New York State Partnership for Patients

Engaging and Optimizing Care Partners
Frontline Checklist

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PREADMISSION TO ADMISSION	
Identify care partner as soon as possible	✓ upon check-in or preadmission testing for elective admission
	✓ upon registration or admission
Document care partner information	✓ in electronic medical record
	✓ on whiteboard
	✓ share with healthcare team
Obtain written and/or verbal consent to speak/share with care partner	✓ upon registration or admission
Share care partner information with team	✓ at rounds, huddles, and shift-to-shift handoffs

HOSPITAL STAY	
Include the care partner in all aspects of care	✓ orient the care partner to the unit environment and routine
Educate the care partner on what it means to be a care partner	✓ *My Care Transition Plan* brochure
	✓ *What is a Care Partner?* brochure
Invite the care partner to participate in meaningful interactions	✓ admission assessment
	✓ medical and medication history
	✓ readmission risk assessment
Empower the care partner to perform simple tasks as defined by hospital	✓ use of whiteboards
	✓ purposeful rounding
	✓ structured handoffs
	✓ standardized communication tool
	✓ care plan and goals of care
	✓ utilize teach-back for medication reconciliation, wound care, use of equipment, signs and symptoms to watch for, and simple tasks, including nutritional support, bathing, and toileting

PRIOR TO DISCHARGE	
Verify readiness for discharge with review of care items listed above	✓ review *My Care Transition Plan* brochure with patient and care partner
	✓ address any concerns identified
Prepare the care partner for post-hospital care	✓ assess using teach-back to ensure patient and care partner understand: • disease knowledge and management • proper medication administration and storage • safety interventions • food intake/nutrition
	✓ signs and symptoms of worsening disease and what to do: • how to assist patient in self-management • who to call • where to go
Handoff to receiving providers	✓ home care, hospice, primary care provider, skilled nursing facility (SNF), or other facility
Post-discharge phone call/circle back with patient and care partner	✓ home care, hospice, primary care provider, SNF, or other facility