THE COMMUNITY - HOSPITAL HOMELESS HEALTH EDUCATION AND LEARNING SERIES (C-HEAL) PRESENTS:

Hospital Discharge Processes

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Agenda

- Emergency Department Discharge Processes (20 mins)
- In-patient Mental Health (20 mins)
- General Internal Medicine (20 mins)
- Q&A (30 mins)

Objectives

- Learn about information gathering on clients in hospital
- Understand discharge process from ED, GIM and In-patient Psychiatry
- Learn about patients leaving against medical advice / left without being seen
- Facilitate discussion around transitions out of hospital

Emergency Department Discharge Processes

Nicole Champagne

Emergency Department Arrival

- Patient is brought in by EMS, Police, Mobile Crisis Intervention Team (MCIT), or arrives independently seeking care.

- Pt registers and is triaged based on their chief complaint to Ambulatory, Acute, Mental Health Emergency Service Area (MHESA) or Trauma:

  Ambulatory (12 rooms) = minor complaints that can be seen in basic exam room

  Acute (36 beds) = complaints that would require more medical supervision and equipment

  MHESA (9 beds) = Mental Health concern without any acute medical needs

  Trauma (2 beds)

- Once triaged patients are assigned an area for care provision, they may wait in one of three areas.

- From 10am - 6pm Monday-Friday there is a Community Support Worker who can assist with complex patient needs for those waiting to be seen.

Seeing Clinicians in the ED

- Patient will be seen by RN and MD with possible consults for Social Work, Geriatric Emergency Nurse, Health Promoter, and/or Home and Community Care Coordinator

- Nursing assessments provide baseline information related to: physical / psychiatric reason for ED visit, functional status (ambulation/ gait aid/ cognition), medication history

- Physicians complete assessment, diagnostics, support symptoms through medication/treatments, consults another specialty (GI, Gyne, Urology, Ortho, Neuro etc.), review tests, diagnose patients and determine disposition

- If admission is <u>not</u> necessary (i.e. patient does not require ongoing acute medical care) patient is discharged after receiving ED care (85% of patients are discharged from the ED)

Scope of Social Work in the ED

- SW speaks with patient / family, reviews chart, checks Connecting Ontario, LHIN services, previous admissions, and previous SW involvement. Note: SW determines if there is a Community Worker involved through these channels. It may also be that the Community Worker has called ED.

- SW can support pts with access to medication, transportation, food, referrals to case management, shelter beds, liaise with police, liaise with OW/ODSP/Trillium workers to ensure income security.

- If patient has a Community Worker, SW will try and connect to confirm appropriate patient discharge location, gather further collateral regarding baseline, and communicate follow up care if required

Scope of Social Work in the ED

- If patient is known to have a shelter bed – will call shelter to inform them that patient is returning
- If patient needs a shelter bed, SW will call Central Intake in attempt to secure bed
- If no bed is available through Central Intake, but patient is stable with no nursing care needs, SW will follow direction of Central Intake which is often to send pt to Drop-in or Respite Centre
- Referrals to infirmary, detox, and safe beds can be made from ED often using our Rotary Transition Centre if an evening stay is required to transition patient to appropriate service for those able to care for themselves

ED Documentation

- SMH ED uses a combination of paper charts and electronic documentation.
- All paper documentation is scanned into the electronic medical record within 48 hours of discharge
- No discharge summary of patient's visit exists as patient was not "admitted" to hospital
- Family physicians are notified of patient ED visits and information about the visit can be found on Connecting Ontario
- **If there is important collateral that should be given in regards to a patient being sent to ED, please call the ED SW line: 416 457 0786**

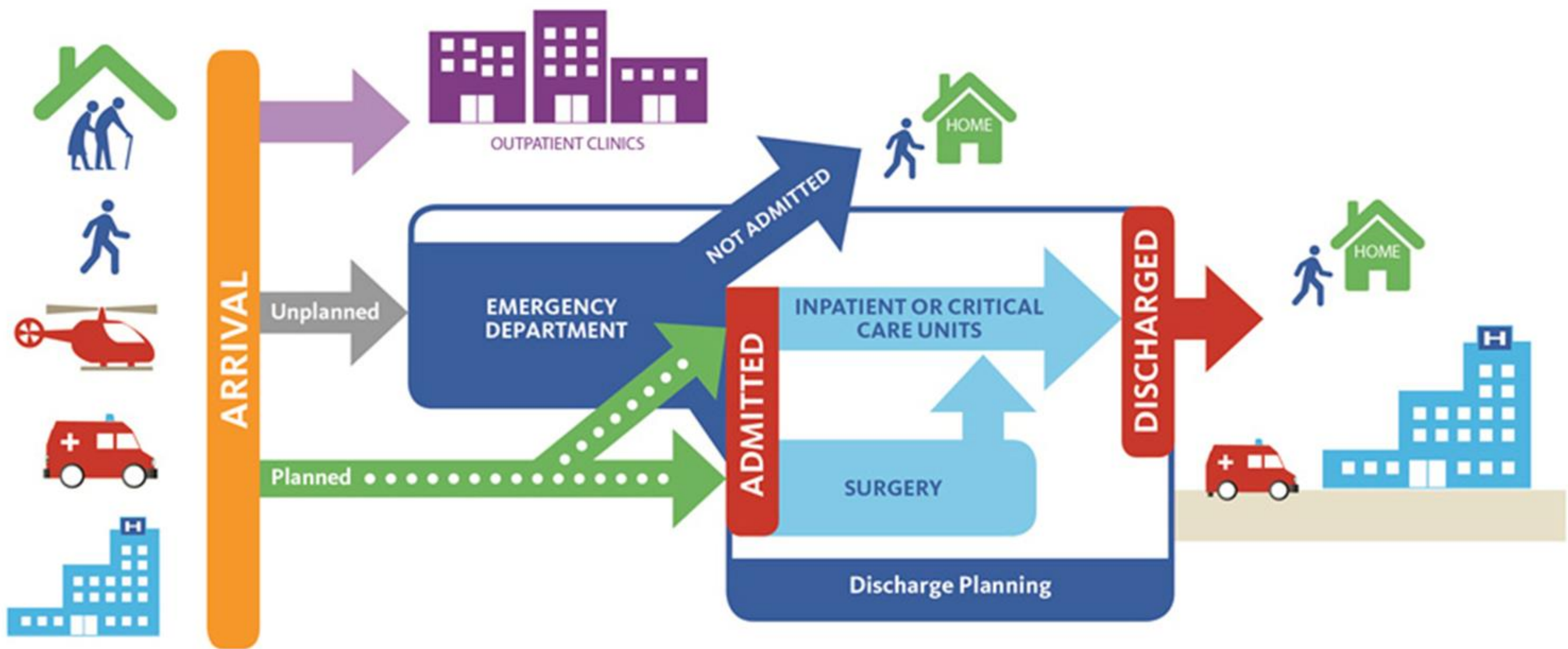
When Patients Leave AMA/LWBS

- Patients can leave *before* assessment or before their treatment is provided. It is charted on our board as LWBS “Left Without Being Seen”
- When patients express a need to leave the ED once assessed, and treatment is proposed the physician discusses the risk of leaving with the patient and may ask the patient to sign an AMA form (Against Medical Advice)
- If patient capacity is questioned and the patient is wanting to leave, the patient may be placed on a **FORM 1** if there is a concern of harm to self or others - the patient can be kept involuntarily for further assessment
- If the patient has a known Community Worker, the SW will call the Worker to share the current situational information. Community Worker can also contact SW in ED (or other relevant department) to ask if patient left AMA/LWBS.

Inpatient Mental Health and General Internal Medicine

Nicole Schroeder and Vicky Wen

Transitions from Hospital



General Internal Medicine Overview

- 70 physical beds
- Census on Average 80 – 100 patients a day
- 4000 admissions a year
- 8 CTFs (including coverage for our Geriatric and Stroke team which is also under the GIM portfolio)
- 14% of patients attending ED are admitted and 40% of those admitted are admitted to GIM service
- Average Length of stay is 7-10 days

Inpatient Mental Health (MH) Unit

- 33 bed unit
- 2 Care and Transition Facilitators responsible for hospital journey and discharge planning
- 5 psychiatrists
- Nursing
- Allied health team including OT, Dietician and Peer Support.
- Average length of stay is 23 days

Pathway: Patient Admission to Discharge for admits to GIM and MH (Floor 14 & 17)

- On day of admission: Medical Resident / Team Lead provides baseline information:
  - Medical/ psychiatric reason for admission
  - Functional status (ambulation/ gait aid/ cognition)
  - Psycho-social needs - check if patient is from shelter/ 'streets'/ couch surfing/ respite/drop in, known agencies/ community supports following patient
  - Care and Transition Facilitator (CTF) is assigned to patient; CTF's help patients navigate during hospital stay

The Role of the SW/CTF

- Information gathering:
  - Speak with patient / family (if family is known)
  - Review chart, check Connecting Ontario, LHIN services, previous admissions
  - If known worker /agency – will connect with agency

Care planning:

- If known worker/ agency will provide patient status update
- Assessing which services are needed for patient to provide a successful transition to community.
- Will determine need for case conference prior to discharge should patient have complex nursing / care needs or concerns be raised by worker/ agency about patient returning to live in community.

Days leading up to Discharge from MH and GIM

- Determine supports/ resources necessary for patient upon leaving hospital (e.g. CATCH referral/ Health Link/ FOCUS/ TC LHIN/ Addictions/ Family Doctor liaison/ ICFHT)
- Connect with worker / shelter to discuss care plan/ follow up appointments and provide an estimated date of discharge
- Decision to discharge lies with physicians, CTFs support a plan for disposition. Discharge readiness means that a pt. is medically or psychologically stable and no longer require acute care hospitalization.

Day of Discharge from MH and GIM

- If patient is known to shelter / has saved bed – we call shelter to inform them of discharge (e.g. Seaton House, Maxwell Meighan, Gateway, Women's Res)
- Will fax discharge summary and prescription to appropriate pharmacy
- For a referral to a shelter program including 24 hour respites, we call Central Intake with the client present, i.e. we facilitate the call to Central Intake.
- Discharged patients who refuse to contact Central Intake will be referred to 129 Peter Street by hospital staff.

When capable patients leave MH and GIM Against Medical Advice (AMA)

- On the units, we work hard to support patients' social needs while in hospital but there are times when patients choose to leave before recommended treatment is complete

- When patients express a need to leave the hospital, the physician discusses the risk of leaving with the patient and may ask the patient to sign an AMA form. The physician would document the conversation

- Note: If patient leaves AMA and is on a Form 1, the hospital notifies police to return the patient to hospital *or* cancels the Form 1 if there are no further concerns for patient safety

When patient leaves without notifying hospital staff:

- Unit staff will discuss with physician if the patient needs to return to the hospital for further care
- If the patient is capable and has known worker / shelter then we will call and inform community support/ shelter
- If patient is found by the Community Worker and is agreeable to return within four hours, the inpatient bed can occasionally be saved/ held for patient
- If the patient is at shelter, found and refuses to return, we will fax (to the shelter) over prescription and if necessary put in appropriate LHIN supports / outpatient follow-up

Q & A