The preparation for hospital discharge and home care begins during the admission assessment. Short- and long-term goals are established to meet the child's physical and psychosocial needs. For children with complex care needs, discharge planning focuses on obtaining appropriate equipment and health care personnel for the home. Discharge planning is also concerned with treatments that parents or children are expected to continue at home. In planning appropriate teaching, nurses need to assess (1) the actual and perceived complexity of the skill, (2) the parents' or child's ability to learn the skill, and (3) the parents' or child's previous or present experience with such procedures.

The teaching plan incorporates levels of learning, such as observing, participating with assistance, and finally acting without help or guidance. The skill is divided into discrete steps, and each step is taught to the family member until it is learned. Return demonstration of the skill is requested before new skills are introduced. A record of teaching and performance provides an efficient checklist for evaluation. All families need to receive detailed *written* instructions about home care, with telephone numbers for assistance, before they leave the hospital. Communication between the nurse performing discharge planning and home health care is essential for ensuring a smooth transition for the child and family.

After the family is competent in performing the skill, they are given responsibility for the care. When possible, the family should have a transition or trial period to assume care with minimal health care supervision. This may be arranged on the unit; during a home pass; or in a facility, such as a motel, near the hospital. Such transitions provide a safe practice period for the family, with assistance readily available when needed, and are especially valuable when the family lives far from the hospital.

In many instances, parents need only simple instructions and understanding of follow-up care. However, the often overwhelming care assumed by some families, coupled with other stressors that they may be experiencing, necessitates continued professional support after discharge. A follow-up home visit or telephone call gives the nurse an opportunity to individualize care and provide information in perhaps a less stressful learning environment than the hospital. Appropriate referrals and resources