DEVELOPMENT OF A DISCHARGE PLANNING RESOURCE FOR OLDER ADULT ALC PATIENTS

By

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Abstract

Background: Providing alternate level of care services in an acute care hospital is not optimal as it introduces an increased risk for patient injury and systemic bottlenecks. Discharge planning is an effective strategy to streamline safe and timely discharge for older adult alternate level of care patients.

Purpose: To develop a discharge planning resource to guide interdisciplinary healthcare teams through the discharge process for older adult alternate level of care patients.

Methods: An integrative literature review of 10 sources using inductive analysis and synthesis, consultations with Western Memorial Hospital discharge planners, and an environmental scan were conducted.

Results: A relevant discharge planning pathway was found during the environmental scan. Findings from the literature review and consultations informed the adaptation of the pathway to a local context.

Implications: The discharge planning pathway has been presented to the NL Health Services Clinical Efficiency team as part of a provincial alternate level of care policy that supports the appropriateness of care. Incorporating a consistent approach to discharge planning for older adults may help improve care equity across the province, reduce inappropriate designations, and identify priorities for government initiatives that support care for older adults.

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Introduction

Acute care services in hospitals are primarily designed to deliver short-term inpatient care and necessary treatment for a disease or severe episode of illness, then discharge patients as soon as they are medically stable (Canadian Institute for Health Information [CIHI], 2021). However, patients often require comprehensive and coordinated efforts to ensure that post-hospitalization care and support are in place before hospital discharge (Rutherford et al., 2020). Alternate Level of Care (ALC) is a widely used term describing patients who do not require the intensity of services provided in an acute care setting but do not have access to the services required to facilitate their discharge (Robert et al., 2021). In 2021-2022, 5.8% of hospital stays in Canada had ALC days. In NL, patients with ALC designations occupy 20% of all acute care beds (Health Accord NL, 2022). There is growing concern that providing ALC services in an acute care hospital is not optimal provision of care (CIHI, 2024a). Adults over 65 years of age, or older adults, are especially vulnerable, as more than 33% of hospitalized older adults are at risk of frailty, which is defined as having six or more deficits such as nutrition and wasting, infection, and immobility (CIHI, 2023). Frail older adults are three times more likely to be high users of hospital beds or to be hospitalized for 30 days or longer. They are also two times more likely to be readmitted within 30 days after discharge or to die within one year after discharge. In 2022-23, 19.1% of older adults hospitalized in NL were at risk for frailty; however, in the Western Zone (WZ), that number is alarmingly higher at 23.4% (CIHI, 2023).

Prolonged acute care stays for older adults who are designated as ALC have been linked to increased frailty, falls, hospital-related adverse events, and mortality, as well as poor patient and family experiences and premature institutionalization (Barnable et al., 2015; Cadel et al., 2022; Robert et al., 2021). Systemically, high ALC rates contribute to hospital-wide patient flow

issues, increased wait times for service access, and increased healthcare costs (Cadel et al., 2021; Coffey et al., 2019). Improving discharge planning is a critical to optimizing patient outcomes and ensuring that patients move smoothly from one part of the care continuum to another, whether patients are discharged home from the hospital, referred to an outpatient/ambulatory care program, or transferred to a rehabilitation facility or another health care setting (Department of Health and Community Services, personal communication, 2023). Discharge planning is a health system routine aimed at reducing delayed discharge from the hospital, improving the coordination of services following discharge, and reducing the risk of hospital readmission (Gonçalves-Bradley et al., 2022). Health Accord NL (2022) suggests that with appropriate discharge planning, many ALC patients can return home or lower care level.

NL Health Services (NLHS) supports a vision that all residents will have access to the support and services they need to age with dignity (Health Accord NL, 2022) and has embraced a Home First (HF) philosophy to ensure patients and clients receive the right care at the right time from the right provider at the right cost. This appropriateness of care approach promotes early and structured discharge planning to help patients transition from hospital to home as soon as possible with appropriate support (Department of Health and Community Services, personal communication, 2023; Health Accord NL, 2022). Still, there are no standardized frameworks to simplify the discharge process and support timely transitions from hospital to home (Barnable et al., 2015). Developing a discharge planning resource based on credible research that aligns with the local context will enable a more streamlined and consistent approach to discharge planning and provide better outcomes for our older adult population.

Objectives

The overall goal of this practicum project was to develop a discharge planning resource to guide interdisciplinary healthcare teams through the discharge process for older adult ALC patients. The specific objectives of the practicum project are as follows:

1. Describe the impact of delayed discharge from acute care on patient outcomes and patient flow.
2. Identify issues and gaps in discharge planning within NLHS-WZ.
3. Identify and compare discharge planning resources and interventions used in other facilities across Canada.

Overview of Methods

This practicum project used three methods to meet the project objectives and inform the development of a discharge planning resource. First, an integrative literature review was conducted to gather credible research on discharge planning in older adult ALC patients and summarize the findings in literature summary tables (see Appendix A). Second, consultations were conducted to obtain perspectives, needs, and recommendations from discharge planner colleagues (see Appendix B). Finally, an environmental scan was completed to provide a broad view of existing discharge planning tools across Canada (see Appendix C). The information was then reviewed and compiled to support the development of a discharge planning resource for older adult ALC patients (see Appendix D).

Summary of the Literature Review

An integrative review was conducted better to understand discharge planning for older adult ALC patients. Four databases were searched using Boolean operators and MESH terms, indexed keywords, and subject headings "discharge planning" OR "hospital discharge" AND

"alternate level of care." Limits of age >65 years, English language, and peer-reviewed articles were applied. Inclusion criteria were specified for qualitative, quantitative, systematic reviews, and mixed methods studies conducted between 2019 and 2024 focusing on discharge planning from acute care hospitals for ALC or older adult populations. As a high-income country, Canada is frequently compared to the United States and the United Kingdom for healthcare efficiencies and services (CIHI, 2022; MacKinnon et al., 2023). In keeping with these comparisons, studies completed outside these geographical regions were excluded, thus limiting the selection and review of studies to those more pertinent to the Canadian context. In total, ten studies were used in the literature review: six quantitative retrospective cohort studies (Arthur et al., 2021; Bai et al., 2019; Edelstein & Scandiffio, 2022; Evans et al., 2021; Grafton et al., 2023; Meo et al., 2020), one quantitative controlled before-after study (Popejoy et al., 2021), one quantitative descriptive case series (Lim Fat et al., 2022), one qualitative study (Guilcher et al., 2021), and one systematic review (Goncalves-Bradley et al., 2022).

All articles in the literature review were evaluated using relevant critical appraisal tools. The quantitative studies were evaluated using the Public Health Agency of Canada (PHAC, 2014) Analytic Critical Appraisal Tool; The systemic review was evaluated using the PHAC (2014) Literature Review Critical Appraisal Tool; the qualitative study was evaluated using the Critical Appraisal Skills Programme (CASP, 2024) qualitative study checklist. Overall, the quality of the studies ranged from low to high. Of the retrospective cohort studies, four were rated as low quality (Bai et al., 2019; Edelstein & Scandiffio, 2022; Grafton et al., 2023; Meo et al., 2020) and two were rated as medium quality (Arthur et al., 2021; Evans et al., 2021). The systematic review presented by Goncalves et al. (2022) and the case series presented by Lim Fat et al. (2022) were rated high quality.

Key Findings

Data was analyzed using inductive analysis. Two main themes were generated from the literature: the impacts of delayed discharge, which was divided into sub-themes of infectious outcomes, non-infectious outcomes, and hospital-associated deconditioning, and the advantages of discharge planning, which was divided into sub-themes of decreased readmission rates, decreased length of stay, and early identification of complex discharge.

Impact of Delayed Discharge. Three studies discussed the impact of delayed discharge in older adults (Bai et al., 2019; Guilcher et al., 2021; Lim Fat et al., 2022). Compared to the non-ALC cohort, Bai et al. noted significantly higher rates of complications in hospital ($p<0.0001$) in the ALC cohort, such as delirium (4.7% vs. 0.7%), aspiration (3.5% vs. 0.4%), nosocomial infections (14.1% vs. 1.9%), urinary tract infections (6.7% vs. 0.8%), pneumonia (5.9% vs. 0.6%), and clostridioides difficile colitis (3.1% vs 0.2%). Lim Fat et al. (2022) identified the most common infectious adverse outcomes in ALC patients as urinary tract infections (13.1%), respiratory infections (7.18%), skin infections (3.87%), and gastrointestinal infections (0.83%). Similarly, Bai et al. reported a higher average Length of Stay (LOS) among the ALC cohort ($M=30.85$ days) compared to the non-ALC cohort ($M=3.95$ days) ($p<0.0001$; 95% CI [19.79 to 69.99]; 95% CI [2.29 to 7.57]). Both studies identified in-hospital deaths among the ALC population in their studies and identified delirium as the top non-infectious adverse event among hospitalized ALC patients.

Participants in the qualitative study by Guilcher et al. (2021) described feelings of boredom and depression from decreased stimulation and isolation and voiced concern about the lack of physical activity and motivation. Deconditioning from the lack of activity left participants frustrated and uncertain about future living arrangements, as many patients could not return to

their pre-hospital residences. Participants also described the impact of limited social interactions and shared physical environments on older adults in the hospital.

Advantages of Discharge Planning. Eight studies were conducted to determine the effectiveness of discharge planning in acute care hospital settings. The majority of the studies were retrospective cohort studies (Arthur et al., 2021; Bai et al., 2019; Edelstein & Scandiffio, 2022; Evans et al., 2020; Grafton et al., 2023; Meo et al., 2020); one study was a controlled before-after study (Popejoy et al., 2021); and one a systematic review (Goncalves-Bradley et al., 2022). Three overarching themes were identified as advantages to discharge planning: decreased admission rates, decreased length of stay, and early identification of complex discharge.

Readmission rates can be influenced by various factors, including inpatient and outpatient care quality, the care transition and coordination effectiveness, and the availability and use of effective disease management community-based programs (CIHI, 2024b). Although not all readmissions are avoidable, lower rates are desirable. Popejoy et al. (2021) conducted a controlled before-after study to test the effect of standard and enhanced deliveries of the Re-Engineered Discharge (RED) program. The standard group had higher odds of being readmitted in the pre-intervention versus post-intervention period; however, the result was not statistically significant. After adjusting coefficients using Poisson regression, in the pre-intervention period, the adjusted number of rehospitalizations for the Standard group was 45% higher at 30 days, 50% higher at 60 days ($p = 0.01$), and 39% higher at 180 days ($p = 0.001$). Similarly, in their systematic review of 33 trials, Goncalves et al. (2022) conducted a meta-analysis. They pooled the readmission rates in 17 trials to find relative reductions in readmission for older adults with individualized discharge plans compared to those receiving standard care (RR 0.89, 95% CI [0.81 to 0.97]).

Three studies in this literature review presented information on timely discharge in the older adult population. Evans et al. (2020) and Edelstein and Scandiffio (2022) completed retrospective cohort studies to explore associations between positive perceptions and timely discharge and a formalized restoration program and LOS, respectively. The systematic review by Goncalves et al. (2022) also reported on LOS.

Evans et al. reported that successful discharge was more likely in cases where patients had positive beliefs toward discharge. The adjusted probability of successful discharge was 63.8% (95% CI [63.8 to 63.9]) among patients with positive beliefs and 57.8% (95% CI [57.3 to 58.4]) among those with negative beliefs. Thus, positive beliefs conferred a 6.0% (95% CI [5.4 to 6.6]) increase in the probability of successful discharge. In the study by Edelstein and Scandiffio, patients who participated in the Humber's Elderly Assess and Restore Team (HEART) program, which includes customized discharge planning, had a lower excessive length of stay (Median 0.1 vs 0.5 days, p=0.04) and were more likely to be discharged home (OR=2.85, 95% CI=2.03 to 3.99) compared to those receiving standard care. The systematic review by Goncalves et al. (2022) used a meta-analysis to pool the results of 11 trials. They found the mean hospital LOS was 0.73 days lower (95% CI [1.33 to − 0.12] for participants who received comprehensive discharge planning compared to those who did not.

Four cohort studies explored the early prediction of complex discharges to reduce delayed discharges and ALC designation rates. Across all studies, ALC designation was considered a complex case with delayed discharge, and seven predictors were identified. Two studies (Arthur et al., 2021; Bai et al., 2019) reported that age, dementia, and complicated chronic diseases were significant predictors of ALC designation. One study reported allied health referrals (Bai et al., 2019), financial discharge barriers (Meo et al., 2020), disruptive discharge

behaviors (Meo et al., 2020), disagreement with the discharge plan (Meo et al., 2020), and scores ≥ 10 on an early screening for discharge planning tool (Grafton et al., 2023) as predictors.

Summary of Consultations

A user survey was disseminated to care facilitators (n=5), clinical managers (n=5), program directors (n=2), and allied health professionals (n=24) at WMH. These surveys aimed to obtain perspectives, needs, and recommendations from discharge planner colleagues to support the development of a discharge planning tool in a local context. Emails were sent to potential participants describing the project's purpose, the timeline for completion, reassurance of anonymity, and a link to the survey. All survey responses were completed electronically and automatically saved within the Microsoft Forms program. Descriptive statistical analysis built into Microsoft Forms was used to describe demographic data. The qualitative data was transcribed into Microsoft Excel and analyzed using the qualitative content analysis process outlined by Lindgren et al. (2020). Explicit participant responses were divided into phrases or sentences, or semantic meaning units, and entered in an Excel spreadsheet. Repetitions were removed, and each meaning unit was labeled with a descriptive code close to the original text to maintain content integrity and align with the project's aim. Finally, same and similar codes were sorted and combined into categories or themes. A summary of the findings was compiled in a consultation report.

Key Findings

A 44% response rate was achieved (n=16) by the set deadline. All respondents were female, and the majority were allied health professionals (n=11), followed by care facilitators (n=2), managers (n=2), and directors (n=1). Fifty-six percent were employed for 15 years or more, and the majority (38%) were aged 40-49. Most respondents felt that discharge planning

should be initiated early in the admission, with seven respondents identifying the initial admission process as the optimal time and five identifying the first 24 hours as the optimal time. When asked what factors should be considered when assessing a patient's readiness for discharge planning, 73% of respondents described the availability of support as the main factor, including formal home support, family support, equipment support, and social support. Similarly, the central theme generated from the responses about barriers to discharge was lack of support, further broken down into subthemes of lack of home support, lack of family support, lack of financial support, and lack of access to community support and programming.

Lack of Support. Participants in the survey reported a lack of home support related to delays in agency response times and an insufficient number of home support workers to meet the demand. Healthcare professionals often look to families to bridge the gap and help facilitate a timely discharge in light of the delays associated with organizing formal home support. However, according to participants in this consultation, older adults may not all have access to the family support they need. Although patients discharged as part of the Home First philosophy can access required services for up to eight weeks without a financial assessment, once completed, the financial assessment determines the patients' responsibility to contribute to the cost of ongoing services (Department of Health and Community Services, personal communication, 2023). Participants described financial barriers to timely discharge as a "lack of affordable housing," "lack of knowledge about financial situation," and "inability to afford the recommended equipment and services." Respondents also described community support services as restrictive, suggesting that patients remained in the hospital to access physician follow-up and allied health resources that are not readily available in the community, such as physiotherapy and occupational therapy.

Discharge Planning Resources. Sixty-three percent (n=10) of respondents felt a need for a discharge planning resource to help guide the discharge process for older adult ALC patients. Among those respondents, the majority (n=5) felt a decision tree or algorithm would be most helpful, while one respondent reported checklists and flow maps as most useful. Analysis of the free-text responses suggesting elements to include in discharge planning generated two main themes: continued follow-up and patient education/information.

Although the Home First philosophy focuses on removing barriers within regular programming and wrapping support around people in their homes and communities to provide continuity across the continuum of care (Department of Health and Community Services, personal communication, 2023), participants in this consultation survey suggested there are issues with continued follow-up and offered suggestions for improvement such as initiating allied health outpatient referrals for medication management, mobility progression, and equipment installation; initiating community referrals for ongoing monitoring of health conditions; and introducing clinician phone calls to ensure patients and families are coping at home. Including patient education and information in the discharge planning process was also recommended through suggestions such as providing pre-admission information so that patients knew what to expect once admitted, providing contact information so that patients and families knew whom to contact with questions, and ensuring ongoing communication on plan of care during and after hospitalization.

Patient and Family Feedback. Fifty-six percent (n=9) of respondents indicated that they had received either positive (n=3), negative (n=2), or both positive and negative (n=4) feedback from patients and families on their discharge experience. Analysis of the free-text responses describing the positive feedback suggested that patients and families appreciated the

collaborative efforts of the discharge planning team and the communication from the allied health team on setting goals and providing updates on their progress. A similar analysis of the free-text responses describing the negative feedback suggested that some patients and families either felt rushed to leave the hospital before they were ready or were frustrated with the slow pace of planning due to staff shortages and lack of physician interaction.

Summary of Environmental Scan

An environmental scan was completed to provide a broad view of existing discharge planning tools across Canada. The environmental scan helped determine if it would be necessary to develop an entirely new tool, customize an existing tool so that it is transferrable to the older adult population in NLHS-WZ, or adopt an existing tool as is. An internal scan involved a review of organizational documents, including the Policy Framework to Reduce ALC Rates in NL (Newfoundland & Labrador, personal communication, 2024), the Provincial Home First Policy Framework (Department of Health and Community Services, personal communication, 2023), the Provincial Surgical Backlog Task Force Report (Martin et al., 2023), NL Health Accord (2022), the Home First Steering Committee work plan (D. Clarke & K. Harding, personal communication, September 24, 2024), and a presentation on a dischargeHUB service currently in practice in Eastern Zone (Seafair Capital, personal communication, June 2024). An external review involved a broad Internet search using Google and Google Scholar for links to discharge planning programs and associated discharge tools within Canada. Relevant tools were downloaded and saved whenever possible, ensuring adherence to copyright material.

An Excel spreadsheet organized the information collected during the environmental scan. The spreadsheet columns were labeled to identify this project's relevant components: Canadian-based, inclusion of a checklist or algorithm, clearly defined roles and responsibilities, identifiable

decision points, and realistic and achievable solution suggestions. As websites and resources were reviewed for relevancy, jot notes were noted under each component category in the spreadsheet. Resources found to include or address all components were flagged for further consideration for the project.

Key Findings

Three resources were reviewed as potential options for this project: the Blaylock Risk Assessment Screen Score (BRASS), a discharge planning algorithm used at the Royal Victoria Regional Health Center, and the dischargeHUB service being piloted in NLHS-Eastern Zone. The strengths and limitations of each resource were explored to determine suitability for adoption or adaptation for this project.

BRASS. The BRASS has been shown the tool to be effective in predicting the risk of prolonged hospitalization (Bocci et al., 2017; Colognesi et al., 2021; Dal Molin et al., 2014; Zarovska et al., 2018), which aligns with the recommendations of the literature review and the consultations. However, there is also potential that the assessment completed upon admission may not accurately capture the patient's status or family resources available on discharge and, therefore, not accurately identify the patient's risk for complex discharge (Colognesi et al., 2021).

Discharge Planning Pathway. The pathway provides information that is considered relevant for this project. There is a visual flow chart that identifies critical decision points, escalation points, timelines, and outcomes. The pathway uses the BRASS on admission to establish a baseline and references Ontario legislation to strengthen the decision point outcomes. While NL does not have legislation related explicitly to substitute decision-makers, there is comparable language in the Advanced Health Care Directive Act that could support the mandates in the discharge planning pathway. Attempts to reach the PPNO for further information

and clarity were unsuccessful; however, follow-up with the Operations Director at Royal Victoria Regional Health Center (RVH) offered additional information and sharing of the original document.

DischargeHUB. While not a specific discharge planning tool, the DischargeHUB (Seafair Capital, personal communication, June 2024) resource found in the internal scan is being piloted by NLHS to help reduce hospital lengths of stay associated with delayed access to services and equipment. It is an external service that coordinates home health care services such as home support, home oxygen, and equipment for discharged patients so that skilled clinicians can focus on clinical work. Unfortunately, the service is not linked with the provincial Special Assistance Program (SAP), which provides funding for long-term home support and equipment services, or the National Indigenous Health Benefit (NIHB) program, which covers the financial cost of health services for the Indigenous population. Therefore, the only patients who would benefit from this service would be the ones who could afford to pay privately. Since the others would have to remain in the hospital until clinicians could arrange their resources, this service would not provide equal access to care.

Summary of the Resource Development

The final project was the development of a discharge planning resource for the interdisciplinary team in NLHS-WZ. Using findings from the literature review, consultations, and environmental scan, the resource aimed to bridge the gaps in discharge planning that result in adverse patient outcomes and systemic bottlenecks. Discharge Planners recommended that discharge planning commence early in admission and be guided by a discharge planning resource such as an algorithm or flow map. Since the discharge planning pathway used in the

RVH provided a solid framework for discharge planning, written permission was sought from the Operations Director to adapt the document for use in NLHS (see Appendix E).

Proposed Resource

The first proposed resource was a process map to guide users through the DischargeHUB referral service. However, after considering the delays in the service implementation and the continued exclusion of the SAP and NIHB programs, it was decided that this resource would not achieve the desired project outcomes. Therefore, efforts were concentrated on adapting the existing RVH pathway for use in NLHS.

Description and Intended Use

The NLHS Discharge Planning Pathway is designed to be a clinical resource to guide discharge planners in their approach to discharge planning and ALC designation. The pathway is designed as a colorful visual flow map using various page dividers, shapes, fonts, and descriptors to identify timelines, decision points, and escalation points during discharge planning. All the information is contained on one single-sided page and includes a legend to identify the significance of the included shapes and colors. The pathway is intended to serve as a reference for all team members involved in the discharge planning process and can be laminated for repeated use and quick reference. While the underlying design of the flow map remains similar to the original document, the content has been adapted to include additional discharge options, a step-by-step LTC application process, and more defined time parameters.

Discussion of Advanced Nursing Practice Competencies

A primary objective of this practicum project was to meet the competencies of advanced nursing practice as outlined by the Canadian Nurses Association (CNA, 2019). Completing this practicum has provided an opportunity to demonstrate four Advanced Nursing Practice (ANP)

competencies: optimizing the health system, research utilization, leadership, and consultation and collaboration.

Optimizing the Health System

The CNA (2019) describes APNs as contributors to the effective functioning of health systems through advocacy, promoting innovative client care, and facilitating equitable, client-centered health care. As a former nursing and allied health manager, I gained extensive knowledge of the discharge planning processes within WZ. However, I also noted that many frontline clinicians did not fully understand the discharge process and often used different approaches with varied results. After identifying this gap in the discharge planning process, I engaged interdisciplinary team members, developed a pathway to optimize discharge processes, and initiated a system-level change that better supports our older adult population, thus demonstrating the APN's competency in optimizing the health system.

Research Utilization

APNs are committed to generating, synthesizing, critiquing, and applying research evidence (CNA, 2019) to improve client care and healthcare systems. This APN competency was demonstrated throughout this practicum project. I demonstrated the competency of critical appraisal and synthesis of literature by completing an integrative review and drawing implications for practice based on the strength of the evidence. Once validating the need to enhance discharge planning processes, I completed consultations with discharge planning colleagues to understand barriers to successful discharge and the preferred format of a discharge planning resource. This data was then utilized to inform internal and external environmental scans, which provided a foundational framework and focus for the final project.

Leadership

APNs are leaders in their organization and act as agents of change as they seek effective new ways to practice and improve care (CNA, 2019). NLHS supports a vision that all residents will have access to the support and services they need to age with dignity (Health Accord NL, 2022) and has embraced a HF philosophy to ensure patients and clients receive the right care at the right time from the right provider at the right cost. This appropriateness of care approach promotes early and structured discharge planning to help patients transition from hospital to home as soon as possible with appropriate support (Department of Health and Community Services, personal communication, 2023). Nevertheless, NLHS lacks standardized frameworks that can simplify the discharge process and support timely transitions from hospital to home (Barnable et al., 2015).

Through this practicum project, I demonstrated leadership by evaluating programs in the organization and developing an innovative approach to the complex discharge planning issue. By focusing on the older adult ALC population, my project contributes to the organizational vision and provides an opportunity to realize that vision.

Consultation and Collaboration

Effective collaboration and communication with stakeholders whose services impact the determinants of heath represent important aspects of all nursing practice; therefore, APNs are expected to consult and collaborate with colleagues across sectors and at the organizational, provincial, national, and international levels (CNA, 2019). This competency was demonstrated throughout this practicum project through timely and appropriate consultations with discharge planner colleagues within NLHS and other health organizations in Canada. To understand current practices, challenges, and recommendations to optimize the discharge planning process

within NLHS, consultations were conducted with nursing, allied health, and management. The document's owner was consulted to gain further insight into applying the pre-existing discharge planning pathway in practice. This consultation also garnered permission to modify the pathway for use within NLHS.

Next Steps

This project did not involve the implementation of the discharge planning pathway; however, it has been presented to the NLHS Clinical Efficiency team as part of a draft provincial ALC reduction policy. The vision of NLHS supports the appropriateness of care for our older adult population as a strategy to age with dignity. Incorporating a consistent approach to discharge planning for older adults may help improve care equity across the province, reduce inappropriate ALC designations, and identify priorities for government initiatives that support care for older adults.

Conclusion

The older adult ALC population in NL is at risk for adverse outcomes, and the rising ALC rates create patient flow issues within our healthcare system. However, many older adults have complex and chronic conditions requiring coordination of care and support when transitioning from one part of the healthcare system to another, so even when medically ready to be discharged, they often need to wait in the hospital for post-discharge care to be arranged.

To reduce the adverse outcomes associated with ALC designations, it is essential that planning for the transition from hospital to home or another healthcare setting is initiated early in the admission process and follows a standardized pathway with clear decision points and escalation points. Although the NL Health Accord calls us to protect the safety and dignity of our senior population, NLHS lacks a standardized discharge planning tool to support the timely

discharge of our older adult ALC population. Discharge planners in WMH support developing a resource to help streamline discharge planning, overcome barriers, and improve patient outcomes and experiences. Adapting an existing discharge planning tool based on credible research that aligns with the local context promotes consistency, bridges the gap in discharge planning in NLHS, and promotes better outcomes for our older adult population.

References

Arthur, S. A., Hirdes, J. P., Heckman, G., Morinville, A., Costa, A. P., & Hébert, P. C. (2021). Do premorbid characteristics of home care clients predict delayed discharges in acute care hospitals: A retrospective cohort study in Ontario and British Columbia, Canada. *BMJ Open*, *11*(2), e038484–e038484. https://doi.org/10.1136/bmjopen-2020-038484

Bai, A. D., Dai, C., Srivastava, S., Smith, C. A., & Gill, S. S. (2019). Risk factors, costs and complications of delayed hospital discharge from internal medicine wards at a Canadian academic medical centre: Retrospective cohort study. *BMC Health Services Research*, *19*(1), 935–935. https://doi.org/10.1186/s12913-019-4760-3

Barnable, A., Welsh, D., Lundrigan, E., & Davis, C. (2015). Analysis of the influencing factors associated with being designated alternate level of care. *Home Health Care Management & Practice*, *27*(1), 3–12. https://doi.org/10.1177/1084822314539164

Bocci, G., Kundisova, L., Guadagni, G., Stefani, L., Cepollaro, C., Nante, N., Dei, S., & D'Amato, M. (2017). Blaylock risk assessment screening score as a predictor of length of hospital stay. *European Journal of Public Health*, *27*(suppl_3), 175. https://doi.org/10.1093/eurpub/ckx187.446

Cadel, L., Guilcher, S., Kokorelias, K., Sutherland, J., Glasby, J., Kiran, T., & Kuluski, K. (2021). Initiatives for improving delayed discharge from a hospital setting: A scoping review. *BMJ Open*, *11*(2), e044291–e044291. https://doi.org/10.1136/bmjopen-2020-044291

Canadian Institute for Health Information. (2021). *Acute care*. https://www.cihi.ca/en/acute-care.

Canadian Institute for Health Information. (2023). *CIHI hospital frailty risk measure, 2023 – Data tables*. Ottawa, ON.

Canadian Institute for Health Information. (2024a). *A profile of hospitalized seniors at risk of frailty in Canada – Infographic*. Ottawa, ON. https://www.cihi.ca/en/a-profile-of-hospitalized-seniors-at-risk-of-frailty-in-canada-infographic

Canadian Institute for Health Information. (2024b). *All patients readmitted to hospital.* https://www.cihi.ca/en/indicators/all-patients-readmitted-to-hospital

Canadian Nurses Association. (2019). *Advanced practice nursing: A pan-canadian framework.* Ottawa, ON: Author. https://www.cna-aiic.ca/-/media/cna/page-content-pdf-en/apn-a-pan-canadian-framework.pdf

Coffey, A., Leahy-Warren, P., Savage, E., Hegarty, J., Cornally, N., Day, M. R., Sahm, L., O'Connor, K., O'Doherty, J., Liew, A., Sezgin, D., & O' Caoimh, R. (2019). Interventions to promote early discharge and avoid inappropriate hospital (re)admission: A systematic review. *International Journal of Environmental Research and Public Health*, *16*(14), 2457. https://doi.org/10.3390/ijerph16142457

Colognesi, S., Fagnani, C., Panceri, F., Ruggero, M., Di Florio, F., Passoni, C., Fantini, V., Boracchi, P., Orenti, A., Fumagalli, M. A., & Vergani, M. (2021). Hospital discharge: Testing the "Blaylock Risk Assessment Screening Score" in a surgical department. *Acta bio-Medica: Atenei Parmensis*, *92*(S2), e2021039. https://doi.org/10.23750/abm.v92iS2.10761

Critical Appraisal Skills Programme. (2024). CASP qualitative checklist. https://casp-uk.net/checklists/casp-qualitative-studies-checklist-fillable.pdf

Dal Molin, A., Gatta, C., Derossi, V., Guazzini, A., Cocchieri, A., Vellone, E., Alvaro, R., & Rasero, L. (2014). Hospital discharge: Results from an Italian multicenter prospective

study using Blaylock Risk Assessment Screening Score. *International Journal of Nursing Knowledge*, *25*(1), 14–21. https://doi.org/10.1111/2047-3095.12016

Edelstein, B., & Scandiffio, J. (2022). Effectiveness of an assess and restore program in treating older adults with physiological and functional decline: The HEART program. *Archives of Gerontology and Geriatrics.*, *99*. https://doi.org/10.1016/j.archger.2021.104609

Evans, E., Kosar, C. M., & Thomas, K. S. (2021). Positive beliefs and the likelihood of successful community discharge from skilled nursing facilities. *Archives of Physical Medicine and Rehabilitation*, *102*(3), 480–487. https://doi.org/10.1016/j.apmr.2020.09.375

Gonçalves-Bradley, D. C., Lannin, N. A., Clemson, L., Cameron, I. D., & Shepperd, S. (2022). Discharge planning from hospital. *Cochrane Database of Systematic Reviews*, *2*(2), CD000313–CD000313. https://doi.org/10.1002/14651858.CD000313.pub6

Grafton, J., Bowen Brady, H., Kelly, J., Kelly, M., Lang, K., Wolski, P., Ray, S., Loescher, C., Pearson, M., & Mendu, M. (2023). Implementation of a modified early screening for discharge tool to optimize case manager efficiency and impact length of stay. *Professional Case Management*, *28*(6), 262–270. https://doi.org/10.1097/NCM.0000000000000658

Guilcher, S. J. T., Everall, A. C., Cadel, L., Li, J., & Kuluski, K. (2021). A qualitative study exploring the lived experiences of deconditioning in hospital in Ontario, Canada. *BMC Geriatrics*, *21*(1), 169–169. https://doi.org/10.1186/s12877-021-02111-2

Health Accord NL. (2022). *Our province. Our health. Our future. A 10-year health transformation: The report.* https://healthaccordnl.ca/final-reports/s

Lim Fat, G. J., Gopaul, A., Pananos, A. D., & Taabazuing, M.-M. (2022). Healthcare-associated adverse events in alternate level of care patients awaiting long-term care in hospital. *Geriatrics.*, *7*(4). https://doi.org/10.3390/geriatrics7040081

Lindgren, B.-M., Lundman, B., & Graneheim, U. H. (2020). Abstraction and interpretation during the qualitative content analysis process. *International Journal of Nursing Studies*, *108*, 103632–103632. https://doi.org/10.1016/j.ijnurstu.2020.103632

Meo, N., Liao, J. M., & Reddy, A. (2020). Hospitalized after medical readiness for discharge: A multidisciplinary quality improvement initiative to identify discharge barriers in general medicine patients. *American Journal of Medical Quality*, *35*(1), 23–28. https://doi.org/10.1177/1062860619846559

Martin, R. (2023). *Provincial surgical backlog task force: Report.* https://www.gov.nl.ca/hcs/files/23324-Report-Provincial-Surgical-Backlog-Taskforce.pdf

Popejoy, L. L., Vogelsmeier, A. A., Wang, Y., Wakefield, B. J., Galambos, C. M., & Mehr, D. R. (2021). Testing re-engineered discharge program implementation strategies in SNFs. *Clinical Nursing Research.*, *30*(5), 644–653. https://doi.org/10.1177/1054773820982612

Robert, B., Sun, A. H., Sinden, D., Spruin, S., & Hsu, A. T. (2021). A case-control study of the Sub-Acute care for Frail Elderly (SAFE) unit on hospital readmission, emergency department visits and continuity of post-discharge care. *Journal of the American Medical Directors Association.*, *22*(3), 544-550.e2. https://doi.org/10.1016/j.jamda.2020.07.020

Rutherford, P., Anderson, A., Kotagal, U., Luther, K., Provost, L., Ryckman, F., & Taylor, J. (2020). *Achieving hospital-wide patient flow: The right care, in the right place, at the right time*. Institute for Healthcare Improvement. www.ihi.org

Zarovska, A., Evangelista, A., Boccia, T., Ciccone, G., Coggiola, D., Scarmozzino, A., & Corsi, D. (2018). Development and validation of a simplified BRASS index to screen hospital patients needing personalized discharge planning. *Journal of General Internal Medicine 33*(7), 1084–1091. https://doi.org/10.1007/s11606-018-4405-y

Appendix A

Literature Review

A Literature Review of Discharge Planning in Acute Care Hospitals

Acute care services in hospitals are primarily designed to deliver short-term inpatient care and necessary treatment for a disease or severe episode of illness, then discharge patients as soon as they are medically stable (Canadian Institute for Health Information [CIHI], 2021). However, patients often require comprehensive and coordinated efforts to ensure that post-hospitalization care and support are in place before hospital discharge (Rutherford et al., 2020). Alternate Level of Care (ALC) is a widely used term describing patients who do not require the intensity of services provided in an acute care setting but do not have access to the services required to facilitate their discharge (Robert et al., 2021). In 2021-2022, 5.8% of hospital stays in Canada had ALC days. In NL, patients with ALC designations occupy 20% of all acute care beds, with older adults occupying approximately 300 of those beds each day (Health Accord NL, 2022). There is growing concern that providing ALC services in an acute care hospital is not optimal provision of care (CIHI, 2024a). Adults over 65 years of age, or older adults, are especially vulnerable, as more than one-third of hospitalized older adults are at risk of frailty, which is defined as having six or more deficits such as nutrition and wasting, infection, and immobility (CIHI, 2023). Frail older adults are three times more likely to be high users of hospital beds or to be hospitalized for 30 days or longer. They are also two times more likely to be readmitted within 30 days after discharge or to die within one year after discharge. In 2022-23, 19.1% of older adults hospitalized in NL were at risk for frailty; however, in the Western Zone, that number is alarmingly higher at 23.4% (CIHI, 2023).

Prolonged acute care stays for older adults who are designated as ALC have been linked to increased frailty, falls, hospital-related adverse events, and mortality, as well as poor patient and family experiences and premature institutionalization (Barnable et al., 2015; Cadel et al.,

2022; Robert et al., 2021). Systemically, high ALC rates contribute to hospital-wide patient flow issues, increased wait times for service access, and increased healthcare costs (Cadel et al., 2021; Coffey et al., 2019). Improving transitional care planning is a critical step to optimizing patient outcomes and ensuring that patients move smoothly from one part of the care continuum to another, whether patients are discharged home from the hospital, referred to an outpatient/ambulatory care program, or transferred to a rehabilitation facility or another health care setting (Department of Health and Community Services, personal communication, 2023) Discharge planning is a health system routine aimed at reducing delayed discharge from the hospital, improving the coordination of services following discharge, and reducing the risk of hospital readmission (Gonçalves-Bradley et al., 2022). Health Accord NL (2022) suggests that with appropriate discharge planning, many ALC patients can return home or to a lower level of care.

Newfoundland and Labrador Health Services (NLHS) supports a vision that all residents will have access to the support and services they need to age with dignity (Health Accord NL, 2022) and has embraced a Home First (HF) philosophy to ensure patients and clients receive the right care at the right time from the right provider at the right cost. This appropriateness of care approach promotes early and structured discharge planning to help patients transition from hospital to home as soon as possible with appropriate support (Department of Health and Community Services, personal communication, 2023; Health Accord NL, 2022). Nevertheless, there are no standardized frameworks to simplify the discharge process and support timely transitions from hospital to home in the WZ of NLHS (Barnable et al., 2015).

Purpose

This literature review aims to synthesize recent research related to discharge planning for ALC older adults admitted to acute care hospitals to inform the development of a discharge planning tool for NLHS-WZ.

Review Methods

Design

An integrative review was conducted to gain a comprehensive understanding of discharge planning for older adult ALC patients. According to Whittemore and Knafl (2005), integrative reviews are the broadest type of research review as they allow for the simultaneous inclusion of experimental and non-experimental research to better understand a phenomenon of concern. This integrated review will follow the framework suggested by Whittemore and Knafl to include a) problem identification, b) literature search, c) data evaluation, d) data analysis, and e) presentation of data through narrative summary and literature summary tables.

Search Methods

Four databases were searched, including CINAHL (n = 238), Scopus (n = 60), The Cochrane Library (n = 3), and PubMed (n=51) using a Boolean search of the MESH terms, indexed keywords, and subject headings “discharge planning" OR "hospital discharge" AND "alternate level of care." The term "older adults" was initially included as a free text search term but yielded results >10,000 items. Therefore, the limit of age >65 years was applied instead. Limits also included English language and peer-reviewed articles.

Inclusion Criteria

The COVID-19 pandemic altered the shape of healthcare systems across the globe. Service shutdowns, mass resignations of healthcare staff, and increased medical and surgical care

demand have created unprecedented capacity crises within our healthcare systems (Grafton et al., 2023), making research completed before 2019 somewhat incomparable to today's reality. Therefore, inclusion criteria were specified for studies conducted between 2019 and 2024. Qualitative, quantitative, systematic reviews and mixed methods studies focusing on discharge planning from acute care hospitals for ALC or older adult populations were included.

Exclusion Criteria

As a high-income country, Canada is frequently compared to the United States and the United Kingdom for healthcare efficiencies and services (CIHI, 2022; MacKinnon et al., 2023). In keeping with these comparisons, studies completed outside these geographical regions were excluded, thus limiting the selection and review of studies to those more pertinent to the Canadian context to better inform the development of a discharge planning tool for the NL context. Studies were also excluded if they were written in languages other than English, published outside of the specified dates, focused on discharge from healthcare services outside of acute care, or targeted at specific medical conditions. Dissertations, grey literature, opinion articles, and commentaries were excluded.

Search Results

Initial searches with filters applied returned a list of 366 potential studies. Titles were scanned for relevance, and those with duplicate titles, referencing specific medical conditions, or conducted in geographical locations outside of Canada, the US, and the UK were removed, resulting in the removal of 320 studies.

The remaining 46 abstracts were reviewed to confirm the discussion or evaluations of discharge planning for ALC patients in acute care facilities. In total, ten studies were used in this literature review.

Study Characteristics

The articles included in this review were of varied designs. There were six quantitative retrospective cohort studies (Arthur et al., 2021; Bai et al., 2019; Edelstein & Scandiffio, 2022; Evans et al., 2021; Grafton et al., 2023; Meo et al., 2020), one quantitative controlled before-after study (Popejoy et al., 2021), one quantitative descriptive case series (Lim Fat et al., 2022), one qualitative study (Guilcher et al., 2021), and one systematic review (Goncalves-Bradley et al., 2022).

Data Evaluation

All articles in the literature review were evaluated using relevant critical appraisal tools. The quantitative studies were evaluated using the Public Health Agency of Canada ([PHAC], 2014) Analytic Critical Appraisal Tool; The systemic review was evaluated using the PHAC Literature Review Critical Appraisal Tool; the qualitative study was evaluated using the Critical Appraisal Skills Programme (CASP) qualitative study checklist.

The PHAC (2014) Critical Appraisal Toolkit is a guiding document developed by healthcare professionals to critically appraise research evidence to support decision-making on recommendations for practice and policy development. It combines algorithms to identify the type of study design, tools for appraisal of analytic studies, descriptive studies, literature reviews, and instructions for summarizing evidence and drawing conclusions about a body of evidence.

The CASP (2024) qualitative study checklist is a structured critical appraisal tool used by healthcare professionals to assess the study's methodological rigor, validity, and relevance to evaluate the strengths and limitations of a qualitative study and determine its applicability to their practice.

Overall, the quality of the studies ranged from low to high. Of the retrospective cohort studies, four were rated as low quality (Bai et al., 2019; Edelstein & Scandiffio, 2022; Grafton et al., 2023; Meo et al., 2020) and two were rated as medium quality (Arthur et al., 2021; Evans et al., 2021). The systematic review presented by Goncalves et al. (2022) and the case series presented by Lim Fat et al. (2022) were rated high quality. Detailed information about reviewed studies is included in the Appendix.

Data Analysis

Data was analyzed using inductive analysis. Inductive analysis is described as a "bottom-up" process where the researcher reads through the data and generates themes to make meaning from the data (Bingham & Whitowsky, 2022). After reviewing and appraising the studies, the information was reduced into categories based on the research focus. Each article was read three times to ensure no data was missed, and the findings were extracted into a table to organize the focus and findings of the research into categories. Two main themes were generated from the literature: the impacts of delayed discharge and the advantages of discharge planning. The impacts of delayed discharge are discussed under the sub-themes of infectious outcomes, non-infectious outcomes, and hospital-associated deconditioning. The advantages of discharge planning are discussed under the sub-themes of decreased readmission rates, decreased length of stay, and early identification of complex discharge. These themes will be discussed in more detail in subsequent sections.

Impact of Delayed Discharge

Three studies discussed the impact of delayed discharge in older adults (Bai et al., 2019; Guilcher et al., 2021; Lim Fat et al., 2022). All three studies originated from Canada; two were specific for ALC patients aged 65 or older (Bai et al., 2019; Lim Fat et al., 2022). The third study

did not explicitly describe their participants as ALC but did identify the targeted age group. The two quantitative studies (Bai et al., 2019; Lim Fat et al., 2022) used retrospective data to identify the most common adverse outcomes for delayed discharge, including infectious and non-infectious outcomes. Bai et al. (2019) compared data from ALC and non-ALC cohorts in their retrospective cohort study, whereas Lim Fat et al. (2022) reviewed historical data on ALC patients in their descriptive case series study. Both studies reported adverse outcomes for the study participants. There were no positive outcomes noted. The experiences described in the qualitative study by Guilcher et al. (2021) provide insight into the humanistic aspect of hospital-associated deconditioning resulting from prolonged hospitalization. Although this theme was generated from only one study, it emphasizes the importance of understanding the biopsychosocial impacts of prolonged hospitalization (Guilcher et al., 2021). Incorporating perspectives from patients, caregivers, providers, and decision-makers in the data analysis fosters a holistic approach to discharge planning.

Infectious Outcomes. Bai et al. (2019) and Lim Fat et al. (2022) noted various infectious outcomes in the ALC population. Bai et al. noted significantly higher rates of nosocomial infections (14.1%), urinary tract infections (6.7%), pneumonia (5.9%), and clostridioides difficile colitis (3.1%) in their ALC cohort ($p<.0001$). Similarly, Lim Fat et al. (2022) identified the most common infectious adverse outcomes as urinary tract infections (13.1%), respiratory infections (7.18%), skin infections (3.87%), and gastrointestinal infections (0.83%).

Non-Infectious Outcomes. Bai et al. (2019) and Lim Fat et al. (2022) also noted non-infectious adverse outcomes in their studies. Bai et al. reported a higher average Length of Stay (LOS) among the ALC cohort ($M=30.85$ days) compared to the non-ALC cohort ($M=3.95$ days) ($p<.0001$). Both studies identified in-hospital deaths among the ALC population in their studies.

Of the 156 ALC patients in the study by Lim Fat et al., seven died while awaiting LTC, and 36 of the 255 ALC patients in the study by Bai et al. died in hospital. Both studies identified delirium as the top non-infectious adverse event among ALC patients, with 4.7% (Bai et al., 2019) and 21% (Lim Fat et al., 2022) of patients having documented delirium during their hospitalization.

Hospital-Associated Deconditioning. One study focused specifically on the humanistic impacts of hospital-associated deconditioning. Guilcher et al. (2021) completed in-depth semi-structured interviews with 80 patients, providers, decision-makers, and caregivers. Participants described feelings of boredom and depression from decreased stimulation and isolation through statements such as "it's depressing… there's times I looked at that corner, I could just go over there and crawl up in a ball and just die…" (Guilcher et al., 2021. p. 5).

Lack of physical activity and motivation were also cited as concerns by patients and providers, with each emphasizing the reciprocal impact one has on the other (Guilcher et al., 2021). The deconditioning resulting from the lack of activity left participants feeling frustrated as they struggled to accept their new identity with physical limitations and an inability to participate in their usual hobbies. The deconditioning also introduced uncertainty around future living arrangements as many patients could not return to their pre-hospital residences. One caregiver articulated her uncertainty and frustration as her questions about where her loved one would go if they could not return home remained unanswered by the healthcare team.

Finally, participants in the study by Guilcher et al. (2021) described the impact of limited social interactions and physical environments available to older adults in the hospital. Although they acknowledged a positive aspect of having a roommate, they also articulated that there was potential for problems when patients in the same room did not mesh well. Sub-optimal hospital

environments were not conducive to patient recovery as loud noises, and wandering patients disrupted sleep-wake cycles. One patient described her experience, "…there were quite a few patients who were howling in the night …and then bells kept going off in the night… my sleep was very badly affected" (p.6). While patients were prescribed sleeping medications to help alleviate sleeping issues, those medications also contributed to increased confusion, decreased participation in physical activities, and further deconditioning. Seeing their loved ones in a deconditioned state, families and caregivers felt the need to visit more frequently to provide care and fill the gaps created by health system constraints and limited staffing (Guilcher et al., 2021).

Advantages of Discharge Planning

Discharge planning has been studied to determine its effectiveness in improving outcomes for hospitalized patients. Successful discharge plans start with the healthcare team identifying patients at risk for delayed discharge and implementing appropriate services to facilitate safe, timely discharge with a reduced likelihood of adverse outcomes. Eight studies were conducted to determine the effectiveness of discharge planning in acute care hospital settings. The majority of the studies were retrospective cohort studies (Arthur et al., 2021; Bai et al., 2019; Edelstein & Scandiffio, 2022; Evans et al., 2020; Grafton et al., 2023; Meo et al., 2020); one study was a controlled before-after study (Popejoy et al., 2021); and one study was a systematic review (Goncalves-Bradley et al., 2022). All studies focused on the ALC or older adult population, so they were found to be relevant to this literature review.

Three overarching themes were identified as advantages to discharge planning: decreased admission rates, decreased length of stay, and early identification of complex discharge.

Decreased Readmission Rates. The readmission rate is one measurement of the quality of care and care coordination among acute care healthcare organizations. They can be influenced

by various factors, including the quality of inpatient and outpatient care, the effectiveness of the care transition and coordination, and the availability and use of effective disease management community-based programs (CIHI, 2024b). Although not all readmissions are avoidable, lower rates are desirable. Interventions during and after hospitalization can effectively reduce readmission rates (CIHI, 2024b).

Two studies that focused on discharge planning as an intervention reported lower readmission rates as an outcome. Popejoy et al. (2021) conducted a controlled before-after study to compare different implementation strategies for the Re-Engineered Discharge (RED) program. In contrast, Goncalves et al. (2022) conducted a systematic review of 33 trials to determine the effectiveness of discharge planning from hospitals. The RED program described by Popejoy et al. is an organized approach to discharge planning. A discharge advocate nurse works with patients to arrange follow-up appointments, reconcile medications, conduct education sessions, communicate discharge information to primary care providers, and provide a follow-up phone call to patients after discharge. Previous research has shown the effectiveness of the intervention (Jack et al., 2009; Gardner et al., 2020), and it has been endorsed by the Agency for Healthcare Research and Quality (AHRQ, 2023). Popejoy et al. determined that patients in the standard RED implementation group had significantly fewer readmissions ($p<.05$) at 60 and 180-day marks compared to the enhanced RED implementation group, which received more intense education and follow-up.

The research findings from Popejoy et al. (2019) are also supported by the systematic review conducted by Goncalves et al. (2022), who assert that discharge planning has a differential effect on different populations. Their review of randomized trials found relative

reductions in readmission for older adults with individualized discharge plans compared to those receiving standard care (95% CI [0.81 to 0.97]).

Decreased Length of Stay. LOS represents the average length of a single inpatient hospital stay (CIHI, 2024c). It is largely influenced by the types of cases that make up the hospital's patient population and, to some extent, by the ability of hospitals to discharge patients to an appropriate setting when patients are ready to leave the hospital. Knowing how long an average patient stays in the hospital may help understand patient flow patterns and hospital efficiency (CIHI, 2024c). Although there are no standardized results for this measure, healthcare facilities use yearly data trends for various medical conditions presented by CIHI as benchmarks for their performance.

Three studies in this literature review presented information on timely discharge in the older adult population. Evans et al. (2020) and Edelstein and Scandiffio (2022) completed retrospective cohort studies to explore associations between positive perceptions and timely discharge and a formalized restoration program and LOS, respectively. The systematic review described in the previous section also reported on LOS (Goncalves et al., 2022).

Evans et al. (2020) compared the probability of successful discharge for patients and staff who exhibited positive beliefs toward successful discharge to those who exhibited negative beliefs; Edelstein and Scandiffio (2022) compared the LOS and ALC rates of patients who participated in the Humber's Elderly Assess and Restore Team (HEART) program to those who received standard care. Evans et al. reported that successful discharge was more likely in cases where patients and staff had positive beliefs toward discharge (95% CI [63.8-63.9]); Edelstein and Scandiffio reported that HEART program participants had lower lengths of stay (p=.04) and

were less likely to remain in hospital with ALC designations (95%CI [2.03-3.99) compared to those receiving standard care.

Similarly, the systematic review by Goncalves et al. (2022) also reported a slight reduction in hospital LOS for seniors who received comprehensive discharge planning (95%CI [-1.33 to -0.12]). Their review included various discharge planning interventions but did not compare the effects of each intervention. Instead, the review provided an overall comparison of collective patients who received discharge planning to those who did not.

Early Identification of Complex Discharge. Many older adults have complex and chronic conditions requiring care coordination and better support when transitioning from one part of the healthcare system to another. Waiting until they are medically ready for discharge leaves little time for clinicians to coordinate the required support; therefore, increased care needs should be assessed as close as possible to admission to address issues before transition. Identifying at-risk patients ensures earlier discussions between healthcare team members, clients, and families to ensure everyone works together to facilitate a return home with appropriate support once acute care is no longer required (Health Quality Ontario, nd).

Four cohort studies explored the early prediction of complex discharges to reduce delayed discharges and ALC designation rates. Across all studies, ALC designation was considered a complex case with delayed discharge, and seven predictors were identified. Two studies (Arthur et al., 2021; Bai et al., 2019) reported that age, dementia, and complicated chronic diseases were significant predictors of ALC designation. One study reported allied health referrals (Bai et al., 2019), financial discharge barriers (Meo et al., 2020), disruptive discharge behaviors (Meo et al., 2020), disagreement with the discharge plan (Meo et al., 2020), and scores ≥ 10 on an early screening for discharge planning tool (Grafton et al., 2023) as predictors.

For example, Meo et al. (2020) found that patients in the prolonged admission cohort were more likely to report financial discharge barriers ($p<.05$), lack decision-making capacity ($p<.05$), exhibit disruptive or dangerous behaviors ($p<.001$) or disagree with the discharge plan ($p=.005$). In contrast, Grafton et al. (2023) used scores from the Early Screening for Discharge Planning (ESDP) tool to identify patients at risk for complex discharges. They found that scores >10 indicated a potential complex discharge, thus allowing case managers to prioritize their caseloads better.

Implications for Nursing Practice

According to the Canadian Nurses Association (CNA, 2019), Advanced Practice Nurses (APNs) integrate extensive clinical experience with theory, research, and in-depth nursing knowledge to guide decision-making in complex clinical situations. Furthermore, the CNA describes APNs as contributors to the effective functioning of health systems and leaders in their organization as they seek effective new ways to practice and improve care.

Older adult ALC patients are at risk for adverse outcomes associated with hospital-associated deconditioning; therefore, nurses must be advocates for timely discharge. Evidence suggests that slower implementation strategies work best for the older adult population as they require time to process information and establish new routines; therefore, nurses should initiate discussions about discharge early in the admission process. Meaningful engagement with patients and caregivers must include what matters most to them during the hospital stay and care transitions to inform personalized discharge plans. Embracing the HF philosophy supports the appropriateness of care; therefore, nurses need to promote a comprehensive discharge planning process that supports transitions across the care continuum.

Implications for Practicum Project

The findings of this literature review indicate that discharge planning can positively affect outcomes for the older adult ALC population (e.g., reduced readmission, decreased length of stay, and early identification of complex discharge cases) and substantiates the need for a discharge planning tool to guide nurses through the decision-making process. Unfortunately, recent literature specifically focused on discharge planning tools tested in Canada or comparable countries is scarce, making it challenging to establish relativity. Therefore, the logical direction for progressing toward successful discharge planning in NLHS-WZ is developing a discharge planning tool that can help support timely decision-making in a local context. Previously developed discharge planning tools found through an environmental scan could serve as a framework for my practicum project, and consultations with discharge planners would provide insight into the local challenges in facilitating discharges to ensure the tool serves its intended purpose.

Conclusion

Numerous studies have shown that remaining in the hospital longer than medically necessary can be detrimental to older adults for various reasons, including the potential for a hospital-acquired infection, a decline in physical and mental abilities, and premature institutionalization. In addition, when patients remain in the hospital longer than necessary, their beds are not available for new patients, which may cause systemic bottlenecks that result in the cancellation of scheduled surgeries and longer wait times for people being admitted to get assigned their beds. However, many older adults have complex and chronic conditions requiring coordination of care and support when transitioning from one part of the healthcare system to

another. Even when medically ready to be discharged, they often need to wait in the hospital for post-discharge care to be arranged. These patients are referred to as ALC patients.

In order to reduce the adverse outcomes associated with ALC designations, it is essential that planning for the transition from hospital to home or another healthcare setting is initiated early in the admission process. Early identification of potential complex discharge cases is essential as it provides additional time for post-discharge care arrangements to be put in place. Mitigation strategies can effectively reduce readmission rates, decrease lengths of stay, and identify complex discharge cases; our HF philosophy challenges us to facilitate appropriateness of care, and our Health Accord calls us to protect the safety and dignity of our senior population. However, NLHS has no standardized discharge planning tools to support the timely discharge of our ALC population. As nurses, we must act as leaders and provide the comprehensive care required to uphold our healthcare system through timely discharge planning processes. Developing a discharge planning tool based on credible research and local consultations will help bridge the gap in discharge planning in NLHS and promote better outcomes for our older adult population.

References

Agency for Healthcare Research and Quality. (2023). *Re-Engineered Discharge (RED) toolkit*. https://www.ahrq.gov/patientsafety/settings/hospital/red/toolkit/index.html

Arthur, S. A., Hirdes, J. P., Heckman, G., Morinville, A., Costa, A. P., & Hébert, P. C. (2021). Do premorbid characteristics of home care clients predict delayed discharges in acute care hospitals: a retrospective cohort study in Ontario and British Columbia, Canada. *BMJ Open*, *11*(2), e038484–e038484. https://doi.org/10.1136/bmjopen-2020-038484

Bai, A. D., Dai, C., Srivastava, S., Smith, C. A., & Gill, S. S. (2019). Risk factors, costs and complications of delayed hospital discharge from internal medicine wards at a Canadian academic medical centre: Retrospective cohort study. *BMC Health Services Research*, *19*(1), 935–935. https://doi.org/10.1186/s12913-019-4760-3

Barnable, A., Welsh, D., Lundrigan, E., & Davis, C. (2015). Analysis of the influencing factors associated with being designated alternate level of care. *Home Health Care Management & Practice*, *27*(1), 3–12. https://doi.org/10.1177/1084822314539164

Bingham, A.J., & Witkowsky, P. (2022). Deductive and inductive approaches to qualitative data analysis. In C. Vanover, P. Mihas, & J. Saldaña (Eds.), *Analyzing and interpreting qualitative data: After the interview* (pp. 133-146). SAGE Publications.

Cadel, L., Guilcher, S., Kokorelias, K., Sutherland, J., Glasby, J., Kiran, T., & Kuluski, K. (2021). Initiatives for improving delayed discharge from a hospital setting: A scoping review. *BMJ Open*, *11*(2), e044291–e044291. https://doi.org/10.1136/bmjopen-2020-044291

Canadian Institute for Health Information (2021). *Acute Care*. https://www.cihi.ca/en/acute-care.

Canadian Institute for Health Information (2022). How does Canada's hospital spending compare internationally? Retrieved from https://www.cihi.ca/en/how-does-canadas-hospital-spending-compare-internationally

Canadian Institute for Health Information. (2023). *CIHI Hospital Frailty Risk Measure, 2023 – Data Tables*. Ottawa, ON.

Canadian Institute for Health Information. (2024a). *A profile of hospitalized seniors at risk of frailty in Canada – Infographic.* Ottawa, ON. https://www.cihi.ca/en/a-profile-of-hospitalized-seniors-at-risk-of-frailty-in-canada-infographic

Canadian Institute for Health Information. (2024b). *All Patients Readmitted to Hospital.* https://www.cihi.ca/en/indicators/all-patients-readmitted-to-hospital

Canadian Institute for Health Information. (2024c). *Average Length of a Hospital Stay (Days).* https://www.cihi.ca/en/indicators/average-length-of-a-hospital-stay-days

Canadian Nurses Association (2019). *Advanced practice nursing: A Pan-Canadian Framework.* Ottawa, ON: Author. https://www.cna-aiic.ca/-/media/cna/page-content-pdf-en/apn-a-pan-canadian-framework.pdf

Cipriani, A., Furukawa, T. A., & Barbui, C. (2011). What is a Cochrane review? *Epidemiology and Psychiatric Sciences*, *20*(3), 231–233. https://doi.org/10.1017/s2045796011000436

Coffey, A., Leahy-Warren, P., Savage, E., Hegarty, J., Cornally, N., Day, M. R., Sahm, L., O'Connor, K., O'Doherty, J., Liew, A., Sezgin, D., & O'Caoimh, R. (2019). Interventions to promote early discharge and avoid inappropriate hospital (re)admission: A systematic review. *International Journal of Environmental Research and Public Health*, *16*(14), 2457-. https://doi.org/10.3390/ijerph16142457

Critical Appraisal Skills Programme. (2024). CASP qualitative checklist. https://casp-uk.net/checklists/casp-qualitative-studies-checklist-fillable.pdf

Edelstein, B., & Scandiffio, J. (2022). Effectiveness of an assess and restore program in treating older adults with physiological and functional decline: The HEART program. *Archives of Gerontology and Geriatrics.*, *99*. https://doi.org/10.1016/j.archger.2021.104609

Evans, E., Kosar, C. M., & Thomas, K. S. (2021). Positive beliefs and the likelihood of successful community discharge from skilled nursing facilities. *Archives of Physical Medicine and Rehabilitation*, *102*(3), 480–487. https://doi.org/10.1016/j.apmr.2020.09.375

Gardner, R. L., Pelland, K., Youssef, R., Morphis, B., Calandra, K., Hollands, L., & Gravenstein, S. (2020). Reducing hospital readmissions through a skilled nursing facility discharge intervention: A pragmatic trial. *Journal of the American Medical Directors Association*, *21*(4), 508–512. https://doi.org/10.1016/j.jamda.2019.10.001

Gonçalves-Bradley, D. C., Lannin, N. A., Clemson, L., Cameron, I. D., & Shepperd, S. (2022). Discharge planning from hospital. *Cochrane Database of Systematic Reviews*, *2*(2), CD000313–CD000313. https://doi.org/10.1002/14651858.CD000313.pub6

Grafton, J., Bowen Brady, H., Kelly, J., Kelly, M., Lang, K., Wolski, P., Ray, S., Loescher, C., Pearson, M., & Mendu, M. (2023). Implementation of a modified early screening for discharge tool to optimize case manager efficiency and impact length of stay. *Professional Case Management*, *28*(6), 262–270. https://doi.org/10.1097/NCM.0000000000000658

Guilcher, S. J. T., Everall, A. C., Cadel, L., Li, J., & Kuluski, K. (2021). A qualitative study exploring the lived experiences of deconditioning in hospital in Ontario, Canada. *BMC Geriatrics*, *21*(1), 169–169. https://doi.org/10.1186/s12877-021-02111-2

Health Accord NL. (2022). *Our province. Our health. Our future. A 10-year health transformation: The report.* https://healthaccordnl.ca/final-reports/s

Health Quality Ontario. Nd. *Adopting a common approach to transitional care planning: Helping health links improve transitions and coordination of care.* https://www.hqontario.ca/Portals/0/documents/qi/health-links/bp-improve-package-traditional-care-planning-en.pdf

Jack, B. W., Chetty, V. K., Anthony, D., Greenwald, J. L., Sanchez, G. M., Johnson, A. E., Forsythe, S. R., O'Donnell, J. K., Paasche-Orlow, M. K., Manasseh, C., Martin, S., & Culpepper, L. (2009). A re-engineered hospital discharge program to decrease rehospitalization: A randomized trial. *Annals of Internal Medicine*, *150*(3), 178–187. https://doi.org/10.7326/0003-4819-150-3-200902030-00007

Lim Fat, G. J., Gopaul, A., Pananos, A. D., & Taabazuing, M.-M. (2022). Healthcare-associated adverse events in alternate level of care patients awaiting long-term care in hospital. *Geriatrics.*, *7*(4). https://doi.org/10.3390/geriatrics7040081

MacKinnon, N. J., Emery, V., Waller, J., Ange, B., Ambade, P., Gunja, M., & Watson, E. (2023). Mapping health disparities in 11 high-income nations. *JAMA Network Open*, *6*(7), e2322310. https://doi.org/10.1001/jamanetworkopen.2023.22310

Meo, N., Liao, J. M., & Reddy, A. (2020). Hospitalized after medical readiness for discharge: A multidisciplinary quality improvement initiative to identify discharge barriers in general

medicine patients. *American Journal of Medical Quality*, *35*(1), 23–28. https://doi.org/10.1177/1062860619846559

Popejoy, L. L., Vogelsmeier, A. A., Wang, Y., Wakefield, B. J., Galambos, C. M., & Mehr, D. R. (2021). Testing re-engineered discharge program implementation strategies in SNFs. *Clinical Nursing Research.*, *30*(5), 644–653. https://doi.org/10.1177/1054773820982612

Robert, B., Sun, A. H., Sinden, D., Spruin, S., & Hsu, A. T. (2021). A case-control study of the Sub-Acute Care for Frail Elderly (SAFE) Unit on hospital readmission, emergency department visits and continuity of post-discharge care. *Journal of the American Medical Directors Association.*, *22*(3), 544-550.e2. https://doi.org/10.1016/j.jamda.2020.07.020

Rutherford, P., Anderson, A., Kotagal, U., Luther, K., Provost, L., Ryckman, F., & Taylor, J. (2020). *Achieving hospital-wide patient flow: The right care, in the right place, at the right time*. Institute for Healthcare Improvement. www.ihi.org

Whittemore, R., & Knafl, K. (2005). The integrative review: Updated methodology. *Journal of Advanced Nursing, 52*(5), 546-553. https://doi.org/10.1111/j.1365-2648.2005.03621.x

Literature Summary Tables

Legend

ALC	Alternate Level of Care
CASP	Critical Appraisal Skills Programme
CENTRAL	Cochrane Central Register of Controlled Trials
ESDP	Early Screen for Discharge Planning
HEART	Humber's Elderly Assess and Restore Team
MDS	Minimum Data Set 3.0
RAI-HC	Resident Assessment Instrument for Home Care

Study/Design/Purpose	Sample and Methods	Key Results	Comments
Authors: Arthur et al. (2021) Design: Retrospective Cohort Purpose: To identify premorbid demographic and clinical characteristics of long-stay home care clients associated with delayed discharge after admission to acute care.	N: 210 931 ALC patients Country/Setting: Canada Data Collection: • RAI-HC assessments • Discharge Abstract Database Records Relevant Outcome: • Delayed discharge Analysis: • logistic regression	Predictors of ALC designation: • advancing age (OR 1.67 – 2.72 95% CI [1.59 to 1.75] – [2.55 to 2.90]) • parkinsonism (OR 1.34, 95% CI [1.28 to 1.41]) • Alzheimer's disease and related dementias (OR 1.27, 95% CI [1.23 to 1.31]) • multiple sclerosis (OR 1.15, 95% CI [1.02 to 1.29]) • morbid obesity (OR 1.18, 95% CI [1.12 to 1.25])	Strength of Design: moderate Quality: medium Issues: • potential information bias due to reliance on previously documented information • potential misclassification bias due to inconsistent definition and designation of ALC across Canadian Provinces

Study/Design/Purpose	Sample and Methods	Key Results	Comments
Authors: Bai et al. (2019) Design: Retrospective Cohort Purpose: To describe complications associated with delayed discharge and validate a tool for predicting the risk of delayed discharge.	N: 4311 adults over age 65 ALC Patients: 255 Non-ALC Patients: 4056 Country/Setting: Canada Data Collection: • Electronic medical records • Discharge Abstract Database Relevant Outcome: Adverse Outcomes Analysis: • Chi-Square Test • logistic regression	The ALC Cohort significantly higher ($p<.0001$) adverse outcomes compared to non-ALC Cohort in • nosocomial infections (14.1%) • urinary tract infections (6.7%) • pneumonia (5.9%) • clostridioides difficile colitis (3.1%) Associations between ALC designation and: • age over 80 years (OR 2.80, 95%CI[1.85 to 4.29]) • female gender (OR 1.52, 95% CI [1.00 to 2.31]) • dementia (OR 3.40, 95% CI [2.05 to 5.59]) • complicated diabetes (OR 1.61, 95% CI [1.02 to 2.53]) • referrals for physiotherapy (OR 3.28, 95% CI [1.76 to 6.28]), occupational therapy (OR 6.15, 95% CI [3.83 to 10.16]), or speech-language pathology (OR 2.80, 95% CI [1.57 to 4.89]).	Strength of Design: moderate Quality: low Issues: • potential selection bias as the study was limited to one hospital • potential misclassification bias due to inconsistent definition and designation of ALC across Canadian Provinces • potential information bias due to reliance on previously documented information

Study/Design/Purpose	Sample and Methods	Key Results	Comments
Authors: Edelstein & Scandiffio (2022) Design: Retrospective Cohort Purpose: To assess the effectiveness of the HEART program	N: 1094 adults ≥ 65 years HEART Participants: 547 Non-HEART Participants: 547 Country/Setting: Canada Data Collection: • Hospital Administrative Database Relevant Outcome: Length of Stay Analysis: • Chi-Square Test • logistic regression	HEART program participants: • lower lengths of stay (p=.04) • less likely to remain in hospital with ALC designations (95%CI [2.03-3.99)	Strength of Design: moderate Quality: low Issues: • Potential selection bias as the study was limited to one hospital • potential misclassification bias as data obtained from only one hospital database. Patients could have been readmitted to other hospitals • potential information bias due to reliance on previously documented information.

Study/Design/Purpose	Sample and Methods	Key Results	Comments
Authors: Evans et al. (2020) Design: Retrospective Cohort Purpose: Examine the association between beliefs about capability and successful discharge.	N: 526 432 adults ≥ 66 years Positive Belief Participants: 487 236 Negative Belief Participants: 39 196 Country/Setting: United States Data Collection: • Medicare Master Beneficiary Summary File • Medicare Provider Analysis and Review Files • Hospice and home health claims • MDS Relevant Outcome: Length of Stay Analysis: • Chi-Square Test • linear regression	Positive belief toward capability is more likely to result in successful discharge (95% CI [63.8-63.9])	Strength of Design: moderate Quality: medium Issues: • potential information bias due to reliance on previously documented information

Study/Design/Purpose	Sample and Methods	Key Results	Comments
Authors: Goncalves-Bradley et al. (2022) Design: Systematic Review Purpose: To assess the effectiveness of individualized discharge plans for patients in acute care hospitals	N: 30 Randomized Control Trials Country/Setting: Multiple Countries Data Collection: • CENTRAL, MEDLINE, Embase databases Relevant Outcome: • Length of Stay • Readmission Rate Analysis: Cochrane Risk of Bias criteria GRADEpro	A personalized discharge plan leads to a slight reduction in LOS and reduces readmission rates	Quality: High • All studies were Randomized Controlled Trials with a low risk of bias Issues: • Potential that studies may have been incorrectly included or excluded due to the inclusion of discharge planning in more complex interventions

Study/Design/Purpose	Sample and Methods	Key Results	Comments
Authors: Grafton et al. (2023) Design: Prospective Cohort Purpose: Evaluate the effect of a redesigned discharge tool in identifying complex cases.	N: 718 adults Control Cohort: 342 Intervention Cohort: 376 Country/Setting: United States Data Collection: ESDP: • Self-rated walking scale • Age • Prior living status • Modified Rankin Disability Scale • A score>10 indicates the need for early discharge planning Relevant Outcome: Complex cases Analysis: • t-test	• Intervention group ESDP scores >10 • Control group ESDP scores <10 • Results not statistically significant	Strength of Design: moderate Quality: low Issues: • Sample comprised only patients admitted during Monday-Friday • Researchers substituted a portion of the ESDP tool for a pre-existing assessment. Tool not validated with changes. • No explanation was offered of how patients were assigned to cohorts.

Study/Design/Purpose	Sample and Methods	Key Results	Comments
Authors: Guilcher et al. (2021) Design: Qualitative Purpose: To explore hospital-associated deconditioning from the perspective of patients, caregivers, providers, and decision-makers	N: 80 participants Patients: 30 Caregivers: 22 Providers: 17 Decision-Makers: 11 Country/Setting: Canada Data Collection: • semi-structured interviews • Patient and Caregiver interviews explored experiences in hospital, relationships, formal and information supports prior to admission, health trajectories, discharge plan, and concerns related to discharge • Provider and Decision-Maker interviews explored role in relation to care transitions, overall experience in planning and delivery of care, challenges and success stories, and resources needed to support discharge and care transitions better Analysis: • Occurred concurrent with data collection • Data Saturation • Qualitative Analysis Guide of Leuven • Transcripts reviewed independently • Codebook was developed and compared • Data stratified to identify core categor	Low level of activity: • Boredom • Depression • Lack of physical activity • Lack of motivation Tensions around patient identity and care transition uncertainty: • Patient identity – things are different • Uncertainty around care transitions Physical and social context: • Social factors – role of roommates, volunteers, and providers • Physical factors – sub-optimal environment	CASP Qualitative Checklist: Rated acceptable for inclusion. Strengths: The researchers presented a multi-dimensional perspective Recommendations: • reassessments of physical and psychological functioning during admission for early identification of deconditioning • redesign hospital environments to encourage social interactions • maximize volunteer resources • increase access to rehabilitative services • encourage social interactions • measure functional status Limitations: • limited physician participation • Limited participant diversity

Study/Design/Purpose	Sample and Methods	Key Results	Comments
Authors: Lim Fat et al. (2022) Design: Descriptive Case Series Purpose: To examine the burden of healthcare-associated adverse events in the ALC population	N: 156 ALC patients ≥ 65 years Country/Setting: Canada Data Collection: Patient Health Records Relevant Outcome: Nosocomial Infections Delirium Falls Analysis: • Restricted cubic spline regression	Infectious Outcomes: • urinary tract infections (13.1%) • respiratory infections (7.18%) • skin infections (3.87%) • gastrointestinal infections (0.83%) Non-Infectious Outcomes: • delirium (21%) • falls (10.77%)	Strength of Design: weak Quality: high Comments: • Representative of the target population • Researchers completed practice reviews to reduce information bias • Relationship between adverse events and LOS should be explored further

Study/Design/Purpose	Sample and Methods	Key Results	Comments
Authors: Meo et al. (2020) Design: Retrospective Cohort Purpose: Compare discharge barriers for extended hospitalization patients to prolonged hospitalization patients	N: 1494 adults Extended hospitalization Participants: 172 Prolonged hospitalization Participants: 40 Country/Setting: United States Data Collection: • Multidisciplinary rounds documentation Relevant Outcome: Discharge barriers Analysis: • t-test	patients in the prolonged admission cohort were more likely to have financial barriers preventing their discharge ($p<.05$), lack decision-making capacity ($p<.05$), exhibit disruptive or dangerous behaviors ($p<.001$) or disagree with the discharge plan ($p=.005$).	Strength of Design: moderate Quality: low Issues: • weak intervention integrity as coding of barriers is subjective and could be inconsistent • potential information bias due to reliance on previously documented information • potential confounders as authors did not indicate if the same individuals completed multidisciplinary rounds

Appendix B

Consultation Report

Project Introduction and Background

My experience as an inpatient manager in acute care at Western Memorial Hospital (WMH) introduced me to the challenges associated with the rising number of Alternate Level of Care (ALC) patients in healthcare systems. Although I understood there was a risk for adverse outcomes, as a frontline nurse, I was not exposed to the long-term effects of prolonged hospitalization and ongoing systemic pressures resulting from high ALC rates. When I moved into my current role as the Regional Director of Operational Flow for Newfoundland and Labrador Health Services – Western Zone (NLHS-WZ), I was challenged to improve overall hospital flow and respond to the growing concern surrounding the ALC population. The NL Health Accord (2022) emphasized the need to protect the older adult population in NL. It highlighted the value of comprehensive discharge planning that supports timely discharge and helps prevent hospital-associated deconditioning and premature institutionalization while freeing up valuable hospital resources. Unfortunately, NLHS has no standardized discharge planning tools to support staff and providers in decision-making through the discharge process, so older adult ALC patients remain in the hospital for prolonged periods. This practicum project was conceptualized in response to the lack of guidance in discharge planning that supports the timely discharge of the older adult ALC population.

Through the completion of a literature review on discharge planning for the older adult ALC population, it was evident that prolonged hospital stays introduce adverse outcomes such as hospital-acquired deconditioning, infections, delirium, and premature institutionalization. The literature also supports comprehensive discharge planning to reduce the length of stay, reduce readmission, and identify potentially complex cases earlier so that appropriate measures can be implemented to facilitate timely discharge. Although the literature review generally supports the

development of standardized care guidelines and decision-support tools, it is also essential to understand the specific needs and perspectives of discharge planners working in WZ Health as they are the focus of this practicum project.

To inform the development of a discharge planning tool for NLHS-WZ, a user survey was disseminated to care facilitators, managers, directors, and allied health professionals at WMH. These surveys aimed to obtain key stakeholders' perspectives, needs, and recommendations to support the development of a discharge planning tool in a local context. The consultation findings will guide an environmental scan to search for pre-existing tools that may be adopted or customized for the unique needs of Western Newfoundland's older adult ALC population.

Specific Objective(s) for the Consultations

1. Identify the learning needs of nurses involved in discharge planning for older adult ALC patients in Western Memorial Hospital (WMH).
2. Explore current discharge planning practices used at WMH.
3. Identify barriers to timely discharge for the older adult population.
4. Explore nurses' perceptions of the need for a discharge planning tool.
5. Gain an understanding of the preferred discharge planning tool option.

Methods

Setting and Sample

Emails were sent to care facilitators (n=5), clinical managers (n=5), program directors (n=2), and allied health professionals (n=24) at WMH, describing the project's purpose, the timeline for completion, reassurance of anonymity, and a link to the survey—the first question of the questionnaire addressed consent. If participants did not consent to their responses being

included in the consultation report, they were directed to the end of the survey. A copy of this email is included in Appendix A, and the survey is included in Appendix B.

Data Collection and Analysis

All survey responses were completed electronically and automatically saved within the Microsoft Forms program. Descriptive statistical analysis built into Microsoft Forms was used to describe demographic data. The qualitative data was transcribed into Microsoft Excel and analyzed using the qualitative content analysis process outlined by Lindgren et al. (2020). Explicit participant responses were divided into phrases or sentences, or semantic meaning units, and **entered in an Excel spreadsheet. R**epetitions were removed, and each meaning unit was labeled with a descriptive code close to the original text to maintain content integrity and align with the project's aim. Finally, **same and similar codes were sorted and combined into categories or themes.** The qualitative sections of the survey results were read and re-read to ensure no data was missed.

Ethical Considerations

The development of this practicum project does not require review by the Health Research Ethics Authority (HREA), as indicated by the HREA screening tool in Appendix C. To ensure that the WZ senior leadership was informed of the consultation process, approval was requested and received from the Senior Director of Hospital and Clinical Care to conduct consultations with staff members.

Results

A 44% response rate was achieved (n=16) by the set deadline. The low response rate could be partially attributed to the competing priorities facing the leadership team at WMH, as

they were at the end stages of transitioning to a new acute care hospital at the time of survey distribution.

Demographics

Of the 16 respondents, all were female, and the majority were allied health professionals (n=11), followed by care facilitators (n=2), managers (n=2), and directors (n=1). Fifty-six percent were employed for 15 years or more, and the majority (38%) were aged 40-49.

Initiating Discharge Planning

Most respondents felt that discharge planning should be initiated early in the admission, with seven respondents identifying the initial admission process as the optimal time and five identifying the first 24 hours as the optimal time. Two respondents felt the first week of admission was optimal, and two felt that the optimal time to initiate discharge planning was when the patient was medically ready and cognitively ready to do so. When asked what factors should be considered when assessing a patient's readiness for discharge planning, 73% of respondents described the availability of support as the main factor, including formal home support, family support, equipment support, and social support. Mobility status and cognition were also frequently reported as factors to consider.

Barriers to Discharge Planning

Respondents were asked to identify the most common barriers to timely discharge planning through an open-ended question. The main theme generated from the responses was lack of support, which was then further broken down into subthemes of lack of home support, lack of family support, lack of financial support, and lack of access to community support and programming.

Lack of Home Support

Many patients with complex care needs require home support to facilitate a timely discharge (Department of Health and Community Services, personal communication, 2023). Short term support is often associated with continued rehabilitation or end of life services at home; whereas long-term support is associated with ongoing risk for injury or decreased cognitive or behavioral functioning (Department of Health and Community Services, personal communication, 2023). Participants in the survey reported a lack of home support related to delays in agency response times and an insufficient number of home support workers to meet the demand. One participant described their frustration with process delays for arranging home supports, stating "it is not uncommon for home support agencies to say they will check to see if they have a worker available but will then never call the social worker back with their answer and the social worker then has to call them again". Other participants simply listed "lack of home support workers" as a barrier.

Lack of Family Support

Family caregivers are relatives, friends, partners, or neighbors who provide unpaid assistance to someone who has limitations in their physical, mental, or cognitive functioning. While family members have traditionally been a source of supplemental support, the aging of the population, increased longevity of older adults with significant chronic disease and disability, and an underfunded and fragmented health and social support system have all contributed to placing the major burden of care on family members (Schulz et al., 2020). In light of the delays associated with organizing formal home support, healthcare professionals often look to families to bridge the gap and help facilitate a timely discharge. However, according to participants in this consultation, older adults may not all have access to the family support they need. One participant suggested that geographical limitations make family support difficult as not all older

adults have their family members living nearby. Another participant suggested that even when willing to provide support, families may not have the ability, skills, and training to provide the level of support required.

Lack of Financial Support

Patients discharged as part of the Home First philosophy can access required services for up to eight weeks without a financial assessment; however, during that time, a financial assessment is completed to determine the patients responsibility to contribute to the cost of ongoing services (Department of Health and Community Services, personal communication, 2023). Participants described financial barriers for timely discharge as a "lack of affordable housing," "lack of knowledge about financial situation," and "inability to afford the recommended equipment and services."

Lack of Access to Community Support and Programming

The NL Health Accord calls for equal access to healthcare services (Health Accord NL, 2022). Similarly, the Home First Initiative aims to shift the focus of healthcare from the acute care system to the community (Department of Health and Community Services, personal communication, 2023). However, participants in the consultation process suggest that access to community support services is not easily accessed. Several participant responses suggest that patients remained in hospital to access allied health resources such as physiotherapy and occupational therapy due to a lack of allied health services in the community. Lack of family physicians in the community was also noted as a barrier to discharge as patients would not have access to the required follow up care. One participant described the paperwork required to secure equipment through the community support program as "unnecessary" and further commented that there were "too many steps" in the process, resulting in delayed discharge.

Discharge Planning Resources

Sixty-three percent (n=10) of respondents felt a need for a discharge planning resource to help guide the discharge process for older adult ALC patients. Among those respondents, the majority (n=5) felt a decision tree or algorithm would be most helpful, while one respondent reported checklists and flow maps as most useful. Two respondents elaborated on the "other" option to identify patient education and information resources as most useful. The remaining two respondents felt that either option would be helpful.

Analysis of the free-text responses suggesting elements to include in discharge planning generated two main themes: continued follow-up and patient education/information.

Continued Follow-Up

The Home First philosophy focuses on removing barriers within regular programming and wrapping supports around people in their homes and communities to provide continuity across the continuum of care (Department of Health and Community Services, personal communication, 2023). However, participants in this consultation survey suggested there are issues with continued follow-up and offered suggestions for improvement such as initiating allied health outpatient referrals for medication management, mobility progression, and equipment installation; initiating community referrals for ongoing monitoring of health conditions; and introducing clinician phone calls to ensure patients and families are coping at home. One participant described the importance of an allied health referral to assist with medication management planning, stating "I know that medication management is a concern not often addressed…they may lack the cognition to organize themselves around precautions for the meds, the times they need to be taken, etc."

Patient Education and Information

Including patient education and information in the discharge planning process was recommended through suggestions such as providing pre-admission information so that patients knew what to expect once admitted, providing contact information so that patients and families knew whom to contact with questions, and ensuring ongoing communication on plan of care during and after hospitalization. No further context was provided in the responses.

Patient and Family Feedback

Fifty-six percent (n=9) of respondents indicated that they had received either positive (n=3), negative (n=2), or both positive and negative (n=4) feedback from patients and families on their discharge experience.

Positive Feedback

Analysis of the free-text responses describing the positive feedback suggested that patients and families appreciated the collaborative efforts of the discharge planning team and the communication from the allied health team on setting goals and providing updates on their progress. One participant recounted specific feedback they received from families, stating "just this week someone told me that they would not have been able to get through these past few months without my help." The participant further explained that people appreciated that staff were approachable and did not make them feel stupid when they asked questions.

Negative Feedback

A similar analysis of the free-text responses describing the negative feedback suggested that some patients and families felt rushed to leave the hospital before they were ready. In contrast, others felt frustrated with the slow pace of planning due to staff shortages and lack of physician interaction. One participant recalled specific concerns voiced by patients using

examples of "I was treated like a number," "no one is listening to what I want," "I just need more time to get back on my feet," "I don't want to go to LTC, but I guess I have to."

Implications for Project Development

The results of these consultations mirror the findings from the literature review in that most respondents see value in initiating discharge planning early in the admission of older adults. This is further substantiated by the reported feedback from patients and families, who appreciated the collaboration and communication during the discharge planning process and felt frustrated with stalled progress. Since most respondents recommended a discharge planning tool to help guide the discharge planning process for older adult ALC patients, this consultation process reinforces the need to develop a resource. However, considering the mixed recommendations for a discharge planning resource format, an exploration of previously developed resources across Canada through an environmental scan would further inform the project.

Conclusion

The older adult ALC population is at risk for adverse outcomes. Therefore, it is essential that planning for the transition from hospital to home or another healthcare setting is initiated early in the admission process. Discharge planners in WMH support the development of a resource to help streamline discharge planning to help overcome barriers and improve patient outcomes and experiences; however, the lack of consensus on the resource format requires further follow-up to ensure this project achieves its intended outcomes.

References

Health Accord NL. (2022). *Our province. Our health. Our future. A 10-year health transformation: The report.* https://healthaccordnl.ca/final-reports/s

Lindgren, B.-M., Lundman, B., & Graneheim, U. H. (2020). Abstraction and interpretation during the qualitative content analysis process. *International Journal of Nursing Studies*, *108*, 103632–103632. https://doi.org/10.1016/j.ijnurstu.2020.103632

Schulz, R., Beach, S. R., Czaja, S. J., Martire, L. M., & Monin, J. K. (2020). Family caregiving for older adults. *Annual Review of Psychology*, *71*(1), 635–659. https://doi.org/10.1146/annurev-psych-010419-050754

Appendix A: Email Invitation to Discharge Planners

Hi everyone

As many of you know, I am currently enrolled in the Master of Science in Nursing program through Memorial University. As a part of this program, I am completing a practicum project on discharge planning for the ALC population in the Western Zone.

Through an extensive literature review, I have identified the impacts of extended hospitalization for the older adult population and some of the common barriers that prevent timely discharge. My next step is to gather information from a local context through a short survey. As a healthcare professional who actively participates in discharge planning, your perspectives and recommendations are essential in identifying gaps in our discharge planning process and determining whether discharge planning guidelines, tools, or processes would help bridge those gaps to promote better outcomes for our older adult ALC population.

Participation in the survey is entirely voluntary and anonymous and should take no more than 5 minutes to complete. If you are interested in participating, please use the link below to access the survey. The survey link will remain open until June 19th.

https://forms.office.com/r/Dm9D41LbZF?origin=lprLink

Thanks

Deanna

NL Health Services

Deanna Clarke BN, RN

Regional Director of Operational Flow

NL Health Services – Western Zone

Email: deanna.clarke@westernhealth.nl.ca

Phone: 709-784-5088 /709-632-9845

Appendix B: Online Questionnaire

Discharge Planning at WMH

The responses included in this questionnaire will be anonymous and used only for the purposes of informing the development of a discharge planning tool for WMH as part of a practicum project for Memorial University Master of Science in Nursing program. No identifying information will be collected.

* Required

1. I understand the purpose of this questionnaire. By selecting "yes", I am consenting to my responses being included in the organizer's practicum report. *

- ◯ Yes
- ◯ No

2. What is your position at WMH? *

- ◯ Staff Nurse
- ◯ Care Facilitator
- ◯ Allied Health Professional
- ◯ Manager
- ◯ Director

3. How long have you worked at WMH? *

- ◯ less than 1 year
- ◯ 1-5 years
- ◯ 5-10 years
- ◯ 10-15 years
- ◯ 15 years or more

4. Which best describes your age category? *

- ◯ 21-29
- ◯ 30-39
- ◯ 40-49
- ◯ 50-59
- ◯ 60 or older

5. How do you describe your gender? *

- ◯ Male
- ◯ Female
- ◯ Other

12. Have you ever received feedback from an older adult regarding the quality of discharge planning at WMH? *

- ◯ Yes
- ◯ No

6. When do you feel is the best time to initiate discharge planning for the older adult (aged 65 years or older)? *

- ◯ during the admission process
- ◯ within 24 hours of admission
- ◯ within the first week of admission
- ◯ once they are medically cleared for discharge
- ◯ when the patient and/or family feels they are ready to go home
- ◯ when the interdisciplinary team has determined the discharge plan
- ◯ Other

7. What factors do you consider when assessing an older adult's readiness for discharge? *

Enter your answer

8. In your experience, what are the most common barriers to timely discharge of the older adult population? *

Enter your answer

9. Do you believe there is a need for a discharge planning resource to guide the discharge process at WMH? *

- [x] Yes
- [ ] No

10. What form of discharge planning tool would you find most useful? *

- [ ] discharge checklist
- [ ] flowmap
- [ ] decision tree / algorithm
- [ ] Other

11. What elements do you suggest be included in a discharge planning resource? *

Enter your answer

12. Have you ever received feedback from an older adult regarding the quality of discharge planning at WMH? *

- [ ] Yes
- [ ] No

13. Was the feedback positive or negative? *

- [ ] Positive
- [ ] Negative
- [ ] Both

14. Please list the most common descriptors that patients used to describe their positive experiences. *

Enter your answer

15. Please list the most common descriptors that patients used to describe their positive experiences. *

Enter your answer

Appendix C: Health Research Ethics Authority (HREA) Screening Tool

Student Name: Deanna Clarke

Title of Practicum Project: Development of a Flow Map to Support Discharge Planning from Acute Hospital Services in NLHS-Western Zone.

Date Checklist Completed:

This project is exempt from Health Research Ethics Board approval because it matches item number _____3_____ from the list below.

1. Research that relies exclusively on publicly available information when the information is legally accessible to the public and appropriately protected by law; or the information is publicly accessible and there is no reasonable expectation of privacy.
2. Research involving naturalistic observation in public places (where it does not involve any intervention staged by the researcher, or direct interaction with the individual or groups; individuals or groups targeted for observation have no reasonable expectation of privacy; and any dissemination of research results does not allow identification of specific individuals).
3. Quality assurance and quality improvement studies, program evaluation activities, performance reviews, and testing within normal educational requirements if there is no research question involved (used exclusively for assessment, management or improvement purposes).
4. Research based on review of published/publicly reported literature.
5. Research exclusively involving secondary use of anonymous information or anonymous human biological materials, so long as the process of data linkage or recording or dissemination of results does not generate identifiable information.
6. Research based solely on the researcher's personal reflections and self-observation (e.g. auto-ethnography).
7. Case reports.
8. Creative practice activities (where an artist makes or interprets a work or works of art).

For more information please visit the Health Research Ethics Authority (HREA) at https://rpresources.mun.ca/triage/is-your-project-exempt-from-review/

Appendix C

Environmental Scan Report

Project Overview and Background

In Newfoundland and Labrador (NL), health programs for frail older adults are rudimentary despite 23.6% of the population being 65 years and older in 2021 (Health Accord NL, 2022). Many frail older adults are admitted to acute care hospitals and subsequently designated as Alternate Level of Care (ALC) because they no longer require the intensity of resources and services provided in that setting, but the required preparation and planning for discharge has not yet been finalized. Compared to other Canadian provinces, NL has higher ALC designation rates and prolonged lengths of stay associated with those ALC designations (Barnable et al., 2015; Health Accord NL, 2022). Through my leadership roles at Western Memorial Hospital, I have felt the systemic pressures from the high number of older adult ALC patients in the Western Zone. From a patient perspective, there is an increased risk for hospital-associated deconditioning, infections, and premature institutionalization. From a systemic perspective, beds used to maintain ALC patients create delays in access to care for patients who need acute care services, longer wait times in the emergency department, and delayed or canceled surgeries.

In response to the rising ALC rates, NL has developed a policy framework that outlines strategies to reduce ALC rates in acute care hospitals across the province, including discharge planning (Newfoundland & Labrador, personal communication, 2024). Discharge planning is a health system routine aimed at reducing delayed discharge from the hospital, improving the coordination of services following discharge, and reducing the risk of hospital readmission (Gonçalves-Bradley et al., 2022). Unfortunately, NLHS has no standardized discharge planning tools to support the timely discharge of our ALC population. This practicum project aims to develop a discharge planning tool based on credible research and local consultations to assist

interdisciplinary healthcare teams in timely decision-making and help bridge the gap in discharge planning in NL. The project is comprised of three main components: 1) an integrative literature review that substantiates the need for an improved discharge planning process, 2) consultations with discharge planners to provide a comprehensive understanding of the current discharge processes, the perceived barriers to timely discharges, and the preferred discharge planning tool format, and 3) an environmental scan to provide a broad view of existing discharge planning tools across Canada. This scan will help determine if it is necessary to develop an entirely new tool, customize an existing tool so that it is transferrable to the older adult population in NLHS-WZ, or adopt an existing tool as is.

Specific Objective(s) for the Environmental Scan

1. To determine what discharge planning tools are available in NLHS to assist in the safe and timely discharge of older adults from acute care.
2. To identify discharge planning tools available online at other Canadian acute care hospitals.
3. To evaluate existing discharge planning tools for relativity to NL's older adult ALC population.

Sources of Information/Data Collection

The environmental scan consisted of internal and external environment reviews.

Internal Sources

For the internal review, consultations were completed and reported to obtain information regarding existing discharge planning processes and gather recommendations for developing a discharge planning tool. The internal scan also involved a review of organizational documents, including the Policy Framework to Reduce ALC Rates in NL (Newfoundland & Labrador,

personal communication, 2024), the Provincial Home First Policy Framework (Department of Health and Community Services, personal communication, 2023), the Provincial Surgical Backlog Task Force Report (Martin et al., 2023), NL Health Accord (2022), the Home First Steering Committee workplan (D. Clarke & K. Harding, personal communication, September 24, 2024), and a presentation on a dischargeHUB service currently in practice in Eastern Zone (Seafair Capital, personal communication, June 2024).

External Sources

For the external review, a broad Internet search using Google and Google Scholar was conducted using relevant phrases such as "discharge planning tools in Canada" and "discharge planning for older adults in hospital." Websites for Alberta and British Columbia healthcare organizations, the University of Toronto, Health Quality Toronto, and the Professional Practice Network of Ontario (PPNO) were explored for links to discharge planning programs and associated discharge tools. Relevant tools were downloaded and saved whenever possible, ensuring adherence to copyright material.

Data Management and Analysis

An Excel spreadsheet organized the information collected during the environmental scan. The consultation process did not identify one preferred form of a discharge planning tool or resource; however, discharge checklists and algorithms were the top two selected formats. Therefore, discharge resources that did not include a checklist or algorithm format were excluded. Furthermore, since this practicum project aims to simplify the discharge process for the older adult ALC population, resources that required a multifaceted and formal change initiative for implementation were excluded. For example, the bestPATH transitions of care workbook (Health Quality Ontario, 2013) offers a complete organizational change management

package, including implementing medication reconciliation practices, multiple risk assessments, and itemized discharge planning suggestions. While all elements of a discharge planning process are valuable, the workbook did not provide a single simplified discharge planning tool to meet the goals of this practicum project. Any remaining resources were reviewed for relevancy.

The spreadsheet columns were labeled to identify this project's relevant components. Since this environmental scan aims to inform discharge planning within the Canadian context, only Canadian-based resources were considered relevant. Similarly, through the consultation phase of this project, most participants identified a preference for a checklist or algorithm. Therefore, a tool in the preferred format was considered a relevant component. The final three components of clearly defined roles and responsibilities, identifiable decision points, and realistic and achievable solution suggestions were derived from personal experience in discharge planning, policy development, and change management. As websites and resources were reviewed for relevancy, jot notes were noted under each component category in the spreadsheet. Resources found to include or address all components were flagged for further consideration for the project.

Overall, the environmental scan yielded 14 resources that referenced discharge planning from hospital. Of the six internal resources, none met all inclusion criteria. However, there was an unexpected finding of a new discharge initiative being piloted in NLHS-Eastern Zone, so it was flagged for further review. Seven external websites were explored, resulting in eight possible resources. However, upon further review, one website was noted to be US-based (Agency for Healthcare Research and Quality, n.d) and therefore excluded. Of the remaining seven resources, five were excluded: three were noted to be patient education resources (Alberta Health Services, 2023; Healthwise Staff, 2022; Institute for Healthcare Improvement, 2020), one

was a flyer for an educational workshop (University of Toronto, 2024), and one was a multi-year organization change initiative (Health Quality Ontario. 2013). Upon initial review, two external resources met all inclusion criteria (Alberta Health Services, n.d; PPNO, 2022).

Results

Three resources were reviewed as potential options for this project: the Blaylock Risk Assessment Screen Score (BRASS), a discharge planning algorithm used at the Royal Victoria Regional Health Center, and the dischargeHUB service being piloted in NLHS-EZ. The strengths and limitations of each resource were explored to determine suitability for adoption or adaption for this project.

Blaylock Risk Assessment Screen Score

The external scan provided a link to a discharge tool, BRASS, used by Alberta Health Services (n.d). However, no context or information was provided for the tool on the website. The BRASS index is a screening tool used at hospital admission to identify patients at risk of prolonged hospitalization requiring specific discharge planning (Bocci et al., 2017; Colognesi et al., 2021; Zarovska et al., 2018). Using the tool, providers assign values to 10 domains of age, living situation/emotional support, functional status, cognition, behavior pattern, mobility, sensory deficits, previous admissions or emergency room visits, number of active medical problems, and drugs. The total score allows providers to divide patients into three risk groups, reflecting different severity of patients' clinical conditions and needs for discharge planning (Colognesi et al., 2021; Zarovska et al., 2018).

Strengths

The literature review conducted as part of this project suggested early identification of complex discharge as a successful strategy to reduce ALC designation rates and delayed

discharges (Arthur et al., 2021; Bai et al., 2019; Grafton et al., 2023; Meo et al., 2020). Similarly, consultations with discharge planners identified the need to initiate discharge planning early in the admission process, which is the recommended time to conduct the BRASS index assessment. Research studies conducted in Italy have shown the tool to be effective in predicting the risk of prolonged hospitalization (Bocci et al., 2017; Colognesi et al., 2021; Dal Molin et al., 2014; Zarovska et al., 2018).

Limitations

Through consultations, participants identified a lack of family support as a barrier to discharge planning. Unfortunately, while the BRASS Index includes the domain of situation or emotional support, it does not consider that existing caregivers may be unable to provide the level of assistance required to support discharge (Colognesi et al., 2021).

The literature review conducted as part of this project suggests that prolonged hospitalization leads to hospital-associated deconditioning in the older adult population. Therefore, there is potential that the assessment completed upon admission may not accurately capture the patient's status on discharge. Similarly, since the BRASS index tool is completed only during the admission process, there is a potential that family resources or patient's planning needs may not be known at admission and, therefore, not accurately identify the patient's risk for complex discharge (Colognesi et al., 2021).

During the internal review of the HF Steering Group minutes, it was noted that the BRASS index tool had been implemented and discontinued in WZ. A rationale for the decision was not found within the minutes; however, subsequent consultations with the Director of Patient Services for WMH found that it was only used by one program area and was discontinued as alternate intake processes for the program were implemented.

Discharge Planning Pathway

The external scan provided a link to a discharge planning pathway promoted by the PPNO (2022). The pathway provides a flow map identifying key decision points, escalation points, and clear roles and responsibilities. The remainder of the document explains each step in the planning process and links to legislation supporting the decision points. There are also sample letter templates that appear to be used by the Royal Victoria Regional Health Center.

Strengths

The pathway provides information that is considered relevant for this project. There is a visual flow map that identifies key decision points, escalation points, and the person or role that is most responsible for each step. This flow map will allow for continued progression through the discharge planning process as discharge planners will have a clear direction. It also includes detailed information sheets for each escalation point to support discharge planners and administration in conversations with patients and families. Including references to support decisions is essential as it promotes consistent policy enforcement. The letter templates could be easily adapted to the NLHS format.

Limitations

Although it can be beneficial to include clear escalation pathways in a discharge planning resource, there also needs to be some allowance for exceptional circumstances. For example, the document has predetermined timelines for patient and family response to notification of discharge date; if they fail to leave the hospital within 24 hours of that date, they are charged a fee of $1227.00 for each additional day in the hospital. While this can effectively reduce unnecessary discharge delays, it can also create additional stress and undue hardship for those who cannot comply with the discharge date. In order to avoid the additional costs, patients may

leave the hospital without having all the necessary support arranged, placing themselves at a higher risk for injury and readmission. Furthermore, in my experience, political parties in NL are responsive and reactive to patients and families who disagree with administrative decisions in our healthcare system. NL does not have comparable legislation to support the PPNO discharge planning pathway mandates. Therefore, administrators may not receive the support required to enforce the outcomes outlined in the document.

Finally, the document in the link contains overlapping prints and pictures, resulting in missing information. Multiple attempts to reach the PPNO for further information and clarity were unsuccessful.

DischargeHUB

While not a specific discharge planning tool, the DischargeHUB (2024) resource found in the internal scan is piloted by NLHS to help reduce hospital lengths of stay associated with delayed access to services and equipment. It is an external service that coordinates home health care services such as home supports, home oxygen, and equipment for discharged patients so that skilled clinicians can focus on clinical work. A meeting with a representative for the dischargeHUB project was requested for June 18, 2024, via Microsoft Teams. The project lead presented additional information on the current processes and plans for service expansion.

Strengths

Current processes in NLHS-WZ require skilled clinicians to make multiple phone calls to arrange resources supporting discharge, taking up valuable time better spent on direct patient care. DischargeHUB offers a service to coordinate services such as home support, equipment purchase or rentals, and home oxygen assessment and setup so that skilled clinicians such as physiotherapists and occupational therapists can focus on direct patient care. This dedicated

service would expedite discharges that may be delayed due to the increased demand for allied health services.

Limitations

The service is currently not linked with the provincial Special Assistance Program (SAP), which provides funding for long-term home support and equipment services. It is also not linked to the National Indigenous Health Benefit (NIHB) program that covers the financial cost of health services for the Indigenous population. Therefore, the only patients who would benefit from this service would be the ones who could afford to pay privately. Since the others would have to remain in the hospital until clinicians could arrange their resources, this service would not provide equal access to care. However, during the meeting with the dischargeHUB representative, suggestions to improve the service to meet the unique needs of the older adult population in WZ were readily accepted and appreciated.

Implications for Practicum Project

The literature review conducted for this project suggests that prolonged hospitalization leads to adverse outcomes in the older adult ALC population. Similarly, the consultation process supports the development of a discharge planning resource to help streamline the discharge process. While the BRASS index tool has successfully identified patients at risk for prolonged hospitalization, research appears to be primarily conducted in Italy. Further searches would need to be conducted to determine if this tool has been successful within the Canadian healthcare system. Additionally, since this tool is already available but not used within WZ, it is not recommended for this project.

Upon initial review, the discharge planning pathway presented by the PPNO (2023) appeared to be an option that could meet all objectives of this project. However, upon further

review, the lack of legislation within NL to support the mandates in the pathway could leave administrators without justification to enforce their decisions. The inability to obtain the required information and permissions also means this tool cannot be adopted as is. However, it could be considered a framework for developing a new discharge planning tool.

Implementing a service that can expedite discharges and allow clinicians to focus on direct patient care could indirectly support the outcomes of this project. Since NLHS currently supports it as a pilot project, if dischargeHUB can be expanded to include programs such as SAP and NIHB, it would be considered the optimal recommendation for implementation. As my position within NLHS oversees patient flow for NLHS-WZ, I would be directly involved in the implementation process. I could help design the service to address our most pressing discharge barriers. Developing a flow map that helps delineate the process for referring to the dischargeHUB service will help support discharge planners in their decision-making and meet the objectives of this practicum project. Unfortunately, there is no definitive timeline for dischargeHUB implementation in WZ; therefore, the service may not be implemented within the timelines of this project. However, through collaboration with the dischargeHUB team, a draft algorithm can be developed to prepare for service expansion to WZ.

Ethical Considerations

This environmental scan includes only information on public websites and shared organizational documents. No patient information was collected. Based on the Health Research Ethics Authority (HREA) Screening Tool in the Appendix, this environmental scan did not require formal ethics approval from the NLHS ethics committee.

Conclusions

The older adult ALC population in NL is at risk for adverse outcomes, and the rising ALC rates create patient flow issues within our healthcare system. This environmental scan suggests that while NLHS does not have a standardized discharge planning tool, it invests in strategies to support timely discharge. While this project initially intended to develop a discharge planning tool, the environmental scan results suggest that developing an algorithm to support the implementation of the dischargeHUB service would best align with the ongoing initiatives to support the older adult population in WZ.

References

Agency for Healthcare Research and Quality. (n.d.). *Care transitions from hospital to home: IDEAL Discharge Planning implementation handbook*. https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engagingfamilies/strategy4/Strat4_Implement_Hndbook_508_v2.pdf

Alberta Health Services. (2023). *Hospital discharge planning*. My Health Alberta. Retrieved from https://myhealth.alberta.ca/Health/pages/conditions.aspx?hwid=ug5158

Alberta Health Services. (n.d). Blaylock Discharge Planning Risk Assessment Screen. https://www.albertahealthservices.ca/frm-09373.pdf

Arthur, S. A., Hirdes, J. P., Heckman, G., Morinville, A., Costa, A. P., & Hébert, P. C. (2021). Do premorbid characteristics of home care clients predict delayed discharges in acute care hospitals: a retrospective cohort study in Ontario and British Columbia, Canada. *BMJ Open*, *11*(2), e038484–e038484. https://doi.org/10.1136/bmjopen-2020-038484

Bai, A. D., Dai, C., Srivastava, S., Smith, C. A., & Gill, S. S. (2019). Risk factors, costs and complications of delayed hospital discharge from internal medicine wards at a Canadian academic medical centre: Retrospective cohort study. *BMC Health Services Research*, *19*(1), 935–935. https://doi.org/10.1186/s12913-019-4760-3

Barnable, A., Welsh, D., Lundrigan, E., & Davis, C. (2015). Analysis of the influencing factors associated with being designated alternate level of care. *Home Health Care Management & Practice*, *27*(1), 3–12. https://doi.org/10.1177/1084822314539164

Bocci, G., Kundisova, L., Guadagni, G., Stefani, L., Cepollaro, C., Nante, N., Dei, S., & D'Amato, M. (2017). Blaylock risk assessment screening score as a predictor of length of

hospital stay. *European Journal of Public Health*, *27*(suppl_3). https://doi.org/10.1093/eurpub/ckx187.446

Colognesi, S., Fagnani, C., Panceri, F., Ruggero, M., Di Florio, F., Passoni, C., Fantini, V., Boracchi, P., Orenti, A., Fumagalli, M. A., & Vergani, M. (2021). Hospital discharge: Testing the "Blaylock Risk Assessment Screening Score" in a surgical department. *Acta bio-Medica:Atenei Parmensis*, *92*(S2), e2021039. https://doi.org/10.23750/abm.v92iS2.10761

Dal Molin, A., Gatta, C., Derossi, V., Guazzini, A., Cocchieri, A., Vellone, E., Alvaro, R., & Rasero, L. (2014). Hospital discharge: Results from an Italian multicenter prospective study using Blaylock Risk Assessment Screening Score. *International Journal of Nursing Knowledge*, *25*(1), 14–21. https://doi.org/10.1111/2047-3095.12016

Gonçalves-Bradley, D. C., Lannin, N. A., Clemson, L., Cameron, I. D., & Shepperd, S. (2022). Discharge planning from hospital. *Cochrane Database of Systematic Reviews*, *2*(2), CD000313–CD000313. https://doi.org/10.1002/14651858.CD000313.pub6

Grafton, J., Bowen Brady, H., Kelly, J., Kelly, M., Lang, K., Wolski, P., Ray, S., Loescher, C., Pearson, M., & Mendu, M. (2023). Implementation of a modified early screening for discharge tool to optimize case manager efficiency and impact length of stay. *Professional Case Management*, *28*(6), 262–270. https://doi.org/10.1097/NCM.0000000000000658

Health Accord NL. (2022). *Our province. Our health. Our future. A 10-year health transformation: The report.* https://healthaccordnl.ca/final-reports/s

Health Quality Ontario. (2013). bestPATH: Transitions of Care: Evidence informed improvement package. Retrieved from

https://www.hqontario.ca/Portals/0/documents/qi/health-links/bp-improve-package-transitions-en.pdf

Healthwise Staff. (2022). *Hospital discharge planning*. Healthlink BC. https://www.healthlinkbc.ca/health-topics/hospital-discharge-planning

Institute for Healthcare Improvement. (2020). *SMART discharge protocol*. http://www.ihi.org/resources/Pages/Tools/SMARTDischargeProtocol.aspx

Martin, R. (2023). *Provincial surgical backlog task force: Report.* https://www.gov.nl.ca/hcs/files/23324-Report-Provincial-Surgical-Backlog-Taskforce.pdf

Meo, N., Liao, J. M., & Reddy, A. (2020). Hospitalized after medical readiness for discharge: A multidisciplinary quality improvement initiative to identify discharge barriers in general medicine patients. *American Journal of Medical Quality*, *35*(1), 23–28. https://doi.org/10.1177/1062860619846559

Professional Practice Network of Ontario. (2022). *Discharge planning pathway: Assisting patients in returning home.* https://www.ppno.ca/wp-content/uploads/2022/01/Discharge-Planning-Pathway.pdf

University of Toronto. (2024). *Hospital discharge planning for older adults: An online workshop for healthcare & other professionals.* https://aging.utoronto.ca/events/workshops/hospital-discharge-planning-for-older-adults/

Zarovska, A., Evangelista, A., Boccia, T., Ciccone, G., Coggiola, D., Scarmozzino, A., & Corsi, D. (2018). Development and validation of a simplified BRASS index to screen hospital patients needing personalized discharge planning. *Journal of General Internal Medicine*, *33*(7), 1084–1091. https://doi.org/10.1007/s11606-018-4405-y

Appendix: Health Research Ethics Authority (HREA) Screening Tool

Student Name: Deanna Clarke

Title of Practicum Project: Development of a Flow Map to Support Discharge Planning from Acute Hospital Services in NLHS-Western Zone.

Date Checklist Completed: May 30, 2024

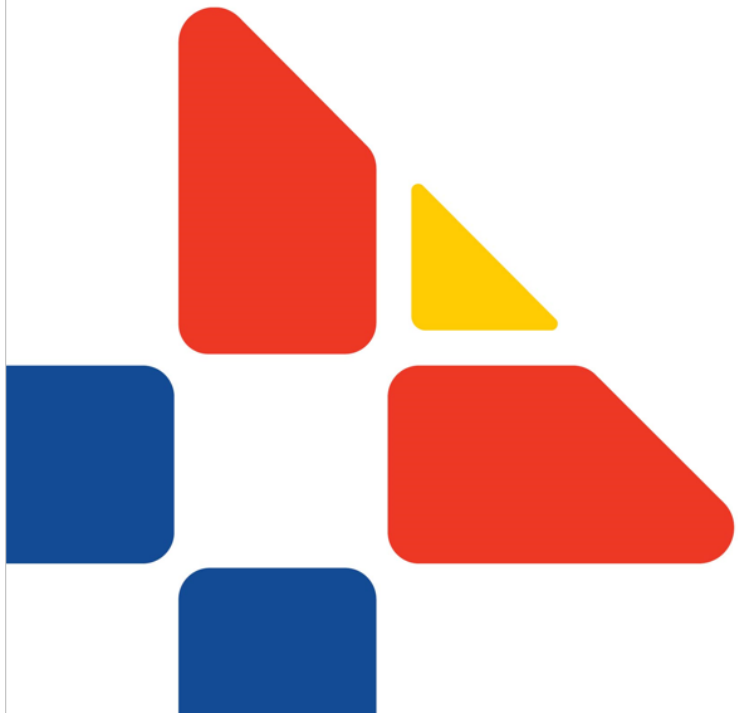
This project is exempt from Health Research Ethics Board approval because it matches item number __3_____ from the list below.

1. Research that relies exclusively on publicly available information when the information is legally accessible to the public and appropriately protected by law; or the information is publicly accessible and there is no reasonable expectation of privacy.
2. Research involving naturalistic observation in public places (where it does not involve any intervention staged by the researcher, or direct interaction with the individual or groups; individuals or groups targeted for observation have no reasonable expectation of privacy; and any dissemination of research results does not allow identification of specific individuals).
3. Quality assurance and quality improvement studies, program evaluation activities, performance reviews, and testing within normal educational requirements if there is no research question involved (used exclusively for assessment, management or improvement purposes).
4. Research based on review of published/publicly reported literature.
5. Research exclusively involving secondary use of anonymous information or anonymous human biological materials, so long as the process of data linkage or recording or dissemination of results does not generate identifiable information.
6. Research based solely on the researcher's personal reflections and self-observation (e.g. auto-ethnography).
7. Case reports.
8. Creative practice activities (where an artist makes or interprets a work or works of art).

For more information please visit the Health Research Ethics Authority (HREA) at https://rpresources.mun.ca/triage/is-your-project-exempt-from-review/

Appendix D

Discharge Planning Resource

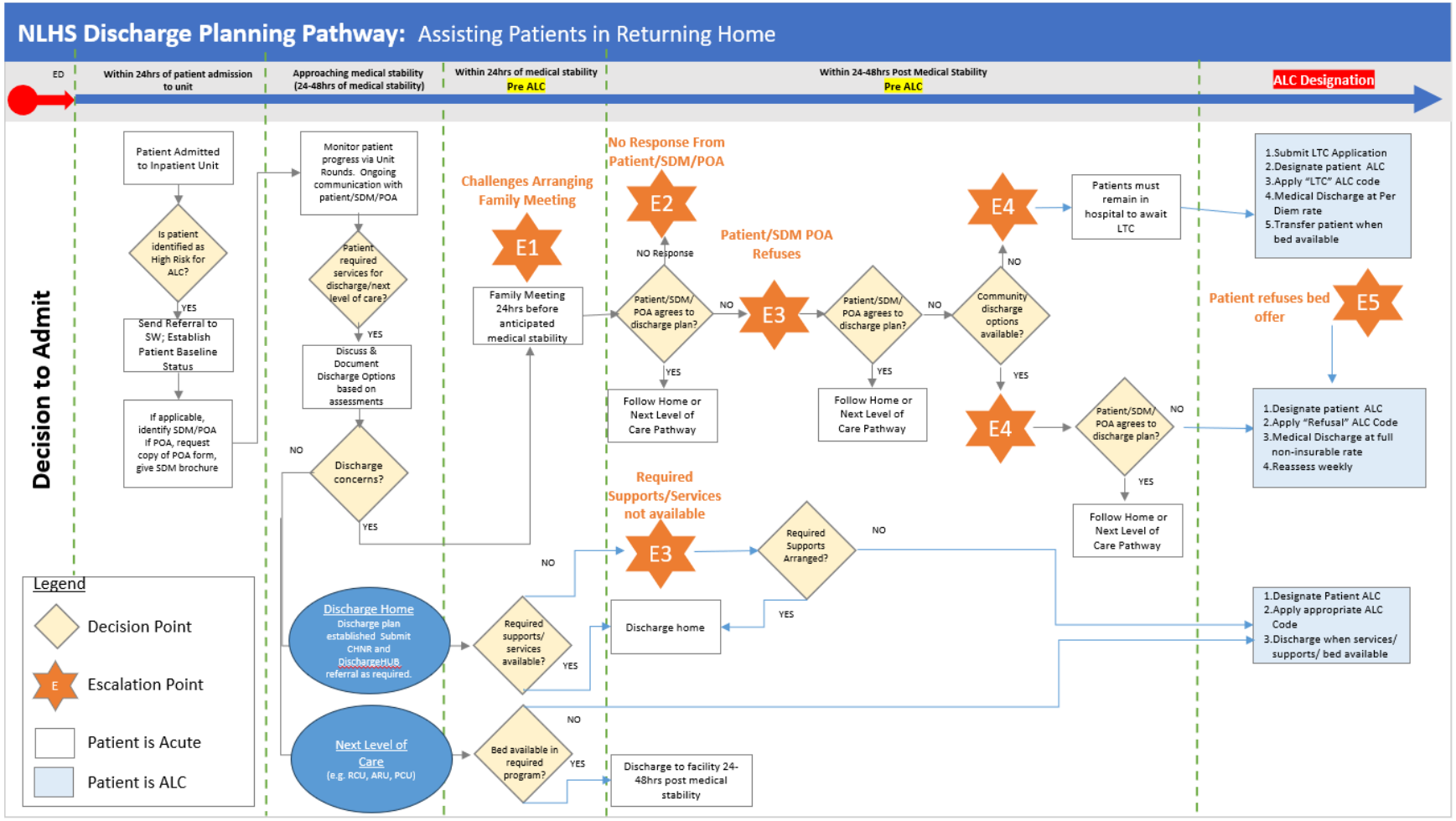


NL Health Services

Discharge Planning Pathway:

A standardized approach to assist patients in returning home

September 2024


NLHS Discharge Planning Pathway: Assisting Patients in Returning Home
ED
Within 24hrs of patient admission to unit
Approaching medical stability (24-48hrs of medical stability)
Within 24hrs of medical stability
Pre ALC
Within 24-48hrs Post Medical Stability
Pre ALC
ALC Designation
Decision to Admit
Patient Admitted to Inpatient Unit
Is patient identified as High Risk for ALC?
YES
Send Referral to SW; Establish Patient Baseline Status
If applicable, identify SDM/POA If POA, request copy of POA form, give SDM brochure
Monitor patient progress via Unit Rounds. Ongoing communication with patient/SDM/POA
Patient required services for discharge/next level of care?
YES
Discuss & Document Discharge Options based on assessments
Discharge concerns?
NO
YES
Challenges Arranging Family Meeting
E1
Family Meeting 24hrs before anticipated medical stability
No Response From Patient/SDM/POA
E2
NO Response
Patient/SDM/ POA agrees to discharge plan?
NO
YES
Follow Home or Next Level of Care Pathway
Patient/SDM POA Refuses
E3
Patient/SDM/ POA agrees to discharge plan?
NO
YES
Follow Home or Next Level of Care Pathway
E4
Community discharge options available?
NO
YES
Patients must remain in hospital to await LTC
E4
Patient/SDM/ POA agrees to discharge plan?
NO
YES
Follow Home or Next Level of Care Pathway
1.Submit LTC Application
2.Designate patient ALC
3.Apply "LTC" ALC code
4.Medical Discharge at Per Diem rate
5.Transfer patient when bed available
Patient refuses bed offer
E5
1.Designate patient ALC
2.Apply "Refusal" ALC Code
3.Medical Discharge at full non-insurable rate
4.Reassess weekly
Required Supports/Services not available
E3
Required Supports Arranged?
NO
YES
Discharge home
Discharge Home
Discharge plan established Submit CHNR and DischargeHUB referral as required.
Required supports/ services available?
NO
YES
Next Level of Care
(e.g. RCU, ARU, PCU)
Bed available in required program?
NO
YES
Discharge to facility 24-48hrs post medical stability
1.Designate Patient ALC
2.Apply appropriate ALC Code
3.Discharge when services/ supports/ bed available
Legend
Decision Point
E
Escalation Point
Patient is Acute
Patient is ALC

Discharge Planning Risk Assessment

- Completed by the primary nurse during admission assessment
  - For patients that score ≥11 and are identified at risk for discharge; automatically generates a referral to social work for complex discharge planning

Risk Assessment Tool: Blaylock

Blaylock Discharge Planning
Risk Assessment Screen

Circle all that apply and total. Refer to scoring index for recommendations regarding discharge planning.

Age	55 years or less	0	Functional Status	Independent in activities of daily living and instrumental activities of daily living	0
	56 - 64 years	1		**Dependent in**	
	65 - 79 years	2		Eating / Feeding	1
	80+ years	3		Bathing / Grooming	1
Living Situation/ Social Support	Lives only with spouse	0		Toileting	1
	Lives with family	1		Transferring	1
	Lives alone with family support	2		Incontinent of bowel function	1
	Lives alone with friend's support	3		Incontinent of bladder function	1
	Lives alone with no support	4		Meal Preparation	1
	Nursing home / residential care	5		Responsible for own medication administration	1
Number of Previous Admissions / Emergency Room Visits	None in the last 3 months	0		Handling own finances	1
	One in the last 3 months	1		Grocery Shopping	1
	Two in the last 3 months	2		Transportation	1
	More than two in the last 3 months	3	Behaviour Pattern	Appropriate	0
Number of Active Medical Problems	Up to three medical problems	0		Wandering	1
	Three to five medical problems	1		Agitated	1
	More than five medical problems	2		Confused	1
Number of Drugs	Fewer than three drugs	0		Other	1
	Three to five drugs	1	Mobility	Ambulatory	0
	More than five drugs	2		Ambulatory with mechanical assistance	1
Cognition	Oriented	0		Ambulatory with human assistance	2
	Disoriented to some spheres (person, place, self, time) some of the time	1		Non ambulatory	3
	Disoriented to some spheres (person, place, self, time) all of the time	2	Sensory Deficits	None	0
	Disoriented to all spheres (person, place, self, time) and some of the time	3		Visual or hearing deficits	1
	Disoriented to all spheres (person, place, self, time) all of the time	4		Visual and hearing deficits	2
	Comatose	5			

Total Score	Signature	Date *(yyyy-Mon-dd)*

Scoring Index		
0 - 10	At risk for home care services	
11 - 19	At risk for discharge planning	
20+	At risk for placement other than home	

Family Meeting, team approach

Discharge Planning Meeting includes Patient/family, Most Responsible Provider (MRP), Discharge Planner (DP), and other appropriate team members to plan a supportive discharge, answer questions, and minimize delays and gaps in communication

**Arrange a family meeting while patient is acute, at least 24hrs before medical stability (patient is not ALC)*

Assumptions:

- Initial Assessment (i.e RAI) has been completed to determine patient care needs
- Discussion regarding discharge options has occurred

Guidelines:

- **Team Approach**: discharge planning meeting with MRP, DP, and other, and appropriate members of the patient's health care team allows patient and family to receive answers to questions minimizing back and forth
- **Consistent messaging**
- **Upfront understanding** to ensure discharge plan and services offered are aligned with patients needs
- **Safe transition from hospital to community**

Outcomes:

1. Patient agrees ⇨ Discharge patient
2. Patient disagrees ⇨ Reinforce discharge plan.
3. Patient still refuses ⇨ **Escalate E3**
4. Plan for discharge to community not viable at this time and patient needs to wait in Hospital for Long Term Care ⇨ **Escalate to E3**

Long-Term Care Process

Some patients may be permitted to wait in hospital for a short period of time for Long Term Care
During their stay they will be reassessed to determine if they are eligible for discharge home

Assumptions:

- RAI assessment has been completed and indicates a Level of Care ≥3
- Family Meeting has occurred; Care team have met with patient and family together
- Escalation E3 has occurred
- Escalation E4 has occurred; a complex case review has occurred. Program Director & RD Operational Flow has approved patient to temporarily wait in hospital

LTC Process:

Discharge Planner and Unit Manager meet with patient/SDM/POA

1. **Discharge Planner:** Provide LTC Application consent form, discuss hospital policy regarding medical discharge co-payment, geographical zones, and refusal of bed offer. Document that information was given and Patient/SDM/POA signed or refused to sign. Place form on patient's chart
2. **HCC:** Proceed with placement application
3. **Change to Medical Discharge:** Upon confirmation of LTC approval, DP changes status to Medically Discharge; co-payment begins

LTC Approval (within 5 days):

If Assessment and Placement Coordinator does not provide acceptance/rejection within 5 days, the DP escalates to unit manager for follow up with LTC manager

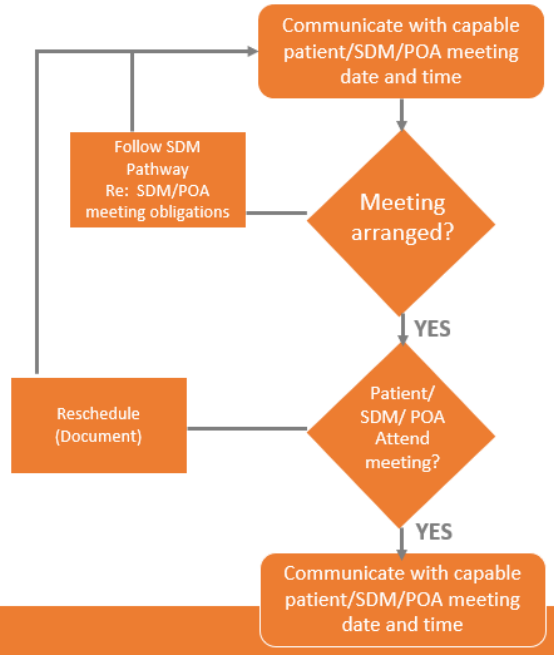
Patient Reassessment:

DP to reassess patient to determine if their condition has improved and are eligible to return to community on a weekly basis

Patient refuses bed offer –refer to E5

Escalation E1

Escalation	Resources	Summary	Timeframe
E1	1. DP 2. Unit Manager	Challenges arranging Family Meeting with SDM/POA	24-48hrs



- Follow Process Diagram
- Ensure SDM/POA has received SDM/POA brochure
- Inform SDM/POA of their responsibility

Refer to next slides for scenario's below

1. No reply from SDM/POA
2. SDM/POA schedules meetings but does not attend

- Refer to SDM/POA pathway for more information

Escalation E1

Escalation	Resources	Summary	Timeframe
E1	1. DP 2. Unit Manager	Challenges arranging Family Meeting with SDM/POA	24-48hrs

1. <u>No reply from SDM/POA</u>

- Make 3 attempts to contact SDM/POA; document each attempt
- 3 attempts are necessary before moving to the next SDM/POA or PG&T
- Refer to SDM/POA pathway for more information

Process

- Day 1 –Attempt 1 (leave voicemail and document)
- Day 2 –Attempt 2 (leave voicemail and document)
  - Inform SDM/POA that one more attempt will be made tomorrow, if they do not reply and co-operate in the discharge plan, we will move onto the next SDM/POA or PG&T as per Section 10 of the Advance Health Care Directives Act
  - Inform Unit Manager
- Day 3 –Final Attempt (leave voicemail and document)
  - Inform SDM/POA that this was the final attempt, we will be moving onto the next SDM/POA or PG&T as per Section 10 of the Advance Health Care Directives Act
  - Inform Unit Manager

Escalation E1

Escalation	Resources	Summary	Timeframe
E1	1. DP 2. Unit Manager	Challenges arranging Family Meeting with SDM/POA	24-48hrs

2. <u>SDM/POA Schedules Meeting but does not attend</u>

- Make 3 attempts to meet with SDM/POA; document each attempt
- 3 attempts are necessary before moving to the next SDM/POA or PG&T
- Refer to SDM/POA pathway for more information

Process

- Day 1 –Meeting 1 (call to arrange meeting next day and document)
- Day 2 –Meeting 2 (call to arrange meeting next day and document)
  - Inform SDM/POA that one more attempt will be made tomorrow, if they do not attend and co-operate in the discharge plan, we will move onto the next SDM/POA or PG&T as per Section 10 of the Advance Health Care Directives Act
  - Inform Unit Manager
- Day 3 –Final Meeting (call to arrange meeting next day and document)
  - Inform SDM/POA that this was the final attempt to meet and we will be moving onto the next SDM/POA or PG&T as per Section 10 of the Advance Health Care Directives Act
  - Inform Unit Manager

Escalation E2

Escalation	Resources	Summary	Timeframe
E2	1. DP 2. Unit Manager 3. CS Manager 4. HCC Manager	No response from patient/SDM/POA for consent/refusal of discharge plan	24-48hrs

No Response from Capable Patient

- Discharge Planner to obtain consent/refusal to discharge plan from patient within 24hrs
- Escalate to Unit Manager if patient does not provide a response
- Unit Manager may consult Hospital and Clinical Care and Community Support Managers to inquire about additional services to facilitate discharge
- Unit Manager to reinforce importance of discharge plan with patient
- Escalate to E3 if patient does not provide a response within 24hrs

No Response from SDM/POA

- Follow SDM/POA pathway if no response from SDM/POA

Escalation E3

Escalation	Resources	Summary	Timeframe
E3	1. DP 2. Unit Manager 3. HF/CS Manager	1. Patient/SDM/POA refuses discharge plan 2. Plan for discharge home not viable at this time and patient currently needs to wait in Hospital for Long-Term Care	24-48hrs

1. Patient/SDM/POA refuses discharge plan or Capable Patient does not respond

- Assumptions:
  - DP and team members met with patient to accept discharge plan (within 24hrs)
  - DP escalated to Unit Manager.
  - DP and Unit Manager meet with patient to accept discharge plan (within 24hrs)
- If patient/SDM/POA refuses, unit manager to request complex case review
- If no resolution, Unit manager Escalate to E4

2. Plan for discharge home not viable at this time and patient currently needs to wait in Hospital for Long Term Care

- Assumptions:
  - RAI Assessment has been completed and patient deemed Level of Care ≥3
  - Home First options have been explored and exhausted in collaboration with Community Support Managers
- Unit Manager Escalate to E4

Escalation E4

Escalation	Resources	Summary	Timeframe
E4	1. Program Director 2. RD Operational Flow 3. RD Community Supports	• Following E3, if patient **(A)** refuses discharge plan, or **(B)** plan for discharge is not viable at this time and patient needs to wait in hospital for Long Term Care • Program Director to explore options below	24hrs

Patient/SDM/POA refuses recommended discharge plan to await LTC

- Program Director consults with RD Operational Flow and RD Community Supports to discuss case and verify eligibility for discharge
- Give refusal of discharge letter (give to patient/SDM/POA or send through registered mail)
- Patient no longer eligible for per diem rate. Full uninsured hospital rates will apply

Program Director determines discharge home is not viable at this time and patient needs to wait in hospital for Long Term Care

- Manager to complete escalation paperwork for ALC to LTC wait in hospital. Once signed by VP, approve patient to temporarily wait in hospital for Long Term Care with the expectation that they will be reassessed to revisit their discharge home if their condition improves
- Start co-payment and give per diem rate letter, discuss hospital policy regarding refusal of bed offer
- Document and scan letter into chart

Escalation E5

Escalation	Resources	Summary	Timeframe
E5	1. Assessment & Placement Coordinator 2. Unit Manager 3. Manager HCC 4. Program Director 5. RD Operational Flow	• Patient refuses bed offer	24hrs

Refusal of LTC Bed or No Response to Offer

1. Assessment & Placement Coordinator informs patient of refusal of bed policy
2. Assessment & Placement Coordinator informs unit manager & HCC manager
3. Unit Manager notifies patient/SDM/POA of responsibility to arrange discharge within 48 hrs as per policy
4. Unit Manager notifies Program Director
5. Program Director informs Senior Director of Hospital and Clinical Care
6. If patient remains in hospital past the allotted 48 hrs, patient/SDM/POA issued notification via letter or through registered main that per diem rate no longer applicable and full uninsured daily hospital rates will be charged.

Appendix E

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Clarke, Deanna (Patient Services)

From: Barney, Rebecca <BarneyR@rvh.on.ca>
Sent: Thursday, October 3, 2024 12:57 PM
To: Clarke, Deanna (Patient Services)
Subject: RE: Discharge Planning Pathways

Hi Deanna,

Happy to provide you with permission to adapt our document into your studies and your role as director.

Look forward to continued collaboration.

Rebecca Barney
(she,her,hers)
Operations Director|Patient Flow
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NOTE * if you are reporting an absence please click here

From: Clarke, Deanna (Patient Services) <Deanna.Clarke@westernhealth.nl.ca>
Sent: Thursday, October 3, 2024 11:21
To: Barney, Rebecca <BarneyR@rvh.on.ca>
Subject: Discharge Planning Pathways

Hello Ms. Barney

Thank you for accepting my phone call to discuss the Discharge Planning Pathway currently being used by the Royal Victoria Regional Health Center. As outlined in our discussion, I am the Regional Director of Operational Flow for NL Health Services – Western Zone, with a significant focus on ALC reduction. I am also enrolled in the Masters of Science in Nursing program at Memorial University of Newfoundland. As part of my studies, I will complete a practicum project on discharge planning for the older adult ALC population in Western Newfoundland. Upon reviewing your pathway, I am seeking permission to adapt your document to an NL context while maintaining the overall integrity of the original document. Since this pathway is applicable to both my studies and my role within NL Health Services, I plan to use the modified document to support my practicum project and my provincial work with ALC reduction.

I appreciate your support thus far and look forward to continued collaboration and information sharing as we strive for quality care and improved patient flow.

Sincerely,

Deanna Clarke

NL Health Services

Deanna Clarke BN, RN
Regional Director of Operational Flow
NL Health Services – Western Zone
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