C-HEAL Info Sheet – St. Michael's Hospital, Hospital Discharges

SMH Emergency Department (ED)

- Patient is brought in by EMS, Police, Mobile Crisis Intervention Team (MCIT), or arrives independently seeking care.
- Patient 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)
- **From 10am - 6pm Monday - Friday there is a Community Support Worker who can assist with complex patient needs for those waiting to be seen.**
- Social Worker (SW) speaks with patient / family, reviews chart, checks ConnectingOntario, LHIN services, previous admissions, and previous SW involvement. SW determines if there is a Community Worker involved through these channels. It may also be that the Community Worker has called ED.

Scope of Social Work in SMH Emergency Department: ED SW line: 416 457 0786

- SW can support patients with access to medication, transportation, food, referrals to case management, shelter beds, liaise with police, and 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
- **If there is important collateral information that should be given in regards to a patient being sent to ED, please call the SW line**
- If patient is known to have a shelter bed, SW 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 patient to Drop-in or Respite Centre. Referrals to infirmary, detox, and safe beds can be made from ED often using Rotary Transition Centre if an evening stay is required to transition patient to appropriate service for those able to care for themselves.
- 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 ConnectingOntario**
- 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 Against Medical Advice (AMA form)
- 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 or LWBS.

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Pathways for Admission and Discharge to General Internal Medicine (GIM) and Mental Health Units

On day of admission: Medical Resident / Team Lead provides baseline information on:

- 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; CTFs help patients navigate during hospital stay

Scope of Social Work (SW) or Care Transition Facilitator (CTF) on General Internal Medicine (GIM) and Mental Health Units

Information Gathering & Care Planning

- Speak with patient/family (if family is known)
- Review chart, check ConnectingOntario, LHIN services, previous admissions
- If known worker/agency SW/CTF will provide patient status update
- Assess which services are needed for patient to provide a successful transition to community
- 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 Prior to Discharge

- 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
- Discharge readiness means that a patient is medically or psychologically stable and no longer requires acute care hospitalization. Decision to discharge lies with physicians, SW/CTFs support a plan for disposition.
- If patient is known to shelter/has saved bed – SW/CTF will 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, SW/CTF will call Central Intake with the client present, i.e. 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 Mental Health or General Internal Medicine (GIM) Units Against Medical Advice (AMA)

On the units, SW/CTFs 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 documents 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 Mental Health or General Internal Medicine (GIM) Units 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 SW/CTF will call and inform community support/shelter. If patient is found by the Community Worker and is agreeable to return within 4 hours, the inpatient bed can occasionally be saved/ held for patient. If the patient is at shelter, found and refuses to return, SW/CTF will fax (to the shelter) over prescription and if necessary put in appropriate LHIN supports/outpatient follow-up.