FLOW CHART 1

Patient Flow as it Relates to Long-Term Care Home Placement from Hospital

When should discharge planning begin?

Discharge planning is a collaborative process that should begin as early as possible during a patient's hospital admission. This early start allows the patient, their substitute decision-maker, and family or caregivers sufficient time to understand and explore the appropriate discharge options in partnership with the health care team and Ontario Health atHome, if applicable. Ontario Health's "home first" approach requires that "every effort is made to ensure adequate resources are in place to support patients to remain at home whenever possible, and ultimately return home upon discharge from all bedded levels of care." Home should be considered the preferred discharge destination before exploring options such as long-term care placement.

What are the next steps if home is not a viable discharge option?

At times, home is not a viable discharge destination for a patient and long-term care must be considered. This flow chart will assist hospital discharge planning teams to navigate the appropriate steps when an admission to long-term care is the only viable discharge destination. Sections referenced in the flow chart below refer to the corresponding section of Managing Transitions - A Guidance Document (Third Edition) that will provide further guidance. Additionally, if challenges arise when proceeding through the steps of this flow chart, involving an ethicist or a spiritual care provider may help address and resolve complex situations.

Navigating decisions with substitute decision-makers.

If a patient is determined to not have capacity to make decisions with respect to a long-term care admission, a substitute decision-maker will be responsible for providing consent at the various steps of the admission process where consent is required. If any concerns or challenges arise with a patient's substitute decision-maker while progressing through Flow Chart 1, pause at the step in Flow Chart 1 where the concern arose and refer to Flow Chart 2.

START

The hospital team, in collaboration with OHaH, discuss viable discharge options with the patient.

Are there appropriate discharge options, other than LTC, including OHaH services?

YES

NO

OHaH care coordinator escalates to OHaH Manager/Director that patient is on trajectory of becoming ALC-LTC. Hospital Team escalates in accordance with hospital policy, typically to Manager/Director, that patient is on trajectory to become ALC-LTC.

Patient assessed for eligibility for LTC admission. If patient (or SDM) does not consent to assessment for eligibility, assessment will be completed based solely on review of existing hospital records. Is patient determined to be eligible for LTC? (Ref: Section 5)

NO

YES

OHaH attempts to obtain informed consent from patient (or SDM) to apply for LTC and provides LTC counseling. If informed consent obtained, OHaH proceeds with LTC application(s). (Ref: Section 6)

If informed consent is not obtained, OHaH may proceed with application(s) in absence of consent. (Ref: Section 4)

To expedite LTC admission, OHaH may apply to additional LTC homes, including those with shorter wait lists, without patient's (or SDM's) consent, where appropriate.

Patient is designated ALC to LTC, and OHaH will add crisis designation if criteria are met. (Ref: Section 5)

LTC homes must review within 5 business days.

Are any applications approved? (Ref: Section 5)

Patient (or SDM) engaged in ongoing counselling to expand LTC choices throughout hospitalization.

NO

Are there other appropriate discharge options including OHaH services?

YES

NO

Consider appealing the decision of LTC home(s) as well as applying to additional LTC homes.

YES

Is a bed available?

NO

Are there other appropriate discharge options including OHaH services?

YES

NO

Patient remains on waitlist for all LTC homes where their application was accepted.

Determine applicability of co-payment. (Ref: Section 8)

Does a bed become available within 3 months?

YES

NO

OHaH reassesses application and updates LTC file.

If improvement in status, community discharge options re-explored.

Are there other appropriate discharge options including OHaH services?

YES

NO

YES

Does the patient (or SDM) accept bed?

Note: Patient (or SDM) ***must provide consent*** *for transfer to LTC home to occur, even if application was made without consent.*

Patient has 24 hours to accept and must transition before noon of the fifth day after accepting. (Ref: Section 5)

NO

Hospital bed refusal escalation process engaged.

Hospital required to charge daily rate for patient who refuses bed offer from a LTC home to which they applied. (Ref: Section 9)

Are there other appropriate discharge options including OHaH services?

YES

NO

Charge daily rate and consider seeking legal advice.

YES

Was it the patient's first choice?

YES

Patient admitted and file closed.

NO

Patient admitted to LTC home and remains on waitlist (without crisis priority) for other homes. Hospital no longer involved in patient's LTC file.

Glossary

ALC: alternate level of care

LTC: long-term care

OHaH: Ontario Health atHome

SDM: substitute decision-maker

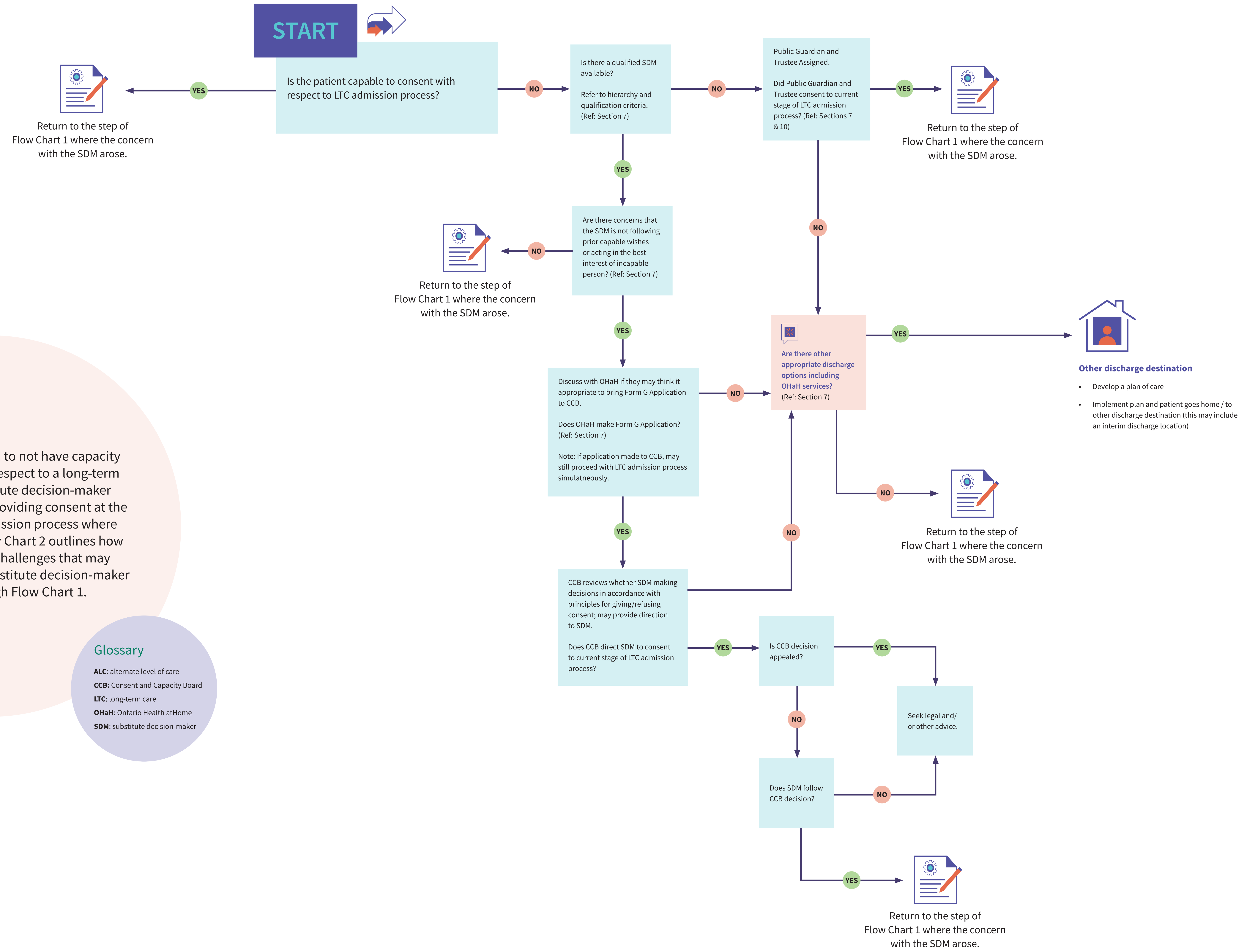
Other discharge destination

- Develop a plan of care
- Implement plan and patient goes home / to other discharge destination (this may include an interim discharge location)

OHA Ontario Hospital Association

FLOW CHART 2

Navigating Interactions with Patient’s Substitute Decision-Makers



If a patient is determined to not have capacity to make decisions with respect to a long-term care admission, a substitute decision-maker will be responsible for providing consent at the various steps of the admission process where consent is required. Flow Chart 2 outlines how to navigate concerns or challenges that may arise with a patient’s substitute decision-maker while progressing through Flow Chart 1.

Glossary

ALC: alternate level of care
CCB: Consent and Capacity Board
LTC: long-term care
OHaH: Ontario Health atHome
SDM: substitute decision-maker