

Care – Discharge / Transitions

Effective discharge planning and transition of care protocols are critical to achieving optimal delivery of patient care and coordination in the care continuum. Breakdowns in discharge planning and transition of care protocols may result in longer wait times, re-admissions, miscommunication among healthcare providers, and patient / family dissatisfaction. Ultimately, these can lead to serious patient harm. This document contains information entered by HIROC subscriber organizations (acute and non-acute) in the Risk Register application to help you in your assessment of this risk.



Ranking / Ratings¹

- Likelihood – average score 3.56
- Impact – average score 3.72

The Risk Register allows for risks to be assessed on a five-point likelihood and impact scale, with five being the highest.

Key Controls / Mitigation Strategies

- Discharge / Transition Planning
 - ✓ Corporate discharge planning policy, outlining the process for timely development of interdisciplinary, comprehensive and documented discharge plans for all patients
 - ✓ Incorporate discharge planning into the admission process
 - Discharge planning discussions with the patient / substitute decision maker on admission that focus on the community discharge destinations
 - ✓ Policies and procedures include the responsibility of the patient / substitute decision maker to identify and provide placement choices for those patients being assessed for long-term care facilities
 - ✓ Process for early identification of expected day of discharge
 - Communication of expected day of discharge to all patients shortly following admission
 - Timely communication and documentation of discharge date to ensure proactive discharge planning with teams
 - ✓ Formal roles or teams designated to the planning and coordination of discharge (e.g. Transition Coordinator or Discharge Planner) for any given patients
 - ✓ Standardized forms, including (but not limited to):
 - Medication reconciliation forms for discharge and transfer
 - Discharge instructions form
 - Discharge / transition checklist
 - ✓ Alternate level of care avoidance framework
 - ✓ Early identification of patients at risk for being designated alternate level of care
- Partnerships
 - ✓ Service level agreements with rehabilitation facilities to access beds for alternate level of care
 - ✓ Build relationships with providers within the community to ensure appropriate care and support transitions (e.g. provision of adult primary care, relationships with alternative housing, adult complex respiratory care)
 - ✓ Regular meetings with community agencies to identify and work through barriers to patient discharges
- Patient / Family-Centered Care
 - ✓ Patient and family advisory council
 - ✓ Patient oriented discharge summary tool to help patients / families manage post-hospital care
 - ✓ Post discharge follow-up phone calls to avoid hospital re-admission
 - ✓ Include a section on discharge in the patient information handbook
 - ✓ Education (e.g. brochures, information pamphlets) for procedure at time of discharge
 - ✓ Standardized discharge package for all patients discharged back to long-term care
 - ✓ Evaluate patient satisfaction with their discharge process for opportunities for improvement
 - ✓ Provide information about discharge processes on the organization's website
 - ✓ Ethics consultation services



Care – Discharge / Transitions



- Communication
 - ✓ Inter-disciplinary team rounds, case / care conferences, family meetings, structured bullet / rapid patient rounds, discharge rounds, access and flow meetings
 - ✓ Standardized transfer of accountability tools (e.g. bedside report, shift report, handover processes, discharge plans, discharge summaries, whiteboards)
 - ✓ Implementation of electronic bed board to keep track of the bed availability
 - ✓ Enhanced communication between Emergency Department and patient care units
 - ✓ Clear accountability for communicating post-discharge test results to family physicians
 - ✓ Consistent, timely and accurate communication of important medical information (e.g. patient care summary, medication changes, follow-up plans to family physician, home health agency, other care providers) as part of the pre discharge planning

Monitoring / Indicators



- Number of patient safety incidents related to transfer of accountability
- Patient satisfaction / experience survey results for discharge and transition planning and management
 - ✓ Patient complaints reporting:
 - ✓ Number of complaints related to transfer of accountability
 - ✓ Number of complaints related to discharge planning
- Audits of health records to ensure compliance with Patient Oriented Discharge Summary program key indicators:
 - ✓ Percentage of discharge patients that received the Patient Oriented Discharge Summary tool
- Audits of health records on adherence to discharge practices / guidelines:
 - ✓ Audits to ensure completion of the discharge instructions forms
 - ✓ Percentage of discharge sheets faxed to family health team on discharge
- Alternate level of care rate
- Number of alternate level of care rounds
- Medication reconciliation at discharge rate
- Readmission rate