WRH DISCHARGE PLANNING POLICY

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PURPOSE

The purpose of the discharge policy for WRH is to set out the principles and practices that must be followed by staff in working with patients and families to support them to go home after their acute medical/mental health event. Windsor Regional Hospital is committed to ensuring that all patients have access to and receive the care most suited to their needs, as promptly as possible, and are discharged home, whenever possible, enabling the right care at the right time in the right place. WRH is committed to make transition home as smooth as possible and working in partnership with the Erie St. Clair Community Care Access Centre (CCAC) to enable a collaborative approach to discharging patients.

POLICY

On admission to hospital, including the Emergency Department, it is important to start planning for the patient's safe discharge home so that we can develop a treatment plan in hospital and a care plan upon discharge that will enable the patient to return home for the next stage of care. Screening for risk of a challenging discharge is a component of determining the need for early discharge planning and a screening tool will be implemented at the time of admission to hospital. For those patients that screen positive for the need for discharge planning, a referral for service will be initiated to the Erie St. Clair Community Care Access Centre (CCAC) for assessment of all options to discharge home with supports.

The CCAC will initiate contact with the patient/SDM/family within 48 hours of admission and engage with the discharge planning process with the patient/SDM/family throughout their stay, to ensure appropriate post-discharge care planning occurs. All members of the care team (hospital staff, physicians and the CCAC) will consistently communicate home as the preferred option. The (CCAC) care coordinators are part of the hospital inter-professional care team and will work with patients and their family to explore all available community options to enable a safe transition home. Discharge planning will focus on a final destination of home based on the individual patient's needs and requirements. Hospital staff and physicians will work proactively to ensure timely access to needed inpatient treatment and communicate the expected date of discharge (EDD)/expected date of medical stability to the patient and the interdisciplinary team, inclusive of the CCAC Care Coordinator. The hospital will also advise the patient's family doctor of the patient's admission and anticipated date of medical stability/discharge within 24 hours of admission. The interdisciplinary care team will provide the patient requiring discharge planning and their family with information on supports available upon discharge.

The discharge plan for each patient will provide timely and continuous identification of care needs, establishment of patient centered goals, interdisciplinary collaboration, communication and education, as well as continuous evaluation of the discharge plan. The patient's discharge needs will be assessed by the hospital and the CCAC and all discharge plans will be made in collaboration with the patient and their family. Family conferences involving the patient, family and/or substitute decision maker, attending physician and interdisciplinary team members, may be arranged by the hospital and CCAC as required.

No one will be designated as Alternate Level of Care (ALC) – Waiting for Long-Term Care until full exploration of all the community options have occurred and senior leadership from both the hospital and CCAC agree that waiting in hospital for LTC is the only option . To ensure that ALC LTC process is followed, the ALC LTC sign off sheet will be signed by all parties. The discharge occurs once the inter-professional team has arranged any needed community care and the Most Responsible Physician (MRP) writes the discharge order. From home, with CCAC and/or other community support, the patient can recuperate and stabilize, and then make further care and accommodation decisions in a safe, comfortable environment.

If it is not possible to return home and the patient is eligible for placement in a Long-Term Care Home (LTCH), the patient and substitute decision makers will be asked to choose five (5) Long- Term Care Homes. If no bed is available in the preferred home, then the patient will be offered the first available open bed in one of the chosen Long-Term Care Homes to await transfer to the preferred home. Idle beds in Long Term Care that are available in the region will also be offered to the patient as an alternative to waiting for their preferred Long Term Care Home (LTCH) in hospital.

The hospital will charge a monthly co-payment to patients awaiting placement to a Complex Continuing Care, where applicable, or Long-Term Care Home in accordance with Ministry of Health and Long-term Care directives. The co-payment is similar to the charge the patient would pay as a resident in those LTCHs. If this applies, the patient will receive detailed information from the Business Office.

If a patient is deemed appropriate for discharge to home by the MRP and can be supported at home with CCAC or other community services and the patient refuses to leave, they will be charged a per diem acute care rate to cover the accommodations of the hospital bed after a reasonable notice period

KEY PRINCIPLES

1) **Identify Patients at Risk.**

   Windsor Regional Hospital and the ESC CCAC will begin discharge planning with the patient and the patient's family at the earliest possible opportunity. Screening for risk of a complex discharge is a component of determining the need for early discharge planning and a screening tool will be completed by the Utilization Nurse when the patient has been admitted. A Utilization Nurse will screen the patient at the time of admission (to occur in the ED if the patient remains in the ED for greater than 12 hours) and if the patient screens positive for the need for a more involved discharge planning process, a referral will go to the CCAC who will begin engagement with the patient/caregiver within 48 hours. **See Addendum A: ED Complex Discharge Screening Tool.**

2) **Proactively collaborate to establish processes which promote patient flow through the organization in a timely manner.**
   a) The hospital will have an established process to ensure timely access to an inpatient bed from the ED (Daily Flow Report, VIBE, ED tracking system and ED Overflow Protocol).
   b) The hospital and CCAC will track and monitor (daily, weekly, monthly and yearly) identified key CCAC WRH performance metrics that impact patient safety, quality and flow. The hospital will work collaboratively with CCAC on improvement of these results.
   c) The hospital (WRH SW, UM, CCAC), working in collaboration with the patient's most responsible physician/delegate (MRP), will provide the patient and the interdisciplinary team (inclusive of the CCAC Care Coordinator) an Expected Date of Discharge (EDD).. Escalation and WRH Surge Policy and Protocol initiated as necessary.
   d) The hospital will complete the repatriation/transfer form (utilizing the PHRS system where applicable) if the patient is moving to another acute care setting.
   e) The Hospital will refer the patient to the CCAC and Post-Acute Assessors if the patient will be moving to Complex Continuing Care/ Palliative Care /Rehabilitation
   f) Utilizing the guiding principles outlined in the Managing Transitions document and the Home First philosophy, the CCAC will begin engagement with the patient/caregiver within 48 hours to ensure appropriate post discharge care planning occurs in a timely fashion. WRH and CCAC will monitor and track compliance utilizing joint performance metrics.

3) **Promote home as the primary discharge destination.**

   Other than planned surgical procedures where the discharge and discharge planning process occurs in advance of the elective procedure, all discharge planning will start at the time of admission and will include a planned discharge

date and discharge time before 1100h seven days per week. Patients and families will be included in discharge planning throughout the admission. **See Addendum B: Letter on Admission for Patients Referred to CCAC**

4) **Provide patient and family relevant information**.

The hospital will provide the patient requiring discharge planning with information on supports available on discharge using the patient/family letters. **See Addendum C: Getting Home from Hospital** and **Addendum D: Settling In At Home**. Information will include the risks of staying in hospital. If all known community supports have been explored and it has been deemed by the team in consultation with the patient and their family that no other option is available other than to wait in hospital for Long Term Care, a process will be followed to engage leadership at the Hospital and the CCAC to ensure process was followed and no option was missed. **See Addendum E: ALC-LTC Sign-off Form.**

5) **Long-Term Care applications will not typically be completed in hospital, but rather in community,** if needed**.**

The discharge plan for each patient will provide timely and continuous identification of care needs, establishment of patient centered goals, interdisciplinary collaboration, communication and education, as well as continuous evaluation of the discharge plan. The patient's discharge needs will be assessed by the hospital and the CCAC Care Coordinator and all discharge plans will be made in collaboration with the patients and their family. Family conferences involving the patient, family and/or substitute decision maker, attending physician and interdisciplinary team members, may be arranged by the hospital and CCAC as required. As part of the planning to help each patient safely transition home, the Hospital and CCAC need to ensure that all options have been considered and explored prior to designating a patient ALC-LTC and waiting in hospital for Placement. To demonstrate this joint commitment, a joint "sign-off" signed by leadership of the CCAC and the hospital must be completed before a patient is designated ALC-LTC. . Prior to getting to the sign-off process, an escalation process must be followed.

If the patient is to wait for LTC or other accommodations such as supportive housing in hospital before discharge home, the hospital will request that the patient and their family make five choices for Long Term Care placement and will provide them with information on their eligibility for co-payment. **See ADDENDUM F: Patient Copay Letter**.

On Admission to Hospital

- The discharge planning process begins at the time of patient admission. All staff will clearly articulate the hospital's expectations regarding discharge policy to all patients / SDMs and families.
- Upon admission to the inpatient unit the Nurse will provide the patient with a letter containing information about the goal of returning home and reasons why, discussion about planning on admission for discharge arrangements and supports. Information will be provided by the Nurse about the discharge time and the responsibility of arranging necessary transportation.
- Patients will be assessed on admission by Social Work & CCAC for current living arrangements and supports .

Within 24-48hrs After Admission

- The Most Responsible Physician (MRP) must complete History and Physical (H&P) assessment and treatment plan within 24 hours of patient admission or otherwise specified per hospital bylaws. The MRP will also initiate the Acuity Summary Form (with support from the Utilization Nurse). The care plan should contain working diagnosis, required investigations, and treatment.
- The Utilization Nurse in collaboration with CCAC will assess and document the patients acute care needs daily. The Utilization Nurse using the ACTIV tool in Medworxx and will assess readiness for discharge using the Medworxx criteria set. This is confirmed by the MRP and this information is provided to the care team during care rounds, including CCAC. The Utilization Nurse in collaboration with CCAC will also have this discussion with the patient (SDM) and family.
- The Estimated Length of Stay (ELOS) and Estimated Date of Discharge (EDD) will be determined by the Utilization Nurse based on the documented most appropriate diagnosis, comorbidity levels and flagged interventions.
- The ELOS/EDD will be communicated and documented on the Care Round Board, discussed at Care Rounds and reviewed with the MRP. THE EDD will be tracked in Medworxx by the Utilization Nurse.

Ongoing

CCAC will be notified early on in the admission that a patient is high risk for ALC utilizing the Complex Discharge Screening Tool at admission. As appropriate given discharge destination, patients designated ALC will be referred to CCAC

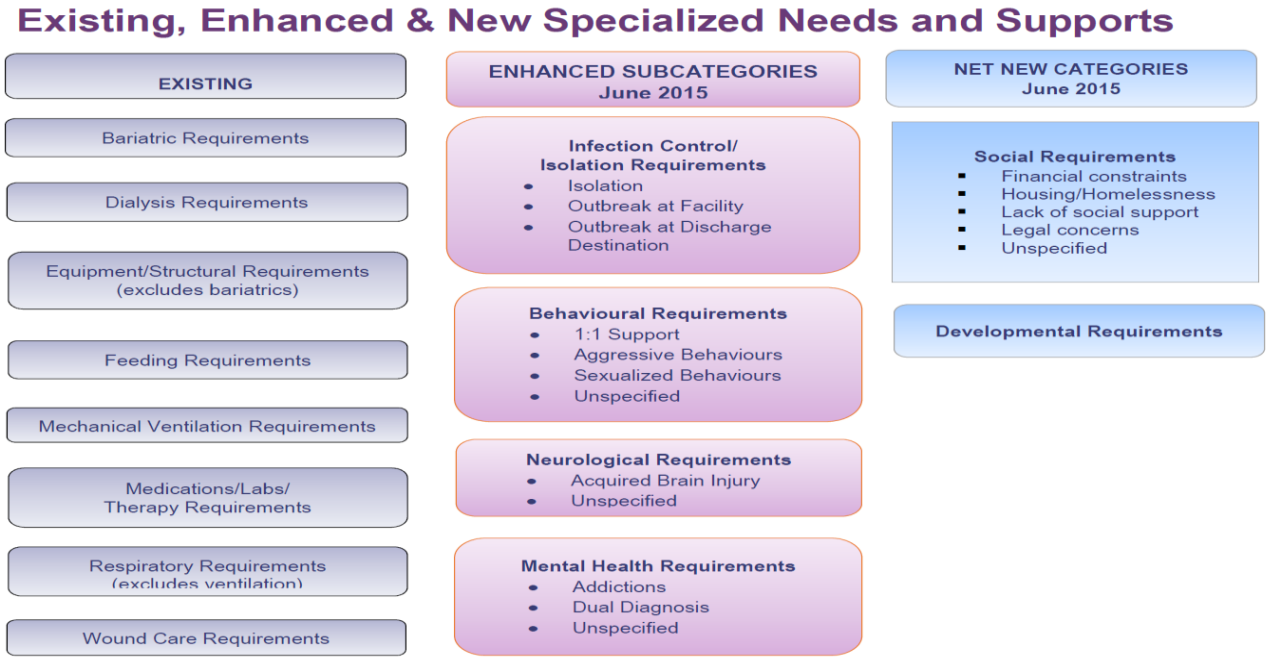
Identification of Barriers to Discharging Home

Discharge planning is a collaborative process which begins as early as possible to allow the patient, substitute decision maker (SDM), family and the care providers enough time to understand and explore the options for the most appropriate plan. The individual nature of each patient's discharge plan or transition through the health care system can be complex and requires specialized care needs and supports.

The specialized care needs and supports for patients at the ALC discharge destination are defined as:

- **Specialized Needs**: the specialized care needs/supports of the patient required at the ALC discharge destination that are not preventing or are not known to be preventing discharge.
- **Barriers**: the specialized care needs/supports of the patient required at the ALC discharge destination that is preventing discharge.

The following illustration shows the context of special needs and supports:



6) **Discharge Order.**

When a patient no longer requires hospital care, the MRP will inform the patient of their discharge. The MRP will issue a Discharge Order that indicates that the patient is ready for discharge. The discharge date will be communicated and reinforced by the care team to the patient/caregiver/SDM. Each member of the health care team in the hospital and CCAC and other community health care agency providers, as applicable, will be involved in the discharge planning process to ensure that the patient will be ready when discharged. Care conferences will facilitate the inclusiveness of all health system partners that are required to support the patient's discharge home. The primary discharge destination is the patient's previous living arrangement.

7) **Patient Refusal to Leave.**

The purpose of the patient refusal to leave letter in the discharge policy is to set out the principles and practices that must be followed by staff in working with patients and families, who no longer require acute care as determined by the MRP, yet want to remain in hospital.

g) **Refusal to Leave**. When it becomes apparent that a patient will refuse, or is refusing, to leave the hospital, the hospital's administration in collaboration with CCAC administration will meet with a patient to ensure the patient understands the options for discharge being proposed and the consequences of refusing to leave the hospital. They will review a joint care plan with the patient and the meeting will be documented in the patient's chart and provided to the patient. The hospital will identify the daily rate that the patient will be charged for uninsured inpatient services if the patient doesn't leave the hospital when discharged.

h) **Confirmation of Consequences of Refusal to Leave**. If the patient still refuses to leave the hospital, hospital administration will be notified and a letter confirming the consequences of not leaving will be given to the patient. **See Addendum G: Patient Refusal to Leave – Unregulated Rate Letter**.

8) **WRH Discharge Policy Algorithm.**
Hospital staff, CCAC and community partners will work collaboratively in discharging patients to their most appropriate discharge destination. **See Addendum H: WRH Discharge Policy Algorithm**.

REFERENCES

- Home First
- Alternate Level of Care (ALC): Cancer Care Ontario, 2009 Erie St Clair LHIN, Discharge Policy Information (2013) Ministry of Health and Long Term Care Act (2002)
- Public Hospitals Act Memorandum 2012
- Health Insurance Act Sec 10 Regulation 552
- Bluewater Health Discharge Planning Policy (2013)
- "Managing Transitions – A Guidance Document" – Ontario Hospital Association" (2015)

ADDENDUM A: ED COMPLEX DISCHARGE SCREENING TOOL

- Click here to access

ADDENDUM B: LETTER ON ADMISSION FOR PATIENTS REFERRED TO CCAC

- Click here to access

ADDENDUM C: GETTING HOME FROM HOSPITAL

- Click here to access

ADDENDUM D: SETTLING IN AT HOME

- Click here to access

ADDENDUM E: ALC-LTC SIGN-OFF SHEET

- Click here to access

ADDENDUM F: PATIENT COPAY LETTER

- Click here to access

ADDENDUM G: PATIENT REFUSAL TO BE DISCHARGED - UNREGULATED RATE LETTER

- Click here to access

ADDENDUM H: WRH DISCHARGE POLICY FLOW CHART