QUINTE HEALTHCARE CORPORATION

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Discharge and the Home First Approach

Title: Discharge and the Home First Approach		**Policy No:**	**3.2** **SELHIN 006**
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Department:	**Corporate**	**Policy Lead:**	Manager Patient Flow
Approved By:	**Operations Committee**		

1. PURPOSE

This Policy is intended to support effective discharge planning, including ensuring a) a safe and efficient, patient-centred transition between acute care, rehabilitation facilities, outpatient settings, primary care physician, and community while b) maintaining a continuity of care and coordination of services that will optimize patient and caregiver well-being. Effective discharge planning is essential for these smooth transitions of care. Delayed or incomplete planning leads to prolonged hospital stays and/or an increased risk of adverse events following discharge.

The purpose is to ensure a coordinated approach between the hospital and community partners, thereby ensuring that all Quinte Health Care patients have access to quality care in the most appropriate care setting from admission through transitional points of care. The discharge planning process begins on admission for all patients.

POLICY STATEMENT:

Discharge planning is a coordinated, interprofessional approach that supports smooth care transitions for patients and aligns services between Quinte Health Care and community partners. The Care Team, made up of patients, their family, the Quinte Health Care interprofessional team, the South East LHIN and where applicable our community partners, work collaboratively to ensure a timely, appropriate discharge when the patient no longer requires the intensity or resources of the hospital setting. The Home First philosophy will be supported throughout the discharge planning process beginning at the time of admission. Quinte Health Care is committed

to creating an exceptional experience across the continuum. Every opportunity to support patients to return to the community will be fully pursued.

2. DEFINITIONS

Complex Discharge
Patients who are identified as at risk of requiring a change in discharge destination, who require significant SE LHIN Home and Community Care (H&CC) support and/or who are defined as a complex discharge as per the discharge complexity assessment.

Family
Family is defined as any person the patient identifies as family or wishes to be involved in the discharge planning process as part of the care team.

Home First
Home First is a *philosophy* that promotes safe and timely care to meet healthcare needs of patients and families in the most appropriate setting. Every patient admitted to the hospital should expect to return home, and be provided the opportunity to make any long term living decisions from home.

Power of Attorney
A legal document that gives someone else the right to act on your behalf. A Power of Attorney for Personal Care (POAPC) covers your personal decisions, such as housing and health care. (The Office of the Public Guardian and Trustee, 2010)

Substitute Decision Maker (SDM)
Under Ontario's Health Care Consent Act, every individual is presumed capable of making his or her own decisions about treatment, admission to a long-term care facility and personal assistance services in a care facility. It is presumed that an individual has this capacity unless there are reasonable grounds to believe otherwise. A substitute decisions maker is someone authorized by the Ontario Health Care Consent Act to make health care decisions on behalf of an individual who has been deemed incapable of making his or her own decisions. A substitute decision maker is the highest-ranking individual (or individuals) from a list of appropriate substitute's outlines in the Ontario Health Care Consent Act;

1. Guardian
2. Attorney for personal care
3. Representative as appointed by the Consent and Capacity Board
4. Spouse or partner
5. Child (16 or older) or parent
6. Parent with access only
7. Brother or sister
8. Any other relative
9. Public Guardian and Trustee

If there are no appropriate substitute decision makers, then the Public Guardian and Trustee assume the role. If there is more than one person at the highest level, then all of them act as the patient's substitute and must either make decisions as a group or select one group member to act for the rest. If they all want to act as substitutes and cannot agree on a health care decision, health practitioners must turn to the Public Guardian and Trustee for health care Decisions

3. PROCEDURE

3.1 Upon admission or pre-admission: At the point of pre-admission or admission, proactive and effective communication with the patient or substitute decision maker (SDM), family, and the interprofessional team will outline alternatives to the hospital stay that will maximize the patient potential and facilitate effective outcomes. Early screening and validated risk assessment tools will identify patient needs and potential risk that may impact timely discharge or care transition to the most appropriate location. (Appendix A – Discharge Planning Process)

On admission or pre-admission:

a. The pre-admission or admission nurse provides the patient with the Home First Patient Flyer information both verbally and in written form. (Link – Home First Patient Flyer).

b. The MRP documents the plan of care and the estimated length of stay within 24 hours of admission and communicates this information to the patient and family

c. The Most Responsible Provider (MRP) and team continually assess high risk factors for discharge.

d. In collaboration with the interprofessional team, the Patient Flow coordinator (PFC) discharge planner/social worker or team delegate assesses the status of the patient's discharge plan, identifies patients at risk of not returning home or to the community within 48 hours of admission.

e. The interprofessional team will make appropriate referrals based on the patient's needs. All members of the interprofessional team will endeavor to complete assessments to facilitate timely discharge within 24 hours of referral

f. All members of the care team will support the collaborative care plan and work with the patient to reach their discharge goals by reviewing each patient's care plan daily (or less frequently based on patient acuity).

g. The interprofessional team will refer all patients with uncertain destinations based on at risk identification and/or need for enhanced SE LHIN H&CC supports to the Patient Flow Coordinator and/or Social worker/Social Service worker immediately

3.2 Repatriation: In some cases, a patient is transferred for specific care that cannot be provided at the referring facility. Discharge may involve repatriation to the referring hospital when the MRP deems that specific care requested is no longer required. In all cases, if the patient can be discharged home from the receiving site, this should occur rather than proceeding with repatriation.

3.3 Alternate Level of Care (ALC): Most patients can be safely and appropriately cared for in the community with SE LHIN H&CC supports while waiting for a more permanent disposition (Home First).

3.4 Discharge Support: When challenges arise, the Unit Manager and Manager of Patient Flow should be consulted as soon as possible to support the patient and staff through the discharge planning process. (Appendix C SELHIN Wide Home First Referral Process) Complex discharge scenarios may include:

- Patient/SDM declines to be discharged home
- Patient/SDM declines to participate in discharge planning process by delaying initiation of the process or the submission of choices
- Patient/SDM declines to consent to an ALC designation where co-pay applies
- Patient/SDM declines to accept the first available bed from among their choices

3.5 Non-Compliance with the Discharge Plan:

a. When there are continued challenges implementing the discharge planning policy and procedure the staff will follow the escalation process. (Appendix B SELHIN Home First Discharge Escalation Procedure)

b. At each level of escalation a letter will be customized and provided to the patient or SDM as appropriate.

3.6 Decline of First Available bed on choice list

An ALC patient who does not move into an available bed in a LTC home to which the patient has previously applied within 5 days of the offer being made may be discharged from hospital*

*In accordance with .16 of Regulation 965 made under the Public Hospitals Act (PHA), if a patient no longer in need of treatment in the hospital, the attending physician, nurse practitioner, or other authorized person as described in the Regulation must communicate a discharge order to the patient. The hospital must then discharge the patient, and the patient must leave the hospital. Treatment of an ALC patient in the hospital may no longer be required if a bed becomes available in a LTC home to which the patient has previously applied. If the patient does not

move into the available LTC home bed within 5 days of the offer being made to the patient, the hospital may discharge the patient, unless:

- The patient has a health condition, short-term illness or injury which prevents the patient from moving into the home at that time or which would make moving into the home at that time detrimental to the applicants health, or
- There is an emergency in the home or outbreak of disease which prevents the applicant from moving into the home at that time

Patients who have been discharged but choose to remain in hospital may be charged an unregulated rate by the hospital. *Section 10 of Regulation 552 of the Health Insurance Act, which sets co-payment amounts that may be charged to chronic care patients, does not apply to patients who have been discharged in accordance with the provisions of the PHA*

APPENDICES AND REFERENCES

Appendices:

Appendix A – Discharge Planning Process
Appendix B – SELHIN Home First Discharge Process and Escalation
Appendix C – SELHIN Home First Referral Process

References:

Trillium Health Centre (2010) *Patient Flow Bed Management*
Trillium Health Centre (2010) *Home First Messaging*
Northumberland Hills Hospital (2011) *NHH Discharge Planning Process*
Toronto East General Hospital (2010) *Right Patient Right Unit*
Sunnybrook Health Sciences Centre (2011) *Discharge Planning*
Southlake Regional Health Centre. (2010) *Discharge Planning*: *Alternate Level of Care Awaiting Long Term Placement and/or Home*
University Health Network (2010) *Clinical – Bed Management*
University Health Network (2010) *Clinical – Discharge Planning*
Hamilton Niagara Haldimand Brant LHIN (2015) – *Planning Your Care & Next Steps: Discharge and Transitions. A toolkit for hospital implementation*
South West LHIN (2014) *Hospital Discharge Planning Tool Kit*
Public Hospitals Act (PHA)