WATTLE AND RIVER
HOME HEALTH

GOONDIWINDI

AFTER A HOSPITAL STAY

Why the first 30 days at home matter *most.*

A practical conversation and referral resource for GP's, practice nurses, discharge planners, and health professionals supporting older people as they return home after a hospital admission.

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Why this window matters.

For many older people, discharge is not the end of the risk period. It is the point where several risks move from the hospital environment into the home: medication changes, altered mobility, fatigue, reduced confidence, delayed follow-up, wound or infection concerns, and family uncertainty about what is normal and what needs escalation. Families often feel relieved that their parent, partner or relative is home, while also sensing that something is more fragile than before. That concern is often reasonable. The first month at home is a period where small changes can become clinically significant if they are not observed, communicated and acted on early.

Purpose of this guide

This guide is designed to help referrers explain the early post-discharge period in plain English, support families to notice clinically meaningful change, and identify when structured in-home support may reduce risk and improve coordination.

It is not a replacement for discharge planning, GP review, clinical judgement, or urgent care pathways.

When this guide may be useful

This resource may be helpful when an older person is being discharged, has recently returned home, or is presenting to primary care soon after hospitalisation with emerging concern rather than one clear acute issue.

- Recent admission, ED presentation or short-stay hospital episode.
- New or changed medication regimen.
- Fall, near fall, reduced mobility or loss of confidence.
- New wound, pressure area, infection concern or increased pain.
- Changed cognition, delirium recovery, low mood or increased confusion.
- Poor appetite, hydration concerns, weight loss or difficulty preparing food.
- Family carer strain, uncertainty or difficulty interpreting discharge instructions.
- Need for short-term private support while public services or longer-term arrangements are being explored.

Particularly useful for discharge planners

This guide can be given to families at discharge or in the days after discharge when they are trying to understand what to watch for at home. It helps translate a clinical risk period into practical observations: meals, medication, mobility, wound changes, sleep, confusion, fatigue and family concern.

What *good* hospital-to-home support looks like.

Effective transitional care is not simply more hours of care. It is the right clinical work at the right time, with clear communication and escalation built in.

Medication reconciliation early after discharge.
The current medication list is compared with the pre-admission list and discharge information, with changes clarified and concerns communicated to the GP or pharmacist where appropriate.

A baseline and risk-focused observation plan.
The person is observed against what has changed since admission, including cognition, appetite, pain, hydration, mobility, wound healing, elimination, sleep and fatigue.

Falls and mobility reassessment.
Even a short admission can reduce strength, confidence and balance. The home environment, equipment and routines may need review once the person is back in their own space.

Clear escalation pathways.
Families and support workers need to know what to watch for, who to contact, and when to seek urgent medical advice. This should not be left to informal judgement alone.

Communication with the treating team.
With consent, key observations and concerns can be shared back with the GP or nominated clinician so the home picture does not sit separately from clinical care.

Family guidance.
Families often carry the cognitive load after discharge. They may need simple explanations, a named contact, and a practical plan for what happens next.

Where transitional care often *breaks down.*

- The discharge summary arrives late or is not available to the family or home team.
- Medication changes are not clearly reconciled in the home environment.
- Observations continue as if nothing has changed, missing new post-discharge risks.
- The GP, family and home support team each hold part of the picture, but no one is connecting it.
- Families are told to “watch for deterioration” but are not given practical signs to notice night-time concerns, falls risk or carer fatigue are not discussed until there is a crisis.

Referrer prompt

A useful question to ask is: “What has changed since the admission, and who is watching that change at home?”

When reflection is not enough: *Red Flags.*

This resource is not suitable for urgent or escalating clinical concerns. Families should be advised to seek urgent medical attention or call 000 if there is immediate risk or acute deterioration.

Do not wait for a routine referral if there is:

- Sudden confusion or suspected delirium.
- Chest pain, breathing difficulty or suspected stroke symptoms.
- Uncontrolled pain or acute deterioration.
- Serious fall, head injury or inability to mobilise safely.
- Signs of sepsis or rapidly worsening infection.
- Medication error with possible harm.
- New or worsening wound concern requiring urgent review.
- Immediate safety risk to the person or carer.

Suggested wording *for referrers.*

"The first few weeks at home after hospital can be a vulnerable time. This does not mean something will go wrong, but it is worth having a clear plan for medication changes, mobility, meals, sleep, wounds, confusion and who to call if something changes."

"This guide is not a test or a judgement about whether home is failing. It is simply a way to notice what has changed and decide what support might make home safer and more manageable."

"If you are not sure what is normal after discharge, write down what you are noticing. Small changes are often the information clinicians need."

Questions worth asking before or after discharge:

- What changed during the admission: medication, mobility, continence, cognition, wounds, appetite or confidence?
- Who has the current medication list, and has it been reconciled against the discharge information?
- What needs to happen in the first 48 hours at home?
- Who is checking for falls risk, hydration, pain, wound changes or confusion?
- Who should the family call during business hours, after hours and in an emergency?
- What would make home unsafe, even temporarily?
- What information should be sent back to the GP or treating team?

When to consider referring to *Wattle and River Home Health.*

A referral or suitability conversation with WRHH may be appropriate when an older person would benefit from private, clinically led support at home during the transition period after hospital.

- The person is going home with increased risk, but does not require hospital-level care.
- Family members are anxious, unavailable or unsure how to support the transition safely.
- Medication changes, wound care, mobility changes or cognitive changes need closer observation.
- The person is waiting for public services, aged care assessment, allied health input or longer-term supports.
- Short-term stabilisation, nursing oversight or daily living support may prevent avoidable deterioration.
- There is uncertainty about whether home is still safe and realistic without structured support.

Working alongside the treating team

WRHH does not replace the person's GP, specialist, hospital team or allied health providers. Our role is to support the person safely at home, observe and escalate concerns, coordinate practical support, and communicate clearly with the family and treating team where appropriate and with consent.

What Wattle and River Home Health *can provide.*

- Initial intake conversation with the person, family or referrer
- Clinical assessment by phone, telehealth or in person where appropriate
- Nursing-led observations and care planning
- Medication, mobility, nutrition, cognition, wound and daily function observations within scope
- Short-term transitional support after discharge
- Clear escalation pathways for family and staff
- Family communication and practical guidance
- Collaboration with GPs, specialists, allied health and hospital teams where appropriate and with consent

WHAT WRHH CAN PROVIDE BACK TO REFERRERS

With the person's consent, WRHH can provide a concise written update following assessment or early support, including relevant observations, identified concerns, immediate recommendations, escalation issues and proposed next steps for support at home.

HOW TO REFER OR DISCUSS SUITABILITY

To discuss whether WRHH may be suitable, **contact our team on 1300 280 065.** Referrals or enquiries may come from a GP, hospital discharge planner, practice nurse, allied health professional, family member or the person themselves. WRHH will consider the person's needs, location, urgency, clinical complexity, staffing availability and whether privately funded in-home support is appropriate.

Suggested family-facing explanation

Referrers may wish to give families simple language they can take home:

"The hospital has treated the acute issue, but the first few weeks at home still matter. This is when changes in medication, mobility, appetite, sleep, confidence or confusion can show up. Having the right support during this period can help everyone understand what is settling, what needs attention, and whether home is working safely."

Consent and communication

WRHH will only share information with referrers, family members or other providers in line with the person's consent and relevant privacy obligations. Where urgent safety concerns are identified, WRHH will support appropriate escalation.

Contact WRHH

Phone: 1300 280 065
Website: wrhealth.com.au
Location: Goondiwindi region and surrounding communities

Disclaimer

General information only. This resource is intended to support referrer and family conversations. It is not personalised medical advice, a diagnostic tool, a validated risk assessment, a substitute for clinical judgement, or an emergency response pathway. ***If urgent medical assistance is required, call 000.***

Privately funded in-home support is considered based on the person's needs, location, clinical complexity, staffing availability and suitability for care at home.