

Halton Healthcare Services/Community Care Access Centre of Halton

Conjoint ALC Long Term Care Flow Process

This document outlines the processes and steps followed by Case Managers at the Community Care Access Centre of Halton (CCAC) in collaboration with their Halton Healthcare (HHS) colleagues, the Discharge Planners and Social Workers; as they conjointly work together to find the most appropriate Long Term Care (LTC) placement for patients designated as requiring an Alternate Level of Care (ALC), in the most expeditious fashion. It provides a written guide to and amplification of the attached flow sheet.

Staff are encouraged to work closely and professionally together on behalf of their patients, using the flow sheet and written description as a guide, recognizing that there will be situations where considered flexibility will improve outcomes for our patients.

For ease of description the steps in the overall process have been divided into four sections. Accountability for the various steps is indicated, as are performance indicators where these are available or have been proposed.

Phase I – ALC Determination

The accountability for the steps in this phase rests with HHS staff – nurses, social workers (SW), discharge planners (DP), and physicians.

- 1.1 The patient is deemed non-acute as per physician ALC order; the person no longer requires an acute care bed.
- 1.2 The SW/DCP and the health care team in conjunction with the patient, and family/significant others as appropriate, determines the appropriate type and level of care. Options could include rehabilitation, hospice care, retirement home, complex continuing care, home with CCAC support or referral to CCAC for Long Term Care Placement.
- 1.3 Should the team/patient see LTC as the most appropriate, the health care team/physician will make the determination of medical stability in preparation for referral to the CCAC Case Manager.

INDICATORS

- Weekly number of ALC-LTC patients in acute, rehab and CCC; by cases and days, trended over time, and as a percentage of overall bed-days and of overall cases.

Phase II – LTC Assessment

The accountability changes at each step as indicated.

- 2.1 The SW/DCP will obtain written consent from the patient/substitute decision-maker (SDM) to make the referral to CCAC. If the patient is not capable of giving informed consent to refer to CCAC, the SW/DCP will determine if there is a SDM. In the absence of a SDM, or family member to give consent, SW/DCP will refer patient to the Public Guardian and Trustee (PGT). (SW/DCP)

- 2.2 HHS staff will communicate HHS policy regarding those designated ALC and referred for LTC placement. At this time SW/DCP will provide patient/family/SDM with the Chief Executive Officer's (CEO's) letter and information regarding facility choices. This will be documented on the patient's health record. The SW/DCP will introduce the facility choice form and if the patient/family/SDM are prepared to make choices (as per hospital policy), the form will be filled out, all but signature. SW/DCP will initial and date the upper right hand corner of the form for compliance purposes.
- 2.3 The communication tool is completed by SW/DCP and the patient is referred to CCAC. (SW/DCP)
- 2.4 Should the person not be capable to consent and lack a substitute decision-maker, rights advice will be provided by the CCAC staff prior to the process of determining a substitute decision-maker. (CCAC accountability) The assumption is that the patient continues to be capable to give consent in their discussions with CCAC staff about possible placements, or that there is an existing substitute decision-maker. If not, CCAC will
- (i)Ensure that the patient receives appropriate Rights Advice regarding the establishment of a Substitute Decision-Maker to make decisions regarding placement issues.
- (ii)An appropriate Substitute Decision-maker is determined.
- (iii)The Public Guardian and Trustee (PGT) will be involved if necessary.
- (iv)Consent and Capacity Board hearings will be arranged if necessary.
- 2.5 CCAC carries out capacity assessment for Long Term Care, obtains consent and completes the Client ID Form.(CCAC)
- 2.6 The Health Assessment Form is completed by the Physician and obtained by the SW/DCP. (This may be done earlier in the process as the date of completion can be prior to date of eligibility).(SW/DCP)
- 2.7 CCAC case managers complete the RAI-HC (CCAC)
- 2.8 CCAC determines LTC eligibility. (CCAC)
- 2.9 If eligible, CCAC CM signs off on the patient's Facility Choices. SW/DCP can sign off on this form if eligibility has been determined at the point of meeting with the family. Facility Choices are completed as per HHS policy and charted on the patient's health record. The CEO letter outlining hospital policy may be attached to the Facility Choice Form when a patient/family's choices are not in compliance with hospital policy. (CCAC/SW/DCP)
- 2.10 If the patient is not eligible, CCAC CM notifies the SW/DCP and an alternate discharge plan is developed. (CCAC)
- 2.11 CCAC Case manager returns completed communication tool to SW/DCP

INDICATORS

- %tage of open files on which there is no complete health assessment after one week, trended over time
- %tage of CCAC files with incomplete RAI over 1 week from referral
- %tage of facility choices completed in less than one week
- %tage of patients not in compliance with HHS policy

Phase III – LTC Bed Match

In this phase accountability changes at each step as indicated. It is important to remember that assessment of medical stability is an ongoing issue, both in this phase and elsewhere in the process.

- 3.1 CCAC determines the actual bed through the matching process. (CCAC)
- 3.2 At the point of bed offer from CCAC, the charge nurse or designate in consultation with the physician, will reconfirm to the CCAC that the patient is medically stable. (Charge Nurse/ Physician)
- 3.3 The charge nurse obtains a physician's discharge order for LTC. (Charge Nurse/ Physician)
- 3.4 If the patient is now medically unstable, HHS staff and physicians will need to review medical status and determine medical readiness; at which point CCAC is advised.(CCAC)

INDICATORS

- %tage of patients medically stable/unstable at certain key points in this phase
- average length of time patients remain unstable after those key points.

Phase IV – LTC Bed Offer and Placement

In this phase accountability changes at each step as indicated and is based on the assumption that the patient is medically stable.

- 4.1 CCAC CM offers the bed to the pt./family and notifies the SW/DCP. (CCAC Accountability)
- 4.2 If the bed offer is accepted, SW/DCP arranges transportation as per admission information provided by the CCAC CM.
- 4.3 If bed offer is not accepted, the CCAC CM notifies the SW/DCP who initiates the Administrative Review. (CCAC CM & SW/DCP)

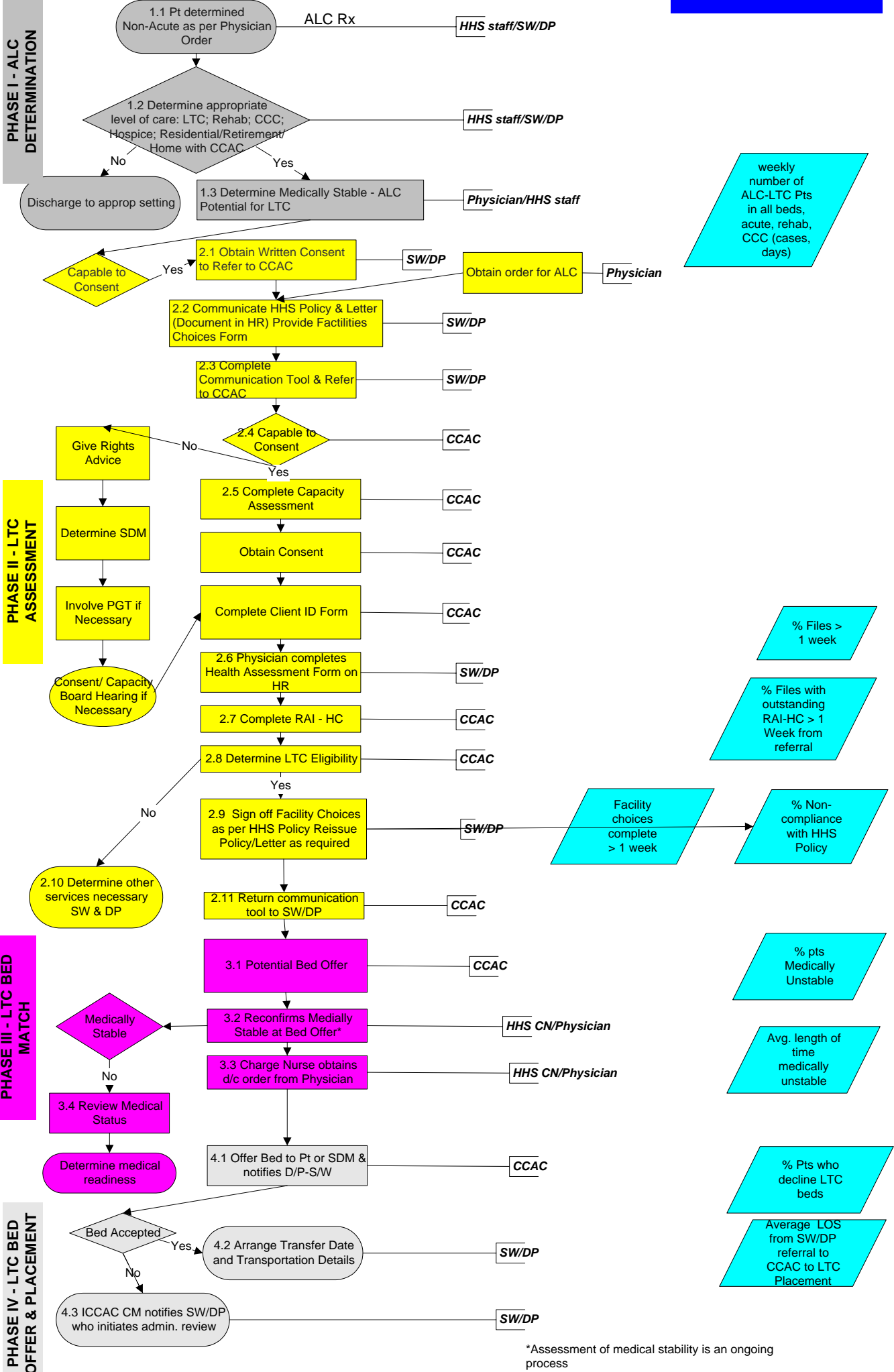
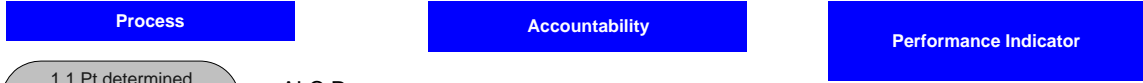
INDICATORS

- %tage of patients who declined LTC Beds
- Average LOS from SW/DCP referral to CCAC to LTC Placement.

Croxall/Raiskums

**HHS/CCAC
Conjoining ALC Long-Term Care Flow Process**

Revised
Feb. 11, 2004



weekly number of ALC-LTC Pts in all beds, acute, rehab, CCC (cases, days)

% Files > 1 week

% Files with outstanding RAI-HC > 1 Week from referral

Facility choices complete > 1 week

% Non-compliance with HHS Policy

% pts Medically Unstable

Avg. length of time medically unstable

% Pts who decline LTC beds

Average LOS from SW/DP referral to CCAC to LTC Placement

*Assessment of medical stability is an ongoing process