FROM HOSPITAL TO HOME GUIDE

CHANGING THE WAY THE WORLD AGES

FROM HOSPITAL TO HOME

A Guide to Understanding the Hospital Discharge Process and Providing Care to Patients Post-Hospitalization

One of the leading causes of readmission or slow post-hospitalization recovery is the lack of proper support immediately following a hospital discharge. This guide was created to provide an overview of the challenges and resources associated with each step in the transition from hospital to home. The guide will first describe what the discharge process entails and the key players involved. Next, it will provide a step-by-step summary on ensuring optimal care post-hospitalization. The transition out of the security of the hospital setting may seem daunting at first, but remember that you are not alone in this process. There is a team of individuals inside the hospital and in the greater care community to ensure that all of your needs are met. We hope the From Hospital to Home Guide will equip you with the information you need to make the best decision possible.

WHO ARE THE KEY PLAYERS IN THE DISCHARGE PROCESS?

The Patient: The most important person in the discharge planning process is the patient. The care team will typically respect the patient's preferences during the discharge process. Recent studies have demonstrated that recovery at home is comparable to, and in some cases, more favourable than recovery at a facility. However, every patient has his or her own preferences and needs when it comes to discharge. This is why it's critical to establish open lines of communication with the care team as early as possible during the hospitalization. Clear communication allows the patient to voice personal wishes and concerns and allows the discharge team and family members to share their thoughts and recommendations.

The Patient's Family Members and Caregivers: Family members and caregivers are a vital part of the discharge planning process because they are the ones who will help coordinate the patient's care in the home or post-hospitalization facility. They can provide valuable input to the discharge team that the patient may not have fully considered. For example, a patient may be steadfast in the desire to return home, but the patient's family may alert hospital staff that there is no one in the home strong enough to transfer the patient, who cannot yet walk independently. It often falls to the family to ensure that the best possible decisions are made for a successful recovery and for the patient's well-being.

The Discharge Planner: The discharge planner, usually a nurse or a social worker,

coordinates a patient's discharge from the hospital and their post-hospitalization care strategy. The discharge planner wears several hats. He/she has to consider cost effectiveness for the hospital, while also considering the family's wishes and the well-being of the patient. To balance these priorities, the discharge planner must maintain good relationships with post-hospitalization care providers such as rehabilitation hospitals, nursing facilities, palliative care centers and home care companies.

The Nursing Team: Nurses who have taken care of the patient day in and day out are an extremely valuable resource during the discharge planning process. They are able to comment, for instance, on a patient's mental status, stamina, ability and willingness to follow directions. They will also be able to provide valuable advice to the family based on their experience and understanding of the patient's time at the hospital.

The Physician: The physician signs off on the final discharge plan and is responsible for prescribing medications, which can have a direct bearing on the patient's comfort and mood. The physician's primary goal is the patient's physical and mental well-being.

The Social Worker: The social worker has three responsibilities: (1) to assess the patient for psychosocial factors that could impact discharge plans, (2) to help connect families with relevant community resources and (3) to provide emotional support and guidance to patients and their families. Social workers can be a tremendous resource, especially if the patient has spent significant time in the hospital or is at risk of depression or other emotional issues during the transition home.

The Skilled Therapist (OT/PT/ST): Occupational therapists, physical therapists and speech therapists can play a role in the discharge planning process by communicating the patient's capabilities and deficits to the discharge planner. These skilled therapists will also play an important role in the post-hospitalization care process.

CLSC (CIUSSS): CLSCs are an integral part of the Integrated University Health and Social Services Centres (CIUSSSs) in Quebec. They provide health and social services on their premises, but also in schools, at work and at home. CLSC services for the people within their territory include: routine health and social services (nursing care, blood tests, vaccinations, morning-after contraception, etc.); preventive or medical services (medical consultations with or without an appointment); rehabilitation and reintegration services; and public health activities. These services, though limited, are free of charge.

Home Care Agencies: Private home care agencies provide non-medical and where necessary, medical care via caregivers (PABs) and nurses (LPNs & RNs). Caregivers assist with activities of daily living (ADLs), such as bathing, grooming, dressing, light housekeeping, meal preparation* and companionship, LPNs and RNs where medical care is required. Home care is often an integral component of the post-hospitalization recovery process, especially during the initial weeks after discharge when the patient still requires some level of regular physical assistance.

*These activities, though non-medical, are often extremely challenging for a post-hospitalization patient.

WHERE DOES THE DISCHARGED PATIENT GO?

While many patients want to immediately return home following discharge, this is not always the best option. As a stay in the hospital draws to a close, the patient will typically be presented with two options for the recovery process.

Option A:

Rehab Hospital
After a patient has undergone a procedure in the hospital, such as a hip replacement, or has been admitted for an unexpected medical event, such as a stroke, a discharge planner will typically recommend a stay in a rehabilitation facility. Ultimately, the patient and their loved ones can decide if this is a good option.

Advantages:
A stay in a rehabilitation centre is typically covered by Régie de l'assurance maladie du Québec (RAMQ). These benefits will frequently cover three to four hours per day of active rehabilitation – whether that is physical therapy, occupational therapy or speech therapy. Additionally, each rehab facility is overseen by a team of healthcare professionals. For skilled nursing facilities, the RAMQ benefits pay as long as the patient demonstrates progress in therapy, or that their condition is stable enough to no longer require around-the-clock care.

Disadvantages:
Any extended stay in a medical facility can increase the risk of infection or illness, simply due to the proximity to other patients recovering from illness. Likewise, for some people, further stay in a hospital setting can lead to depression or a feeling of being institutionalized. By nature, facility care is very structured and, outside of pre-set therapy times, patients are often bedbound. In addition, care staff is often spread across many patients, limiting the amount of individual attention. In fact, for many procedures, including hip replacement, a carefully planned discharge to the home is a more effective recovery solution. Further, though RAMQ typically covers some level of post-hospitalization rehabilitation, coverage is not guaranteed and subject to regular evaluations of the patient's condition.

Option B:

Recovery at Home
Patients who prefer familiar surroundings have the option of recovering and undergoing the rehabilitation process in their home. Home care agencies are available to provide a range of support services.

Advantages:
Working with a personal caregiver provides the individual with customized attention, ranging from a few hours a day to full-time 24/7 care. Likewise, visiting therapists can cater to the specific recovery needs of a client at home. For example, to practice climbing stairs, a therapist can utilize the exact staircase the patient will eventually need to use. This level of customization is not available in a rehab facility*. For most adults transitioning out of a hospital setting, home care is the solution that offers the greatest security and happiness for the client and the most peace

of mind to his or her family.

Disadvantages
While short-term CLSC costs are covered by RAMQ, home visits are often limited and usually task related (e.g. medication, wound care, hygiene, etc). Additional help would require private home care which is typically an out of pocket expense.

Option C:

Senior Residence
Seniors facing a loss of autonomy may be encouraged to move into a publicly funded or private facility. Housing advisors are available to meet with families and guide them through the selection process.

Advantages:
Senior residences are often the most cost effective means of receiving care. The costs are spread out across many individuals. Services typically include meals, housekeeping, personal care, activity programs and access to common areas such as gyms, pools and more.

Disadvantages

While this can be a good choice for some families, it does mean uprooting the elderly person from their familiar environment and moving them to a place where their individual desires may take second seat to the community routine. Things like meal times or activity choices may be different than what the person prefers. Many families find that even though their loved one is living in a care facility, they still have to hire a personal caregiver because the aides working at the facility are stretched too thin to provide the level of care their loved one requires.

CONCLUSION

In summary, be sure to ask questions. Inform yourself and understand all the options available to you as you navigate the journey from hospital to home. The following pages provide checklists to help you evaluate your options. Investing a little bit of time now will help you make the best decision.

*In addition, the patient benefits psychologically from the comfort of home and has a smoother transition back to a familiar routine and lifestyle. Furthermore, patients recovering at home can benefit from full-time, 24-hour services from a caregiver, the level of care is far more personalized than at a nursing facility and families enjoy peace of mind knowing a trained professional is always at home.

CHOOSING A HOME CARE AGENCY

Questions to Ask	Minimum Requirement	Company 1	Company 2
Are they available to meet with the family in the hospital or home to evaluate the clients needs?	A Care Managers will meet the client wherever necessary, evaluate their needs and create a customized care.		
Are the caregivers screened, bonded and insured?	Conduct extensive screening and background checks.		
Does the company employ its caregivers and take care of taxes, withholding and workers' compensation?	Caregivers are employees, not contractors, to protect clients from liability.		
Does the company conduct any caregiver training?	Certified with minimum CPR / First aid.		
Does the company guarantee a personality match and offer caregiver interviews?	Ensure a personality match and will not change your caregiver as long as you're satisfied.		
Does the company offer back-up caregiver in case of emergency?	They have an extensive roster of trained employees available for all clients' needs.		
Are Care Managers available on-call 24/7, including nights and weekends?	Available 24/7 for clients' needs including evenings, holidays and weekends.		
Does the company peform regular quality assurance visits, client satisfaction reviews and caregiver evaluations?	Regular quality assurance visit to ensure ongoing client satisfaction.		
Does the company offer a satisfaction guarantee without any long-term contract or commitments?	No long-term contracts with option to cancel.		
Is the company a recognized leader in the senior care industry?	A member of the Canadian Home Care Association® and a recognized Provider of Choice by Home Care Pulse®.		

CHOOSING A HOUSING ADVISOR

Questions to Ask	Minimum Requirement	Company 1	Company 2
Is there an experienced Senior Advisor that will visit with the family in the hospital or in the family's home ?	A Senior Advisor will meet with the family anytime during the day or evening, 7 days a week.		
Will there be a complete assessment to review care needs, budget, culture, environment, language, likes and dislikes?	A Senior Advisor will complete an assessment to get a full understanding of the client's exact needs.		
Will they search for appropriate retirement residences that will meet the client's specific needs?	A thorough search will be performed in their database of over 1000 senior residences located throughout the desired region.		
Will they present a list of ideal retirement residences in a face-to-face meeting with the family?	A minimum of 5 options will be discussed while explaining the advantages and disadvantages of each.		
Will they organize tours for the family of a short list of ideal options?	The Senior Advisor will organize tours of the top 2-3 options that best meet the client's needs at a date and time that is convenient.		
Will these services be provided FREE of charge?	These services are provided at no charge or obligation as they are subsidized by the retirement residences upon signing of the lease.		
Do they offer services outside of Montreal if there is a need in other parts of Canada?	They have a database of residences across Canada and a team of Senior Advisors available.		
Can they coordinate support services such as the sale or downsizing of a home or a move?	They can coordinate the hiring of professional services specializing in senior transitions such as real estate brokers, downsizing and estate specialists, and moving companies.		

CIUSS / CLSC Contact Information

Home Care Agency Recommendations

Home Care Assistance – 514-907-5065 / www.hcamtl.ca

Housing Advisor Recommendations

Lianas Services – 514-622-8074 / www.lianasservices.com

Discharge Planner

Social Worker

Physician

Skilled Therapist (OT/PT)

This document is created by Home Care Assistance as a guide for post hospitalization. For more information visit www.hcamtl.ca