

DISCHARGE PLANNING GUIDELINES FOR INPATIENT REHABILITATION

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

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

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

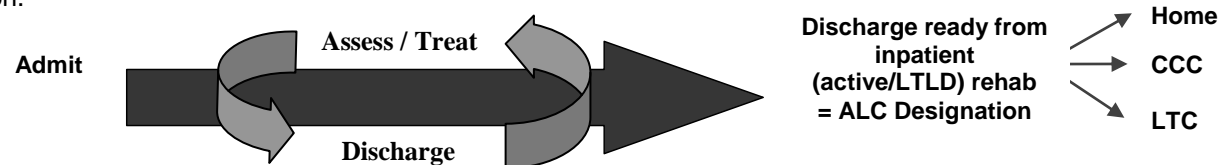
Discharge Planning Guiding Principles and Standards

Guiding Principles

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

Standards

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



SECTION 1: NEW WORKING DEFINITION OF ALC¹ IN REHAB FOR REGULAR STREAM AND LOW TOLERANCE LONG DURATION/SLOW STREAM REHAB

IMPLEMENTATION OF THE NEW ALC IN REHAB DEFINITION²:

A new working definition³ of ALC in Rehab has been approved by the GTA Rehab Network's Coordinating Council for implementation across its Network member organizations. The use of this new working definition, developed by the Network's Patient Access and Flow Committee, will support consistency in the tracking of ALC patients in rehab across organizations.

This working definition applies to:

1. Regular stream rehab provided in designated rehab beds and
2. Low tolerance long duration/slow stream rehab, typically provided in complex continuing care beds.

WORKING DEFINITION OF ALC IN REHAB FOR REGULAR STREAM AND LOW TOLERANCE LONG DURATION/SLOW STREAM REHAB

The working definition includes the following 3 components:

1. An ALC patient in rehab:

- a) Has completed the inpatient phase of his/her rehabilitation based on the following criteria:
 - Rehab goals have been met as documented in the plan of care by the interprofessional team or
 - Progress has reached a plateau or
 - Current level of care is not required/suitable (e.g. 24 hour nursing care is not required or amount/intensity of rehab is not appropriate) or
 - Patient is no longer able or willing to participate in the current level of rehab
- b) Remains in an inpatient rehab/CCC bed in a regular stream or low tolerance long duration rehab program while awaiting transfer to an alternate level of care (e.g. LTC; Complex Continuing Care; supportive housing; home with appropriate services/modifications/equipment; different level of rehab intensity).

2. ALC Formula for calculation of ALC days:

ALC in Rehab = Actual Discharge Date minus Actual Date Ready for Discharge*

*Calculation of ALC days should be based on actual not projected dates.

3. Processes involved in ALC Designation:

- Designation of ALC is a team process with physician involvement. While the patient/family is informed about the designation, the ultimate decision regarding ALC designation is team/physician based.
- Following the team discussion and decision, a physician order is required to designate the patient as ALC.
- Once a patient is designated as ALC, the level of rehab services provided will be, at a minimum, equivalent to the level that will be provided in the alternate level of care to which the patient has applied and that the patient is able to tolerate.

Note: Formal recognition of an ALC in rehab designation may require organizations to consider policies and practices related to co-payment for patients designated ALC in rehab. The Ministry of Health and Long Term Care's position is not entirely clear and is currently being investigated.

¹ Alternate Level of Care

² Date of implementation: October 1, 2008

³ There will be an opportunity for feedback on the definition in six months following implementation.

SECTION 2: DISCHARGE READINESS INDICATORS

Patients whose medical and functional status has <u>improved</u> in inpatient rehab are ready for discharge to the community when...					
<p>Considerations for current care needs</p>	<p><u>Medical Stability:</u></p> <ul style="list-style-type: none"> ✓ Vital signs stable and ✓ Hemodynamically stable and ✓ Lab work within accepted ranges and ✓ All necessary/urgent medical consults and tests have been performed and ✓ Pain is well-controlled (e.g. patient is able to manage pain independently or with the assistance of a pain management clinic) and ✓ Established and managed bowel & bladder routine and ✓ Established medication management and practices and <p><u>Nursing/MD Requirements:</u></p> <ul style="list-style-type: none"> ✓ 24 hour specialized skill nursing care is not required and ✓ On-site access to MD is not required and ✓ Patient may or may not require home-based nursing (e.g. wound care, IV) or other health professional services 	<p><u>Suggested measurement tools:</u></p> <ul style="list-style-type: none"> ▪ Vital Signs: As determined by MD ▪ Lab Work: Completed before discharge and ongoing requirements for lab work can be met in the community ▪ Pain Management: As determined by established pain management scales (e.g. Visual Analog Scale, Numerical Rating Scale) (See Appendix A and B) ▪ Patient/caregiver/family demonstrates effective management of bowel & bladder routine ▪ Patient/caregiver/family demonstrates effective medication management 			
<p>and</p>	<p><u>Rehab Goal Attainment:</u>⁵</p> <ul style="list-style-type: none"> ✓ Identified rehab goals for the inpatient setting have been met such that the inpatient setting is no longer required and <p><u>Rehab Potential:</u></p> <ul style="list-style-type: none"> ✓ Additional progress can be achieved independently or with the assistance of a caregiver at home or ✓ Patient's rehab potential can be further maximized through community-based rehabilitation such that: <p><u>Functional Level:</u></p> <ul style="list-style-type: none"> ✓ Patient is independent (or able to function with the assistance of a caregiver) in the areas below or ✓ Patient requires in-home rehabilitation (if home-bound) or outpatient/ambulatory rehab to maximize independence in one or more of the areas listed below <table style="width: 100%; border: none;"> <tr> <td style="vertical-align: top;"> <ul style="list-style-type: none"> ✓ <u>Activities of Daily Living:</u> <ul style="list-style-type: none"> ▪ Toileting ▪ Bathing ▪ Dressing ▪ Instrumental ADLs </td> <td style="vertical-align: top;"> <ul style="list-style-type: none"> ✓ <u>Cognition/Communication</u> <ul style="list-style-type: none"> ▪ Memory ▪ Insight/Judgment ▪ Communication ✓ <u>Mobility:</u> <ul style="list-style-type: none"> ▪ Transfers ▪ Mobility +/- mobility aid </td> <td style="vertical-align: top;"> <ul style="list-style-type: none"> ✓ <u>Other Areas:</u> <ul style="list-style-type: none"> ▪ Vocational / avocational activities ▪ Psychosocial functioning </td> </tr> </table>	<ul style="list-style-type: none"> ✓ <u>Activities of Daily Living:</u> <ul style="list-style-type: none"> ▪ Toileting ▪ Bathing ▪ Dressing ▪ Instrumental ADLs 	<ul style="list-style-type: none"> ✓ <u>Cognition/Communication</u> <ul style="list-style-type: none"> ▪ Memory ▪ Insight/Judgment ▪ Communication ✓ <u>Mobility:</u> <ul style="list-style-type: none"> ▪ Transfers ▪ Mobility +/- mobility aid 	<ul style="list-style-type: none"> ✓ <u>Other Areas:</u> <ul style="list-style-type: none"> ▪ Vocational / avocational activities ▪ Psychosocial functioning 	<p><u>Suggested measurement tools:</u></p> <ul style="list-style-type: none"> ▪ Goal attainment scale or patient satisfaction rating of goal attainment (e.g. See Appendix C) may be utilized by specific rehab programs ▪ Functional Level Assessment: FIM™ (NRS) score within range of patient's goals. ▪ Continuing Care Reporting System (MDS) ▪ Cognition/communication Assessment: Cognition as assessed by Mini Mental State Examination (MMSE) ▪ Other areas assessed as per progress notes and achievement of goals including recreation therapy and psychometric testing ▪ Some rehab goals are better suited to an out-patient setting (e.g. Vocational training; community reintegration; Driver evaluation)
<ul style="list-style-type: none"> ✓ <u>Activities of Daily Living:</u> <ul style="list-style-type: none"> ▪ Toileting ▪ Bathing ▪ Dressing ▪ Instrumental ADLs 	<ul style="list-style-type: none"> ✓ <u>Cognition/Communication</u> <ul style="list-style-type: none"> ▪ Memory ▪ Insight/Judgment ▪ Communication ✓ <u>Mobility:</u> <ul style="list-style-type: none"> ▪ Transfers ▪ Mobility +/- mobility aid 	<ul style="list-style-type: none"> ✓ <u>Other Areas:</u> <ul style="list-style-type: none"> ▪ Vocational / avocational activities ▪ Psychosocial functioning 			



ALC DESIGNATION⁴



⁴ The patient is designated as ALC if s/he is ready for discharge but is awaiting transfer to discharge destination (e.g. supportive housing; home with appropriate services/modifications/equipment)

⁵ Throughout this document, the identification of goals refers to a collaborative process between the patient/family and team. The identified goals are documented in the plan of care by the interprofessional team.

SECTION 2: DISCHARGE READINESS INDICATORS (cont'd)



Patients whose medical and functional status have <u>remained the same, changed minimally or declined</u> in inpatient rehab are ready for discharge to Long Term Care (LTC) or Complex Continuing Care (CCC) when...			
	Patients requiring referral to LTC	Patients requiring referral to CCC	
<p>Considerations re: current care needs</p>	<p><u>Medical Stability:</u></p> <ul style="list-style-type: none"> ✓ Vital signs stable and ✓ Hemodynamically stable and ✓ Lab work within accepted ranges and ✓ All necessary/urgent medical consults and tests have been performed or may be carried out on an outpatient basis and ✓ Patient requires a residential setting with 24 hour supervision and on-site nursing care to assist with self-care and other care needs and ✓ On-site access to MD is required for weekly monitoring 	<p><u>Medical Stability:</u></p> <ul style="list-style-type: none"> ✓ Vital signs stable and ✓ Hemodynamically stable but may require regular diagnostic monitoring and ✓ All necessary/urgent medical consults and tests have been performed or may be carried out on an outpatient basis and ✓ Patient requires 24 hour specialized skilled nursing care and 24 hour access to physician care and ✓ Care needs cannot be met in LTC 	<p><u>Suggested measurement tools:</u></p> <ul style="list-style-type: none"> ▪ Vital Signs: As determined by MD ▪ Lab Work: Completed before discharge ▪ For analysis of resource requirements, use such tools as FIM™ (NRS) and Continuing Care Reporting System (MDS)
<p>and</p> <p>Considerations re: rehab goals, rehab potential and functional status</p>	<p><u>Rehab Goal Attainment:</u></p> <ul style="list-style-type: none"> ✓ The identified goals for inpatient rehab have been met or the patient's functional status has plateaued and <p><u>Rehab Potential:</u></p> <ul style="list-style-type: none"> ✓ Patient is not demonstrating any significant progress towards making further gains but may have the potential to make minimal gains over time which could be achieved in LTC and <p><u>Functional Level:</u></p> <ul style="list-style-type: none"> ✓ None of the publicly-funded community services and none of the caregiving, support or companionship arrangements in the patient's home can meet the patient's functional and care needs.⁷ 	<p><u>Rehab Goal Attainment:</u></p> <ul style="list-style-type: none"> ✓ Patient has not sufficiently met their inpatient rehab goals for return home or discharge to LTC and <p><u>Rehab Potential:</u></p> <ul style="list-style-type: none"> ✓ Rehab potential cannot be met because of patient's medical condition/needs and <p><u>Functional Level:</u></p> <ul style="list-style-type: none"> ✓ Patient's current functional status precludes his/her capacity to demonstrate significant progress towards the achievement of those rehab goals 	<p><u>Suggested measurement tools:</u></p> <ul style="list-style-type: none"> ▪ Goal attainment scale or patient satisfaction rating of goal attainment (e.g. See Appendix C) ▪ Functional Level Assessment: FIM™ⁱ score within range of patient's goals. ▪ Cognition/communication Assessment: Cognition as assessed by Mini Mental State Examination (MMSE) ▪ Other areas assessed as per progress notes and achievement of goals including recreation therapy and psychometric testing ▪ If progress has plateaued in active rehab, there has been no or minimal gains seen in patients who have been medically stable and able to participate in rehab <u>over 2 weeks of observation</u> or ▪ If progress has plateaued in LTLD rehab, there has been no or minimal gains seen in patients who have been medically stable and able to participate in rehab <u>over 4 weeks of observation</u>

ALC DESIGNATION⁶

⁶ The patient is designated as ALC if s/he is ready for discharge but is awaiting transfer to discharge destination (e.g. LTC, CCC)

⁷ Nursing Home Act, Government of Ontario

SECTION 3: DISCHARGE PLANNING CONSIDERATIONS

 To be considered from date of admission through inpatient rehab stay 	
Identification of Goals	<ul style="list-style-type: none"> ✓ The identification of rehab goals takes into account that rehabilitation can continue throughout the care continuum and as such, rehab goals specific to the inpatient setting are identified through a collaborative process with the patient/family ✓ The process of identifying rehab goals includes education to the patient/family to promote realistic expectations for the inpatient setting ✓ The identified goals should be specific, individualized and meaningful to the patient, measurable, attainable, realistic and timely and should also include a description of what the patient's behaviour will be when the goal is achieved. ✓ The identified goals are documented in the plan of care by the interprofessional team
Community Resources	<p>If services are required upon discharge:</p> <ul style="list-style-type: none"> ✓ All services/supplies required to ensure safety within the home at time of discharge are available. Team may request home safety assessment before patient goes home. ✓ If services are not available within the home community or start of services will be delayed due to lengthy wait lists, alternate services to be considered in the interim (e.g. referral to CCAC services, private services). ✓ Follow-up appointments arranged ✓ If patient is referred to outpatient/ambulatory rehab, determine if patient has transportation to / from outpatient / ambulatory clinic and, if required, caregiver accompaniment for treatment sessions (e.g. patient requires assistance with toileting or other supervision) ✓ If patient requires dialysis, then dialysis is arranged and/or transportation to dialysis is arranged
Patient / Family / Home situation	<ul style="list-style-type: none"> ✓ Patient/family has participated in and has been informed of discharge plan ✓ Adequate family / social support is available to support a safe discharge home ✓ Caregiver/family is aware of post-discharge appointments and/or other services needed ✓ Caregiver is able to provide some assistance with self-care and instrumental needs if required ✓ If needed, the home environment has been modified / adapted to accommodate the patient's functional status and to reduce safety risks. These may include: <ul style="list-style-type: none"> ▪ Ramps, handrails, raised toilet seat, assisted devices if applicable, equipment arranged (rented by patient/family) <p style="margin-left: 40px;">Note: Where major modifications are required, recommendations have been made and the timeframe for implementation has been negotiated</p> <p>For patients discharged to CCC or LTC:</p> <ul style="list-style-type: none"> ✓ Complex care co-payment fees and LTC fees have been discussed with the patient/family ✓ Patients and families are informed that discharge from CCC will be discussed if the patient's medical situation requires less intensive care which can be managed in a LTC home.

Visual Analogue Scale

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

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

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

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

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

No Pain _____ Very severe pain

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

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

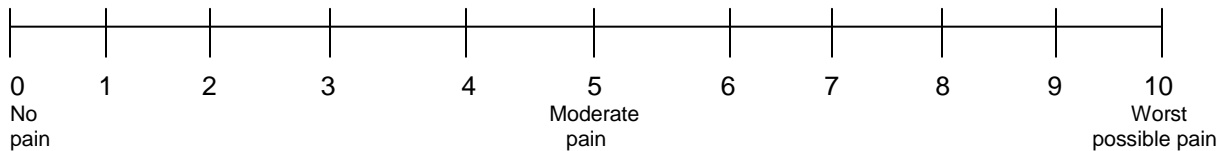
NICOLA CRICHTON

Numerical Rating Scale

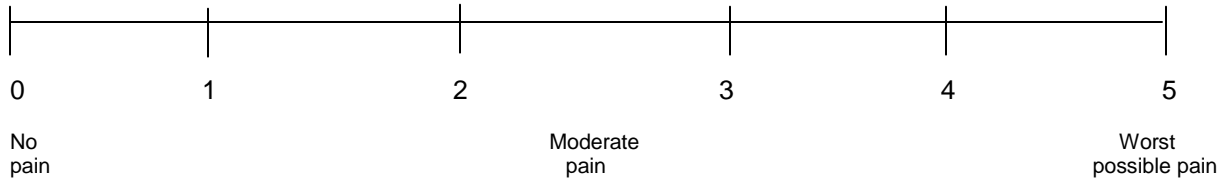
Instructions: Show the pain scale to the resident. Verbally read the scale to the resident and wait for a reply. On the 0-10 pain rating scale, 0 means no pain and 10 means the worst pain possible. The middle of the scale around 5 is moderate pain. A 2 or 3 would be mild pain, but 7 and higher is severe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

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

0-10 Numerical Rating Scale



0-5 Numerical Rating Scale



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

Goal Coordinator:

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

SMART Short Term Goals

Outcome at Completion

S=Specific M=Measureable A=Achievable R=Relevant T=Timely N=Not achieved P=Partially achieved A=Achieved E=Exceeded DC=Discontinued

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

Patient's Satisfaction with Performance towards overall patient goal (initial each score)

Date														
Outcome														
Extremely satisfied 10 9 8 7 6 5 4 3 2 1 Not satisfied at all														

Review Dates & Outcomes towards overall patient goal (initial each outcome) (OPTIONAL)

Date														
Outcome														
N=Not achieved P=Partially achieved A=Achieved E=Exceeded DC=Discontinued														
*For final patient goal outcome of N or P, record reason on Discharge Summary Goal Attainment Outcome form														

Short Term Goal Attainment Outcome Collation (OPTIONAL)

Total # of Short Term Goal Outcomes	N	P	A	E	DC
Total # of Short Term Goals					

Signature: _____ Initial _____ Signature _____ Initial _____

ENDNOTES

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