DISCHARGE PLANNING GUIDELINES FOR INPATIENT REHABILITATION

The Discharge Planning Guidelines for Inpatient Rehabilitation have been developed by the GTA Rehab Network's Patient Access and Flow Committee to promote effective, efficient and consistent discharge planning processes in inpatient active/regular stream and Low Tolerance Long Duration/slowstream rehabilitation. These guidelines include 3 sections:

- Section 1: ALC in Rehab Definition
- Section 2: Discharge Readiness Indicators
- Section 3: Discharge Planning Considerations

The Discharge Planning Guidelines for Inpatient Rehabilitation are supported by the following guiding principles and timeframes:

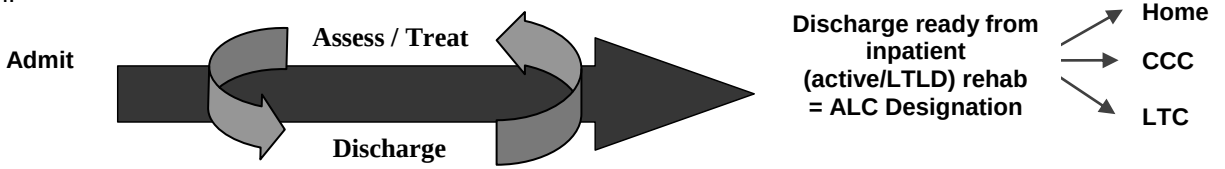
Discharge Planning Guiding Principles and Standards

Guiding Principles

- Assessment, treatment and discharge planning is an ongoing iterative process conducted throughout the admission period
- There are established mechanisms for the development and communication of goals and plans with each patient/family
- The identification of rehab goals takes into account that rehabilitation can continue throughout the care continuum and as such, rehab goals specific to the inpatient setting are identified and documented through a collaborative process with the patient/family.

Standards

- Within 7 days of admission, determine an estimated date of discharge and provisional destination.
- Within 7 days of admission, screen for factors that may delay discharge and develop a plan of care for addressing the identified barriers to discharge.
- For the patient in an active rehab program who has been identified as at risk for delayed discharge, schedule the first patient/family team meeting by the second week of admission. For patients in LTLD/slowstream rehab who are at risk for delayed discharge, schedule the first patient/family team meeting within 4-6 weeks of admission.
- Conduct weekly team meetings to promote consistency in the treatment approach by identifying and reviewing the patient's care plan, treatment goals, progress and discharge plans.
- Throughout the admission, consider the discharge readiness indicators and determine appropriate timing for ALC designation.



SECTION 1: PROVINCIAL ALTERNATE LEVEL OF CARE (ALC) DEFINITION

PROVINCIAL ALTERNATE LEVEL OF CARE (ALC) DEFINITION
For implementation in all acute and post-acute hospitals*
(Adapted from the Wait Time Information Strategy)

Provincial ALC Definition

The healthcare system aspires to deliver care in a setting that is congruent with the clinical needs of a patient as defined by the patient's health status, treatment plan and goals.

The definition applies to all patient populations waiting in all patient care beds in an acute or post acute care hospital in Ontario.

Definition:

When a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting (Acute, Complex Continuing Care, Mental Health or Rehabilitation), the patient must be designated Alternate Level of Care (ALC)[1] at that time by the physician or her/his delegate. The ALC wait period starts at the time of designation and ends at the time of discharge/transfer to a discharge destination[2] (or when the patient's needs or condition changes and the designation of ALC no longer applies).

Note 1

The patient's care goals have been met ***or***
- progress has reached a plateau ***or***
- the patient has reached her/his potential in that program/level of care ***or***
- an admission occurs for supportive care because the services are not accessible in the community (e.g. "social admission").

This will be determined by a physician/delegate, in collaboration with an interprofessional team, when available.

Note 2

Discharge/transfer destinations may include, but are not limited to:
- home (with/without services/programs),
- rehabilitation (facility/bed, internal or external),
- complex continuing care (facility/bed, internal or external),
- transitional care bed (internal or external),
- long term care home,
- group home,
- convalescent care beds,
- palliative care beds,
- retirement home,
- shelter,
- supportive housing.

This will be determined by a physician/delegate, in collaboration with an interprofessional team, when available.

Final Note

The definition **does not** apply to patients:
- waiting at home,
- waiting in an acute care bed /service for another acute care bed/service (e.g., surgical bed to a medical bed),
- waiting in a tertiary acute care hospital bed for transfer to a non tertiary acute care hospital bed (e.g., repatriation to community hospital).

*as of July 1, 2009

SECTION 2: DISCHARGE READINESS INDICATORS

Patients whose medical and functional status has <u>improved</u> in inpatient rehab are ready for discharge to the community when…

Considerations for current care needs

<u>Medical Stability:</u>

- ✓ Vital signs stable ***and***
- ✓ Hemodynamically stable ***and***
- ✓ Lab work within accepted ranges ***and***
- ✓ All necessary/urgent medical consults and tests have been performed ***and***
- ✓ Pain is well-controlled (e.g. patient is able to manage pain independently or with the assistance of a pain management clinic) ***and***
- ✓ Established and managed bowel & bladder routine ***and***
- ✓ Established medication management and practices ***and***

<u>Nursing/MD Requirements:</u>

- ✓ 24 hour specialized skill nursing care is not required ***and***
- ✓ On-site access to MD is not required ***and***
- ✓ Patient may or may not require home-based nursing (e.g. wound care, IV) or other health professional services

<u>Suggested measurement tools</u>:

- Vital Signs: As determined by MD
- Lab Work: Completed before discharge and ongoing requirements for lab work can be met in the community
- Pain Management: As determined by established pain management scales (e.g. Visual Analog Scale, Numerical Rating Scale) (See Appendix A and B)
- Patient/caregiver/family demonstrates effective management of bowel & bladder routine
- Patient/caregiver/family demonstrates effective medication management

and

Considerations for rehab goals, rehab potential and functional level

<u>Rehab Goal Attainment:</u>[2]

- ✓ Identified rehab goals for the inpatient setting have been met such that the inpatient setting is no longer required ***and***

<u>Rehab Potential:</u>

- ✓ Additional progress can be achieved independently or with the assistance of a caregiver at home ***or***
- ✓ Patient's rehab potential can be further maximized through community-based rehabilitation such that:

<u>Functional Level:</u>

- ✓ Patient is independent (or able to function with the assistance of a caregiver) in the areas below ***or***
- ✓ Patient requires in-home rehabilitation (if home-bound) or outpatient/ambulatory rehab to maximize independence in one or more of the areas listed below

✓ <u>Activities of Daily Living:</u>
- Toileting
- Bathing
- Dressing
- Instrumental ADLs

✓ <u>Cognition/Communication</u>
- Memory
- Insight/Judgment
- Communication

✓ <u>Mobility:</u>
- Transfers
- Mobility +/- mobility aid

✓ <u>Other Areas:</u>
- Vocational / avocational activities
- Psychosocial functioning

<u>Suggested measurement tools:</u>

- Goal attainment scale or patient satisfaction rating of goal attainment (e.g. See Appendix C) may be utilized by specific rehab programs
- Functional Level Assessment: FIM^{TMi} (NRS) score within range of patient's goals.
- Continuing Care Reporting System (MDS)
- Cognition/communication Assessment: Cognition as assessed by Mini Mental State Examination (MMSE)
- Other areas assessed as per progress notes and achievement of goals including recreation therapy and psychometric testing
- Some rehab goals are better suited to an out-patient setting (e.g. Vocational training; community reintegration; Driver evaluation)

ALC DESIGNATION[1]

[1] The patient is designated as ALC if s/he is ready for discharge but is awaiting transfer to discharge destination (e.g. supportive housing; home with appropriate services/modifications/equipment)

[2] Throughout this document, the identification of goals refers to a collaborative process between the patient/family and team. The identified goals are documented in the plan of care by the interprofessional team.

SECTION 2: DISCHARGE READINESS INDICATORS (cont'd)

Patients whose medical and functional status have <u>remained the same, changed minimally or declined</u> in inpatient rehab are ready for discharge to Long Term Care (LTC) or Complex Continuing Care (CCC) when…

	Patients requiring referral to LTC	*Patients requiring referral to CCC*		
Considerations re: current care needs	<u>Medical Stability:</u> ✓ Vital signs stable ***<u>and</u>*** ✓ Hemodynamically stable ***<u>and</u>*** ✓ Lab work within accepted ranges ***<u>and</u>*** ✓ All necessary/urgent medical consults and tests have been performed or may be carried out on an outpatient basis ***<u>and</u>*** ✓ Patient requires a residential setting with 24 hour supervision and on-site nursing care to assist with self-care and other care needs ***<u>and</u>*** ✓ On-site access to MD is required for weekly monitoring	<u>Medical Stability:</u> ✓ Vital signs stable ***<u>and</u>*** ✓ Hemodynamically stable but may require regular diagnostic monitoring ***<u>and</u>*** ✓ All necessary/urgent medical consults and tests have been performed or may be carried out on an outpatient basis ***<u>and</u>*** ✓ Patient requires 24 hour specialized skilled nursing care and 24 hour access to physician care ***<u>and</u>*** ✓ Care needs cannot be met in LTC	<u>Suggested measurement tools</u>: ▪ Vital Signs: As determined by MD ▪ Lab Work: Completed before discharge ▪ For analysis of resource requirements, use such tools as FIM™ (NRS) and Continuing Care Reporting System (MDS)	**ALC DESIGNATION[3]**
<u>and</u> **Considerations re: rehab goals, rehab potential and functional status**	<u>Rehab Goal Attainment:</u> ✓ The identified goals for inpatient rehab have been met or the patient's functional status has plateaued ***<u>and</u>*** <u>Rehab Potential:</u> ✓ Patient is not demonstrating any significant progress towards making further gains but may have the potential to make minimal gains over time which could be achieved in LTC ***<u>and</u>*** <u>Functional Level:</u> ✓ None of the publicly-funded community services and none of the caregiving, support or companionship arrangements in the patient's home can meet the patient's functional and care needs.[4]	<u>Rehab Goal Attainment:</u> ✓ Patient has not sufficiently met their inpatient rehab goals for return home or discharge to LTC ***<u>and</u>*** <u>Rehab Potential:</u> ✓ Rehab potential cannot be met because of patient's medical condition/needs ***<u>and</u>*** <u>Functional Level:</u> ✓ Patient's current functional status precludes his/her capacity to demonstrate significant progress towards the achievement of those rehab goals	<u>Suggested measurement tools:</u> ▪ Goal attainment scale or patient satisfaction rating of goal attainment (e.g. See Appendix C) ▪ Functional Level Assessment: FIM™ [i] score within range of patient's goals. ▪ Cognition/communication Assessment: Cognition as assessed by Mini Mental State Examination (MMSE) ▪ Other areas assessed as per progress notes and achievement of goals including recreation therapy and psychometric testing ▪ If progress has plateaued in active rehab, there has been no or minimal gains seen in patients who have been medically stable and able to participate in rehab <u>over 2 weeks of observation</u> ***or*** ▪ If progress has plateaued in LTLD rehab, there has been no or minimal gains seen in patients who have been medically stable and able to participate in rehab <u>over 4 weeks of observation</u>	

[3] The patient is designated as ALC if s/he is ready for discharge but is awaiting transfer to discharge destination (e.g. LTC, CCC)
[4] Nursing Home Act, Government of Ontario

SECTION 3: DISCHARGE PLANNING CONSIDERATIONS

	To be considered from date of admission through inpatient rehab stay
Identification of Goals	✓ The identification of rehab goals takes into account that rehabilitation can continue throughout the care continuum and as such, rehab goals specific to the inpatient setting are identified through a collaborative process with the patient/family ✓ The process of identifying rehab goals includes education to the patient/family to promote realistic expectations for the inpatient setting ✓ The identified goals should be specific, individualized and meaningful to the patient, measurable, attainable, realistic and timely and should also include a description of what the patient's behaviour will be when the goal is achieved. ✓ The identified goals are documented in the plan of care by the interprofessional team
Community Resources	If services are required upon discharge: ✓ All services/supplies required to ensure safety within the home at time of discharge are available. Team may request home safety assessment before patient goes home. ✓ If services are not available within the home community or start of services will be delayed due to lengthy wait lists, alternate services to be considered in the interim (e.g. referral to CCAC services, private services). ✓ Follow-up appointments arranged ✓ If patient is referred to outpatient/ambulatory rehab, determine if patient has transportation to / from outpatient / ambulatory clinic and, if required, caregiver accompaniment for treatment sessions (e.g. patient requires assistance with toileting or other supervision) ✓ If patient requires dialysis, then dialysis is arranged and/or transportation to dialysis is arranged
Patient / Family / Home situation	✓ Patient/family has participated in and has been informed of discharge plan ✓ Adequate family / social support is available to support a safe discharge home ✓ Caregiver/family is aware of post-discharge appointments and/or other services needed ✓ Caregiver is able to provide some assistance with self-care and instrumental needs if required ✓ If needed, the home environment has been modified / adapted to accommodate the patient's functional status and to reduce safety risks. These may include: ▪ Ramps, handrails, raised toilet seat, assisted devices if applicable, equipment arranged (rented by patient/family) **Note:** Where major modifications are required, recommendations have been made and the timeframe for implementation has been negotiated **For patients discharged to CCC or LTC:** ✓ Complex care co-payment fees and LTC fees have been discussed with the patient/family ✓ Patients and families are informed that discharge from CCC will be discussed if the patient's medical situation requires less intensive care which can be managed in a LTC home.

APPENDIX A

Visual Analogue Scale

A Visual Analogue Scale (VAS) is a measurement instrument that tries to measure a characteristic or attitude that is believed to range across a continuum of values and cannot easily be directly measured.

For example, the amount of pain that a patient feels ranges across a continuum from none to an extreme amount of pain. From the patient's perspective this spectrum appears continuous ± their pain does not take discrete jumps, as a categorization of none, mild, moderate and severe would suggest. It was to capture this idea of an underlying continuum that the VAS was devised.

Operationally a VAS is usually a horizontal line, 100 mm in length, anchored by word descriptors at each end, as illustrated in Fig. 1.

The patient marks on the line the point that they feel represents their perception of their current state.

The VAS score is determined by measuring in millimetres from the left hand end of the line to the point that the patient marks.

No Pain _____ Very severe pain

There are many other ways in which VAS have been presented, including vertical lines and lines with extra descriptors. Wewers & Lowe (1990) provide an informative discussion of the bene®ts and shortcomings of different styles of
VAS. As such an assessment is clearly highly subjective, these scales are of most value when looking at change within individuals, and are of less value for comparing across a group of individuals at one time point. It could be argued
that a VAS is trying to produce interval/ratio data out of subjective values that are at best ordinal. Thus, some caution is required in handling such data. Many researchers prefer to use a method of analysis that is based on the rank ordering
of scores rather than their exact values, to avoid reading too much into the precise VAS score.

Further reading Wewers M.E. & Lowe N.K. (1990) A critical review of visual analogue scales in the
measurement of clinical phenomena. Research in Nursing and Health 13, 227±236.

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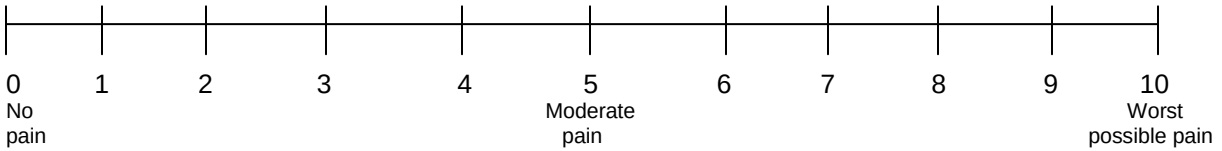
APPENDIX B

Numerical Rating Scale

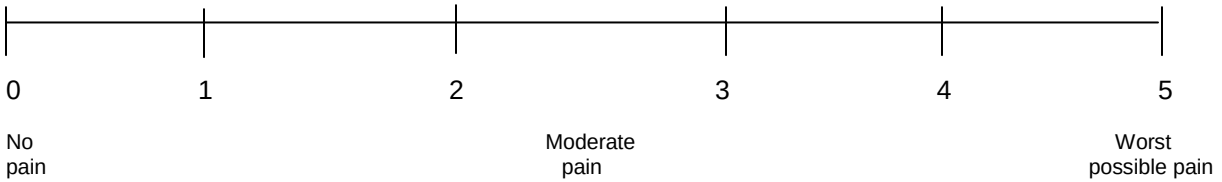
Instructions: Show the pain scale to the resident. Verbally read the scale to the resident and wait for a reply. On the 0-10 pain rating scale, 0 means no pain and 10 means the worst pain possible. The middle of the scale around 5 is moderate pain. A 2 or 3 would be mild pain, but 7 and higher is severe pain.

Repeat the directions if the resident is having difficulty; use words other than “pain”: aching, cramping, sore, uncomfortable, stiff, dull, pressure, burning, shooting. If the resident does not like it or understand it, switch to another scale. Always use the same scale for each follow-up assessment. Document the scale used as the Numerical Rating Scale (NRS).

0-10 Numerical Rating Scale



0-5 Numerical Rating Scale



APPENDIX C: GOAL SETTING FORM/INTERPROFESSIONAL CARE PLAN (Toronto Rehab)

Goal Coordinator:

_____ (Goal #)	**Patient's Goal:** Info from [initial]: PT [ ] SDM [ ] Other [ ] _____ "_____"
_____ (Initial)	**Participation Statement (s):** (Reflects involvement in life roles as per WHO ICIDH-2 and may be the same for different goals) _____
_____ (Date)	_____

SMART Short Term Goals
S=Specific **M**=Measureable **A**=Achievable **R**=Relevant **T**=Timely

Outcome at Completion
N=Not achieved **P**=Partially achieved **A=**Achieved **E**=Exceeded **DC**=Discontinued

Goal ID	Date	Short Term Goals (steps identified by prof.)	Prof. / Initial	Interventions / Actions	Outcome - Initial

Patient's Satisfaction with Performance towards overall patient goal (initial each score)											
Date											
Outcome											
Extremely satisfied 10 9 8 7 6 5 4 3 2 1 **Not satisfied at all**											

Review Dates & Outcomes towards overall patient goal (initial each outcome) (OPTIONAL)											
Date											
Outcome											
N=Not achieved **P**=Partially achieved **A=**Achieved **E**=Exceeded **DC**=Discontinued *For final patient goal outcome of **N** or **P**, record reason on Discharge Summary Goal Attainment Outcome form											

Short Term Goal Attainment Outcome Collation (OPTIONAL)					
Total # of Short Term Goal Outcomes	**N**	**P**	**A**	**E**	**DC**
Total # of Short Term Goals					

Signature:_____ **Initial** _____ **Signature** _____ **Initial** _____

ENDNOTES

[i] FIM™ is a trademark of the Uniform Data System for Medical Rehabilitation, a division of UB Foundation Activities, Inc. The Functional Independence Measure (FIM) assesses physical and cognitive disability in terms of burden of care. It includes an 18-item ordinal scale that measures independence in self-care, sphincter control, mobility, locomotion, communication, and social cognition. The optimal timing for stroke rehab assessment is 5-7 days post-stroke onset.