

Discharge of Hospital Patients

Follow-up to VFM Section 3.02, *2010 Annual Report*

Background

Ontario hospitals discharged more than 1 million patients in each of the last five years, and about 20% of these patients required post-discharge care, either at home (for example, nursing and personal-care services such as bathing) or in a long-term-care home.

Hospital physicians determine the medically appropriate time to discharge a patient. This determination is important because longer-than-necessary hospital stays carry risks for patient health, including the risk of getting a hospital-acquired infection such as *C. difficile*. As well, hospital care costs more than post-discharge care. Further, patients staying in hospital longer than necessary block access to hospital beds by others requiring hospital care.

As a result, the Ministry of Health and Long-Term Care (Ministry), hospitals and Community Care Access Centres (CCACs) have introduced initiatives to facilitate the discharge of patients from hospital. The CCACs also assess eligibility for, and arrange access to, both home care and long-term-care homes.

In 2010, we conducted work at three hospitals to assess whether they had implemented effective processes for the safe and timely discharge of

patients. The three hospitals we visited were the Credit Valley Hospital in Mississauga, now the Credit Valley site of the Credit Valley Hospital and Trillium Health Centre; St. Michael's Hospital in Toronto; and St. Thomas–Elgin General Hospital in St. Thomas.

We concluded that the hospitals were managing their discharge processes well in some areas and were in the process of changing other systems to improve patient flow. However, we noted that processes at all three hospitals could be improved in some areas. For example, we reported at the time that, province-wide, more than 50,000 patients who were ready to be discharged waited in hospital beds because of delays in arranging post-discharge care (also known as waiting for an alternate level of care, or ALC). The total number of days that ALC patients were hospitalized increased by 75% over the previous five years and at the time represented 16% of total patient-days in Ontario hospitals. However, no one, including the Local Health Integration Networks (LHINS), the CCACs or the hospitals, was specifically accountable for ensuring that community-based services, including home care and long-term care, were available when patients were ready to be discharged.

Among our other significant observations:

- Although quick multidisciplinary team meetings on discharge planning activities

were held at all three hospitals, physicians attended these meetings at only one hospital, and CCAC representatives attended most meetings at only one other hospital.

- A ministry expert panel recommended that hospital physicians prepare a discharge summary to communicate patient information, such as follow-up appointments, pending test results and medication changes, to subsequent health-care providers. Although discharge summaries were generally prepared, one hospital was consistently very late with them. At all three hospitals, a recommended reconciliation of medications on admission and those on discharge was often not prepared, increasing the risk of subsequent medication errors.
- At the hospitals we visited, less than 10% of total discharges to long-term-care, complex continuing care, and rehabilitation facilities occurred on weekends even though the patient could have been discharged then, because many of these facilities would not accept the patient until the next business day.
- Wait times in hospital for ALC patients varied significantly across the province. For example, 90% of discharged ALC patients in the North West LHIN were placed within 27 days of being designated ALC, compared to 97 days in the North East LHIN.
- There were minimal guidelines on how long it should take from hospital referral to patient placement in a long-term-care home. Of ALC patients waiting province-wide, 90% were placed in long-term-care homes within 128 days, with 50% placed within 30 days.
- At the one CCAC that tracked this data, long-term-care homes rejected between 25% and 33% of applications because patients required too much care or exhibited behavioural problems. Accepted applicants were often just added to a lengthy wait-list. On the other hand, patients often did not want to go to homes with short or no wait-lists

because, usually, these facilities were older or far from family.

We made a number of recommendations for improvement and received commitments from the Ministry and the three hospitals that they would take action to address our concerns.

Status of Actions Taken on Recommendations

In the spring and summer of 2012, the Ministry and the three hospitals we visited in 2010 provided us with information on the current status of the recommendations made in our *2010 Annual Report*. According to this information, significant progress has been made in implementing more than half the recommendations. While some progress has been made on all of the others, the extent of progress varies among the hospitals. Fully addressing certain recommendations (by, for example, implementing a standardized process for moving patients from hospital to long-term-care homes) will take more time. The current status of the actions taken by the Ministry and hospitals is summarized after each recommendation.

PLANNING FOR IN-PATIENT DISCHARGE

Recommendation 1

To provide sufficient time for a patient's family and other caregivers to prepare for patients' post-discharge needs, hospitals should ensure that:

- *key discharge information, such as the patient's estimated discharge date and discharge destination, is established and documented for every patient by the time of admission or shortly thereafter, and revised if the patient's condition warrants a change in the discharge date;*
- *quick round-table discussions regarding patients' readiness for discharge are attended by key decision-makers from the multidisciplinary*

team, such as the patient's physician, who is responsible for discharging the patient, and if the patient is going to a long-term-care home or requires home-care services, by a representative of the Community Care Access Centre; and

- *the estimated discharge date and discharge plans are communicated to patients and their families by using visual displays, such as whiteboards in patient rooms, as recommended by the Flo Collaborative.*

Status

At the time of our follow-up, two of the hospitals said key information, such as estimated discharge date and destination, is generally established for every patient at the time of admission or shortly thereafter. One of the two indicated it was upgrading its system to make it easier to document the expected discharge date after admission. The third hospital said it was implementing strategies to establish target dates for patient discharge but added that such estimates are complex, as patients are often required to wait for test results and consultations with specialists before the estimated discharge date can be determined.

One of the hospitals said that physicians and CCAC representatives generally attend quick round-table discussions about patients' readiness for discharge. A second indicated that while physicians generally attend or can be consulted during such discussions, CCAC representatives attend meetings only at high-volume in-patient units. The third said CCAC representatives attend discharge discussions twice a week, but attend fewer of the daily quick meetings because of resource constraints. This hospital also launched a pilot project in one unit in May 2012 that was expected to improve attendance by physicians at the daily quick meetings.

Two of the hospitals indicated at the time of our follow-up that in addition to verbal communication by staff, they were using whiteboards in patient rooms to advise patients and their families of the estimated date and plans for discharge. The third said that while physicians verbally communicated

the estimated discharge date to their patients, and some units used whiteboards, it expected to have hospital-wide communication of discharge dates, using whiteboards, in place by fall 2012.

ARRANGING POST-DISCHARGE CARE

Arranging for Home-care Services and Equipment

Recommendation 2

To better ensure that any required home-care services are available when eligible patients are ready to be discharged, hospitals, in conjunction with their Community Care Access Centres (CCACs) and Local Health Integration Networks (LHINs), should develop time frames that are standardized within each LHIN that provide adequate advance notice of the date such services will be needed and keep the CCAC apprised of any changes to the required commencement of home-care services.

Status

All three hospitals noted that they had started to take steps to address this recommendation. While all three hospitals indicated that they had not yet implemented standardized time frames within their LHINs to provide advance notice to their CCACs of the date patients would need home-care services, two said their LHINs were developing a consistent discharge process for hospitals within each LHIN.

One hospital indicated that it was using a decision guide developed in conjunction with its CCAC and in use at the time of our 2010 audit. The guide specifies timelines required to establish home-care services and helps ensure that appropriate home-care services are in place prior to a patient's discharge from acute care. This hospital also said that it understood that an electronic Resource Matching and Referral System had been implemented across its LHIN, enabling hospitals to provide advance notice directly to the CCAC of the date patient services will be needed, as well as any subsequent changes in the date or services needed. The hospital further noted that it has been working to increase

its community referrals through the Community Navigation and Access Program, which uses a centralized telephone number to connect patients to community support services.

Another hospital noted that implementation of this recommendation depended on other organizations, and that it was working with its CCAC to create new processes, standards and expectations around timely discharge of patients requiring home-care services. The hospital expected that standardized time frames for patient referrals to the CCAC would be implemented over the next year.

The third hospital noted that its CCAC was usually involved with patients soon after admission and therefore was generally aware of the anticipated date of discharge and whether or not home-care services would be required. In May 2012, this hospital also implemented a system to electronically refer patients to its CCAC for assessment. The hospital noted that this system will enable it to better track how much advance notice it is providing the CCAC about patient discharge dates and the home-care services they require.

Arranging for Long-term Care

Recommendation 3

To improve the process for admitting hospitalized patients to a long-term-care home, the Ministry, working in conjunction with the Local Health Integration Networks (LHINs), Community Care Access Centres (CCACs), long-term-care homes, and hospitals, should determine the best approach to placing a patient in a long-term-care home and establish benchmark standards for completing each stage in this process, such as determining patient eligibility, completing applications to long-term-care homes, and the long-term-care homes' processing of patient applications. The Ministry should also consider whether LHINs should be made accountable for monitoring adherence to the target time frames.

Status

At the time of our follow-up, the Ministry said it had begun to review information quarterly on patients waiting in hospital for a long-term-care home and discussing the status with the LHINs. The Ministry observed that these reviews, among other things, promote the development, dissemination and adoption of best practices in hospital discharge and long-term-care home placement. As well, the Ministry noted that the LHINs are in the process of standardizing the referral management process province-wide for moving patients from hospitals to long-term-care homes. The Ministry expected that standardized referral forms would be developed by March 2013. Further, as part of the initiative to standardize the referral process, one LHIN has implemented an electronic Resource Matching and Referral System, which enables the referral and matching of patients to the earliest available appropriate long-term-care home. Another LHIN has implemented a paper-based Resource Matching and Referral System. The Ministry expected the other LHINs would pilot resource matching and referral systems during the 2013/14 fiscal year that were expected to shorten the process for placement into long-term-care homes.

The Ministry planned to collaborate with the LHINs and the CCACs by fall 2012 to identify the steps in the hospital-to-long-term-care home placement process for which benchmarks or guidelines would likely contribute to reductions in the overall time to placement. The Ministry also said that obtaining data from the Resource Matching and Referral System on actual time frames would be the first step in creating benchmark guidelines and standards for completing each stage in the process of placing a hospital patient in a long-term-care home. Once target time frames are in place, the Ministry expected LHINs to be responsible for monitoring the CCACs' performance and reporting periodically to the Ministry.

Two of the hospitals commented that the Home First/Wait at Home program has helped reduce the number of patients waiting in hospital for

placement in a long-term-care home. One said it was developing a process to ensure that all options for patients are exhausted before they wait in hospital for a long-term-care bed; the other said that it asks the families of people waiting in hospital for long-term care to choose five homes within five to seven days, and encourages them to select homes that have either an available bed or a short wait-list. This hospital further noted that although the *Long-Term Care Homes Act* requires homes to accept or reject a patient's application within five days, it has found that homes usually do not respond within that time frame.

COMMUNICATING INFORMATION TO SUBSEQUENT HEALTH-CARE PROVIDERS

Recommendation 4

To ensure that medical information essential for the continuity and quality of patient care is communicated in a timely manner to subsequent health-care providers, hospitals should:

- *require discharge summaries to be completed for all patients in accordance with the Guide to Better Physician Documentation developed by the Ministry's Physician Documentation Expert Panel;*
- *establish a target time frame, such as a maximum of 10 days, for completing discharge summaries and forwarding them to the patient's family physician or other subsequent health-care providers; and*
- *consider the use of a medication reconciliation template to be completed for each patient detailing any changes between the medications the patient was taking on admission and the medications that the patient will be taking post-discharge.*

Status

The three hospitals said they were completing discharge summaries for all patients. One noted that it had developed a standardized discharge instruction sheet based on best practices and feedback from

family physicians in the community and began using it in spring 2012.

Another hospital said at the time of our follow-up that 48% of its discharge summaries were made available to a patient's family physician within 48 hours of the patient's discharge. This hospital's target for the 2012/13 fiscal year was to have 75% of all discharge summaries available within 48 hours. The other two hospitals required completed discharge summaries within 14 days, but one was working toward having them available within a 48-hour deadline.

With respect to a medication reconciliation template, one hospital indicated that its physicians currently complete an electronic discharge summary that includes information and instructions on a patient's previous and new medications. Another hospital expected to have a paper-based medication reconciliation system fully implemented by July 2012. This hospital also planned to implement an electronic medication reconciliation system, but said it was too early to determine the likely timing. The third hospital noted that physicians now complete a medication reconciliation template and that the hospital faxes each patient's new medication regimen to his or her family physician and pharmacy.

The Ministry indicated at the time of our follow-up that about 1,000 physicians had direct electronic access to hospital discharge summaries. Furthermore, eHealth Ontario, in conjunction with the LHINs, was introducing systems province-wide to enable physicians who use provincially certified electronic medical records to directly access hospital discharge summaries by 2015.

HOSPITAL BED AVAILABILITY

Recommendation 5

To help reduce the time admitted hospital patients wait for a bed:

- *hospitals should review the times and days of the week patients are admitted and discharged, and arrange patient discharges to allow sufficient time for beds to be prepared in advance for*

new admissions, especially for patients arriving at known peak admission times; and

- *larger hospitals should assess the costs and benefits of implementing a bed management system that provides “live” information on the status of hospital beds, including which beds are occupied, awaiting cleaning, and available for the next patient, as well as the reasons for delays in placing admitted patients in available beds.*

Status

At the time of our original audit, one hospital had adjusted the timing of patient discharges to better match admissions, and reviewed the days of the week and times that patients are admitted and discharged. It said it was still discharging about a quarter of its patients before 11 a.m. However, this hospital also noted that various factors affect bed availability, including increases in the number of emergency-department patients and higher demand for specialized services, such as psychiatric and respiratory isolation beds. At the time of our follow-up, another hospital said it had also analyzed admission and discharge data to better understand patterns of patient activity, and had aligned services to meet projected bed demand where possible. The third hospital said it monitors patient discharges before 11 a.m. and before 2 p.m., and has introduced a target of having an emergency patient in a hospital bed within 90 minutes of the decision to admit him or her.

At the time of our follow-up, all three hospitals indicated that they had implemented initiatives to help reduce the time that admitted hospital patients wait for a bed. In this regard, one of the hospitals said its bed management system provides “live” information on the status of hospital beds at all times, including whether empty beds are awaiting cleaning or are available for the next patient. Another hospital indicated that its initiatives included a system that tracks the status of beds from the time one patient leaves a bed until a new one occupies it. The third hospital noted that its electronic bed management system provides some

information on the real-time status of beds, but that it must use a separate system to let housekeeping know about beds that need to be cleaned. In this regard, the hospital noted that it had created an action group to focus on reducing the amount of time that beds are vacant.

PATIENTS WAITING IN HOSPITAL FOR POST-DISCHARGE CARE

Recommendation 6

To ensure that patients receive the care they need in the location best for the patient:

- *hospitals, in conjunction with their Local Health Integration Networks (LHINs), should educate all patients and their families on the fact that, for patients whose condition has stabilized and who no longer need acute care (especially older patients), hospitals are not a safe or appropriate place to wait for post-discharge care (for example, because of the risk of getting a hospital-acquired infection such as C. difficile);*
- *the Ministry, in conjunction with the LHINs, should assess the costs and benefits of increasing the level of post-discharge services that can commence on weekends to better enable hospitals to safely discharge patients on weekends; and*
- *the Ministry, in conjunction with the LHINs, hospitals, and Community Care Access Centres, should give increased consideration to options such as more appropriate places for patients to safely wait for placement in an alternate-care facility such as a long-term-care home; or increased supportive-housing arrangements to enable patients to continue to live more independently.*

Further, to help hospitals better manage their patients who are waiting for post-discharge care, the Ministry should:

- *further clarify how alternate-level-of-care (ALC) wait times should be measured so that ALC wait times are being consistently reported to the Ministry’s Wait Time Strategy; and*

- *publicly report the time ALC patients wait in hospital before being discharged into a community-based setting.*

Status

At the time of our follow-up, two of the hospitals said they had processes to educate patients and their families about the risks of a patient waiting in hospital for other care when the patient's condition has stabilized and he or she no longer requires acute care. The third hospital indicated that while it does not have a standardized process, some hospital staff do discuss this issue with patients.

The Ministry said it commissioned a comprehensive study in May 2011 of the costs and benefits of increasing post-discharge services on weekends to facilitate a higher percentage of weekend discharges from hospitals. The Ministry expects the study to be completed by December 2012 and plans to share it with the LHINs, hospitals and other stakeholders to determine how best to proceed. One hospital observed that weekend discharges continue to be a problem because most long-term-care homes and rehabilitation facilities do not accept weekend admissions, which delays patients' discharge from hospital.

The Ministry noted that while it does not have information on the number of new spaces created for supported housing and assisted living since March 31, 2010, it has supported the creation or expansion of 28 supported-housing and assisted-living services since that time, serving 20% more people than before. The Ministry said it has also implemented initiatives, including new geriatric services and enhanced services for the frail elderly, to help seniors live longer in their own homes. The Ministry also funded an expansion of the Home First program, which provides services that help people wait at home until a bed in a long-term-care home becomes available. All three hospitals supported the Home First program and one commented that while legislation permits patients who must wait in hospital to choose up to five long-term-care homes, it is permissible for them to make only one choice even if the wait time for the

home they want is quite long. Two of the hospitals, therefore, encouraged patients waiting in hospital to choose five long-term-care homes, and one of these strongly encouraged these patients to choose at least two homes that either have beds available or have a short wait-list.

The Ministry also indicated that hospitals are provided with ongoing clarification on how alternate-level-of-care (ALC) wait times should be measured so that these times are reported in a consistent way to the Ministry's Wait Time Strategy. At the time of our follow-up, 114 hospitals were submitting ALC data. In addition, the Ministry has made this ALC information available in real time to hospitals, LHINs and CCACs since September 2011.

Given the other initiatives to address ALC wait times, the Ministry noted that public reporting of the time ALC patients wait in hospital was not considered necessary at the time of our follow-up. However, the Ministry said it would monitor the need for public reporting on an ongoing basis.

PERFORMANCE MEASUREMENT

Recommendation 7

To help evaluate the patient discharge process, hospitals should:

- *in conjunction with their Local Health Integration Networks (LHINs) and Community Care Access Centres, develop measures for monitoring and reporting on the effectiveness and safety of hospital processes for discharging patients, and compare results among hospitals to help identify areas for improvement or best practices that can be shared with other hospitals; and*
- *regularly report key discharge performance indicators to senior management and the board of directors.*

As well, to help monitor, on a province-wide and regional basis, unplanned returns to hospital for the same or related conditions, the Ministry, in conjunction with the LHINs, hospitals, and the Canadian Institute for Health Information, should track post-discharge emergency-department visits as well as

readmissions to any hospital that occur within a few days (or otherwise established reasonable time frame) after a patient is discharged from a hospital.

Status

At the time of our follow-up, all three hospitals indicated that they were monitoring and reporting on certain hospital discharge processes. One said it compares its readmission rates for patients with certain diagnoses to those of other hospitals across Canada. Another said it compares key performance measures, including readmission rates, to peer hospitals in its LHIN. The third said that while it does not perform regular comparisons to other hospitals, its LHIN compares its percentage of patients discharged by 11 a.m. and 2 p.m. each day to the percentages discharged from other hospitals as part of its Pay-for-Results program.

All three hospitals indicated that they were reporting key discharge performance indicators to senior management and their boards of directors;

at the time of our 2010 audit, only one hospital was doing this.

The Ministry noted that it does not regularly track emergency-department visits by recently discharged patients for the same or a related condition, although it periodically reviews cases of people who for any reason visit an emergency department within seven days of discharge from the same hospital. The Ministry also tracks unplanned readmissions to the same or different hospitals within 30 days of discharge for all persons in defined age groups with certain medical conditions (for example, people 45 or older with congestive heart failure). The Ministry noted that most unplanned readmissions occur through the emergency department of the same hospital from which the person was discharged. The Ministry also indicated that it meets with the LHINs quarterly to review hospital performance, including readmission rates.