Policy & Procedure:	**Discharge from Residence Policy**		
Performed by:	All HCO Staff working in Residence and Physicians at HCO		
Approved by:	Executive Director		
Date Approved:	Nov. 16, 2021		

PURPOSE:

This policy outlines the discharge planning process to be a standardized approach for all of our patients admitted to Hospice Care Ottawa (HCO) Residence in order to maintain the highest quality care for all of our patients and their families/support network and to maximize access to our residential services.

Policy:

This policy applies to All HCO staff and physicians working in residence. HCO is required to continually evaluate patients' eligibility for hospice care during their stay with us and this is done through the care team.

If a patient or their substitute decision maker refuses to be discharged once the care team has determined that they are ready to be discharged, initiation of the non-compliance process will commence.

Definition:
Care Team: Members of Hospice Care Ottawa that develop a plan of care in collaboration with the patient and family. These individuals are involved in the patient's chart. Can include but does not exclude; nursing staff, PSW's, volunteers, family support, physicians.

Care Circle: The care circle is defined as those persons identified by the patient, who are closest in relationship to them and involved in their ongoing care. They include but is not limited to; family members (by blood and/or marriage), friends, guardians, neighbors, coworkers and any other significant person (s). The Care Circle may also include pets, and service animals.

Background:

Discharge from HCO is unpredictable and is an exception to the majority of residential hospice patients. HCO acknowledges that the disease trajectory for every individual in our care will require an individualized approach. An individual's disease progression and/or stability will be regularly evaluated and discussed by the care team.
The discharge process is outlined upon admission, to ensure that Hospice admission criteria continues to be met.

Procedure:

A discharge planning meeting will occur not earlier than 4 weeks after admission IF the following criteria have been met;

- There are indications of stability of disease process;
  - A consistent and comprehensive review of the patient situation by the care team has been completed and there have been observations of disease plateau
  - Discussions are held that outline the inability for Hospice to meet the needs of a patient who is not acutely end of life

- The care team will discuss first whether or not they feel introducing the topic of discharge to the patient and family is appropriate. The approach to this decision will consider a multitude of factors including but not limited to;
  - Symptom burden/control
  - Psychosocial conditions of patient *and* care circle (eg. Caregiver burnout)
  - Structural vulnerabilities (e.g. Living situation, financial situation, available home care, etc.)
- Individual discussions with the patient and/or care circle are not to occur by any member of the care team before consensus within the team has occurred (eg. The care team has discussed and amenable that a family meeting will be planned to discuss discharge planning)
  - Consensus is to be met by the care team as to what team member will broach the subject with the patient and/or care circle of scheduling the discharge planning meeting
  - Document prudently all care team discussions regarding discharge planning potential
    - Designate an individual to document the discharge planning discussion at weekly rounds when appropriate

Discharge Planning Meeting:

A discharge planning meeting will include the patient and their care circle, the Residence Team Lead and a Family Support Counsellor. The Team Lead and Family Support Counsellor will facilitate the conversation. Hospice physicians will be invited and highly encouraged to attend the meeting.

Resources for the discharge process of transfer/referral will be discussed and provided to the family to support them with the discharge from Hospice.

Discharge location options for patients include;

- Home with Home & Community Care Support Services (HCCSS)

- Retirement Home with/without HCCSS
- Long Term Care (LTC)
    - Note: Home & Community Care Support Services (HCCSS) is solely responsible for eligibility of their services, which includes long-term care.

- The discharge plan is created with active engagement of patients and their care circle. The plan is reviewed regularly.
- Discharges that have been identified as potentially complex should be identified early in the admission process and brought to the attention of Family Support Services as soon as possible for ongoing support and discharge planning support.

The patient and/or substitute decision maker and/or care circle receives the explanation as to why they no longer meet the criteria for Hospice Care Ottawa Residence and that they have exceeded the length of stay our services allow for. The discharge plan includes the patient and/or substitute decision maker and/or care circle and the following:

1. An assessment date scheduled and booked with an HCCSS Care Coordinator within 2 weeks of the family discharge meeting.
2. Facility choices to be selected to provide to HCCSS within 30 days of assessment as outlined by HCCSS. The patient will be responsible for any costs incurred for the transfer from Hospice to transferred destination.

If the following criteria after a discharge meeting is not met, initiate the Non-Compliance with Discharge Plan.

Non-Compliance with Discharge Plan
If a patient or substitute decision maker refuses to participate fully in the discharge process, the **escalation process** as described below, is put into place

1. Inform the Director of Residence Care or their delegate of the situation immediately. Document in the patient's progress notes the details of the discussion with the patient or substitute decision maker.
2. The patient and/or substitute decision maker is provided a date that discharge from Hospice will occur.
3. A plan for a transfer to a transitional and alternate location of care such as Transitional care centres or hospitals, will be coordinated by Hospice Care Ottawa