

Your Guide to Hospital Discharge



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Introduction

There are **over 35 million hospital discharges** in the United States each year.⁽¹⁾

Families leaving the hospital often scramble to get their parent, child, or loved one home safely and quickly. They hurry to find resources, explore options, and organize care for their loved one. Soon, families realize that they are overwhelmed by the difficulty of finding reliable advice, the cost of care, the health and safety of their loved one, and the challenges of organizing a smooth discharge.

This experience is not uncommon. A hospital discharge is a confusing and stressful process for millions of families. The responsibility of protecting a loved one's health and organizing support following discharge is demanding. Families know that proper planning can make the difference between a smooth recovery and an avoidable hospital readmission.

The goal of this guide is to prepare you for the discharge process. We will walk you through a hospital discharge—important considerations, the key players involved, and steps to take after discharge. By following this guide, you can protect the safety of your loved one and create a transition that will support a smooth recovery.

(1) <https://www.uptodate.com/contents/hospital-discharge-and-readmission>

Planning for Discharge

Your loved one is going to the hospital, or perhaps they are already a patient. Regardless of whether or not the visit was planned, it is a difficult time for both of you. It will be a little easier if you know what to expect.

Hospitals typically screen most inpatients within two days of entering the hospital to determine if they need a discharge plan. Medicare requires that hospitals create discharge plans for patients who are at high risk for complications. It can be beneficial to create one even if the hospital does not require it. A discharge plan supports a smooth recovery and helps prevent avoidable hospital readmissions.

What is Discharge Planning?

Hospital discharge planning is a process used to decide what a patient will need for a smooth transition from one level of care to another. There are a variety of options when it comes to deciding where a person will be discharged to. Options include the home, a rehabilitative or long-term healthcare facility, or other permanent residence. Healthcare professionals can help create a discharge plan, but only a doctor can provide an authorization for discharge.

Discharge is most successful when addressed by a group of health care professionals. A team approach is especially important for patients with complex medical conditions or other complicated cases.

On a basic level, a discharge plan consists of the following elements:

Evaluation. First and foremost, hospital staff will evaluate the patient and their needs. The process includes determining what type of care is adequate for the patient, the availability of local health care services, and the availability and capability of family and friends to provide follow-up care.

Discussion. A discharge planner or other hospital staff member will share the discharge plan with the patient or their representative. The plan should include what type of care the patient needs, who will provide the care, and where the patient will be discharged to. It should also include a list of all medications and dosage information, along with details on how to administer medication, the frequency of dosages, and anything else that is considered important by staff. Discharge plans are often written in simple language and should be easy to understand. Hospitals are required to review the plan with the patient.

Preparation. After the plan is outlined, services and supplies should be coordinated. Services include arranging the transfer from the hospital to the home or to a facility, organizing care, and ordering medical supplies. Often, hospitals can refer home care or home health agencies and other support organizations.

Implementation. Upon discharge, your loved one should be able to smoothly transition home or to a facility by following the discharge plan. If the doctor recommends follow-up appointments or tests, schedule them and ensure transportation is available to and from the appointments.

The stress of a hospital stay can be intensified if you and your loved one do not know what to expect. Communication is key to success. As you help prepare a discharge plan, discuss the following topics with your loved one's discharge planner and review the checklist on the following page to ensure that you have the necessary information before leaving the hospital.

Questions to Ask the Discharge Planner

1. What is the expected rate of discharge?
2. What type of care will your loved one be required to have upon discharge? (Talk about the level of skilled care and services required to provide the necessary care.)
3. Will your loved one need assistance with activities of daily living (ADLs), or more advanced care?
4. What discharge options are recommended by staff?
5. Can you provide me with a list of providers for aftercare?
6. Can you provide me with a list of resources for additional information or support?

Discharge Planning Checklist

- The name and location of the facility your loved one is being discharged to, if they are not going home.
- The name of the agency, and date and time of start services, if they are going home.
- The name, date, and time of arranged transportation.
- A list of medications with dosage and frequency information (orders should be put out before discharge).
- A recovery plan, which can include:
 - Wound Care - how often wounds should be cleaned
 - Rehabilitation - the frequency and type of rehab needed
 - Dietary requirements
- A list of symptoms to watch out for (find out what a normal recovery looks like so that you are aware of any symptoms that are out-of-the-ordinary and know when to seek medical care).
- Referral forms, or a list of referrals for specialists and how often you should see them.
- The date and time for follow-up appointments, if required.
Schedule the appointment in advance, if possible.
- Forms for follow-up progress reports, if required.
- Other resources, such as local support groups.

During a hospital visit, it can be easy to get lost in all of the information and paperwork. Between treatments, medical tests, or surgeries, the process can be overwhelming.

Take notes on all of the information you receive so you can review it later if you need to. It is possible that you and your loved may forget important details or think of questions later on.

Gather these notes, along with other important documents, and keep them all in one folder. If possible, take a photo of notes and paperwork as a back-up copy. These photos will allow you to easily share important information with relatives or professionals involved on the case and is accessible wherever you go.

The Discharge Planning Team

Who Are the Key Players?

Now that you know the basics of a thorough plan, let's explore some of the people involved in the discharge process.

The Patient. The patient is the most important member of the discharge planning team. Their needs and preferences guide the actions of all other members. The patient or their representative should communicate what the patient is most comfortable with and open up the discussion on any desires and concerns. From there, the discharge team will share their thoughts and recommendations, and work with the patient on fulfilling these goals.

The Physician. The physician is responsible for evaluating and signing off on the final discharge plan. A well-thought-out plan is safe for the patient: it anticipates and addresses risks, and it appropriately meets the patient's medical needs. The physician is also responsible for prescribing medications. The physician's primary focus is the physical and mental wellbeing of the patient. While the physician may not have control over the care provided at the receiving facility or by the in-home agency, they do have the ability to make a well-placed decision on whether or not the facility/agency's standard of care is appropriate for the patient's post-discharge needs.

In the current state of healthcare in the US, hospitals often encourage hospital staff to reduce a patient's length of stay in an effort to minimize costs. This can increase risk for patients who are discharged before they are ready, or before post-discharge plans are properly arranged. Physicians should be—and often are—wary of such possibilities. The primary concern for physicians and medical teams is discharging patients that are safe and stable.

If you or your loved one is not ready to leave the hospital, tell the discharge planner or another team member that you are uncomfortable. *They will work with you to address any issues and ensure your needs are met.*

Nursing Staff. Nurses hold some of the responsibility for ensuring the patient is ready for discharge. Fortunately, they have a great understanding of their patients. Nurses have cared for your loved one since the moment they entered the hospital. Based on their experience, they are aware of each individual's status, ability, and willingness to follow directions. Because of their knowledge, nurses can provide valuable feedback to the family and care team.

Discharge Planners. Hospitals usually have discharge planners on their staff. Often, a discharge planner is a nurse, social worker, or hospital administrator. They have a good awareness of local resources and maintain healthy relationships with rehabilitation hospitals, nursing facilities, hospice organizations, and home health companies. They can provide clarity on different care options and whether or not they are covered by insurance or private pay. Discharge planners are responsible for ensuring that a patient is released from the hospital to the environment that will provide the most appropriate care.

Case Managers. Discharge is a complex process. It involves multiple people who are all concerned about a person's care arrangements. Case managers focus on care coordination, financial management, and resource utilization to yield cost-effective, patient-centered solutions. They decide what the patient needs during a single episode of care.

Case managers can play an especially important role in discharge planning for patients with more complex needs associated with an acute hospital stay. They can help ensure that discharge goes according to schedule, so that the patient is able to get out of the hospital as soon as they are safely able to do so. Case managers are often a patient's biggest advocate in the discharge planning process.

Care Managers. Care managers come from a variety of backgrounds and work one-on-one with people with disabilities or chronic illnesses, usually in their home or permanent residence. They develop a care plan under the direction of the patient. The difference between case management and care management is their focus: case managers focus on a single episode of care, while care managers focus on a patient's overall quality of life.

While there are geriatric care managers that specialize in working with the senior population, most care managers work with patients of all ages.

Social Workers. The discharge process can be a stressful time, and it often marks a significant medical and social transition for patients. A social workers' role in discharge planning is critical to ensuring that the patient is physically and mentally ready for their new or former living arrangements. They assess the patient for psychological and social factors that could affect the discharge plan. Social workers help patients and families address the impact of a hospital stay and treatment by connecting them to community resources and providing emotional support and guidance.

Skilled Therapists. Depending on the individual needs of the patient, skilled therapists may be able to assist the discharge planner by providing an assessment of the patient's abilities and/or weaknesses. Skilled therapists include:

- **Occupational Therapists (OT)** – OTs help patients develop, recover, or maintain skills needed for everyday activities. They assess the patient's abilities and consider whether or not they will be able to safely and independently function in their new or former environment. Occupational therapists commonly help older adults experiencing physical and cognitive changes, children with disabilities, and individuals recovering from injury.
- **Physical Therapists (PT)** – Physical therapists evaluate the patient's abilities and recommend an appropriate next level of care that ensures their safety. They can help patients reduce pain, promote mobility, restore function, and manage their condition.

- **Speech Therapists (ST)** – Patients who have survived a stroke or other neurological condition may experience communication problems. Speech therapists assess a patient’s language abilities and recommend therapies that will improve their ability to communicate.

Skilled therapy is offered by private practices, rehabilitation facilities, skilled nursing facilities, and some home health agencies. It is usually covered by Medicare, up to a certain limit.

“Having a nurse within my home really facilitated the recovery process and I would highly recommend NurseRegistry.

After my surgery, I requested nursing services from NurseRegistry to help me get through the first few days of my recovery. The nurses who took care of me were professional, competent, friendly, and above all compassionate.

They kept my post-surgical pain and swelling under control while providing excellent nursing care. It was very reassuring to know that a qualified nurse was right there if I needed anything.”

- E.R.

Private Duty Nurses. If your loved one is prepared to transition home, they may need skilled care to support their recovery. Home health may be restrictive when it comes to what it covers. Private duty nursing can be more flexible.

Nurses can provide such services as:

- Wound care management and surgical site monitoring to prevent infections
- Intravenous (IV) therapies
- Airway/management care
- Medication management and administration
- Vital signs monitoring to ensure recovery is going as it should be
- Teaching visits for clients and/or their family members
- Palliative care to enhance the overall comfort of the client
- Other skilled services

Private duty nursing is an ideal solution for individuals who may not want to transition to a skilled nursing facility, but are not ready to transition home by themselves. Private duty nurses can provide the professional support they need, allowing them to enjoy the comfort of healing at home.

Caregivers. There are a variety of care professionals to consider when transitioning from hospital to home. A professional caregiver can assist with activities of daily living, which include bathing, meal preparation, and other daily needs. Caregivers cannot provide medical care or administer medication. Hire the care professional that can safely assist your loved one with their needs. Together, a nurse and caregiver can provide your loved one with the medical care and daily assistance that they need to enjoy a smooth recovery.

Family. No one knows your loved one as well as you do. Perhaps you already provide care for your loved one, or you are willing to lend a hand with their recovery. Either way, let the discharge planners and care team know what you are capable of helping out with and what you can commit to. A family's ability, availability, and willingness to provide care is important for the future well-being of the patient.

From there, you can plan supplemental care around your own schedule and abilities. If you are not comfortable fulfilling all of the responsibilities for your loved one's care, a nurse or caregiver can come on an ongoing or as-needed basis to assist with your loved one's recovery plan. For example, a private duty nurse can lead a teaching visit and show you how to administer intravenous medication.

Caregivers or nurses can also provide respite care, which is temporary care in order to provide relief for the patient's usual caregivers. It's easy to get burned out. An extra hand can help with the responsibility of caring for a loved one.

All of these health care professionals have specialized knowledge to help your loved one smoothly transition out of the hospital. Together, the discharge planning team can ensure a safe recovery for your loved one.

Recovery Facilities vs. Home

What Are the Options?

Although many people prefer to go home, it is not always the best option. A discharge planner will evaluate the safety and effectiveness of each recovery option and present their recommendations to the patient. From there, the patient has the authority to choose or open up a discussion on their preferred solution. Remember, the discharge planners have your loved one's health as their primary focus, and their recommendations should be taken seriously.

Acute Rehab or Skilled Nursing Facility (SNF)

Inpatient services may be a necessary option. Rehabilitation and skilled nursing facilities (SNF) are similar. It is not uncommon for SNFs and rehab facilities to exist as different floors within the same building. The main difference between a skilled nursing facility and a rehab facility is that people usually spend a longer time in SNFs.

An acute rehabilitation (rehab) facility is a place where specialized medical care and/or rehab services are offered to injured, sick, or disabled patients. Services may be provided by nurses and other health care professionals, such as skilled therapists, speech pathologists, and other specialized medical staff.

A rehab facility can provide care for someone following a stroke, surgery, illness, or infection. These conditions may require IV therapies, antibiotic administration, wound care, or other forms of medical care. A stay at these facilities can be covered by Medicare for up to 100 days. Rehab facilities are regulated and certified by the federal government, as well as state and local laws.

Rehab facilities are not permanent residences. Hospitals typically refer patients for short- or long-term care, depending on their needs. After a rehab facility stay, patients are discharged to the home, a nursing home, or other permanent residence.

A skilled nursing facility (SNF) provides skilled nursing care and/or rehabilitation services. Generally, services that are available in a SNF include nursing care by registered nurses, bed and board, physical therapy, occupational therapy, speech therapy, medical social services, medications, medical supplies and equipment, and other services necessary to the health of the patient. Like rehab facilities, staff may include licensed nurses, skilled therapists, and other specialized medical staff.

Medicare offers 20 days of full coverage in a SNF, if Medicare coverage requirements are met. After that, Medicare pays for covered services—except for a daily co-insurance pay—for days 21 through 100.

Your loved one may be eligible for Medicare coverage for their skilled nursing facility care if:

- They have Part A and days left in their benefit period.
- They have a 3-day qualifying hospital stay where they have been admitted as an inpatient, and they are admitted to a SNF within 30 days of a hospital discharge for services related to their hospital stay.
- Their doctor certifies that they need daily skilled care given by, or under the direct supervision of, skilled nursing or therapy staff.
- They get care in a skilled nursing facility that is Medicare certified.

Let's discuss the advantages and disadvantages of staying in a rehab or skilled nursing facility.

Advantages

Inpatient care has a multitude of benefits for the recovery process. These facilities should have adequate professional and material resources to address the patient's medical needs. Your loved one will have access to and benefit from specialist treatment to ensure a smooth, steady recovery.

Stays in these types of facilities tend to be a few weeks—not months. After a few weeks, the patient will be transferred from the facility to their home, a nursing home, or another form of permanent residence. If rehab or skilled nursing services continue to be required, then the patient may use outpatient services, such as an adult day health center, or bring in private duty nurses or caregivers.

Medicare typically covers a stay in these facilities. In SNFs, Medicare can cover weeks of care if the patient demonstrates progress in therapy or if their condition is unstable enough to require around the clock skilled nursing care.

One of the biggest advantages to staying in a rehab or skilled nursing facility is the assurance and peace of mind that comes with supervised care from skilled professionals. Licensed nurses, CNAs, and other medical staff are on location 24/7 to ensure a smooth recovery for your loved one.

Disadvantages

Depending on your perspective, a few weeks in one of these facilities can feel like a long time. If home is a safe option, a rehab or skilled nursing facility may not be your preferred choice.

Although Medicare typically covers these stays, **coverage is not guaranteed**. Patients may sometimes be obligated to pay for care which should be covered by Medicare. Once acquired, coverage may be subject to regular evaluations of the patient's condition. Determine what coverage you may be getting before being discharged from the hospital, and call your insurance provider if you have any questions about coverage requirements.

An extended stay in an inpatient facility can **increase the risk of infection or illness** due to the close proximity of patients recovering from illness. Infection or illness interrupts recovery and increases the risk for hospital readmission. Unfortunately, healthcare-associated infections are a major—yet preventable—threat to patient safety.

A lengthy stay can **lead to depression and inhibit recovery**. Care in a rehab or skilled nursing facility is structured, and there are often schedules for everything, including set shower times. Patients may feel institutionalized, or bedbound.

Care staff may be spread thin and **your loved one may not get the one-on-one attention** they feel they deserve. A simple solution is to hire a private nurse to accompany your loved one at the inpatient facility. Supplemental care offers personalized attention and companionship, which are important parts of the recovery process.

Outpatient Care

Rehab facilities offer outpatient services for patients who have the ability to travel to and from appointments. Outpatient care facilities usually offer physical, occupational, and speech therapies. These facilities are only an option if your loved one's care needs are not acute and do not require inpatient services.

Advantages

If your family member's needs are not acute and do not require inpatient services, outpatient care is a good solution. Your loved one can transition back to their permanent residence while getting the care and therapy they need.

Disadvantages

During recovery, some patients may require therapy or specialized medical appointments multiple times per week. It may be tiring for your loved one to complete the journey each time. In addition, organizing transportation to and from these appointments can be demanding.

Communicate any concerns you have about outpatient services with your loved one and the discharge planner. Keep your loved one's preferences in mind, but remember that their health is everyone's number one priority.

Heal at Home

It may be possible for a patient to recover safely in the comfort of home with adequate post-hospital care in place. However, it must be supported by the discharge planning team.

Advantages

There are a variety of advantages to recovering at home. Besides enjoying the comfort of familiar surroundings, healing at home greatly reduces the risk of infection or illness that is all too common in inpatient facilities.

Patients who recover at home can still receive expert care. Care professionals, such as private nurses and caregivers, can provide much more personalized attention in the home. Visits can range from a few hours to around-the-clock care. With 24 hour care, patients and families can rest assured knowing that a care professional is available at all times.

Skilled therapists can create rehab programs that are customized to the patient's everyday environment. Recovery goals become more realistic, and more meaningful. A physical therapist can guide a patient recovering from hip surgery around their own home. It can feel far more motivating to walk around your home compared to walking laps around an unfamiliar facility. In addition, patients may experience a smoother transition back to their everyday routines.

A hospital stay can negatively impact a person's mental health. Adults may feel fearful or that they lack control over what is happening to them. A well-rounded recovery includes reducing stress and promoting independence, health, and positivity. Fortunately, the psychological benefits of transitioning home go beyond physical therapy training.

Home health care and private duty nursing offer the greatest security and happiness for the client and the most peace of mind to their family.

Disadvantages

Sometimes, transitioning home can be challenging. It may involve coordinating multiple agencies and care professionals. If this seems overwhelming, a case manager can help.

Case managers can:

- Coordinate with family, caregivers, and other medical providers
- Schedule and accompany patient to healthcare appointments
- Order medical supplies, if necessary
- Communicate with all members of a patient's care team, including the family, doctor and other healthcare professionals

It can be beneficial to have a case manager who is a licensed nurse. In addition to the above responsibilities, an RN case manager can assist with medication reconciliation and management, as well as prescription refills.

Home health care may be covered in part by Medicare, though there are many rules and regulations. Consult your loved one's insurance provider to see what coverage works best for them. Typically, home care and private duty nursing care is an out-of-pocket expense.

Other forms of permanent residence may not have skilled aides on staff, so they cannot assist with skilled needs. You should know whether or not a residence has skilled aides before your loved one transitions to that facility. If the facility does not have skilled aides, a private duty nurse can provide personalized medical care for your loved one.

Private duty nurses are available for full-time care. They can support a range of skilled needs, including wound care, IV therapies, feeding pumps, and palliative care.

Skilled care can be especially beneficial for patients with more complex needs associated with an acute hospital stay or chronic conditions. Private duty nursing and other home care services can positively effect a patient's recovery and overall quality of life following a hospitalization.

To explore these options, call (650) 462-1001 to speak with a NurseRegistry Care Advisor about a personalized care plan for your loved one.

*"From the office staff to the compassionate, knowledgeable nurses...my experience was phenomenal! My mom needed more care than I could handle after her surgery. **NurseRegistry went above and beyond to make sure she received the care she deserved.**"*

- Tessa O.

Support Your Loved One's Recovery

A long-term plan is essential to a smooth recovery. Consider the following topics as you help your loved one develop a recovery plan for day one and beyond.

Services and Supplies

In some cases, you may need to order supplies for short-term or ongoing needs. Medical supplies include the proper equipment to administer medications, walkers, wheelchairs, bed pans, ventilators, and other devices. A private duty nurse can lead an educational visit and teach you how to clean wounds and administer medications, among other skills. This one-on-one attention can give you and your loved one the confidence needed to continue down the path to recovery.

Lifestyle Adjustments

New medical devices and home modifications can take time to adjust to. After an illness or surgery, some people may be required to make lifestyle changes, such as a new diet or exercise regimen. Your loved one should discuss what changes they should anticipate after discharge with their healthcare provider.

Support groups can be very beneficial in venting frustrations and connecting with people who are going through similar experiences. Stay positive, and remind your loved one to approach recovery with an open mind.

“NurseRegistry has been an absolute saving grace for my dad and I. When he came home from the hospital we really needed licensed nurses to help with all the medications and wound care. I was so overwhelmed. NurseRegistry sent over a couple of very knowledgeable, wonderful nurses, I couldn’t have asked for more.”

- Heidi A.

Know What to Expect

Recovery can be a life-long process. Knowing what to expect in your loved one’s recovery is a critical first step. Be frank when discussing what the recovery process will look like and the duration. Your loved one should not be disappointed if they are sticking to the plan but not advancing as quickly as they would like. Everyone’s personal journey is different. Overexertion can hinder recovery more than it can help. Allow them to take their recovery a day at a time. If the plan needs to be updated, be open with their doctor and discuss any difficulties that have emerged.

Support Systems

Family and friends are a wonderful first line of support, but sometimes, it can be difficult for them to provide the care needed. There are local support groups for individuals with chronic diseases, or those who have experienced life-altering events, such as a stroke. Your loved one’s care team can share the local resources that will benefit them most.

Caregiver burnout is a real problem for family members who are caring for their loved ones. Many agencies offer respite care to provide you with the relief you deserve. There are also support groups where family caregivers can connect.

It can be easy to want to rush the discharge process and bring your loved one home sooner than they are safely able to do so. Everyone's primary goal should be the health and wellbeing of the patient. Follow this hospital discharge guide, and choose the best recovery plan for your loved one.

To learn more about how a private duty nurse can ease the transition into post-hospital care, call (650) 462-1001 to speak with a NurseRegistry Care Advisor.

"My wife recently suffered a sudden onset of terrible pneumonia. She was rushed to the ER and then transferred to its ICU, where she spent 12 days.

I contacted NurseRegistry before my wife was discharged. *The people I spoke with were empathetic, competent, and professional, in the best sense of that word. When we arrived home from the hospital, a nurse was waiting for us.*

Since then, we have had three nurses from NurseRegistry. *Each nurse has been superb—highly skilled, sympathetic, intelligent, and a pleasure to work with and be with. Without their help, I would have been overwhelmed."*

- Denis C.

About NurseRegistry

NurseRegistry has been a trusted resource to patients and their families since 2009.

Our skilled nurses provide one-on-one medical care and respond to your changing healthcare needs, with the goal of improving quality of life for the individual and their family. Care can be provided in a facility or in the comfort of the client's own home.

Partners in Healthcare. We work closely with each patient's healthcare team to provide the most appropriate level of care. Our nurses hold certifications in a variety of specialty areas and care is tailored to the patient's unique needs.

Flexible scheduling. We have the freedom to offer flexible scheduling—whether you need a short visit or 24/7 care.

Care for all ages. Our nurses provide care to people of all ages, from infants to seniors.

Our staff is available 24/7 to assist with your nursing needs. Call (650) 462-1001 to learn more.

Testimonials

“Finding skilled, professional nurses who are comfortable working outside of the hospital or clinic setting is challenging.

When clients choose to return to their home following an acute hospitalization or have a complex medical problem and require professional nursing services, NurseRegistry has never failed to find well qualified staff for our clients.

NurseRegistry is highly professional, has extensive experience and is very easy to work with. They understand complex medical care needs and are dedicated to excellence. The Life Care Company manages numerous families with complex medical needs and highly recommends NurseRegistry for professional nursing services at home.”

- Kathy Berra, MSN, NP-BC, FAHA, FAAN
Director of [The Life Care Company](#)

“As a geriatrician in the community, it has been a great pleasure to work with NurseRegistry.

I really admire their professionalism and their caring approaches, especially for my vulnerable patients’ population.”

- Mehrdad Ayati, MD
Founder of [Geriatric Concierge Center](#)

“NurseRegistry services are one of the best and most trusted nursing services on the Peninsula.

Our medical practice is a concierge service in Menlo Park and we have a number of patients that require high touch-point nursing care on demand at their house. NurseRegistry is our top go-to-service that we refer our patients to. They are absolutely trustworthy—if they say that they are going to send a nurse, a nurse is sent.

The NurseRegistry team does their very best to find the best possible match between the needs of the patient and their nursing team. We’ve gotten high praises about how much NurseRegistry will accommodate to make patients happy. Their team is always on time. Their nurses are extremely well trained in a number of areas including complicated rare treatments that some of our patients need.

NurseRegistry nurses truly care for patients—they love their jobs and have a true calling—which matters so much when it comes down to providing the most personalized care. Thank you NurseRegistry for all the hard work you do every single day.”

- Ian Kroes, MD

[Peninsula Doctor](#)



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