Discharge Process and Escalation

SECHEF Members

The aim is to prevent or reduce conflict with patients and families while working through the discharge process. (See attached Prevention and Resolution Checklist attached)

Discharge Process Guiding Principles

1) Interprofessional team approach to discharge planning to ensure patient returns home post hospital stay.

2) Patient and family will be informed on admission about the expectation to return home post hospital stay

3) Discharge planning starts on admission with an expected date of discharge or estimated LOS established within 24 hours of admission

4) Planning for patient's discharge care needs will involve regular communication within the team, patient and family.

5) Consistent and clear communication of patient's progress on care pathway and discharge planning with team, patient and family will be key to the patient going home at the right time in their care journey

6) Visual aids will be utilized to assist in the ongoing communication of patient's pending discharge. For example the unit bullet round and individual patient bedside white boards.

7) When patients meet the Provincial definition for ALC designation will occur once the physician has deemed the patient to be medically stable and each discipline has verbally signed off. ALC LTC designation will not occur without a full team discussion, agreement and at minimum Director approval.

Rules of engagement

1) Respect all opinions. The team must agree that the timing is appropriate and patient is medically stable and ready for discharge.

2) All parties agree to proceeding with the Home First (HF) or complex discharge meeting.

3) Finance staff are not to attend HF meetings. This gives the wrong impression if we cue families to bring in all required documentation for co-pay review; we are voicing lack of confidence in the HF process.

4) Requests for combined meetings (pre-approved Home First non-admits) must be authorized by the managers of Patient Flow and the SE LHIN. This will ensure that the message the family hears at the discharge planning meeting is that we have confidence in the HF process. If all parties are in agreement that a plan cannot be put in place to meet the needs of the patient then a combined meeting is acceptable. Please see your manager if clarification needed.

Process

1) Bullet rounds will serve as an interprofessional forum to identify patients who are at risk for a prolonged hospital stay and require a focused discharge plan.

2) Interprofessional team considers patient readiness for discharge and proceeds when appropriate with Home First meeting.

3) The team in collaboration with the patient and family will review whether there is an opportunity for the patient to improve and where this is best facilitated. Appropriate referral will be made with determination of eligibility and consent.

4) The PFC will identify who needs to attend the Home First meeting when members beyond the SE LHIN are required.

5) It is important the SE LHIN and PFC meet prior to booking the HF meeting. This is an opportunity to share concerns and achieve agreement to ensure consistency of messaging when meeting with family and/or caregivers. Input will be sought from appropriate team members or manager if necessary to resolve any outstanding concerns.

6) A review with the Manager Patient Flow and the Manager SE LHIN H&CC to obtain approval to proceed with a non-admit in advance of the HF meeting if there is agreement that an adequate plan cannot be negotiated.

7) Once the SE LHIN H&CC and PFC believe plan can be achieved, the PFC will book a HF meeting after conferring with H&CC regarding target discharge date.

8) If the HF meeting is not going well, identify patient and or family concerns and barriers that you are unable to resolve. Advise patient/family that you will work with the team on the development of a plan to address concerns and that a subsequent meeting will be scheduled. Advise that our goal for the next meeting will be one week max from this initial meeting.

Escalation Process

In keeping with the SELHIN Home First Referral Process once a patient is medically ready for discharge and previous attempts to collaborate on a discharge plan have failed:

1) A Complex/Home First Escalation meeting will be scheduled by the PFC with the patient/family/SDM along with the Unit Manager, Manager Patient Flow and with the SE LHIN H&CC in attendance. **Stage 1** Escalation

2) If there are concerns about potential refusal or safety of the discharge then the PFC or SE LHIN H&CC Coordinator will notify their respective manager prior to booking the meeting in an attempt to ensure all options have been explored.

3) During the **Stage 1** meeting should any barriers be identified that were not foreseen and planned for then the Manager Patient Flow or unit Manager will advise the patient/family/SDM that we will work on a plan to address the concerns.

4) Should the **Stage 1** escalation meeting be unsuccessful with continued a patient/family/SDM refusal then a **Stage 2** Escalation meeting will be booked with the Program Director immediately if possible or within 2 business days. This meeting will be booked by the CNO admin support.

5) Should the **Stage 2** Escalation be unsuccessful then a meeting will be arranged with the VP of the Program. This meeting will be booked by the VP admin support.

6) At any point during the process the patient/family/SDM reach an agreement to the discharge plan then the SE LHIN H&CC Manager and the Manager of Patient Flow are to be notified.

South East **LHIN** | **RLISS** du Sud-Est

QHC Quinte Health Care

Patient Name: _____
Location: _____
SDM Name: _____
Contact Number: _____

Conflict Prevention and Resolution Checklist

Summary of Communication/Correspondence regarding Patient/Substitute Decision Maker (SDM) refusal of Supportive Discharge plan

Procedural Step	Comments	Date
Conflict Prevention – Prior to: Patient/SDM advised that if supportive discharge plan (including transfer to post-acute program) is refused, the hospital will require meetings with escalating levels of leadership		
This information to be communicated to patient/SDM by hospital staff at the point of sharing supportive discharge options.		
This information to be communicated to patient/SDM by Community Care Access Center (CCAC) Care Coordinator at the point of providing supportive discharge plan including CCAC service plan		
Conflict Resolution: At point of patient/SDM expressing wish to refuse supportive discharge option(s) **If not resolved, Level 1 letter signed by Director and delivered prior to next meeting**		
Hospital Clinical Unit Manager and/or Manager Patient Flow to meet with patient/SDM to remind them of the need to participate in development of a discharge plan and attempt to negotiate in support of discharge.		
CCAC Client Services Manager, *where appropriate*, will consider authorization of services beyond CC authorization level		
Continued Refusal: Patient/SDM maintain their refusal to engage in supportive discharge plan **If not resolved, Level 2 letter signed by VP and delivered prior to next meeting**		
Hospital Director or equivalent to meet with patient/SDM. To remind of need to engage and that if unsuccessful a meeting with VP will be required and that per diem rate may be applicable		
Hospital representative to inform Communications Director and Risk Management and the SE LHIN of potential per diem charge		
Dispute: Patient/SDM maintain refusal of supportive discharge plan **If not resolved, Level 3 final letter signed by VP and delivered**		
Hospital VP to meet with patient/SDM in final attempt to resolve. If no resolution, inform patient/SDM that per diem rate will be charged as of XXX date and provide final letter.		
Inter hospital stakeholders informed of implementation of per diem charge		

Note: This document is NOT part of the patient health record and serves the purpose of summarizing communication/correspondence with patient/SDM refusal of a supportive discharge plan (including a refusal of a Post-acute program bed) with expectation of remaining in hospital.

Notification	Date
Legal Counsel/Risk Management	
Patient relations	
VP CNO	
VP CEO	