

Getting Ready for Discharge

This brochure describes how the health care team helps you and your family plan for your discharge from the hospital.

When does the discharge planning begin?

Planning for your discharge begins when you are admitted to the hospital. During your hospital stay, members of the health care team work with you to:

- identify your care needs
- set goals for your care and
- make plans for when you can leave the hospital

When will I be discharged?

When you are in the hospital we provide the acute care services you need. When you reach the goals for your care or your doctor and health care team decide that you no longer need acute care, you are discharged. There are many plans for discharge based on your needs:

- discharge home if you live at home
 - discharge to the care facility where you live
 - discharge to another care facility
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Discharge home if you live at home

If you live at home, getting you back home safely is our goal. If you need support to return home, staff from the Community Care Access Centre (CCAC) helps with these plans. You may be eligible for services such as Meals-on-Wheels and/or nursing and personal care. You may have to pay for some of these services.

Discharge to the care facility where you live

If you came to this hospital from another care facility, members of our health care team help you transfer back there.

Discharge to another care facility

If you lived at home or a care facility but your needs can no longer be met there, you may need to go to another place. There are many choices in this region.

Here are the types of places you may go:

- **Rehabilitation Unit or Facility:** Provides nursing care, physical therapy and occupational therapy services based on goals set by you and your health care team. There is a set amount of time for rehabilitation. The goal for your rehabilitation program is to help you return safely to where you lived before you came to the hospital.
 - **Convalescent Care Facility:** Provides 24 hour nursing care, rehabilitation therapy and medical care in a supportive environment. The goal is to help you return safely to where you lived before you came to the hospital within 90 days. Most people in this type of program stay 30 to 45 days. In this region, you may go to:
 - Shalom Village and Dundurn Place (Hamilton)
 - Linhaven (Niagara)
 - Post Inn Village (Oakville)
 - **Assess and Restore Program:** Assesses you for the level of care or services you need to help you return safely to where you lived before you came to the hospital. You and your health care team set rehabilitation goals that can you can reach within 90 days. In this region, you may go to:
 - Wellington Park Long Term Care-“Back to Home” program (Burlington)
 - Niagara Health System - General Site (Niagara Falls)
 - St. Joseph’s Villa (Dundas)
 - Haldimand War Memorial Hospital (Haldimand)
 - Brant Community Healthcare System (Brantford)
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- **Complex Care Unit:** Provides care for you if you are medically stable but still have medically complex issues that cannot be looked after in another setting. On this type of unit, you and members of your health care team set clearly defined goals that are intended to be met within 45 to 90 days. Placement to a Complex Care Unit is arranged through the Community Care Access Centre (CCAC).
- **Retirement Home or Supportive Housing:** Provides room and board and supervision with medication. Some homes also offer personal care assistance. Many of the homes provide overnight or short stay respite care.
- **Long-Term Care Home:** Provides 24 hour nursing and personal support worker services when you have increased care needs. Placement is arranged through the Community Care Access Centre (CCAC).
- **Palliative and Hospice Care:** Provides symptom management and personal care if you are expected to live 3 months or less. In this region, you may go to:
 - Stedman Community Hospice (Brantford)
 - Carpenter House (Burlington)
 - Dr. Bob Kemp (Hamilton)
 - Emmanuel House (Hamilton)
 - Stabler Centre (St. Catherines)
 - Daval Hospice (Niagara)

How much help do I get to decide on the type of place I should go?

Our Social Worker meets with you and your family to talk about this. You will talk about the type of care you need and the best place for you. Your Social Worker will work with you and your health care team to complete the forms needed.

What if there is a waiting period?

If there is a waiting list, you may be able to go home with additional support, to wait for a bed.

If you need to wait in the hospital for a Long-Term Care or Complex Care bed, you will pay a fee (co-payment). The fee is set by the Ministry of Health and Long-Term Care each year. It will be the same basic fee you pay once at the Long Term Care or Complex Care. The Social Worker and the hospital's Finance Department will give you more information if this fee applies to you. You should know that you will need to accept the first available bed that is offered to you.

Before you leave

- Ask the doctor, nurse and members of your health care team to repeat anything you do not understand.
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- Write down your questions in advance. It can be hard to remember what you want to ask when you are in hospital. 3 questions you may want to ask are:
 - What is my main problem?
 - What do I need to do to eat healthy?
 - What do I do if I become sick again?
 - Why is it important for me to do this?
- Do not leave without having all your questions answered.
- Ask for your medication list. Make sure you understand what medications you are taking and why.
- Repeat any instructions back to your health care provider in your own words. This helps you remember what to do when you get home. It also helps the doctor, nurse and members of your health care team know that you understand. Write the answers down beside your list of questions as well.
- Make an appointment to see your family doctor or health care provider soon after discharge from hospital.
- Tell your nurse if:
 - you are still not sure about what the doctor said
 - you need help making an appointment with a specialist
 - you need a referral to Community Care Access Centre (CCAC) for arranging homecare, obtaining special equipment, such as a cane, wheelchair, walker and commode
 - you have any other concerns

Community Resources:

Hamilton Niagara Haldimand Brant (HNHB) Community Care Access Centre (CCAC)

- 905-639-5228 or 1-800-810-0000

Regional Geriatric Program-Central Older Adult programs and services database

- www.rgpc.ca/oapsd • 905-777-3837 extension 12436
- Consumers Advancing Patient Safety (2009).CAPS Transition Toolkit.
- www.patientsafety.org/page/transtoolkit/
- Partnership for Clear Health Communication at the National Patient Safety Foundation
- Ask Me Three: Materials for Consumers [http://www.npsf.org/askme3/for __patients.php](http://www.npsf.org/askme3/for__patients.php).
- HNHB LHIN (2010). An Integrated Program for Complex Care in the Hamilton Niagara
- Haldimand Brant Local Health Integration Network.

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