The Discharge Planning Process:

The discharge planning process assists in early identification and assessment of patient's needs, and implements timely discharge plans along an integrated continuum of care. The discharge planning process remains dynamic and is continually re- evaluated and redeveloped to reflect the ever changing needs of the patient and to achieve desired outcomes and ensures efficient utilization of hospital and community resources. (The Association of Discharge Planning Coordinators of Ontario Position Statement)

Procedure:

It is the responsibility of all interprofessional team members to set expectations with the patient and family for discharge and return to the community once medical treatment has been completed. This may require new or enhanced community supports with the potential for a new community destination while the patient waits for another level of care. This Home First philosophy will be adopted and supported by all team members beginning at the point of the patient's access to hospital.

1. Discharge planning begins at the point of pre-admission and/or admission with the:
- **a**. Early identification/screening for discharge risk using validated tools and/or the completion of the pre-admission screening tool by scheduled patients and/or substitute-decision maker, and
- **b**. Completion of the Patient History and identification of high risk factors for discharge challenges including identification of existing supports including SE LHIN services, and
- **c.** Completion of early referrals to appropriate interprofessional team members based in discharge screening and initial assessments

2. The patient's discharge needs will be further identified by the interprofessional team during the course of stay, and all discharge goals will be discussed with the patient and/or substitute decision maker.

3. Interprofessional case conferences and discharge meetings (e.g. bullet rounds) are used to better coordinate care, make revisions to the discharge plan and streamline the discharge process. Proactive and effective communication strategies between the team, patient/family are essential. Absence of interprofessional collaboration can yield poor continuity of care, increase length of stay and contribute to discharge planning delays. Interprofessional mechanisms and criteria to define roles, responsibilities and standard work will support effective outcomes.

4. Complex discharge issues or concerns will be referred to the Patient Flow Coordinator (PFC) for consultation and coordination of discharge plans. Examples include uncertain destination, inadequate home support, and non-engagement in the discharge process.

5. To support patients requiring new, enhanced or resumption of home care services to return to the community, a resource matching and referral (RM&R) will be made to the SE LHIN.

6. For those patients who are eligible and require Complex Continuing Care (CCC), the patient care lead/in charge will inform the patient and/or substitute decision maker to gain consent and a referral will be made to CCC. When the CCC bed becomes available, the patient and families will be notified by nursing of the discharge from acute and admission to CCC.

7. Family conferences involving the patient, family and/or substitute-decision maker, the attending physician and relevant members of the multidisciplinary team will be coordinated by the PFC. The goal will be to plan and coordinate care and resolve discharge issues.

8. Every opportunity to support the patient to return to the community will be explored.

9. For those patients who will likely require placement in a long term care facility, the PFC and the SE LHIN H&CC Coordinator will first meet with the patient and/or substitute-decision maker and discuss Home First. If they have been unable to negotiate support for the patient to wait in the community for LTC the escalation process will be considered if cooperation is the barrier. For Home First non-admits, the LTC destination is accepted and arrangements will be made to complete a long term care application.

The patient flow coordinator will work collaboratively with the SE LHIN to ensure the patient/SDM/POA for care has the appropriate and necessary information regarding long-term care placement and the selected choices. The patient or SDM role as a partner consists of selecting and applying to appropriate facilities or homes within three days when applicable, accepting the first available bed from among the chosen homes.

The patient or SDM will be asked to select five homes from the SE LHIN matching profile list including two homes with shorter wait lists. For patients transitioning to LTC the first available bed may be an interim LTC placement until the most preferred home or facility has an available bed.

10. A copy of the Appropriate Discharge Information for Patients and Their Families will be included in the package given to patients or SDM (See – *Letter to Patients and Families about LTC and Discharge*) along with the co-payment package as per standard work processes. This will be documented in the progress note. The SE LHIN will inform the patient and/or substitute decision maker when a bed in a Home of their choosing becomes available.