments required; assist with making appointments as needed
- Plans for transportation to appointments
- Safety tips (*Handout: [Safety Tips](#)*)
- When to notify medical provider (*Handout: [When to Notify A Medical Provider](#)*)
- Importance of self-care for the caregiver (*Handout: [Self-Care for the Caregiver](#)*)
- Community resources
- Ability to obtain and afford services and items required
- Any questions or concerns the resident or caregiver has

Discuss how any potential problems could be managed. Encourage the resident and caregiver to ask questions. Listen to and address concerns. Assure their understanding of the discharge plan.

***Refer to Section II for [resources](#) on specific topics to help with resident/caregiver education**

DISCHARGE PLANNING: DIABETIC MANAGEMENT CHECKLIST

Resident Name: _____

Room #: _____

Anticipated Discharge Date: _____

	Resident	Family	Staff Signature	Comments
Has glucometer for home use.				
Describes when to perform fingerstick.				
Demonstrates how to perform fingerstick.				
Accurately identifies, prepares & administers oral medicine.				
Accurately identifies and prepares injectable medicine.				
Describes proper disposal of sharps in the home and has appropriate equipment/supplies.				
Describes signs/symptoms of hypoglycemia and what to do in response.				
Describes signs/symptoms of hyperglycemia and what to do in response.				
Describes appropriate food choices for diet.				
Describes the effect of exercise in diabetes management.				
Has a plan for exercise routine.				
Describes "sick day" management and/or fasting for labs/diagnostics.				
Describes proper foot care.				

MEDICATION ADMINISTRATION SCHEDULE

Medication	Dose & Route	Time(s) to Take	Special Instructions	Side Effects

DISCHARGE SUMMARY SUGGESTED CONTENT

Documentation should be included in the record of the resident being discharged that includes a summary of the resident's stay, including:

- Reason for admission
- Diagnoses
- Status at admission (e.g., nutritional status, ambulation, functional status, independence in performing ADLs, continence, mental status)
- Symptoms presented
- Treatments/therapies provided
- Medications
- Any unusual occurrences
- Resident and family/caregiver's preference for care
- Status at discharge (e.g., level of independence, mental status, functional status)

Include a description of the plans discussed with the resident and any other persons who will serve as caregivers or who the resident desires to have present. Consider any potential problems that could be anticipated post discharge (e.g., lack of consistent caregiver support, home situation, cultural differences, lack of resources, physical or mental competencies, poor motivation, history of noncompliance) and how they can be addressed.

[Section 1861 \(ee\)](#) of the Social Security Act requires that Medicare participating facilities provide residents being discharged with a list of Medicare-certified home health agencies in the geographic area in which they reside, if such care is needed.

Referrals should be made to medical equipment suppliers, community resources, and any other services that the resident may need post-discharge.

Information should be transmitted within 7 days to the medical provider who will be involved with the resident after discharge.

Post discharge plans should include:

- General goals
- Treatments and other care required
- Diet, any dietary instructions/restrictions
- Assistance resident needs with bathing, dressing, transfer, feeding, toileting; instructions specific to resident for providing necessary assistance
- Who will provide any assistance resident will need
- Medications: purpose, schedule for administration, dosage, any special instructions/precautions, side effects, reactions to call provider about
- Unusual signs to report to medical provider; when to obtain emergency assistance
- Appointments for medical follow up; transportation arrangements for appointments
- Anticipated level of independence

DISCHARGE SUMMARY (FORM)

Resident Name: _____ Room #:

_____ D.O.B. _____ Gender Identification: _____

Date of Discharge: _____

SUMMARY OF THE RESIDENT'S STAY:

Diagnoses/Health Conditions:

Reason for Admission:

Course of Illness/Treatment While in Facility:

Symptoms:

Functional Status:

Pertinent Results for Labs/Radiology/Consults:

Treatments/Therapies Provided:

Other Procedures:

Unusual Occurrences/Complications:

STATUS AT TIME OF DISCHARGE:

Describe Mental Status:

Describe Mood & Behavior:

Describe Psychosocial status:

DISCHARGE SUMMARY (continued)

Advance Directives: (Please attach)

Special Instructions/Precautions:

Who participated in assessment: Resident _____ Family _____ Other caregiver _____

Contact Info:

Health Care Provider from Transferring Facility:

Resident Representative: _____

ONLINE RESOURCES FOR DISCHARGE PLANNING/PREPARATION

<http://www.justiceinaging.org/wp-content/uploads/2016/12/A-Guide-to-the-Revised-Nursing-Facility-Regulations.pdf>

Contains a synopsis of upcoming changes in the federal nursing home regulations related to discharge planning that become effective in November 2017.

https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engaging_families/strategy4/Strat4_Tool_1_IDEAL_chklst_508.pdf

Excellent resource entitled IDEAL Discharge Planning Overview, Process, and Checklist from the Agency for Healthcare Research and Quality. Provides guidance for the discharge process to engage residents and families along with useful checklists.

<https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/institutional-care/downloads/hospital-discharge-checklist.pdf>

The featured brochure on this site is from CMS. It contains a checklist of all discharge planning items for resident/family review to assure resident prepared for discharge.

<https://www.caregiver.org/hospital-discharge-planning-guide-families-and-caregivers>

From the Family Caregiver Alliance, this document provides guidance for residents/families on discharge planning.

<http://www.nextstepincare.org/>

Site provides multiple links to guidance and tools to assist both the home caregiver and the professional in the process of discharge preparation and transition to home. Information is available in English, Spanish, Russian, and Chinese.

<https://consultgeri.org/try-this/general-assessment/issue-22.pdf>

Checklist to assess a family member's preferences for involvement in care.

**SECTION II:
RESIDENT AND CAREGIVER RESOURCES**



MEDICATION SAFETY

Medications have many benefits, but they can cause problems if not used correctly. This is true for both prescription drugs and over-the-counter drugs. Here are some tips to help you use medications safely.

Prescription Drugs

- For each drug you are prescribed know:
 - The reason the drug was ordered
 - The time(s) it is to be taken
 - How it should be taken (by mouth, injected, with food, without food, etc)
 - The side effects the drug and which side effects are serious enough to be brought to your medical provider's attention
 - How long you should take the drug

Over-The Counter Drugs

- Discuss the use of the drug with your medical provider before using it
 - Many over-the-counter drugs can interact with your prescription drugs and cause problems
- Read the label carefully to understand:
 - What the drug is used for
 - The dosage
 - How often you should take it
 - Side effects
 - Any precautions

For All Drugs

- Make sure the medical provider who prescribes a new drug knows all the drugs (prescription and nonprescription) and any vitamins, herbs or other supplements that are being taken as these can have serious interactions with each other
- Follow instructions carefully.
- Measure the dose carefully.
- Use a pill organizer in which you can store pills for each day of the week to help you remember if you've taken them.
- Use a dosage cup or syringe to measure liquid medications. If you have trouble drinking out of a cup, you can use a dropper or syringe to put the liquid medication in and administer it.
- Keep drugs in their original container.
- Know if the drugs need to be stored in any special way, such as in the refrigerator.
- Don't use anyone else's drugs and don't let anyone else use yours.
- Make sure you keep your medications in a place where children or someone confused can't reach them.
- Notify your medical provider if you start to have any of the adverse reactions to the drug.
- Take all of your medications with you to all medical appointments.

TIPS FOR PREVENTING INFECTIONS

Having health problems that caused you to spend time in a health care facility can make you more vulnerable to getting infections. Your risk is especially high if you are over the age of 65 or if you've recently been treated for an infection. To protect yourself and others with whom you have contact, follow the tips below.



Wash your hands often, especially before handling food, before eating, after using the toilet, after touching your genitals, and after touching any body fluids such as drainage, mucus, or vomit.



Avoid having foods that need to be refrigerated sitting out for extended periods.



Do not share cups, glasses, eating utensils, toothbrushes, washcloths, and towels.



Drink plenty of fluids (unless restricted due to medical condition).



Avoid contact with people who have infections or who show signs of possible infections.



Breathe deeply.



Cover your mouth and nose with a tissue when coughing or sneezing.



Do not take antibiotics unless prescribed by your medical provider.



Wash raw fruits and vegetables before eating them.



Keep your immunizations current.

MANAGING CONSTIPATION

Those who take opioid medication for the management of pain are very likely to experience what is known as opioid induced constipation (OIC). These medications slow up the natural movement of the intestines causing a delay in removing stool from the body. Excess water is reabsorbed from the intestines causing hard, dry stool. As a result, you may experience the following:

- Straining, and possibly pain, when trying to force stool from your body
- Feeling full or bloated; noticing a distended belly, or bulges in the belly
- Tenderness in your belly
- Loss of appetite
- Feeling sick and/or very tired

Some lifestyle changes may help to **reduce the risk** for constipation. As you are able, try to do the following

- Add more fiber in your diet. Choose, whole grain breads rather than white bread, brown rice vs. white rice, bran cereal, beans, fruits and vegetables, prunes
- Drink plenty of water. Keep a bottle of water with you all day.
- Increase your exercise as you are able. Take a short walk after meals.
- Add psyllium, which is a fiber supplement

If you experience constipation, talk to your doctor or pharmacist about a laxative that would be best for you. There are several different kinds.

Stool softeners – add oil and water to mix in stool; not for quick relief as they take 1-4 days for effect

Bulk laxatives – adds fiber and traps water to create more bulk in stool and make passage easier; works in 1-3 days

Lubricants – adds lubricant, or oil, to the lining of the intestine for easier passing of stool; works in 1-4 hours

Stimulant laxatives – stimulates intestinal muscles to push stools thru; can cause your intestines to become dependent on the laxative. Works in 6-24 hours

Saline laxatives – pulls water back into the intestines to help move stools thru; works in 1-3 hours. Can cause extreme thirst or even dehydration.

Herbal laxatives – there are different times and some are for mild constipation and others help with more severe constipation; ask your doctor or pharmacist.

WHEN TO NOTIFY A MEDICAL PROVIDER

The following symptoms could be a sign of a problem that needs medical attention. If any of them occur, contact your medical provider to determine what action should be taken. Be sure to have as much information as you can when making the call, such as when the symptom started, what was the person doing before and during the time it appeared, the medications that the person took that day, anything unusual that occurred or that you noted, and how the person describes the problem.

- Abdominal pain (severe or with vomiting)
- Abdominal swelling
- Bedsore (pressure injury)
- Blood pressure decrease of 20 points or more
- Blood pressure increase to level greater than 210/110
- Bloody vomit, stools, urine
- Burning when urinating
- Change in level of alertness
- Chest pain, tightness, heaviness
- Confusion (new or worsening)
- Diarrhea (several episodes) with fever lasting more than one day
- Difficulty breathing
- Dizziness
- Excess drowsiness
- Fall which leaves you in pain, unable to walk, or otherwise injured
- Frequent falling
- Medication overdose
- New problem with ability to speak, see, walk, eat, or eliminate wastes
- Pain (new or worsening)
- Rapid pulse/heart rate
- Repeated vomiting of dark colored vomit
- Seizures (new or worsening)
- Severe headaches
- Severe or worsening weakness
- Sudden change in vision
- Suicidal threats or attempts
- Swelling of legs or abdomen
- Sudden weight gain or loss
- Unsteady walk
- Wheezing

SAFETY TIPS

- Make sure that there is adequate lighting in every room
- Avoid scattered and area rugs as they can be a source of falls
- Keep clutter from floors
- In the bathroom:
 - Keep a small light on at all times
 - Do not leave towels, products, or other items on the floor
 - Make sure the tub and/or shower stall has a nonslip floor and grab rails
 - Consider having grab bars installed near the toilet to assist with lowering and raising self
 - Do not use radios, hair dryers, electrical heaters, or other electrical items
- When using the stove:
 - Do not wear long sleeved clothing when using gas burners
 - Do not leave items cooking unattended
 - Set a timer to remind yourself to turn off the stove at a designated time
 - Call for assistance if you smell gas
- With medications:
 - Do not remove them from their original bottles or packages
 - Take as prescribed
 - Store them in a safe place away from the reach of children
 - Do not use expired medications or medications prescribed for someone else
- Where low-heeled shoes that fit well
- Avoid having pants' legs and robes drag on the floor
- Store cleaning solutions and poisonous liquids in a safe place, away from food
- Change positions slowly when rising from a bed or chair
- Do not climb on chairs or ladders
- Do not open the door for strangers or give unknown callers personal information on the phone
- If you live alone, arrange to have someone phone or check on you in person every day



For Family Members: RECOGNIZING POTENTIAL PROBLEMS

As your relative is discharged and returning home it is important to understand that he or she may not function at the same level as before admission to the nursing home. This can be due to the person needing more time to recover from the health condition that caused the nursing home stay. It also can be the result of permanent declines that prevent the person from functioning in the same way he or she did before the nursing home stay.

Although the nursing home staff has tried to prepare your relative for discharge, there may be problems that won't surface until he or she returns home. By recognizing and addressing these problems, you can help your relative avoid complications and remain at home. Be on the lookout for your relative:

- Having the same number of pills that he or she started with when you check the pill bottles
- Using old medications that are no longer being prescribed
- Self-medicated to treat symptoms
- Experiencing difficulty preparing food (e.g., inability to open cans, use microwave, take food that has been prepared for him or her from refrigerator and heat)
- Not eating or drinking
- Showing unexplained bruises or cuts
- Wearing soiled or foul-smelling clothing
- Leaving food out of the refrigerator for extended periods
- Acting confused (e.g., not remembering where he or she is, if it is day or night, who you are)
- Spending excessive time in bed or sitting when able to walk
- Not taking proper precautions when using oxygen (e.g., smoking, turning on gas stove)

SELF-CARE FOR THE CAREGIVER

As a caregiver you are providing a very special service to the person for whom you are helping. There is a good possibility that person would not be able to live at home without the assistance you offer. You fill a very important role.

While your caregiving provides many benefits for the person being helped, it may produce some negative effects for you. It would not be at all unusual for you to go through periods in which you feel exhausted, frustrated, depressed, impatient, or overwhelmed. These feelings can lead to health problems for you if not properly managed.

Knowing you are at risk of having these types of problems, it is important for you to make a special effort to care for yourself. Although you may find it hard, if you don't care for yourself you could end up being no good to anyone. To be at your best and to be able to meet the challenges of caregiving, try following the tips below.

- Be clear from the start about what you can and cannot do.
- Make sure you eat properly, get enough sleep, and otherwise engage in good health practices.
- Don't try to do everything yourself. Reach out to other family members or agencies for support.
- Identify someone with whom you can vent and share your honest feelings.
- Schedule and take time off.
- Avoid feeling guilty for looking out for your own needs.
- Plan time off. This may require that you ask relatives and friends to fill in for you, or that the person you are caring for stay in someone else's home or a health care facility during your absence.
- Notice signs of possible problems such as feeling depressed, experiencing health problems, frequently arguing with people you care about, neglecting your own personal responsibilities, or feeling like you want to harm the person you're caring for. These are signs that you need a rest and some help yourself.
- Consider joining a support group. Sharing feelings and obtaining advice from people who are experiencing similar issues can prove very beneficial.
- Be kind to yourself. Don't expect to be perfect or in a great mood all the time. Show yourself the same compassion you would give to others. Remember, you're human!

HOW ADVANCED AGE CAN AFFECT SELF-CARE

If you have an older relative, there may be some changes resulting from aging that could affect that person's ability to care for him or herself. By knowing these changes, you can be alert to possible problems that could arise. Some areas to consider are

Memory

- Although the older person may be able to remember details from many years ago, it is not uncommon for him or her to forget recent things, such as if they took their medication today, the date of their next medical appointment, or that something is cooking on the stove. It can help to have paper and pencils in every room and to encourage the person to **write things down**. If the person is going to cook, suggest **a timer be set when the burners or oven are used** as a reminder that the stove is on.

Vision

- Older eyes see items less clearly and have difficulty seeing small print. This can cause medication labels to be read incorrectly. The person may take the wrong medication at the wrong dose at the wrong times. It can help to **write the instructions in large print on a piece of paper that you can tape to the bottle or to have someone else pour the medications in a container** from which the person can take them each day.
- There is a decreased ability to see changes in levels. This could cause a person not to notice when he or she is at a step or curb. **Painting the edge of the area a different color or placing a colored strip of tape across the edge where there is a change in level** could prove helpful.
- Vision to the side is reduced in older eyes. As a result, a person may not see items to the side and bump into them. Water and other items left on a side table may not be seen and not used. **Place items as close to the front of the person as possible.**

Hearing

- High-pitched sounds—especially f, s, sh sounds—are not heard as well by older ears. This can cause instructions to be missed. It can help to **talk in a low-pitched voice, write down important instructions, and ask the person if he or she has heard you.**

Touch

- Older adults may not sense pressure and pain the same as a younger person. They can have a pebble in their shoe and not be aware of it or sit in the same position too long and cause the skin to be damaged. It's a good idea to check the skin surface of the older person for redness and injury.

Walking

- Older people tend to not lift their toes as high as younger people do when they walk which can result in tripping. In addition, balance tends to be more easily lost with advanced age. To prevent falls the person should **wear well-fitting flat shoes, take careful slow steps, and avoid having scattered rugs on the floor.**

ONLINE RESOURCES

The following websites are good sites to obtain information on specific issues for use in teaching residents and caregivers.

HEALTH CONDITIONS

www.emedicinehealth.com

This site contains a wealth of health information on a large variety of health conditions. Information includes an explanation of topics, symptoms, treatment, and personal management. Many topics also have related quizzes and slide show presentations that can be used for discharge teaching. Well worth exploring for helpful information.

ADVANCE DIRECTIVES/MOLST

<http://www.marylandattorneygeneral.gov/Health%20Policy%20Documents/adirective.pdf>

Contains an 18 page booklet from the Maryland Attorney General's Office that serves as a guide to Maryland law and planning for health care decisions. Includes forms that can be used to create an Advance Directive.

<http://mhcc.maryland.gov/consumerinfo/longtermcare/AdvanceDirectiveInformation.aspx>

Information page entitled "Consumer Guide to Long Term Care" that explains Advance Directives and includes links to resources to help with advanced planning.

<http://www.marylandattorneygeneral.gov/Pages/HealthPolicy/AdvanceDirectives.aspx>

Enlarged print version of information/forms for Advance Directives in Maryland.

<http://marylandmolst.org/>

Explains the MOLST form used in Maryland for medical orders for life saving treatment. Contains a link to the form as well as to resources for additional information.

ALZHEIMER'S DISEASE

<https://www.alz.org/health-care-professionals/patient-information-education-care-resources.asp>

This sight has a wealth of information for the home caregiver, including education materials and community and online resources. Education materials are available in **Spanish, Japanese, Korean, Chinese, and Vietnamese.**

Topics include: Med-Alert and Safe-Return Program, daily care, communication, behavior management, caregiver tips, safety, and disaster planning among others. *Information can be easily downloaded and printed for distribution to families.

ALZHEIMER'S DISEASE (cont.)

24/7 Helpline – 1-800-272-3900 TDD 1-866-403-3073

Offers **information, support, referrals, and crisis help. Language translation services are available.**

ANTICOAGULANT THERAPY

<https://health.ucsd.edu/specialties/anticoagulation/patients/Pages/default.aspx>

Contains a variety of educational materials, including an 11-page booklet titled “Your Guide to Anticoagulation Therapy” which provides a simple, easy to read explanation of important information a patient should know about warfarin therapy. Also provides a sample of an emergency medical card that can be kept in a wallet to alert emergency responders to warfarin therapy and the condition that it is treating.

Additional information includes a helpful section on Frequently Asked Questions, Drug Interactions, and information about taking warfarin and vitamin K.

There is also a 2-page guide to Coumadin. It is in relatively simple language, but there is a lot of information packed into the 2 pages. Consider the reading/comprehension ability of the resident.

<http://www.uptodate.com/contents/warfarin-coumadin-beyond-the-basics>

Provides for a good overview of warfarin therapy. There are also a lot of links to other credible web sites that provide information on various health conditions requiring warfarin therapy. Links are categorized in 3 sections: simple/easy to read overview; intermediate level that contains a bit more information, and professional level materials.

ARTHRITIS

<http://www.arthritis.org>

Provides a wealth of information about living with arthritis including an explanation of the condition, treatments, pain management, exercise, and mood. There are a variety of tools including pain questionnaires, pain diary, and a pain management plan. There are also numerous connections to other resources including short videos on arthritis friendly exercise

programs, printed materials, and support networks. Information is available in Spanish as well as English.

<https://www.curearthritis.org>

This organization's primary focus is on research, but there is some helpful information to describe various types of arthritis.

<https://www.ncoa.org/resources/osteoarthritis-and-falls/>

Brochure that explains osteoarthritis and discusses fall risk and prevention.

<https://www.hopkinsarthritis.org/patient-corner/>

Good resource for specific information sheets for drugs commonly used for treatment of arthritis. Has some additional information on assistive devices to help with ADLs/IADLs and alternate therapies.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

www.lung.org/lung-health-and-disease-lookup/copd/

Covers a variety of topics including COPD symptoms, causes, risks, treatments, and living with COPD. Includes questions to ask doctor and links to smoking cessation information. There is a helpline that can be accessed at 1-800-LUNGUSA for free help from a counselor. Free online chat with a counselor is also available. There is a tab to access information in Spanish.

<http://www.thoracic.org/patients/patient-resources/resources/copd-intro.pdf>

Two-page review of COPD designed for patient use, including explanation of condition and treatment. Diagrams included.

<https://www.nhlbi.nih.gov/health/health-topics/topics/copd>

Topics covered include an explanation of COPD, risk factors, signs & symptoms, diagnosis & treatment, prevention, living with COPD. Also includes short video clips that could be used for patient teaching. Additional information on topics such as how the lungs work, oxygen use, smoking cessation, healthy heart and more is included. Much of the material is available in Spanish.

<https://familydoctor.org/how-to-use-a-metered-dose-inhaler/>

Information on how to use a metered-dose inhaler and other considerations for inhalation therapy.

https://www.cdc.gov/asthma/inhaler_video/default.htm

Contains videos on how to use a metered-dose inhaler in both English and Spanish. Can be used for patient education.

<http://www.safemedication.com/safemed/MedicationTipsTools/HowtoAdminister/HowtoUseMeteredDoseInhalers>

Simple guide including illustrations on how to use a metered-dose inhaler.

CONGESTIVE HEART FAILURE

<http://www.calheart.org/handler.cfm?event=practice,template&cpid=10756>

Handout with explanation of the condition with good diagrams.

www.emedicinehealth.com/congestive_heart_failure/article_em.htm

Good information on multiple aspects of heart function and congestive heart failure and its symptoms, including quiz and slide show. Multiple links to related health conditions or information.

https://www.ucsfhealth.org/education/diet_and_congestive_heart_failure/

Good information to guide diet choices for management of CHF.

CULTURAL DIFFERENCES

<https://www.euromedinfo.eu/how-culture-influences-health-beliefs.html/>

Site provides useful information to help understand the attitudes and beliefs about health care in other cultures. Topics presented on the pages of the site include: differences in health attitudes, performing a cultural assessment, negotiating health decisions with someone from a different culture, communication with non-English speaking patients, the use of translators and interpreters, and developing cultural competence.

DIABETES MELLITUS

http://www.hopkinsmedicine.org/gim/core_resources/Patient%20Handouts/

Information available on Types 1 and 2, specific gender issues and diabetes, lifestyle, glucose testing, hyper- and hypoglycemia, foot care, rotation of injection sites, exercise, diet and weight loss, alcohol use and diabetes, smoking and diabetes, sick day guidelines and diabetes related to heart and kidney disease.

<http://www.diabetes.org/research-and-practice/we-support-your-doctor/patient-education-materials.html?referrer=https://search.yahoo.com/>

and

<http://professional.diabetes.org/content/diabetes-educator-resources>

Includes link to Patient Education Library for a variety of education materials on the condition, management, emotional well-being, nutrition, etc. Search can be filtered (on right screen) by category of information and available languages (Arabic, Chinese, English, French, Haitian Creole, Korean, Portuguese, Russian, Spanish, Tagalog, and Vietnamese).

www.emedicinehealth.com (search for 'diabetes')

Contains large variety of information on diabetes, living with diabetes, complications, special issues (sick day, travelling, emergency/disaster, etc.). Includes several quizzes and slide shows that can be used for teaching.

FALL PREVENTION

<https://www.cdc.gov/homeandrecreationalafety/falls/adultfalls.html>

Provides general information about falls and older adults and links to other articles and resources.

https://www.cdc.gov/steady/pdf/STEADI_OlderAdultFactSheet-a.pdf

Handout for older adults, with general information about falls and tips for prevention.

https://www.cdc.gov/steady/pdf/Stay_Independent_brochure-a.pdf

Brochure with risk questionnaire and basic information about safety measures for prevention. Also available in Spanish.

https://www.cdc.gov/steady/pdf/STEADI_CaregiverBrochure-a.pdf

<https://www.ncoa.org/healthy-aging/falls-prevention/preventing-falls-tips-for-older-adults-and-caregivers/6-steps-to-protect-your-older-loved-one-from-a-fall/>

Both of these sites offer information for family caregivers about falls and safety measures for prevention.

https://www.cdc.gov/steady/pdf/STEADI_CheckforSafety_brochure-a.pdf

Useful checklist that guides a person to check for safety issues throughout the various rooms in the home. Also available in Spanish. Pre-printed brochures in Chinese can be ordered from the site.

https://www.cdc.gov/steady/pdf/What_You_Can_Do_brochure-a.pdf

Brochure that discusses what a person can do to reduce the risk of falling. Spanish and Chinese versions can be printed from the site.

<https://www.ncoa.org/resources/osteoarthritis-and-falls/>

Brochure that explains osteoarthritis and falls risk and prevention.

<https://cfosm.com/patient-education/kb/hw-view.php?DOCHWID=aa6973>

Provides information on hip fractures, including risks for fracture, an explanation of the condition, as well as how it is treated.

HIGH BLOOD PRESSURE (HYPERTENSION)

https://www.cdc.gov/bloodpressure/materials_for_patients.htm

This site provides links to numerous educational materials on high blood pressure and related conditions. There are some specific materials in Spanish that relate to blood pressure management in the Hispanic population.

http://www.heart.org/HEARTORG/Conditions/HighBloodPressure/High-Blood-Pressure-or-Hypertension_UCM_002020_SubHomePage.jsp

American Heart Association materials that explain blood pressure and how it can be managed. Also contains links to materials on related heart conditions.

https://www.cdc.gov/bloodpressure/docs/ConsumerEd_HBP.pdf

Patient information sheet with basic information about blood pressure and its management.

http://www.heart.org/idc/groups/heart-public/@wcm/@hcm/documents/downloadable/ucm_300625.pdf

Patient information sheet on limiting salt in diet for blood pressure management.

JOINT REPLACEMENT SURGERY

<http://www.arthritis.org/living-with-arthritis/treatments/joint-surgery/preparing/post-surgery-recovery.php>

Information sheet with tips to prepare the home for post-surgery discharge.

https://www.niams.nih.gov/health_info/joint_replacement/#7

Information on what to expect following joint replacement therapy and descriptions of adverse things to watch out for (blood clots, infection, etc.)

<http://www.healthline.com/health/preparing-your-home-knee-replacement-recovery#2>
<http://www.healthline.com/health/total-knee-replacement-surgery/follow-up-appointments#1>

Both of these sites provide information on recovery from knee surgery. Slide shows are available that may help with patient teaching.

LOW VISION

<http://www.allaboutvision.com/lowvision/resources.htm>

This web page provides helpful resources for learning about benefits that are available for those with low vision, as well as links to a number of organizations and apps that provide low vision services and resources.

<http://www.seniorvision.org/resources/coping-with-visual-impairment>

Provides good, easy-to-follow information on how to recognize visual problems in a loved one, and simple guidance for communication and providing assistance.

<https://www.agingcare.com/articles/helping-your-loved-one-live-with-low-vision-111675.htm>

<https://www.agingcare.com/articles/making-life-easier-for-older-adults-with-low-vision-177792.htm>

Both of these articles provide easy to follow, useful tips for helping someone with low vision.

MEDICATION EDUCATION

<http://www.safemedication.com/default.aspx>

A very good resource for medication information for residents being discharged. Can type in name of medication and it will take you to a listing for that information. Clicking on the name of the appropriate medication will take you to information about why the doctor orders that medication, how to take the medication, special instructions, side effects, etc.

http://www.safemedication.com/safemed/MyMedicineList/MyMedicineList_1.aspx

A useful template called “My Medication List” to review medications that the person may be taking (prescription and non-prescription).

http://www.nextstepincare.org/uploads/File/Guides/Medication/Medication_Management_Guide/Medication_Management.pdf

Provides information for the family caregiver on medication management, including how to read medication labels, a distinction between prescription, over-the-counter, and herbal medications, maintaining a current list of medications, and common questions/problems related to prescription management. It is available in English, Spanish, Russian, and Chinese.

OXYGEN SAFETY

<https://patienteducation.osumc.edu/Documents/ox-sf-rg.pdf>

One page information sheet on safety tips for oxygen use in the home.

https://www.ucsfhealth.org/education/supplemental_oxygen/oxygen_safety/

Discussion of oxygen safety and links to other supplemental oxygen information, including travelling with oxygen.

PNEUMONIA

<http://www.upmc.com/patients-visitors/education/breathing/Pages/pneumonia.aspx>

General information sheet on types of pneumonia, signs and symptoms, treatment and management, and prevention.

<http://www.lung.org/lung-health-and-diseases/lung-disease-lookup/pneumonia/>

Information provided by the American Lung Association. Provides general explanation of pneumonia with various links to related information (including vaccination under 'prevention'). There is a tab for translation into Spanish.

STROKE

<http://www.strokecenter.org/wp-content/uploads/2011/08/Recovering-After-a-Stroke.pdf>

A 17-page booklet that discusses various aspects of care following a stroke. (Publication date is listed as 1995, but content provided is still relevant.)

<http://www.strokecenter.org/wp-content/uploads/2011/08/Stroke-Recovery-Guide.pdf>

A comprehensive 76-page guide to various aspects of life after a stroke. While printing off the entire booklet may be excessive, there are parts which may be specifically relevant to a resident's condition or a family's need that could be copied and printed.

https://www.cdc.gov/stroke/materials_for_patients.htm

Links to various information sheets and education materials for stroke as well as for other chronic conditions that increase the risk for stroke. Some materials available in Spanish.

https://www.cdc.gov/stroke/docs/consumered_stroke.pdf

"Know the Facts About Stroke" – 2 page patient handout.

SUBSTANCE ABUSE

<https://www.centeronaddiction.org/addiction/commonly-used-illegal-drugs>

Information sheet that identifies commonly used illegal drugs, how they are used, their effects and health risks.

<http://www.casacolumbia.org/sites/default/files/files/Final-patient-guide-april-2014.pdf>

Twenty-two page booklet with helpful information about understanding and assessing addiction as well as info to help in recovery. May be a useful guide for staff.

<http://www.projectknow.com/research/resources/>

Site provides numerous links to a variety of information about addiction, substances that are abused (alcohol, tobacco, prescription and illegal drugs), behavioral health issues, treatments, tips for success, risks for relapse, and coping with relapse. Helpful guide to help staff to understand the condition and the needs of the person with an addiction.

<http://www.projectknow.com/research/prescription-drug-by-type/>

Provides a helpful guide for staff on the addiction to various types of prescription drugs; also provides detox and withdrawal information, the effects of overdose, and rehabilitation.

<https://www.alcohollearningcentre.org.uk/Topics/Latest/Severity-of-Alcohol-Dependence-Questionnaire-SADQ/>

Provides a link to the Severity of Alcohol Dependence Questionnaire. Also provides information as to how to score and interpret results.

<https://bha.health.maryland.gov/NALOXONE/Pages/Naloxone.aspx>

Includes information about how to obtain and use naloxone (Narcan, Evzio) in the event of an opioid overdose. Contains various links to access useful information such as the Maryland Overdose Response Program, training sites, and pharmacies participating in the program for access to the drug.

<https://bha.health.maryland.gov/NALOXONE/Pages/Home.aspx>

The website for the Maryland Overdose Response Program. Provides various links to training calendars, and training centers, statewide standing order, and other additional resources.

<https://bha.health.maryland.gov/NALOXONE/Documents/Narcan%20Nasal%20Spray%20Brochure%20final.pdf>

Brochure that shows how to recognize signs of an overdose and depiction of how to administer naloxone and follow-up steps until emergency response arrives.

<http://prescribetoprevent.org/>

Contains links to education on overdose risk and use of naloxone.

<https://bha.health.maryland.gov/NALOXONE/Documents/The%20Maryland%20Overdose%20Response%20Program%20-%20Directory%20August%208,%202017.pdf>

Contact information for centers throughout Maryland that participate in the Overdose Response Program. Also includes a link to the training calendar for dates/locations of training.

URINARY INCONTINENCE

<https://www.mskcc.org/cancer-care/patient-education/improving-your-urinary-continence>

Patient information sheet on tips to manage urinary incontinence.

<https://www.scanhealthplan.com/providers/clinical-guidelines-and-practice-tools/urinary-incontinence/patient-education-resources>

NIH patient brochure on urinary incontinence. Available in Spanish.