



Patient Flow Toolkit





Introduction

In 2008, the Government of Saskatchewan commissioned the *Patient First Review*, to enhance patient care at all levels of the health system. The report and recommendations released in October 2009 were designed to serve as a catalyst for transformation, ensuring that patients came first and, equally important, that all parts of the health system worked together cohesively, and that front-line care providers were empowered to deliver patient and family-centred care. One of the eight negative patient experiences raised within the Review was “feeling inadequately served in hospital emergency rooms.” More specifically, the most commonly heard negative experience was excessively long wait times (i.e. three hours or more) in hospital emergency rooms.

Overcrowding within hospital wards and long delays for many patients who seek help in the emergency departments (EDs) prompted the provincial government to call for improvements to ED wait times in its 2012 Plan for Growth. The Emergency Department Waits and Patient Flow Initiative was created in response to that challenge, and aims to aggressively address ED wait times, in conjunction with other health system efforts to provide **sooner, safer and smarter** care for patients.

There is compelling evidence that gaps in community-based care, the lack of coordination between many different health services in many locations and hospital overcrowding have a direct impact on delays in EDs.

The modules in this toolkit are meant as a resource for operational leaders, managers, and point of care staff in Saskatchewan. The modules are intended to be a guide to make lasting improvements to patient flow, so that patients receive the right care, in the right place, by the right teams across the continuum of care, ultimately shortening wait times in the ED.

For information on this toolkit, or to provide feedback, please contact the **Emergency Department Waits and Patient Flow Initiative** at (306) 668-8810.





Patient Flow Toolkit – Table of Contents

Module 1: Interdisciplinary Rounding (September 2015)

Module 2: Alternate Level of Care (April 2016)

Module 3: Transfers of Care (January 2016)





Patient Flow Toolkit



Module 1:

Interdisciplinary Rounding

Reference guide for acute care inpatient units in Saskatchewan

September 2015



Table of Contents

Module objectives and what is interdisciplinary rounds?	1
Why do interdisciplinary rounds?	2
How to determine if a team has implemented interdisciplinary rounds	3
Self-assessment tool	6
Required attributes of interdisciplinary rounds.	7
PDCA stages: Points for consideration	9
Interdisciplinary rounds planning worksheet	12
Saskatchewan examples:	
1. Intensive Care Unit – St. Paul’s Hospital	13
2. Rural Saskatchewan Hospital – St. Peter’s Hospital.	14
3. Urban Adult Medicine Unit – Pasqua Hospital.	15
Standard work examples	
1. Regina Qu’Appelle Health Region – interdisciplinary rounds with physician	16
2. Saskatoon Health Region – interdisciplinary rounds with physician	17
Resources for introducing patients and families to rounds	
1. Saskatoon Health Region – ICU.	18
2. Five Hills Health Region – Poster	19
Transition checklist example	23
Interdisciplinary rounds worksheet example	24
Commonly asked questions	25
Resources and references	26

For more information about this toolkit, contact the
Emergency Department Waits and Patient Flow Initiative: 306-668-8810

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Module objectives

This module is intended to be a guide for operational leaders, managers, and point of care staff for self-assessment and implementation of a process for interdisciplinary rounds. It was informed by the various types of interdisciplinary rounds that have been piloted in Saskatchewan under the Releasing Time to Care program, Rapid Process Improvement Workshops and other improvement efforts. A future module will include information and resources on enhancing interdisciplinary teamwork and communication.

Interdisciplinary rounds are necessary not only to meet our system needs for communication but also to ensure that patients and families have similar experiences on medical and surgical wards throughout the province.

The objectives of this module are to:

- Provide an assessment tool for measuring progress in implementing rounding;
- Provide teams with information that will help them decide how best to adapt and adopt each best practice in a way that meets the needs of the patients and families accessing care and the care team; and,
- Provide reference templates for standard work, patient/family information materials, etc.

What are interdisciplinary rounds?

Interdisciplinary rounds have been defined as planning and evaluating patient care with health professionals from a variety of other health disciplines. Key activities that can be integrated into interdisciplinary rounds include summarizing patient health data, identifying patient/family problems, defining goals, identifying interventions, discussing progress toward goals, revising goals and plans as needed, generating referrals, reviewing discharge plans, and clarifying responsibilities related to implementation of the plan. Interdisciplinary rounds can occur daily or once, twice, or even three times a week, depending on the patient's need and average length of stay (Gagner, Goering, Halm, Sabo, Smith, & Zaccagnini, 2003).

There are a variety of different names used to describe interdisciplinary rounds, including multidisciplinary rounds, ward rounds, bullet rounds, and structured interdisciplinary bedside rounds.

What do we mean by 'interdisciplinary'?

“Interdisciplinary team approaches integrate separate discipline approaches into a single consultation.... The patient is intimately involved in any discussions regarding their condition or prognosis and the plans about their care. A common understanding and holistic view of all aspects of the patient's care ensures the patient is empowered in the

Module 1: Interdisciplinary Rounding

decision-making process, including setting long-term and short-term goals. Individuals from different disciplines, as well as the patient themselves, are encouraged to question each other and explore alternate avenues, stepping out of discipline silos to work toward the best outcome for the patient.” (Jessup, 2007)

Why interdisciplinary not multidisciplinary?

Multidisciplinary approaches utilize the skills and experience of individuals from different disciplines, with each discipline approaching the patient from its own perspective. Multidisciplinary rounds often do not include the patient and take the form of case conferences. (Jessup, 2007) Because Saskatchewan is committed to patient- and family-centered care, we use the term interdisciplinary as it reflects inclusion of the patient and family as part of the care team and supports the breaking down of discipline silos.

Why do interdisciplinary rounds?

Evidence shows that interdisciplinary rounds have many benefits:

- **Decreased patient length of stay:** This has been demonstrated in medical and critical care units. Two separate studies show decreases of between 8% and 11%. (Curly, McEachern, Speroff, 1998) Use of a Back to Basics Checklist reduces iatrogenic disability, and the use of a Transitions Checklist helps teams ensure safe and timely transitions to appropriate settings in the community.
- **Increased patient safety:** Increased communication between providers and the inclusion of safety conversations in rounds lead to a significant reduction in adverse events. (O’Leary KJ, et al, 2011)
- **Improved patient care, teamwork, and staff satisfaction:** Factor analysis of satisfaction surveys completed by 21 providers of interdisciplinary rounds and 19 providers of traditional rounds showed that providers of interdisciplinary rounds had a greater understanding of patient care, more effective communication, and better teamwork than providers of traditional rounds. (Note: Traditional rounds refers to physicians rounding with no other disciplines.) (Curly, McEachern, Speroff, 1998 and Gausvik C. et al, 2015)

Teams may also choose to add extra items of focus to the rounds discussion to support the patients they serve. You may wish to work with your team or region to capture similar data. Teams that have done so have seen reductions in:

- ICU mortality;
- Ventilator-acquired pneumonia (VAP) rate;
- Catheter-related bloodstream infection (CR BSI) rate; and,
- Urinary tract infection (UTI) rate. (IHI, 2013)

How to determine if a team has implemented interdisciplinary rounds

The goal is to have patients, families, staff, and physicians meet regularly to review all of the items listed on the attributes chart (p.7). A self-assessment tool (p. 6) has been created to support teams in assessing their strengths and opportunities for improvement. This assessment tool should be completed as a baseline measurement and again at regularly scheduled intervals (i.e., 30, 60, 90, and 180 days) to identify areas of success and opportunities for improvement.

The Saskatchewan health care system seeks to be patient and family centered. The core principles of patient- and family-centered care are respect/dignity, information sharing, collaboration and participation. Implementing interdisciplinary rounds aligns with these principles as it creates a scheduled, consistent



forum for patients, families, staff, and physicians to respectfully share information and collaboratively make care decisions.

The assessment tool is based on the International Spectrum for Participation, which has five categories. It seeks to move the level of engagement from involvement to empowerment. This spectrum is important to consider as the team determines what will be discussed and how. It is vital to support and educate patients, families, and providers about how to contribute to the conversation in a meaningful way, while ensuring privacy, respect for time, and student learning. Patients and families should be equal participants and therefore participate in the discussion, decision-making, and implementation of the plan. Each is defined below.

Public Participation Spectrum: International Association for Public Participation

The IAP2 Federation has developed the Spectrum to help groups define the public’s role in any public participation process. The IAP2 Spectrum is quickly becoming an international standard.



	INFORM	CONSULT	INVOLVE	COLLABORATE	EMPOWER
PUBLIC PARTICIPATION GOAL	To provide the public with balanced and objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions.	To obtain public feedback on analysis, alternatives and/or decisions.	To work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered.	To partner with the public in each aspect of the decision including the development of alternatives and the identification of the preferred solution.	To place final decision making in the hands of the public.
PROMISE TO THE PUBLIC	We will keep you informed.	We will keep you informed, listen to and acknowledge concerns and aspirations, and provide feedback on how public input influenced the decision. We will seek your feedback on drafts and proposals.	We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how public input influenced the decision.	We will work together with you to formulate solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible.	We will implement what you decide.

Interdisciplinary rounds assessment tool

Read each box in row A and score your team as a 1, 2, 3, 4, or 5. Place your score in the far right box. Do the same for each row (A - D). Note: You may fall between 2 boxes; score your team in the box where all of the criteria are met. It is the goal to have all teams in the darker shaded boxes (4 or greater).

NOTE: Row C requires reference to Interdisciplinary Rounds Required Attributes Table (p. 9).

	1	2	3	4	5	Score
A	Patients and families do not participate or contribute to rounds. They are informed by the nurse afterwards what decisions were made.	Patients and families do not participate in rounds. They contribute by putting forward questions to their nurse.	Patients and families are informed about rounds and have the opportunity to contribute their questions via their nurse.	Patients and families fully participate by adding information and insights, and asking questions.	Patients and families participate fully by adding information, insight, asking questions, and making decisions regarding their care.	Target ≥4
B	Disciplines round independently. Rounds do not occur at the bedside	Interdisciplinary team rounds occur. Rounds do not occur at the bedside.	Inter-disciplinary teams round together (attending physician is not present). Rounds occur at the bedside.	Inter-disciplinary teams round together (attending physician is present). Rounds occur at the bedside.	Inter-disciplinary teams round together (attending physician and specialists are present). Rounds occur at the bedside.	Target ≥4
C	Standard Work is not in place for rounds. Not all required attributes are included.	Standard Work is in place for rounds, including role of each member. Training has not been completed on standard work.	Standard Work is in place for rounds, including role of each member. Training has been completed on standard work.	Standard Work is in place for rounds, including role of each member. Training has been completed on standard work. Patient and family materials are available to engage family. All required attributes are included in the round.	Standard Work is in place for rounds, including role of each member. Training has been completed on standard work. Patient and family are invited verbally and receive materials to help them participate. All required attributes are included in round.	Target ≥4
D	The care plan is not updated to reflect the rounds discussion.	A team worksheet is used to capture the rounds discussion. All staff members have access to the worksheet. The care plan is not updated to reflect the worksheet.	A team worksheet is used to capture the rounds discussion. All staff members have access to the worksheet. The care plan is updated to reflect the worksheet.	Staff directly update the care plan during rounds to reflect the discussion. All staff have access to the care plan following rounds.	Staff update a care plan and whiteboard to reflect rounds discussion. Patients and families are encouraged to contribute to the plan and use the whiteboard for communication. All staff and the patient have access to the care plan following rounds.	Target ≥4

*Telehealth or phone may be used as a platform to ensure all partners are able to participate.
 • Families are defined by the patient. These individuals should only be welcomed based on the patient’s preference.
 • This model is based on the International Association for Public Participation, Spectrum for Public Participation. www.lap2.org
 Author: Malori Keller

Module 1: Interdisciplinary Rounding

Required attributes of interdisciplinary rounds

Successful interdisciplinary rounds include the attributes listed in the table below. Each item should be discussed during rounds. The table provides suggestions on what could be discussed for each attribute.

- Each team should determine who will lead the discussion and the order of the discussion.
- The items listed in the Quality and Safety Check are suggestions only.
- Your review should include those issues relevant to your patient population.

The attributes list is based on the review of articles listed in the References (p. 25.) The rounds includes a review of Back to Basics care items, which reduces iatrogenic disability.

✓		Suggested Lead										
	Introduction <ul style="list-style-type: none"> • Greet patient and family • Introduce team members by name and role 	Physician										
	Update hospital course <ul style="list-style-type: none"> • List reason for admission, active problems & response to treatment • Discuss interval test results & consultant notes • Invite input from the patient/family 	Nurse										
	Update current status <ul style="list-style-type: none"> • Overnight events and patient goal for the day • Sleep • Back to Basics Care Checklist: <table border="0" style="width: 100%;"> <tr> <td>• Vital signs or pain</td> <td>• Mental status</td> </tr> <tr> <td>• Fluid or food intake</td> <td>• Functional status (as compared to preadmission)</td> </tr> <tr> <td>• Bladder or bowel output</td> <td>• Mobility</td> </tr> </table> 	• Vital signs or pain	• Mental status	• Fluid or food intake	• Functional status (as compared to preadmission)	• Bladder or bowel output	• Mobility	Nurse Patient/Family PT/OT				
• Vital signs or pain	• Mental status											
• Fluid or food intake	• Functional status (as compared to preadmission)											
• Bladder or bowel output	• Mobility											
	Quality safety check <ul style="list-style-type: none"> • May include such items as: <table border="0" style="width: 100%;"> <tr> <td>• Urinary catheter</td> <td>• Pressure ulcer and stage</td> </tr> <tr> <td>• Canula / Central venous catheter</td> <td>• Hypo or hyperglycemia</td> </tr> <tr> <td>• VTE prophylaxis</td> <td>• Fall Risks</td> </tr> </table> 	• Urinary catheter	• Pressure ulcer and stage	• Canula / Central venous catheter	• Hypo or hyperglycemia	• VTE prophylaxis	• Fall Risks	Nurse				
• Urinary catheter	• Pressure ulcer and stage											
• Canula / Central venous catheter	• Hypo or hyperglycemia											
• VTE prophylaxis	• Fall Risks											
	Resuscitation plan <ul style="list-style-type: none"> • Plan is known and documented. 	Physician										
	Synthesize plan using all inputs <ul style="list-style-type: none"> • Verbalize and update Patient Communication Board with plan for the day & transition • Transition Checklist: (See p. 22 for sample templates) <table border="0" style="width: 100%;"> <tr> <td>• Choosing best next care setting</td> <td>• Course in hospital (diagnosis / treatment)</td> </tr> <tr> <td>• Identifying suitable agencies and arranging services</td> <td>• Key data – lab, imaging</td> </tr> <tr> <td>• Verifying coverage</td> <td>• Care plan</td> </tr> <tr> <td>• Patient and family education needs</td> <td>• Medication Reconciliation</td> </tr> <tr> <td>• Clinical summary (single care plan)</td> <td>• Follow-up appointments</td> </tr> </table> 	• Choosing best next care setting	• Course in hospital (diagnosis / treatment)	• Identifying suitable agencies and arranging services	• Key data – lab, imaging	• Verifying coverage	• Care plan	• Patient and family education needs	• Medication Reconciliation	• Clinical summary (single care plan)	• Follow-up appointments	Nurse Physician Social Work / Discharge Planner/ Patient Navigator/ Pharmacist Patient / Family
• Choosing best next care setting	• Course in hospital (diagnosis / treatment)											
• Identifying suitable agencies and arranging services	• Key data – lab, imaging											
• Verifying coverage	• Care plan											
• Patient and family education needs	• Medication Reconciliation											
• Clinical summary (single care plan)	• Follow-up appointments											

What is iatrogenic disability? How will Back to Basics care and safety checks help?

Hospitalization can result in a decrease in a patient's independence and ability to perform activities of daily living. This is defined as iatrogenic disability. (Lafont, et al, 2011)

The following three factors contribute to iatrogenic disability:

- ***Pre-existing patient frailty:*** Frail patients are more vulnerable to stressors such as illness. This can mean increased rates of hospitalization and longer lengths of stay. (Gill, 2010) Frail patients are more likely to go from having no disability to being mildly disabled following discharge.
- ***Severity of the patient's condition that led to their hospitalization:*** This can cause functional decline, regardless of how successfully a patient's condition is treated.
- ***Hospitalization and post-hospitalization processes:*** Admission to hospital results in a sudden interruption in a patient's daily activities that would normally keep them moving (e.g., toileting, meal prep, dressing). Patients are also often confined to a bed during their stay, which results in deconditioning. Hospitalization can also result in inadequate nutrition and a disruption in a patient's regular sleep habits, which can negatively affect his health and strength. (Lafont, et al, 2011)

We have the opportunity to prevent or minimize iatrogenic disability by devoting focused attention on "Back to Basics" care and safety and quality checks in the daily care routine.

"Back to Basics" care: Understanding a person's pre-hospital status, basic care needs, and their goals for the future gives the interdisciplinary team a more comprehensive understanding of the patient's needs and desires. The interdisciplinary approach ensures that all care providers support the basics, in addition to a patient's other medical care needs. Back to Basics includes pain management, nutritional intake, bladder and bowel output, mobility, and a patient's ability to perform daily activities.

How to include in daily rounds: The team can identify the earliest opportunity at which it is safe for a patient to mobilize. Understanding how the patient mobilized prior to their admission or illness should be taken into consideration as the patient and care team determine goals, what assistance is needed, the most appropriate time for mobilization, etc. The team is then clear on the patient's status, with all members responsible for ensuring the patient mobilizes safely to prevent loss of independence and injury.

Example: An 80-year old patient states that she was walking 1 km per day on a walking track without her cane, and used a cane for support on stairs and uneven surfaces. Now, following several days in a hospital bed, the patient is anxious to walk

Module 1: Interdisciplinary Rounding

but is very stiff. She is reluctant to use a cane and unhappy to have to mobilize in this way. This patient may need some encouragement to use the cane, as well as some physical assistance as she begins to mobilize. The team is aware of the patient's abilities before her hospital stay and can work with her to get her back to this baseline. They will also be on alert that she may try to mobilize without the cane and is therefore at risk of a fall.

Safety checks: Teams should incorporate safety and quality checks into their daily routines to review and prevent safety risks. Reviews of adverse events in many health care organizations have identified several common themes, including deficiencies in teamwork and communication, and the failure to include patients and their family members as active members of the team. (Pain, et al, 2012) Identify and incorporate in your team's daily routine those quality and safety checks that are most relevant to your patient population.

How to include in daily rounds: Your unit has a large proportion of patients awaiting long-term care, and many of these patients are immobile. Because these patients are mostly confined to their beds, they are at increased risk of developing pressure ulcers. Your interdisciplinary team should review each patient's risk for pressure ulcers and skin breakdown, and monitor the progress of any existing ulcers. The care team can work with the patient and family to develop integrated prevention and management strategies.

Example: A patient arrives at the hospital with stage 2 pressure ulcers on his heels. Your team should develop an interdisciplinary approach to healing the ulcers and preventing any further breakdown. This could include a plan for repositioning, equipment and surface needs, and nutritional plan. The team will also monitor the ulcers' progress.

Transition checklists: The time when patients transition from their acute care stay back to the community or next stage of care is a period of risk. Transition checklists create standard prompts for discussion that support successful patient and caregiver transitions. Successful transitions require that all care providers and patients and their families are on the same page and working toward a common goal. The team works together to identify barriers to transition that may need to be addressed several days or even weeks in advance.

How to include in daily rounds: Your surgical unit has many patients from outside your region who receive their surgery then return to their home region hospital for additional care before going home. The team can identify these patients early in their stay and make arrangements for their transition.

Example: Your patient is from rural Saskatchewan and has just had surgery in your tertiary centre. She will eventually be returning to her home hospital to convalesce. This patient has unique equipment needs. The team discusses

daily how the patient is progressing, to ensure early preparation occurs, including notifying the receiving hospital so they can prepare for the patient's care needs, such as ensuring medications are available and equipment arrangements are made. This also allows family members to make arrangements so they can be available to help the patient transition.

Including these three key elements (Back to Basics, Safety Checks, Transition Checklists) in your interdisciplinary team's rounding process will ensure an integrated approach to achieving the best possible outcomes for patients.

How do we implement interdisciplinary rounds on our unit or ward?

Below are suggested steps for implementing interdisciplinary rounds, based on a Plan, Do, Check, Act model. *Note: Not all of the actions and tools are required for each unit. In consultation with your team, select those actions, tools, and templates that will best support your needs.*

PLAN

1. Establish a core team of individuals who will support interdisciplinary rounds.

- Participants may include physicians, clinical coordinators, nurses, social workers, physiotherapists, translators, patient navigators, pharmacists, etc.
- Consider identifying a team lead who will help lead the rounds as well as coach staff during the rollout (e.g., Clinical Coordinator, Clinical Nurse Educator or Clinical Nurse Specialist).
- Patient or family advisors may also be invited to participate, especially if your unit has an advisory council to draw these individuals from.
- Identify an interdisciplinary rounds champion and develop a communication plan for the implementation.
- Include not only champions but those who may not be advocates of interdisciplinary rounds.

Module 1: Interdisciplinary Rounding

2. Understand the current state.

- Have the core team talk to staff and physicians about the current state. Questions may include:
 - Is there a process in place for rounding? If so, when? Where? Who is involved? How is it documented?
 - What is working well? What isn't working?
- Have the core team talk to patients and families about the current state. Questions may include:
 - Do they know what the rounds process is?
 - Have they participated?
 - Do they know their treatment plan? Discharge plan?
 - Are they comfortable asking questions?

3. Gather Patient Quality Analysis (PQA) Data.

- Data may include:
 - # of patients
 - # of disciplines involved in care
 - Time that disciplines currently come to unit
 - Average length of stay
 - Baseline from Patient Experience Survey results
 - Critical incidents or patient stories that could have been avoided with improved interdisciplinary team communication.

4. Create a visual to depict the current state.

Consider using tools such as:

- Value Stream Maps
- Spaghetti diagrams
- Time Observation forms
- Pictures/videos

5. Complete interdisciplinary rounds assessment. Determine baseline score (p. 5).

6. Engage team in discussion about current state.

- Learn about interdisciplinary rounds (see p. 26 for videos, articles, toolkits).
- Review existing practices in Saskatchewan (pp. 13-16).
- Review interdisciplinary rounds definition and review baseline assessment.
- Review baseline score. Set target for improvement.
- Complete interdisciplinary rounds planning worksheet (p. 12).

7. Create action plan (Consider the following questions)

- What is the purpose of our round?
- What can we improve right now? ("Just do it" projects)
- How will patients and families be invited to rounds? (see p. 19 for examples)
- What standard work or templates will be used? Who will adapt them? (see p. 18 or kaizentracker.ca for examples)
- How will team members document the rounds discussion? (see p. 24 for an example.)

- What is the start date?
- Daily Visual Management Board: How will this be communicated on our daily visual management board?
- What other unit processes does the interdisciplinary rounds impact?
- How will we minimize distractions to the interdisciplinary team?
- What training or awareness do staff/physicians need to feel comfortable adopting interdisciplinary rounds?
- How will we communicate our plan?

DO

- **Implement action plan.**
- **Engage staff and physician champions to spread enthusiasm about the work.**
 - Encourage these individuals to partner with those who are less eager or are apprehensive about interdisciplinary rounds.
 - Engage these individuals in “just do it” projects and small trials of various tools.
 - Engage these individuals in adapting standard work or training others on standard work.

CHECK

- **Team discussion.**
 - What worked well? What didn't work?
- **Talk to patients and families.**
 - What worked well? What didn't work?
- **Review updated PQA data.**
 - Has length of stay changed?
 - Has there been any changes in patient experience survey results?

ACT

- **How do we sustain the gains?**
 - Keep interdisciplinary rounds on Daily Visual Management Board: How is it working? What needs improving?
 - Audit using the assessment tool: Are we meeting, maintaining, or exceeding the target? Are we ready for a new target?
 - Train and educate: Are all staff and physicians trained to the new interdisciplinary rounds? How do new staff/physicians get oriented to the process?
 - Recognize staff and physician efforts.
 - Share feedback from patients and families.

Interdisciplinary rounds planning — team worksheet

There are several different models for interdisciplinary rounds. Consider the following:

1. What patients will be seen each round?

- All patients on unit
- Patients with urgent care issues and newly admitted patients
- Patients with urgent care issues and patients nearing discharge
- Other: _____

2. Who will attend?

- Patients
- Families
- Physician
- Residents
- Nurse
- Allied Health (social work, PT, OT, SLP, discharge planner, dietician, _____)
- Other: (ie. spiritual care, navigator, educator, _____)

3. Who will lead the discussion about each attribute? What Quality and Safety checks are relevant to our patients?

4. Do we need a team lead? If so, who is the most appropriate person for this role?

5. What time will we host rounds?

- AM _____
- PM _____

6. How will rounds discussions be documented?

7. How will patients and families be informed about rounds? Who will inform patients and families about rounds?

8. How will we accommodate families who can't physically be present for rounds?

(e.g., families from northern or rural areas)

9. How will we identify and address patient's and family's individual needs for rounds?

(e.g., translators, cultural and spiritual needs, etc.)

Saskatchewan example: Interdisciplinary rounds in an Intensive Care Unit

In 2009, the Intensive Care Unit at St. Paul's Hospital began discussing a transition to patient- and family-centred rounds. At that time, rounds occurred at the nursing station so the patient and family were not able to participate. Through collaboration and the sharing of ideas and stories amongst key members of the health care team, the traditional approach to doing rounds has evolved into a new process where patients and families are active participants in the daily rounds.

The new process

Rounds are an interdisciplinary team meeting of physicians, nurses, physiotherapists, respiratory therapists, social work, spiritual care, residents, patients, and families. This occurs at 9:15 AM daily at each patient's bedside.

During this time the team will discuss each patient's condition. This can occur in a number of ways, but most often includes the following:

- Resident gives an overview of patient, history, admitting diagnosis, and course in hospital.
- Respiratory therapist reports on oxygenation and ventilation status.
- Nursing staff reports the patient assessment.
- Residents summarize the patient needs and identify goals for care.
- The attending physician facilitates a discussion with the team regarding treatment options and next steps.
- The attending physician will summarize the discussion in lay language for the patient/family.
- The patient and family are given an opportunity to ask questions and participate throughout the round.
- Depending on patient/family needs, a family conference may be scheduled.

Key learnings

- Staff found they needed to explain to families what rounds are. They had to encourage families to participate the first time, as families did not want to interfere in the care of the patient. Families are now coached and provided information on rounds. Staff are mindful that it is a choice for families to participate and that some may choose not to. Thus, nurse updates and family meetings will remain integral to patient/family communication.
- The ICU Patient and Family Advisory Council created a tool to explain the rounds process to patients and families. This information is found in the Intensive Care Unit Family Guide, which is available in print format and as an iPhone app.
- Patient/family rounds is now standard practice in Saskatoon Health Region's Department of Critical Care. Consistency of practice became important to both the patients/families and the staff. It was challenging to coordinate and to explain

Module 1: Interdisciplinary Rounding

the differences in practice when not all members of the team were engaged in the “new” style of rounds.

For more information, contact:
Manager, Betty Wolfe at
betty.wolfe@saskatoonhealthregion.ca

Saskatchewan example: Interdisciplinary rounds in a rural inpatient unit

At St. Peter’s Hospital in Melville, interdisciplinary rounds are a long-standing routine. At 7 AM daily, report occurs at the nursing station in a report room. This is a shift-to-shift handover for nursing. Other team members — including pharmacy, social work, unit clerk, pastoral care, and therapies — attend on a daily basis.

Between 8 AM and 9 AM, the four physicians arrive at the hospital and after seeing any emergent patients, begin bedside patient rounds. A nurse (RN or LPN) rounds with the physician and as appropriate the social worker, physiotherapist, and pastoral care worker join in to see the patients who need these supports.

During the round, the team will discuss each patient’s condition. This can occur in a number of ways, but most often includes the following:

- Nursing staff gives an overview of patient, history, admitting diagnosis and course in hospital.
- Nursing staff reports the patient assessment.
- The social worker/discharge planner will communicate discharge planning issues or arrangements, or other patient-specific needs, such as addictions counselling, psychiatric referrals, or required family meetings.

- The physiotherapist updates the physicians on treatment plans or completions.
- The physician facilitates a discussion with the team (including the patient/family) regarding patient needs, goals, treatment options, and next steps. He/she then summarizes the discussion in lay language for the patient/family.
- The patient and family are given an opportunity to ask questions and participate throughout the round.
- Depending on patient/family needs, family conferences and meetings may be arranged.



Key learnings

- Because there are a small number of allied health professional staff on this team, they do not round to see every patient. Rather they are asked to be present on a case-by-case basis.
- Originally the nurse manager or charge nurse supported the rounds process. However this led to re-work as they then needed to communicate to the bedside nurse. It is now the bedside nurse who rounds with the physician.
- Each discipline plays a role in charting the discussion of rounds.
- White boards are updated on a continuous basis to support ongoing communication throughout the day.
- Pastoral care is an important part of the team. The pastor often communicates things the patient wants or needs from the team, while respecting confidentiality. Pastors do not attend all of the interdisciplinary rounds, but are there to support the patient/family after upsetting news, at points of transition, etc.

For more information contact:
Nursing Manager, Lori Keller at
lori.keller@shr.sk.ca

Saskatchewan example: Interdisciplinary rounds in an urban medical unit



On Unit 4A at Pasqua Hospital in Regina, interdisciplinary bedside rounds are a new routine. In January 2015, the team adopted Structured Interdisciplinary Bedside Rounds (SIBR) from the In Safe Hands toolkit from New South Wales, Australia. The SIBR script has enhanced the accountabilities for safe care, adding components of quality and safety to ensure patients have safe, effective, and timely care.

At 10:30 AM daily, the physician, bedside nurse, and members of the allied health team gather and begin bedside rounds as a team, following the SIBR work standard (p. 17).

Key Learnings

- Coaching and mentoring is critical to ensuring that all staff know their role and what information they are required to bring to the round.
- Physician attendance at the bedside round is critical to advancing the care of the patient.
- Documenting rounds has been a challenge as there is no direct entry into the care plan. The rounds manager has a worksheet that is passed off to the Most Responsible Physician to ensure that the plan of care for the patient is updated.

Contact:

Nursing Manager, Erica Pederson,
erica.pederson@rqhealth.ca

Sask. example: Interdisciplinary rounds, urban medical unit (continued)

	Team Member		Information needed
A	Attending Physician	1 minute	Presents active problems and current treatments
			Test results / Consult info
			Inputs from patient –family and nurse
B	Bedside Nurse	1 minute	Update Status
			Overnight events and patient’s goal of the day
			Vital signs and pain control
			Fluid and food intake
			Urine and bowel movements
			Mental status
			ADLs
			Quality and Safety
			Foley catheter
			IV or central line
			VTE prophylaxis
			Pressure ulcer/skin
			Glycemic control
C	Allied Care	1 minute	PT/OT/SLP/SW/Dietitian
			Mobility status and equipment needs
			Swallowing or nutritional status
			Anticipated D/C needs or next site of care
			Discharge date and transportation
			Follow-up appointment

Adapted for use from Structured Interdisciplinary Bedside Rounds (SIBR), adapted from Improving Hospital Outcomes through Teamwork in an Accountable Care Unit by Jason Stein, Associate Vice Chair for Quality, Department of Medicine, Emory University School of Medicine (accessed December 3, 2014). See link http://www.crepatientsafety.org.au/seminars/designing_hospital_units/designinghospitalunits-dec11-jasonsteinsession2.pdf

Example of Standard Work – Structured Interdisciplinary Team Rounds (SHR Pediatrics)

Lead	Topic	Time
Resident or JURSI	Introduce team Lead team into room, greet child and family, and introduce team (names and roles) Welcome child and family to participate and confirm wish to have bedside rounds Probe for questions or concerns from child and family	≤ 15secs
	Update status Active problem list and response to treatment Interval test results & consultant inputs Inputs child/family, nurse or other staff	≤ 45 s
Bedside Nurse	Update status Overnight events and progress toward milestones Vital signs, pain control Urine output (cc/kg/day) and stools Mental status & ADLs (including mobility status) Specify concerns and suggestions	≤ 45 s
	Checklist for safety Lines – Shunt, EVD, Central line, Trach, GT, Foley State current precautions and indication – droplet, contact, respiratory, etc	≤ 15s
Dietitian	Update status Type of diet or formula Fluids (% maintenance) and calories (kcal/kg) Weight (kg), including interpretation Specify concerns and suggestions	≤ 45 s
Other Interprofessional Staff	Update status Results of assessment and report recommendations Specify concerns and suggestions	≤ 15 s
Pharmacy	Update status Report MAR Specify concerns and suggestions	≤ 30 s
Resident or JURSI	Promote teamwork and shared decision making Redirect as needed to stay on time Synthesize inputs into a plan-for-the-day including discharge milestones	≤ 30 s
Senior Resident	Promote teamwork and shared decision making Redirect as needed to stay on time Synthesize inputs into a plan-for-the-day including discharge milestones	≤ 30 s
	Teach as able Patient education Physical findings/pathophysiology	≤ 30 s
Attending Physician	Promote teamwork & shared decision making Ensure high level of performance at interdisciplinary bedside rounding Step in to other medical roles as needed	
Social Work	Checklist for discharge planning Seek consensus regarding discharge milestones, anticipated discharge date, needs Clarify outpatient follow-up requirements Probe for questions or concerns from child and family	
Other JURSI or Resident	Enter orders in real time Update whiteboard in real time	
Coordinator	Ensure next bedside nurse ready for team, orient float nurses as required	

Adapted for use from Structured Interdisciplinary Bedside Rounds (SIBR), adapted from Improving Hospital Outcomes through Teamwork in an Accountable Care Unit by Jason Stein, Associate Vice Chair for Quality, Department of Medicine, Emory University School of Medicine (accessed December 3, 2014). See link www.crepatientsafety.org.au/seminars/designing_hospital_units/designinghospitalunits-dec11-jasonsteinsession2.pdf

Resources for introducing patients and families to rounds

Intensive Care Units in the Saskatoon Health Region include the following information in the patient and family handbook and the iPhone app. This was written by patient and family advisors who serve on their advisory council. Please feel free to adapt this into your admission information package or other patient/family information materials.

A family guide to rounds

Every day, the medical team meets at each patient's bedside to discuss their progress. This is called "rounds" and is an opportunity for you to speak with your loved one's doctor. Family can share any additional information with the team.

Rounds begin around 9:00 a.m. and can last until early afternoon. We highly recommend that the decision maker and family spokesperson attend. This is the best opportunity to know what is going on and ask questions.

Team members will review the previous 24 hours of care, then identify goals for the day and current treatment. They will summarize the discussion in terms that are easier for you to understand, and you will be given an opportunity to ask questions. If you do not understand something, or want clarification, make sure to ask. Don't be scared or shy!

If your family requires a more private conversation, or more time to ask questions, let your nurse know. A family conference will be arranged at a time that works for everyone.

Our goal is to help you understand what is happening during this time while your loved one is in this unit.

Module 1: Interdisciplinary Rounding

The Five Hills Health Region uses this letter to invite patient and families to participate in rounds. Please feel free to adapt this to meet the needs of your unit.

Patient Care Rounds **Tuesday Mar 24th at 10:00 am**

We would like to discuss your plan of care with YOU.

Your care team includes:

You
Your family
Your nurse
The nurse in charge of the unit
Transition Coordinator
Dietician
Physiotherapist
Occupational Therapist

With you, we would like to discuss:

Your current care plan
Your plan for your transition from hospital
Your health goal for the day which will help you achieve your transition
Any resources you may need while you are here and after transition

We encourage your family to be present and bring forth any information that would be helpful. Please feel free to write any concerns on the white board in your room in the "Questions/Comments" section.

Please let us know what we can do to help progress your care.



Examples of transition checklists

The Saskatoon Health Region uses this discharge planning document to support communication and documentation of transition planning done during rounds.

Multidisciplinary Discharge Planning

Estimated Date of Discharge: _____ **Date written:** _____

Comments: EDD on White board EDD entered into Bed Management System _____ Initials. EDD on Care Plan

Date & Time of Admission Round: _____

Introduce self and team to patient and family. Explain that our main goal is to get them home safely and in a timely fashion so we want to start planning what going home would look like for them.

We would like to find out if you have any concerns about going home (wait for patient's response and note these concerns below).
.....

Is there anyone at home that you care for?
.....

Do you feel you will be able to function safely when you get home?
.....

Will you need help when you go home?
.....

Do you feel you are prepared to go home with your _____
(colostomy, VAC, PICC etc.) If not, what are your concerns?
.....

Will there be any physical barriers when you return home?
(stairs, bedroom/bathroom facilities).
.....

Do you know who will follow up with your care (Dr., etc.) once you leave the hospital?
.....

Once you are able to leave hospital, who will drive you? How much notice do they need to be able to pick you up before noon?
.....

Are there any other concerns we have not touched on?
.....

Team member(s) notified:
 CPAS Social Work Food and Nutrition OT PT ET

Issues Identified: _____

Signature: _____

Module 1: Interdisciplinary Rounding

The Saskatoon Health Region uses this discharge planning document to support communication and documentation of transition planning done during rounds.

Date & Time of Admission Round: _____

Introduce self and team to patient and family. Explain that their health has improved and we are anticipating that they will be well enough to go home within the next 48 hours.

Do you have transportation home?
Who will drive you?
Are you able to phone them and let them know you're being discharged or do you need the nurses to do that?
How much notice do they need before they pick you up?

Do you feel you will be able to function safely when you get home?

Will you need more help you when you get home?

Is anyone available to help you when you get home?

Do you feel you are prepared to go home with your _____
(colostomy, VAC, PICC etc.)

Will there be any physical barriers when you return home? (stairs, bedroom/bathroom facilities)

Do you know who will follow up with your care (Dr., etc.) once you leave the hospital?

Is there anything else you would like to discuss prior to going home?

Team member(s) notified:
 CPAS Social Work Food and Nutrition OT PT ET

Issues Identified:

Signature: _____

Saskatoon Health Region’s Dube Centre for Mental Health uses this transition checklist to document discharge readiness.

Transition Checklist (Discharge Readiness)

Date & Time of Admission Round: _____

Diagnosis: _____ Admission Date: _____

Predicted Discharge/Transition Date: _____ Involuntary Voluntary

DONE	NEED		DONE	NEED	
		Social Worker: _____			Pharmacy
<input type="checkbox"/>	<input type="checkbox"/>	Financial: _____	<input type="checkbox"/>	<input type="checkbox"/>	Rx Coverage: _____
<input type="checkbox"/>	<input type="checkbox"/>	Housing: _____	<input type="checkbox"/>	<input type="checkbox"/>	EDS
<input type="checkbox"/>	<input type="checkbox"/>	Home Care: _____			Nursing
<input type="checkbox"/>	<input type="checkbox"/>	Family Support	<input type="checkbox"/>	<input type="checkbox"/>	Forward orders to CMHN
		Occupational Therapy: _____	<input type="checkbox"/>	<input type="checkbox"/>	Fax Rx to Pharmacy
<input type="checkbox"/>	<input type="checkbox"/>	Capacity Assessment	<input type="checkbox"/>	<input type="checkbox"/>	Bloodwork to Clozapine
<input type="checkbox"/>	<input type="checkbox"/>	Cognitive Assessment			Dietitian: _____
<input type="checkbox"/>	<input type="checkbox"/>	Driving Screening	<input type="checkbox"/>	<input type="checkbox"/>	In-patient Consult
<input type="checkbox"/>	<input type="checkbox"/>	Coping Skills & Sensory Strategies			Psychiatrist: _____
<input type="checkbox"/>	<input type="checkbox"/>	ADL/Equipment/Functional Assess	<input type="checkbox"/>	<input type="checkbox"/>	Discharge Summary
		Therapeutic Recreation: _____	<input type="checkbox"/>	<input type="checkbox"/>	Discharge Orders/Rx
<input type="checkbox"/>	<input type="checkbox"/>	Leisure Assessment	<input type="checkbox"/>	<input type="checkbox"/>	CTO name: _____
<input type="checkbox"/>	<input type="checkbox"/>	Group Referral	<input type="checkbox"/>	<input type="checkbox"/>	Next Cert Due: _____
		Referrals:			
<input type="checkbox"/>	<input type="checkbox"/>	CMHN: _____	<input type="checkbox"/>	<input type="checkbox"/>	EPIP
<input type="checkbox"/>	<input type="checkbox"/>	Out-pt Psychiatrist: _____	<input type="checkbox"/>	<input type="checkbox"/>	Transition Team (incl. Counselling)
<input type="checkbox"/>	<input type="checkbox"/>	G.P.: _____	<input type="checkbox"/>	<input type="checkbox"/>	Bridges
<input type="checkbox"/>	<input type="checkbox"/>	Concurrent Disorders	<input type="checkbox"/>	<input type="checkbox"/>	McKerracher
<input type="checkbox"/>	<input type="checkbox"/>	Addictions Counselling	<input type="checkbox"/>	<input type="checkbox"/>	In-patient Consult
<input type="checkbox"/>	<input type="checkbox"/>	Adult Outreach	<input type="checkbox"/>	<input type="checkbox"/>	Out-pt RT
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	Out-pt OT
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	Out-pt Dietitian

Module 1: Interdisciplinary Rounding

Regina Qu'appelle Health Region's Medicine 4A Unit uses this worksheet to support their interdisciplinary rounds. It is used to help nurses collect the information needed for rounds.

Structured Interdisciplinary Bedside Rounds (SIBR)

Bedside Nurse Report

Areas of Concentration	Patient 1	Patient 2	Patient 3
1 Goal of the day/Concerns			
2 Status Update			
Overnight events			
Vital Signs and Pain control			
Fluid and food intake			
Urine and Bowel Movements			
Mental Status			
ADLs			
3 Quality and Safety			
Foley Catheter			
IV or Central Line			
VTE Prophylaxis			
Pressure Ulcer / Skin			
Glycemic Control			

Adapted for use from Structured Interdisciplinary Bedside Rounds (SIBR), adapted from Improving Hospital Outcomes through Teamwork in an Accountable Care Unit by Jason Stein, Associate Vice Chair for Quality, Department of Medicine, Emory University School of Medicine (accessed December 3, 2014). See link www.crepatientsafety.org.au/seminars/designing_hospital_units/designinghospitalunits-dec11-jasonsteinssession2.pdf

Commonly Asked Questions

Do all rounds have to be at the bedside?

All patients and families should be asked if they would like the team to round at the bedside. If there are circumstances which have the team unsure about rounding at the bedside, discuss this with the patient/family. For example, if a patient is agitated she may not be comfortable with everyone coming into the room.

How do we deal with privacy concerns in shared rooms?

Many facilities in Saskatchewan have units with shared rooms. In these cases informed consent will need to be obtained to discuss patient's care needs at the bedside. Units should establish a process for explaining the rounds process to patients and families on admission and obtaining consent if privacy will be of concern. If patients do not consent, alternative arrangements should be made to accommodate the needs of patients and families.

How do isolation precautions impact rounds?

The most patient-centred approach would be to don the appropriate Personal Protective Equipment and continue to round at the bedside. Options could include having some members remain at the door or if the patient is not participating but the family is, have the round in another space.

Do you need to round at the bedside for patients who are not alert?

The most patient and family centered approach would be to round at the bedside if the family wishes. Speak about patients as if they are present.

How do you share clinical information?

Clinical jargon can be confusing to patients and families, however using the clinical terms is often necessary. Share the clinical terms and then provide an explanation in laymans terms. Avoid using acronyms. When sharing information such as vital signs you may give some explanation to help inform the patient/family. i.e., "Blood pressure is 120/80, this is normal." or "Pulse is high at 130 and we will discuss how to bring that down to normal."

How do you share information of a sensitive nature?

If there is information you must share which is sensitive in nature or perhaps is a crucial conversation, tell the patient that this is what you need to discuss. Then ask him if he would like you to discuss this with him personally, and if so, support him in having his family leave the room.

Module 1: Interdisciplinary Rounding

How can technology be used to support rounds?

Often computers on wheels have been helpful to support nurses in completing documentation immediately. This may also help with viewing scans or other test results. For families who are separated by distance, a teleconference has been used to engage them in their loved one's care. This could also be used in the event that one of the staff team members isn't able to be present due to extenuating circumstances.

4. The Royal College of Physicians and the Royal College of Nursing have recently developed a guide similar to this module explaining the basics of ward rounds. This is a great tool for supporting physicians and nurses in learning about the roles, types, and need for interdisciplinary rounds. www.rcplondon.ac.uk/sites/default/files/documents/ward-rounds-in-medicine-web.pdf

Helpful Resources

1. The University of Michigan recently released a seven-minute video which explains what multidisciplinary rounds are and how to implement them in a teaching hospital. This video is exemplary, as the rounds depicted also support the use of patient-provider communication whiteboards and nurse shift handover at the bedside. www.youtube.com/watch?v=-oOcJ1-6Fq4&feature=youtu.be
2. The Clinical Excellence Center has a three-minute video showing structured rounds. www.youtube.com/watch?v=fExlkV5jlUI
3. The University of Victoria developed a change and transition toolkit entitled Managing Change and Transition: An Overview. It will provide you with strategies for overcoming culture change barriers. www.uvic.ca/hr/assets/docs/od/Workbook%20-%20Managing%20Change%20and%20Transition2.pdf

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Patient Flow Toolkit



Module 2:

Alternate Level of Care

Reference guide for operational leaders, managers and point-of-care staff

Updated April 2016

Table of Contents

Module Objectives	1
What Is ALC?	1
Why Capture ALC Data?	2
Improvements and Supportive Changes	3
Case Studies	4
Commonly Asked Questions	7
Definitions and Designation Guidelines	8
Resources and Appendices	
Appendix 1 – ALC Form	11
Appendix 2 – ALC Train the Trainer Manual Version 1.3.....	13
Appendix 3 – Definitions and Guidelines to Support ALC Designation in Acute Care	37
Appendix 4 – Patient Brochure Copy for RHAs	40
Appendix 5 – Family Brochure Copy for RHAs	43
Appendix 6 – Alternate Level of Care Patients – Designation, Measurement and Management Memorandum of Understanding	46

For more information about this toolkit, visit www.hqc.ca and select the Emergency Department Waits and Patient Flow Initiative in the Improving Quality of Health Care menu, or call 306-668-8810.

REVISIONS (April 2016)

- page 7, Definitions and Designation Guidelines
- pages 11-13, ALC Form v2.4 replaces previous version
- ALC Train the Trainer Manual

Module objectives

This module aims to provide operational leaders, managers, and point-of-care staff with background information about alternate level of care (ALC), increased awareness of and assistance in applying new ALC coding, and tools to promote a stronger understanding of the changes taking place in Saskatchewan's health care system.

The objectives of this module are to:

- create a common understanding throughout the province of the new provincial definition of ALC;
- provide teams and individuals who regularly care for ALC patients with the tools to capture data and information about this patient population; and,
- create a body of knowledge that will facilitate delivery of better health care and inform future investments of resources to reduce emergency department waits and improve patient flow.

What is Alternate Level of Care?

Acute care is the type of care delivered in a hospital. Alternate level of care (ALC) is the term used to describe all patients who have completed the acute care phase of treatment and are still in the hospital waiting to be transferred to a different care setting or discharged home.

ALC Provincial Definition

An ALC patient is a patient who is occupying a bed in a facility and does not require the intensity of resource and/or services provided in that care setting.

Why Do We Need a Provincial Definition?

Having a common ALC definition ensures that providers/care teams across the province are all designating patients in the same way.

As data is gathered, we will be able to identify when a patient no longer needs acute services. Information on demographics and clinical needs of the ALC patients will show us where there are currently gaps in service. Ultimately, a stronger understanding of the provincial ALC population will help inform targeted investments aimed at improving patient flow and patient care.

In the long term, identifying and classifying patients as ALC will help us provide better health care. It will inform the decisions we make regarding the allocation of resources. It will improve the flow of patients through the health care system. It will reduce wait times in the emergency department. But most importantly, it will support patients in receiving the care that meets their needs.

Module 2: Alternate Level of Care

ALC patients may be waiting for transfer to long-term care (LTC), a personal care home (PCH), home with support, specialized rehabilitation, respite, or another non-acute setting.

The health care team has determined that these patients no longer require acute care. This means another setting, or community-based services, if available, would better meet the needs of the patient.

Why Capture ALC data?

The Emergency Department Waits and Patient Flow Initiative has identified understanding and managing ALC patients as a priority across the health system. Although we know ALC patients using acute care beds is one of the factors contributing to long waits in Emergency Departments, we don't have a complete understanding of the size of the ALC population, nor the demographic or clinical characteristics.

The goal of patient-centred care – putting the patient first – should be to prevent avoidable hospital admissions or, when admission is required, to successfully transition people back into their communities. The longer the hospital stay, the more likely a patient will worsen or get an infection. Long hospital stays can decrease general mobility and quality of life. Once medically stable, it is in a patient's best interest to be transferred as soon as possible to a more appropriate location.

The challenge is twofold: without the application of a provincial ALC definition we don't truly understand the size of the ALC population; and without accurate information about the ALC population, it's difficult to know where to invest resources to best support this population and improve patient flow.

Over the past year, representatives from across the health system – coordinated by the Emergency Department Waits and Patient Flow team – have developed a standard ALC definition and processes for data collection.

In order to think and act as one, all Saskatchewan health regions have agreed to identify and manage ALC patients in the same manner (see Memorandum of Understanding in appendices). Standardized processes throughout the province demonstrate our shared commitment to patient-centred care and the provision of care in the right place at the right time by the right provider.

This agreement also reminds us that the care provided to patients should be driven by the needs of that patient and not by their designation as ALC. In addition, the agreement also promotes the use of standardized education and support materials for patients and families, explaining what ALC is and what an ALC designation means.

Improvements and Supportive Changes

New Form

All regions must use the new common provincial ALC designation and data collection forms. Regions should continue to follow the current process for reporting ALC data to CIHI. Regional coders will utilize the ALC designation form to gather data for CIHI.

The use of a common form and one definition is necessary to more accurately identify and classify patients waiting in a hospital bed for alternate level of care.

A “Train the Trainer” manual has been developed to ensure region staff know how to use the ALC data capture form. It is included in this module as Appendix 2. Training sessions on using the new form are available.

The Role of the Patient

Standardized patient/family education materials have been developed for regions to use. These materials explain what ALC is and what an ALC designation means. Regions may need to add their own local information; a Microsoft Word template is available in the appendices.

The Role of Administration

Health region administrators have a critical role to play in ensuring the new ALC form gets used properly, with data coded correctly and entered into the health information

system in an accurate and timely manner. The information that’s collected will be used to make important decisions about how best to deliver patient care.

The Role of the Physician

Physicians have a crucial role to play in the designation of ALC patients.

Billing

Misunderstanding about the ALC definition has created confusion about how physicians should bill. With the exception of patients designated as awaiting long-term care placement, ALC designation should not impact billing practices nor affect care received. The focus of billing is related to the condition of the patient, the medically required services provided by the physician, and the requirements of the payment schedule fee code.

As care needs vary, so do the medical services provided by a physician. Eligible fee codes will vary depending on the patient’s clinical needs and the physician services provided. As with the billing of all medical services, requirements of the payment schedule code being billed must be met, including appropriate documentation of medical necessity for the service. Some examples include:

- *Counselling on a third-party basis* may be appropriate when a family member is counselled because of the patient’s serious and complex problem. It is not

Module 2: Alternate Level of Care

payable for routine briefing or advice to relatives, which is considered part of the visit service fee. Third-party counselling must be provided at a booked separate appointment/time, is subject to a maximum of 30 minutes, and must be submitted in the counselled individual's name. This code can be billed by any physician (40B, 41B)

- A *case conference* may be appropriate in situations where the patient's care needs to be discussed with other allied health care professionals. These sessions must be a formal scheduled session, and may be billed by any physician (42B, 44B).
- If a patient has *acute needs that are being managed by a physician*, these services may support billing of hospital day care codes (25-28 B-T).
- *Services listed in the "A" section of the Payment Schedule*. These are billable by any physician. This includes patients designated as awaiting long-term care (626A).

Any general billing inquiries can be directed to the Medical Services Branch, Claims Analysis Unit, at 306-787-3454.

The Role of the Interdisciplinary Team

An ALC patient has many touchpoints within the health system and all members of his/her interdisciplinary team contribute to the patient's successful health care. Knowledge and awareness of the ALC designation process and of the importance of collecting ALC data are key to patient health.

Case Studies

The following case studies are designed to illustrate common ALC scenarios, to help health providers understand the standardized ALC provincial definition. These case studies are not intended to replace the clinical decision-making and judgment of the physician or interdisciplinary team.

Case Studies

Scenario	Rationale
A patient in an acute care bed no longer requires acute care and is waiting for a home care program, rehabilitation services, or a long-term care bed.	The patient whose discharge is delayed pending the availability of these services <i>would</i> be considered ALC.
A patient is admitted to a rehab program for therapy after a hip fracture. Once the therapy is completed, the patient must remain in the facility until home care can be provided.	The patient's course of rehab treatment has been completed but he/she is waiting in the rehab bed, so he/she <i>would</i> be considered ALC.
A patient in an acute, mental health, or rehabilitation bed is waiting to go home, but requires the installation of equipment within the home before he/she can be accommodated.	The patient <i>would</i> be considered ALC.
A patient is admitted for respite care to an acute, mental health, or rehabilitation bed.	When a respite care patient is admitted to an acute, mental health or rehabilitation care bed, the patient <i>would</i> be considered ALC for the entire episode of care.
A companion well baby (a baby who does not require acute, mental health, or rehabilitation care but who is admitted to a facility to stay with his/her ill mother) is admitted to a facility.	A companion well baby <i>would</i> be considered ALC.
A patient is documented by the physician or designate as ALC but is subsequently discharged later that same day.	Although the patient's status is designated ALC by the physician or authorized designate, the ALC transfer <i>cannot</i> be captured as the patient is subsequently discharged later the same day. The day of discharge is considered part of the total acute length of stay.

Case Studies

Scenario	Rationale
<p>A patient on an acute care unit who still requires acute care services is waiting for another type of bed within the same hospital.</p>	<p>The patient is <i>not</i> considered ALC until they no longer require the services provided in the hospital.</p>
<p>A patient has been transferred to a sub-acute bed to convalesce post intervention while continuing to receive acute care services.</p>	<p>The patient would <i>not</i> be designated ALC.</p>
<p>A patient has been transferred from an acute care unit to a transition unit in an acute facility while waiting placement and no longer requires acute care services.</p>	<p>The patient <i>would</i> be designated ALC.</p>
<p>A patient is in an inpatient bed and no longer requires the intensity of inpatient resources/services, but cannot be discharged due to lack of available placement options attributed to complex illness-related and/or challenging behaviours.</p>	<p>This patient <i>would</i> be considered ALC waiting for available community placement to match patient care needs, including but not limited to:</p> <ul style="list-style-type: none"> • complex residential care facility; • under-65 early aging facility; or, • other appropriate community based programs.
<p>A patient is in an inpatient bed and no longer requires the intensity of inpatient resources/services, but cannot be discharged due to lack of available community programs/services that would support that patient’s complex needs such as:</p> <ul style="list-style-type: none"> • Home IV therapy; • Therapy services; or, • Complex dressing changes or wound management. 	<p>The patient <i>would</i> be considered ALC even though the services that match the needs of the patient are not available.</p>

Commonly Asked Questions

Who is responsible for designating patients as ALC?

The physician or any health care team member can designate a patient as meeting the criteria for ALC. It will be the responsibility of each region to identify which team member(s) will complete the designation and be responsible for completing the required documentation.

Who qualifies as ALC?

A patient will be designated ALC if he/she:

- is occupying a bed in a facility and does not require the intensity of resource and/or services provided in that care setting;
- is awaiting placement for an alternate level of service; or,
- is admitted directly to a health care facility as ALC because alternate care is unavailable.

Who does not qualify as ALC?

A patient is not considered ALC if he/she:

- is convalescing post intervention and is being treated in a step down unit, designated as sub acute;
- continues to require acute care resources/services while waiting to be transferred to another acute care bed/service within the facility or to a different facility; or

- is waiting in a tertiary acute care facility bed for transfer to a non-tertiary acute care facility bed.

Do you need to know the discharge destination when designating a patient ALC?

No. It is not necessary to know where a patient is being discharged to before making an ALC designation. It may take the health care team longer to identify the needs of some patients and determine what program/services may be required, but that delay doesn't need to affect the ALC designation.

Can a patient be designated ALC when the appropriate level of care is not available in the community to meet the care needs of the patient?

Yes. This type of information will be collected and used for planning.

Can a patient be designated ALC if he/she does not meet the eligibility criteria of the discharge destination?

Yes. Designation of a patient as ALC is not linked to eligibility for any beds/programs/services.

Is there a specific timeframe for the patient's length of stay in order to be designated ALC?

Yes. Patients must meet the definition for ALC for a minimum of 24 hours before they can be designated ALC. The exception to this is

Module 2: Alternate Level of Care

when a patient is admitted as ALC because an alternate level of care is not available (for example, admission for respite care).

Once a patient is designated ALC, can their ALC status be discontinued?

Yes. If the medical status of a patient changes and the patient again requires acute care, the ALC status would be removed. The patient may be re-designated ALC once their care needs are met and they no longer require the level of services provided in their current care setting.

Definitions and Designation Guidelines

The Western Patient Flow Collaborative has created a document called Definitions and Guidelines to Support ALC Designation in Acute Inpatient Care (see Appendix 3). This is intended to assist teams in the determination to designate a patient alternate level of care.

Appendices

ALTERNATE LEVEL OF CARE (ALC)

Appendix 1 – ALC Form

ALC – A patient occupying a bed in an acute care facility and does not require the intensity of resources/services provided in that acute care setting.

Note: The authorized designate may be a Physician, Long Term Care Assessor, Patient Care Manager, Care Team Member, Discharge Planner, etc.

1. Date of Admission: TIME: _____ DATE: _____ 20__

2. ALC Designation: TIME: _____ DATE: _____ 20__

3. Designate Initiating Form & Contact Information: _____

4. Communication to Patient / Next of Kin: No Yes DATE: _____ 20__

5. Reverted to Acute Status: TIME: _____ DATE: _____ 20__ Acute Diagnosis: _____

If patient RETURNS to ALC designation after acute episode a NEW ALC Form is required

Reasons for ALC Designation: Check ONE circle indicating the MAIN reason for ALC designation.
 Check MULTIPLE boxes for ALL contributory reasons that apply.

Note: The one ALC reason is to identify the main reason why the patient is remaining in an acute care facility bed
 Coders: Assign the applicable ICD-10-CA code for all ALC reasons indicated on this form and assign Prefix "A" to link all ALC related documentation on the DAD abstract. Note: Do not use prefix "A" for palliative care reason (Z51.5 if Prefix 8 applies to Z51.5). Prefix 8 takes precedence.

WAITING SERVICE	<input type="radio"/> <input type="checkbox"/> Waiting for assessment to determine ALC care needs (Z75.2) – <i>complete backside of sheet</i>	
	<input type="radio"/> <input type="checkbox"/> Approved and waiting for admission to facility/bed (waitlisted) (Z75.1) – <i>complete backside of sheet</i>	
	<input type="radio"/> <input type="checkbox"/> Waiting for community service/helping agency/home services arrangement (Z75.2) – <i>complete backside of sheet</i>	
	<input type="checkbox"/> Other waiting period for investigation and treatment (*Specify):	
NEED FOR ASSISTANCE	<input type="radio"/> <input type="checkbox"/> Assistance with personal care (Z74.1)	<input type="radio"/> <input type="checkbox"/> 24 hour care/supervision (Z74.3)
	<input type="radio"/> <input type="checkbox"/> Reduced Mobility (Z74.0) <input type="checkbox"/> Supervision <input type="checkbox"/> Assist x 1 <input type="checkbox"/> Assist x 2 <input type="checkbox"/> Sit/Stand Lift (Z99.8) <input type="checkbox"/> Total Lift (Z99.8)	<input type="checkbox"/> Cognitive Impairment <input type="checkbox"/> Mild (F06.7) (*Specify if other than Mild):
	<input type="checkbox"/> Behavioural Issue (*Specify):	Incontinence: <input type="checkbox"/> Urinary (R32) <input type="checkbox"/> Fecal (R15)
MEDS	<input type="checkbox"/> Inability to manage medications (Z73.8)	
	<input type="checkbox"/> Adjusting medications/Patient Stable (Z51.88)	
SOCIAL ISSUES OR HOUSING	<input type="checkbox"/> <input type="checkbox"/> IV medications (longer than 1 week) (*Specify):	
	<input type="radio"/> <input type="checkbox"/> Homeless (Z59.0)	<input type="radio"/> <input type="checkbox"/> Unfit Housing (Z59.1)
	<input type="radio"/> <input type="checkbox"/> Other Housing or Financial Issue (Z59.8) (*Specify):	<input type="radio"/> <input type="checkbox"/> Legal problem (Z65.0, Z65.3) (*Specify):
	<input type="radio"/> <input type="checkbox"/> Inadequate family support (Z74.8) <input type="checkbox"/> Absence of family member (Z63.3)	<input type="checkbox"/> Lives Alone (Z60.2)
	<input type="radio"/> <input type="checkbox"/> Need for assistance at home and no care provider to render care (Z74.2) <input type="checkbox"/> Addiction Issue (*Specify):	<input type="radio"/> <input type="checkbox"/> Caregiver fatigue/Respite (Z75.5)
	<input type="radio"/> <input type="checkbox"/> Patient/Family refusing proposed Discharge / Placement Option / Perception of Readiness (Z76.4)	
OTHER	<input type="radio"/> <input type="checkbox"/> Boarder Caregiver/Baby (No supervision required) (Z76.3)	<input type="radio"/> <input type="checkbox"/> Boarder Baby/Child (Medical/Nursing supervision required) (Z76.2)
	<input type="checkbox"/> Bariatric needs (E66) (*Specify):	<input type="checkbox"/> Palliative care (Z51.5)
	<input type="checkbox"/> Education/Counselling (*Specify):	<input type="checkbox"/> Rehabilitation (*Specify):
	<input type="checkbox"/> Other issues/care needs (*Specify):	

Document all services the patient requires that are NOT available, as applicable

No facility available to meet ALC care needs (Z75.3)
 Specify type(s) of facility that does not exist _____

No community service/helping agency/home service to meet ALC care needs (Z75.4)
 Specify type(s) of Community/Helping agency/Home service that does not exist _____

Patient designated ALC and waiting for ...	CONSULT REQUESTED (DDMMYYYY)	ACCEPTED TO PROGRAM and/or WAITLISTED <input type="checkbox"/> Yes <input type="checkbox"/> No (DDMMYYYY)	COMMENTS
Facility/Program/Service			
<input type="checkbox"/> Rehabilitation <i>(Specify):</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
<input type="checkbox"/> Geriatrics		<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
<input type="checkbox"/> Restorative Care/Convalescent Care <i>(Specify):</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
<input type="checkbox"/> Respite care		<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
<input type="checkbox"/> Transition Location <i>(Specify):</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
<input type="checkbox"/> Repatriation Waiting for admission to facility/bed (waitlisted) <i>(Specify):</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
<input type="checkbox"/> Long Term Care		<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
Housing			
<input type="checkbox"/> Assisted/enriched living		<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
<input type="checkbox"/> Personal Care Home		<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
Community Services			
<input type="checkbox"/> Home Care		<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
<input type="checkbox"/> Therapies		<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
<input type="checkbox"/> Home IV		<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
Palliative Care			
<input type="checkbox"/> Palliative Bed Admission Waiting for admission to facility/bed (waitlisted)		<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
<input type="checkbox"/> Palliative Home Care Waiting for services to be arranged		<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
Mental Health			
<input type="checkbox"/> Inpatient: Waiting for admission to facility/bed (waitlisted)		<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
<input type="checkbox"/> Detox Waiting for Community/helping agency/home services to be arranged		<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
<input type="checkbox"/> Community Waiting for Community/helping agency/home services to be arranged		<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
<input type="checkbox"/> Other (waiting for...) <i>(Specify):</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
<input type="checkbox"/> Other (waiting for...) <i>(Specify):</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	

<p>Discharge status: Was patient discharged to service/program requested? <input type="checkbox"/> No <input type="checkbox"/> Yes If No: <input type="checkbox"/> Deceased <input type="checkbox"/> Other _____</p> <p>Discharge: TIME: _____ DATE: _____ 20_____</p>
--

ALC Train the Trainer

Collecting and Reporting on Alternate Level of Care Data - Training Manual

Version 1.3

April 1, 2016



Emergency Department Waits
and Patient Flow Initiative
putting the Patient First

2016

CONTENTS

- Introduction 2
- Objective 2
- Definitions..... 3
- Capturing the Data..... 5
 - Numbered Section 6
 - Reasons For Designation Section..... 7
 - Discharge Information 9
 - Coding 10
- Audit..... 11
- Mentoring Teams and Continuous Improvement 14
- Appendices..... 16
 - Links to Job Aids from the Canadian Institute for Health Information..... 16
 - ALC Form..... 16
 - Work Standard 1: Criteria for Determining Alternate Level of Care (ALC) 17
 - Work Standard 2: Completion of ALC Form..... 18
 - Work Standard 3: Coding of Alternate Level of Care Form 19
 - Work Standard 4: eHealth Review of ALC Form 21
 - Work Standard 5: Placement of Alternate Level of Care Form in Patient’s Chart at Health Records ... 22
 - Audit Tool for Alternate Level of Care Form..... 23

REVISIONS, APRIL 2016

Pages 2, 4-11, 16, 19-22

INTRODUCTION

Many patients stay in acute care beds, but no longer require that level of care, because there is a lack of options for them in sub-acute care or in the community. These patients would be considered Alternate Level of Care (ALC) patients. Another way to think of ALC is an unnecessary length of stay. These patients could be either at home or in a more appropriate unit or facility, if “X, Y or Z” existed. ALC data is key to understanding what the specific gaps are in sub-acute or community services.

Currently data captured in acute care facilities throughout the province about ALC patients is not only inadequate (usually only capturing those waiting for long-term care placement), but also does not provide any information on why a person is still in hospital and what their unmet needs are. Future development of programs to alleviate this issue requires this context specific information. Currently the number of ALC days is a significant driver for long wait times in the emergency department and poor patient flow.

In January of 2015, a Rapid Process Improvement Workshop (RPIW) was undertaken to:

- Identify what data should be captured about ALC patients to inform decision-making;
- Develop standard provincial definitions and work standards for the capture of the data; and
- Create a provincial template to be used by all Regional Health Authorities (RHAs) to capture and enable consistent reporting of ALC data to the Canadian Institute for Health Information (CIHI).

Subsequent to the RPIW two RHAs (Sunrise and Saskatoon) piloted the form and work standards. This allowed the province to undertake a number of Plan-Do-Check-Act (PDCA) cycles on the data capture form as well as supporting materials. After three months it was identified that inadequate training, monitoring, auditing and communications presented significant challenges to the adoption of the form and data capture process as well as uptake from an administrative and clinical perspective.

In June 2015, eHealth and HQC hosted a one-day intensive Kaizen event in Saskatoon to focus on the drafting of a Training Manual, Communications Plan, and Audit processes that could support a more timely roll-out, adoption and compliance with the new ALC data capture process, form and reporting. Out of this event also came the recommendation of offering a boot camp for all RHAs ready to implement the ALC data capture tool, training and reporting.

This training manual has been developed as a living document to support the standard training and implementation of ALC data capture and reporting throughout Saskatchewan.

OBJECTIVE

The objective of the ALC data capture initiative is to have all Saskatchewan health regions collecting and reporting consistent and timely ALC data by March 31, 2017.

DEFINITIONS

Alternate Level of Care: When a patient is occupying a bed in a facility and does not require the intensity of resources/services provided in that care setting

Community Services - Therapies: When a patient requires therapies to be assessed or set up in the home/community setting to enable them to function in the home setting (i.e. Occupational Therapy and/or Physiotherapy).

Home Care: An array of services, provided in the home and community setting, that encompass health promotion and teaching, curative intervention, end-of-life care, rehabilitation, support and maintenance, social adaptation and integration, and support for the informal (family) caregiver. *(Canadian Home Care Association)*

Long-term Care: A publicly subsidized long-term care system for individuals whose assessed needs cannot be met through community and home-based services or other housing options. *(Ref. Heather Murray, Community Care Branch)*

Mental Health: Refers to the broad range of services and supports available to individuals with mental illness. This also includes addiction services and supports aimed at preventing or reducing/treating substance abuse, substance use disorders and problematic gambling.

Palliative Care: Is active and/or supportive compassionate care of a terminally ill patient at the time when his or her disease is no longer responsive to traditional therapy aimed at a cure or prolonging life. Acute palliative care treatments may include pain control, symptom management, and intravenous therapy, feeding tubes, nerve blocks, radiation therapy and chemotherapy. A non-acute palliative care patient is one whose symptoms are well controlled and who could be cared for in a non-acute setting (for example, home care or hospice). Non-acute palliative patients should be designated as ALC patients if they are occupying an inpatient bed of an acute care facility. *(CIHI DAD)*

Personal Care Home: These are privately owned and operated facilities that provide another option to adults who generally do not require the services of a long-term care facility, but who need to receive assistance or supervision with personal care. *(Ref. Heather Murray, Community Care Branch)*

Rehabilitation: For patients requiring more intensive therapies in a time limited episode of service. Rehabilitation services are provided either in specialized facilities as well as hospital rehabilitation units, programs and designated rehabilitation beds. Admission criteria are specific to each rehabilitation program. *(Adapted from CIHI)*

Repatriation: The process of transferring the patient to his or her referring acute care hospital or to the acute care hospital that is the “closest” to his or her home address once the patient is deemed to be medically stable and/or suitable for transfer. The receiving acute care hospital is determined based on geography and the ability for the patient to receive the required ongoing care. *(Critical care services Ontario – Repatriation guide 2014)*

Respite: For clients who normally live at home but are dependent on family members for support. For example, it can be a planned period of relief for the usual caregiver or a crisis intervention when the patient's usual support system is unavailable due to illness of the usual caregiver. *(CIHI DAD)*

Restorative Care (formerly known as Convalescent Care): is the provision of a period of additional recuperative time following an intervention or serious illness. It is intended to provide clients with the opportunity to recover health/independence in order to return to the community setting. *(CIHI DAD)*

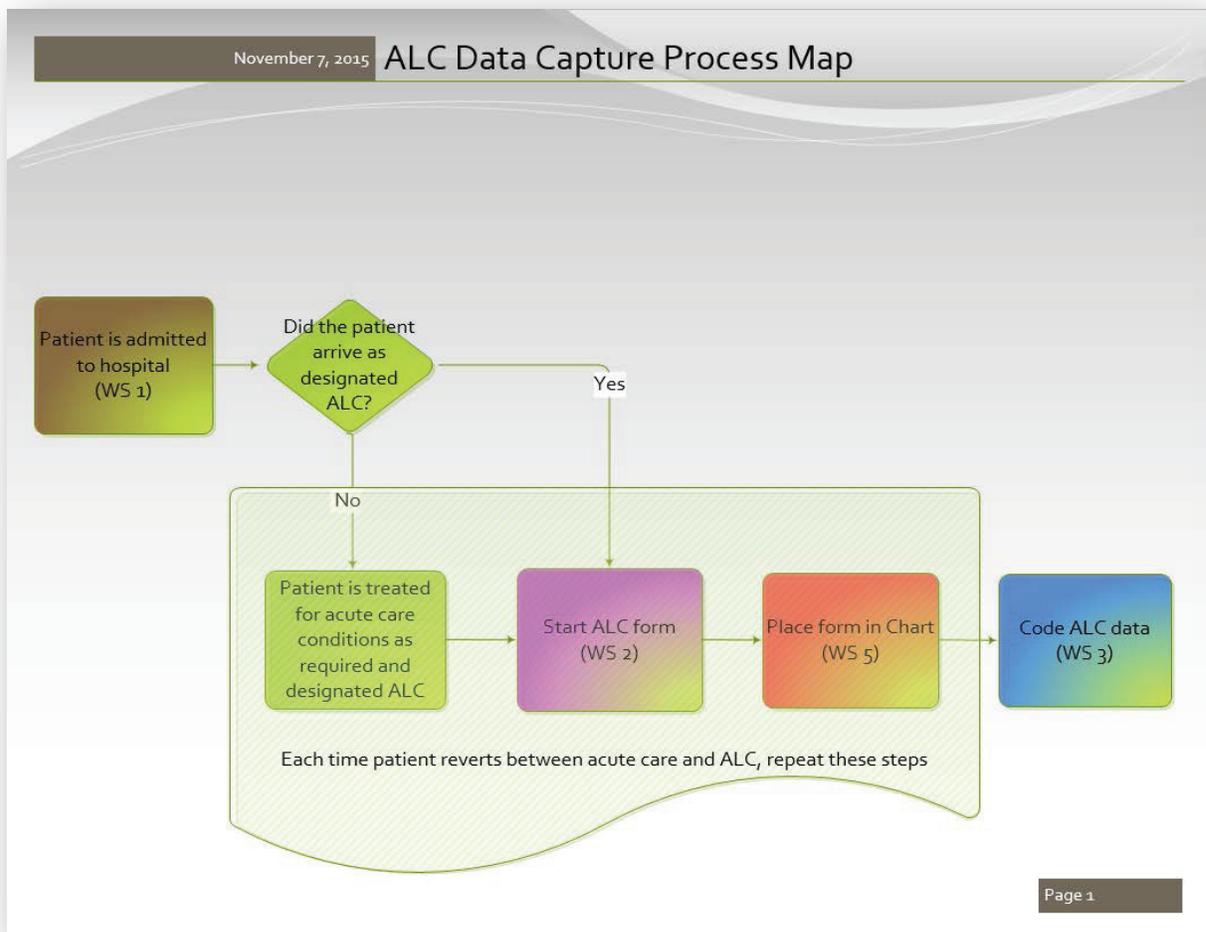
Transition Location: The patient has been transferred, but has not been discharged to their final destination. Transition locations could include an alternate level of care unit, a transition care unit, or an alternate acute care setting such as their home hospital.

CAPTURING THE DATA

ALC designation does not **only** apply to patients waiting for Long-term Care. When a patient is occupying a bed in an acute care facility but does not require the **intensity** of resources/services provided in that care setting the patient must be designated Alternate Level of Care (ALC) at that time by a member/members of the interdisciplinary team. There are many case examples described on page 5 of the toolkit.

For more details on when the ALC form needs to be filled out, please see [Work Standard 1: Criteria for Determining Alternate Level of Care \(ALC\)](#)

When a patient is determined to be ALC, a Provincial ALC data capture form must be initiated and placed on the patient chart. Along with the ALC data capture form, there are a number of Work Standards (WS) that were created to support care providers in understanding how and when information needs to flow during the ALC care process. The following process map shows the ALC Data Capture Process.



FILLING OUT THE FORM

For more detailed instructions on completing the form please refer to the [Work Standard 2: Completion of ALC Form](#).

NUMBERED SECTION

Ensure all numbered fields are completed in the first section, as applicable. Those marked with arrows are always required.

1. Date of Admission: TIME: _____ DATE: _____ 20__

2. ALC Designation: TIME: _____ DATE: _____ 20__

3. Designate Initiating Form & Contact Information: _____

4. Communication to Patient / Next of Kin: No Yes DATE: _____ 20__

5. Reverted to Acute Status: TIME: _____ DATE: _____ 20__ Acute Diagnosis: _____

If patient RETURNS to ALC designation after acute episode a NEW ALC Form is required

Note:

Documentation of reversion back to an acute status is mandatory.

If the patient deteriorates and requires acute care again, the time and date this occurs and the diagnosis should be recorded in the "Reverted to Acute Status" section of the form.

5. Reverted to Acute Status: TIME: 1100 h DATE: June 10 2016 Acute Diagnosis: fell and fractured left hip

NOTE: If the patient returns to ALC designation after an acute episode, a new ALC form must be started.

REASONS FOR DESIGNATION SECTION

There must be a main reason identified for why the patient is ALC. That reason must be chosen from the selections available on page 1 that are indicated with a **circle (o)**. Only one main reason can be selected.

ALL contributory reasons can be indicated by marking the selections indicated with a **box (□)**

Reasons for ALC Designation: Check ONE circle indicating the **MAIN** reason for ALC designation.
 Check MULTIPLE boxes for **ALL** contributory reasons that apply.

Note: The one ALC reason is to identify the main reason why the patient is remaining in an acute care facility bed
 Coders: Assign the applicable ICD-10-CA code for all ALC reasons indicated on this form and assign Prefix "A" to link all ALC related documentation on the DAD abstract. Note: Do not use prefix "A" for palliative care reason (Z51.5) if Prefix 8 applies to Z51.5). Prefix 8 takes precedence.

Main reason

Secondary reasons

WAITING SERVICE	<input type="checkbox"/> Waiting for assessment to determine ALC care needs (Z75.2) – <i>complete backside of sheet</i>	
	<input type="checkbox"/> Approved and waiting for admission to facility/bed (waitlisted) (Z75.1) – <i>complete backside of sheet</i>	
	<input checked="" type="checkbox"/> Waiting for community service/helping agency/home services arrangement (Z75.2) – <i>complete backside of sheet</i>	
	<input type="checkbox"/> Other waiting period for investigation and treatment (*Specify):	
NEED FOR ASSISTANCE	<input type="checkbox"/> Assistance with personal care (Z74.1)	<input type="checkbox"/> 24 hour care/supervision (Z74.3)
	<input type="checkbox"/> Reduced Mobility (Z74.0) <input type="checkbox"/> Supervision <input type="checkbox"/> Assist x 1 <input type="checkbox"/> Assist x 2 <input type="checkbox"/> Sit/Stand Lift (Z99.8) <input type="checkbox"/> Total Lift (Z99.8)	<input type="checkbox"/> Cognitive Impairment <input type="checkbox"/> Mild (F06.7) (*Specify if other than Mild):
	<input type="checkbox"/> Behavioural Issue (*Specify):	Incontinence: <input type="checkbox"/> Urinary (R32) <input type="checkbox"/> Fecal (R15)
	<input type="checkbox"/> Inability to manage medications (Z73.8)	<input checked="" type="checkbox"/> Adjusting medications/Patient Stable (Z51.88)
SOCIAL ISSUES OR HOUSING	<input type="checkbox"/> Homeless (Z59.0)	<input type="checkbox"/> Unfit Housing (Z59.1)
	<input type="checkbox"/> Other Housing or Financial Issue (Z59.8) (*Specify):	<input type="checkbox"/> Legal problem (Z65.0, Z65.3) (*Specify):
	<input checked="" type="checkbox"/> Inadequate family support (Z74.8)	<input checked="" type="checkbox"/> Lives Alone (Z60.2)
	<input type="checkbox"/> Absence of family member (Z63.3)	<input type="checkbox"/> Caregiver fatigue/Respite (Z75.5)
	<input type="checkbox"/> Need for assistance at home and no care provider to render care (Z74.2)	<input type="checkbox"/> Patient/Family refusing proposed Discharge / Placement Option / Perception of Readiness (Z76.4)
	<input type="checkbox"/> Addiction Issue (*Specify):	

It is important to identify services that aren't available, but would assist the patient in returning to the community or an alternate care setting if it was available. Note that this section can be identified as a main reason or contributory reasons. The Facility or Community service/Helping agency/Home service that is not available must be specified in the section provided for comments.

Document all services the patient requires that are NOT available, as applicable

No facility available to meet ALC care needs (Z75.3)

Specify type(s) of facility that does not exist _____

No community service/helping agency/home service to meet ALC care needs (Z75.4)

Specify type(s) of Community/Helping agency/Home service that does not exist _____

If required, the Interdisciplinary Team or responsible provider will determine necessary consults and/or assessments the patient needs to determine the most appropriate care setting for the patient to be transferred to. On the page 2 of the ALC form the following information should be completed:

- The date the consult/service was requested (recorded on the ALC Form under the Consult Requested column);
- The decision if the patient was accepted or waitlisted for the service/support/program or not and the date that decision was made (recorded on the ALC Form under the Accepted to Program/Waitlisted column); and
- Any comments that the team or provider may have in relation to the request or the decision.

Patient designated ALC and waiting for ...	CONSULT REQUESTED (DDMMYYYY)	ACCEPTED TO PROGRAM and/or WAITLISTED <input type="checkbox"/> Yes <input type="checkbox"/> No (DDMMYYYY)	COMMENTS
Facility/Program/Service			
<input checked="" type="checkbox"/> Rehabilitation <i>(Specify):</i>	07/04/16	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Date: 10/04/16	Patient cannot tolerate intensity of therapies.
<input type="checkbox"/> Geriatrics		<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
<input checked="" type="checkbox"/> Restorative Care/Convalescent Care <i>(Specify):</i>	12/04/16	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Date: 15/04/16	
<input type="checkbox"/> Respite care		<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
<input type="checkbox"/> Transition Location <i>(Specify):</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
<input type="checkbox"/> Repatriation Waiting for admission to facility/bed (waitlisted) <i>(Specify):</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
<input type="checkbox"/> Long Term Care		<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
Housing			
<input type="checkbox"/> Assisted/enriched living		<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
<input type="checkbox"/> Personal Care Home		<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
Community Services			
<input type="checkbox"/> Home Care		<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
<input type="checkbox"/> Therapies		<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
<input type="checkbox"/> Home IV		<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
Palliative Care			
<input type="checkbox"/> Palliative Bed Admission waiting for admission to facility/bed (waitlisted)		<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
<input type="checkbox"/> Palliative Home Care		<input type="checkbox"/> Yes <input type="checkbox"/> No	

The "Other" section at the bottom of page 2 may be used if the requested service is not listed. In the example shown, the patient did not meet the criteria for an inpatient Mental Health bed so the team is now investigating an out of province option. The specific program being investigated is noted on the form with additional information in the comments section.

Waiting for services to be arranged		Date:	
Mental Health			
<input type="checkbox"/> Inpatient: waiting for admission to facility/bed (waitlisted)	14/05/16	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Date: 16/05/16	Does not meet admission criteria.
<input type="checkbox"/> Detox Waiting for Community/helping agency/home services to be arranged		<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
<input type="checkbox"/> Community Waiting for Community/helping agency/home services to be arranged		<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
<input checked="" type="checkbox"/> Other (waiting for...) (Specify): Ponoka Brain Injury Program	18/05/16	<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	Seeking source of funding for out of province program.
<input type="checkbox"/> Other (waiting for...) (Specify):		<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	

DISCHARGE INFORMATION

When the patient leaves the acute care hospital, the date and time of discharge and discharge status must be recorded on the ALC form. It must be indicated if the discharge plans were followed and if not, what were the circumstances surrounding the change of plans.

Discharge status: Was patient discharged to service/program requested? No Yes
 If No: Deceased Other _____
 Discharge: TIME: _____ DATE: _____ 20 _____

Discharge status: Was patient discharged to service/program requested? No Yes
 If No: Deceased Other moved to Alberta to live with daughter
 Discharge: TIME: 1400 DATE: June 15 2016

CODING

Once initiated, the ALC form becomes part of the patient's chart and will remain on the chart when it is sent to Health Records for assembly/coding/filing. During assembly, place the ALC form directly after the discharge summary. For more detailed instructions on placing the form see the [Work Standard 5: Placement of Alternate Level of Care Form in Patient's Chart at Health Records](#).

After the chart is assembled, Health Records staff are responsible for coding the chart. As part of your implementation and communications strategy, coding staff must be trained on [Work Standard 3: Coding of Alternate Level of Care Form](#).

When to Code a Patient as ALC

The presence of the form is evidence this patient is no longer receiving acute care treatment and has been designated as ALC for a portion (24 hours or more) of his/her stay, record a Service Transfer of 99. Verify that the ALC length of stay is greater than 24 hours by referring to the ALC designation date and time and the discharge date and time and/or the date and time the patient reverted to acute status. If time is less than 24 hours do not code the ALC form. If there are multiple ALC forms for the stay, add up the days from all forms. Each ALC episode must be > 24 hours.

If the patient has been directly admitted as ALC, regardless if the total length of stay is less than 24 hours, capture the Main Patient Service as 99.

If the coder finds documentation in the chart to indicate that there were ALC days during the acute visit, but there is no ALC form present, the issue should be brought to the attention of the nursing unit manager or clinical coordinator of the nursing unit to which the patient was last admitted.

Calculating ALC Length of Stay

Calculate and enter the ALC length of stay by referring to the ALC designation date and discharge date and/or date reverted to acute status. If the patient has reverted between acute and ALC multiple times during the same admission, enter the ALC service transfer only once and capture the total length of ALC days by adding all ACL days (>24 hours) from all ALC forms.

Diagnosis Codes

In the Diagnosis Field for the "Service Transfer Diagnosis", code the appropriate Z code for the main reason for ALC designation. ALC Designated Z codes are listed in the *DAD Abstracting Manual – Section 3: Alternate Level of Care (ALC)*. Refer to the marked reason indicated in a circle, on Page 1 of the ALC form to determine the designated Z code to capture. The Z codes on page 1 highlighted in red are the defined codes that have been assigned to capture main ALC reasons.

Capture this and all other contributory reasons indicated in the boxes for ALC designation with a Diagnosis Prefix of "A" so that contributory reasons for ALC can be identified on the DAD record. Reasons, listed with a diagnosis code in parentheses are the defined codes that have been assigned to capture those reasons. Where there is documentation provided in ***(Specify)**

code to the most specific ICD-10-CA code to capture the relevant additional information; these codes do not have to be Z codes. This allows more specificity than the main reason Z codes.

ALC diagnoses must be specified on the form or clearly indicated in the chart as an ALC reason. For example, coders cannot assume a behavioral issue mentioned in the chart is a contributing ALC reason unless this same diagnosis is also indicated on the ALC form.

Use the appropriate Diagnosis Type for each code, following the usual rules for diagnosis typing as set out in the DAD Abstracting Manual and the Canadian Coding Standards.

The mandatory Prefix 8 for patients known to be palliative prior to admission takes precedence over Prefix A if Prefix 8 applies to Z51.5. Be sure to follow the Canadian Coding Standards for coding of all other ALC reasons indicated on the form.

For more information

In the event of questionable information on the form, consult with the contact person indicated at the top of the form.

For questions or concerns with respect to coding the ALC Form contact dataquality@ehealthsask.ca.

AUDIT

An audit is used to assess success, failure and improvement possibilities. The deployment of the ALC form will be audited to identify where barriers exist with the use of the form. This audit will not be used to measure the data elements of ALC.

To aid in the audit of the ALC form an audit tool was created to assist in capturing the information to be used by the senior leaders. This information will determine the success of deployment or the need for corrective action. In addition, it will allow for managers responsible for reporting on ALC to know if the data captured is incomplete.

Regions are not expected to audit every completed ALC form, but may choose to audit a predetermined number of forms per week or on a schedule that fits local work flow processes.

How to use the Audit Tool

The Audit tool is a Microsoft Excel spreadsheet consisting of six sections. One line is to be used to record the status of each chart that is audited. It is not necessary to audit every form.

Section 1: Record the basic information for each entry.

	A	B	C	D	E	F	
1	Audit tool for Alternate Level of Care (A						
2							
3	Basic information to be filled out for all rows						In
				Name of person who	Medical Record		Mr In
4	Region	Facility	Unit	Nursing filled out form	Number	Discharge Date	Com
5							
6							
7							
8							

Section 2: Record the *Initial Status* of the form. This section uses a drop down menu. Select Missing, Incomplete or Complete to identify how the original submission of the form was received.

G		H	
Care (ALC) form			
Section 2	Initial Status	Any inaccuracies? Yes/No	What is
	Missing Incomplete Complete		ALC designation date
Section 3			

Section 3: Record if there are *Any Inaccuracies* on the form. This section uses a drop down menu. Select Yes or No. If yes, proceed to section 4; if no, proceed to Section 6.

Section 4: Record the specific information that is *Incomplete* on the form. This section uses a drop down menu. Select Missing or Inaccurate for all that apply.

I	J	K	L	M	N	O	P	Q
What is incomplete? We may not need to audit every field on the form. Perhaps just the critical ones like the date of ALC and the reason declared ALC.								
ALC designation date	ALC designation time	Date reverted to acute status (if applicable)	Initiated by	Reason declared	Service required	Consult request date	Assessment completed date	Accepted to program date

Section 5: Record the turnaround time for the chart that has been sent to the unit for completion. This section requires text entry. Enter the date in the first column that the chart was sent to the unit for form completion. Turnaround time is expected to be within two business days. When the chart is returned from the unit, enter the date it was returned in the second column.

The diagram shows a grid representing the ALC form. The columns are labeled R, S, and T. The grid is divided into two main sections: Section 5 (light blue) and Section 6 (light orange). Section 5 contains the text 'Turn around time (Should be within 2 business days.)' and 'Date sent to unit' and 'Date returned from unit'. Section 6 contains the text 'Final Status' and 'Not ALC Form completed' and 'Form incomplete'. Red arrows point from the labels 'Section 5' and 'Section 6' to their respective areas in the grid.

	R	S	T
	Turn around time (Should be within 2 business days.)		Final Status
Section 5	Date sent to unit	Date returned from unit	Not ALC Form completed Form incomplete

Section 6: Record the *Final Status* of the form. This section uses a drop down menu. Select Not ALC, Form Completed or Form Incomplete as appropriate.

MENTORING TEAMS AND CONTINUOUS IMPROVEMENT

A provincial ALC form is new for Saskatchewan. Training is required for all members of the clinical team and health records on how to use and enter information on the form and how to record this information in the Discharge Abstract Database.

The ALC boot camp on September 28, 2015 was the first such training session. Regional staff trained at this session may be able to help train others in their region.

There is a provincial implementation group who meet regularly to review the form and processes and provide further training and sharing of ideas. The Emergency Department Waits and Patient Flow Initiative also has an outreach support team available to provide coaching and support to regions as they implement this change. For assistance in accessing the outreach team contact edwaits@hqc.sk.ca.

The form and processes are not perfect and will be continuously improved as they are rolled out across the province. eHealth is committed to a quarterly review of the data collected to catch any data quality issues and get ideas for future improvements to the form. See [Work Standard 4: eHealth Review of ALC Form](#) for more details.

We are unable to record all information from the ALC form in the Discharge Abstract Database. For example, there is no place to record the dates that services/consults were requested. Although it may involve manual processes at first, units are encouraged to use the information on the forms in real time to help coordinate the care of ALC patients and measure

improvements. eHealth is currently designing a provincial electronic data capture form that should be ready for all RHA's to use early in fiscal year 2016-17, allowing collection and analysis of all data field.

APPENDICES

LINKS TO JOB AIDS FROM THE CANADIAN INSTITUTE FOR HEALTH INFORMATION

- Alternate Level of Care Diagnosis List: Clarification of Use:
www.cihi.ca/en/alternate_level_of_care_diagnosis_list_en.pdf
- Changes to Z-Codes Allowable with ALC Service 99:
https://www.cihi.ca/en/changes_to_z-codes.pdf
- Definitions and Guidelines to Support ALC Designation in Acute Inpatient Care:
https://www.cihi.ca/en/acuteinpatientalc-definitionsandguidelines_en-web.pdf

ALC FORM

See Appendix 1, Page 11 of the ALC Toolkit.

Document is also available at

<http://hqc.sk.ca/improve-health-care-quality/emergency-department-waits-and-patient-flow-initiative/>

Work Standard 1: Criteria for Determining Alternate Level of Care (ALC)

 	Name of Activity: Criteria for Determining Alternate Level of Care (ALC)		
	Role performing Activity: Physician or designate (typically Nurse Manager or Interdisciplinary/Multi-Disciplinary Team)		
WORK STANDARD	Location: Hospital		Department:
	Document Owner:		Region/Organization where this Work Standard originated: eHealth
	Date Prepared: 28-Jan-2015	Last Revision: 5-Apr-2016	Date Approved:

Work Standard Summary:

Alternate Level of Care Definition: *ALC designation does **not** only apply to patients waiting for Long-term Care.* When a patient is occupying a bed in an acute care facility and does not require the **intensity** of resources/services provided in that care setting the patient must be designated Alternate Level of Care (ALC) at that time by a member/members of the interdisciplinary team. Other examples of ALC include respite care or days waiting in hospital for a home to be renovated to accommodate a patient with mobility issues.

Essential Tasks:	
1.	Patient is admitted to hospital. If a patient enters hospital already designated ALC but does not have an ALC form started, one is to be started.
2.	Patient is treated for acute care conditions as required.
3.	Member(s) of interdisciplinary team assess patient and may determine that the intensity of resources/services of acute care are no longer required but the patient cannot leave the facility without alternate services being made available for the patient in a more appropriate location.
4.	The “ALC Form” is initiated by designate of the interdisciplinary team.
5.	Follow Work Standard 2 for Completion of ALC Form.
6.	When a patient is discharged / transferred, ensure the ALC Form is kept with the patient chart to go to health records.
7.	If a patient reverts between acute care and ALC multiple times within the same admission, a new form must be started with each new episode of ALC.

Work Standard 2: Completion of ALC Form

 	Name of Activity: Completion of ALC Form		
	Role performing Activity: Interdisciplinary team member(s)		
<h1>WORK STANDARD</h1>	Location: Hospital		Department:
	Document Owner:		Region/Organization where this Work Standard originated: eHealth
	Date Prepared: 28-Jan-2014	Last Revision: 04-Apr-2016	Date Approved:

Work Standard Summary:

ALC Form Definition: The ALC Data Capture Form should be used by the Interdisciplinary team to capture information related to the designation of a patient as Alternate level of care (ALC) as well as services required for discharge and rationale for ALC designation.

Essential Tasks:	
1.	Patient is determined to be ALC and an ALC Form is added to the chart.
2.	The designate initiating the ALC Form must put their name and contact information on the form.
3.	The date and time of ALC designation is recorded on the ALC Form.
4.	Using the reasons listed, mark an X on one circle for the main reason that the patient was designated ALC on the Form.
5.	Mark an X on all other boxes that apply for Reason for Designation. <u>Specify the reason or further details when prompted by the form.</u>
6.	If required, the Interdisciplinary team determines necessary consults and/or assessments. The date the consult/service is requested is recorded on the ALC Form under the Consult Requested column. If the service is not available, indicate that at the section at the bottom of page 1 and specify the type of service that does not exist.
7.	If the first assessment for a service/support does not meet the patient's needs and he/she requires a different type of service/support in order to be discharged from the acute care facility; these are also to be documented on page two of the ALC Form along with the date they are requested.
8.	The date the service/support/program accepts the patient is recorded on the ALC Form under the Accepted to Program/Waitlisted column. Note: This is not when the patient has been transferred from care but rather has been accepted and is waiting to be transferred.
9.	If the patient deteriorates or their condition changes and the patient needs to return to acute care status the Interdisciplinary team will record the time, date and diagnosis for return to acute care. <u>If the patient returns to ALC designation a new ALC Form must be started.</u>
10.	When patient is discharged from acute care and transferred to an appropriate level of care, the time and date of discharge must be recorded on the ALC Form. (bottom of second page). If the anticipated discharge destination changed or the patient was decreased, that should also be noted.

Work Standard 3: Coding of Alternate Level of Care Form

 <p>Putting Patients First Transforming Health Care through Lean</p>  <p>Jba-Consulting</p>	Name of Activity: Coding of Alternate Level of Care Form		
	Role performing Activity: Health Information Management Practitioner		
	Location:		Department:
	Document Owner:		Region/Organization where this Work Standard originated: eHealth
Date Prepared: 29-Jan-2015		Last Revision: 04-Apr-2016	Date Approved:

Work Standard Summary:

Essential Tasks:	
1.	The Alternate Level of Care Form will be placed directly after the Discharge Summary in the patient chart.
2.	When the patient is designated as ALC for a portion (24 hours or more) of his/her stay, record the Service Transfer as 99. Verify that ALC length of stay is greater than 24 hours by referring to the ALC designation date and time, the reverted to acute status date and time (if applicable), and the discharge date and time. If the total time is less than 24 hours do not code the ALC form.
3.	<u>If the patient was directly admitted as ALC</u> , regardless if the total length of stay is less than 24 hours, capture the Main Patient Service as 99 and code as ALC.
4.	Calculate and enter the ALC length of stay by referring to the ALC designation date, the date reverted to acute status (if present), and discharge disposition date. If the patient has reverted between acute and ALC multiple times during the same admission, capture the total length of ALC days by adding all ALC days from the multiple forms. Each episode of ALC must be greater than 24 hours.
5.	Refer to the main reason on the ALC form indicated by an X in a circle – found on page 1. Use this designated Z code, in parentheses, to correspond to Main Patient Service 99. If the “primary reason” is documented in a “Specify*” area, code to the most descriptive code listed in the allowable ALC Diagnoses Codes List – see DAD Abstracting Manual, Section 3: Alternate Level of Care.
6.	Boxes with an X identifies the additional issues/needs that are contributing to the main ALC reason. For reasons listed with a diagnosis code in parentheses, capture this code on the abstract. Where there is documentation provided in *(Specify) code to the most specific code to capture the relevant additional information; these codes do not have to be Z codes.
7.	Assign Prefix “A” to ALC Designation code and all additional codes to link all ALC related documentation on the abstract. Do not use Prefix “A” for palliative care reason (Z51.5) if Prefix 8 (palliative care documented as a known component of the patient’s care prior to arrival at the facility) applies.

8.	All assigned codes will adhere to the Canadian Coding Standards – “Diagnosis Typing Definitions for DAD”
9.	In the event of questionable information on the form, clarify with the contact person indicated at the top of the form - Designate Initiating Form.
10.	If the coder finds documentation in the chart to indicate that there were ALC days during the acute visit, but there is no ALC form present, the issue should be brought to the attention of the nursing unit manager or clinical coordinator of the nursing unit to which the patient was last admitted.

Work Standard 4: eHealth Review of ALC Form

 	Name of Activity: eHealth Review of ALC Form		
	Role performing Activity: eHealth Data Quality Team		
<h1>WORK STANDARD</h1>	Location: eHealth		Department: Information Gov
	Document Owner: Director of Info Gov		Region/Organization where this Work Standard originated: eHealth
	Date Prepared: 28-Jan-2015	Last Revision: 05-Apr-2016	Date Approved:

Work Standard Summary:

Review of ALC Data and Reporting: eHealth will be responsible for conducting various quality reviews of both submitted data as well as use of the ALC Form, Work Standards and Definitions. Any updates or changes will be discussed and communicated out provincially.

Essential Tasks:	
1.	Quarterly Review of Form: eHealth will conduct a quarterly review of the entire form. The primary focus of the review will be with regards to formatting and usage changes as a result of feedback from users, as well as results of the other quarterly and monthly reviews as described in steps 2-4.
2.	Quarterly Review of ALC Reasons: eHealth will conduct a quarterly review of the reasons specified on the form. The primary review will focus on the use of “Other issues/care needs as a reason. If there is increased utilization of the “other” categories in a particular facility/region, eHealth will initiate a detailed root cause analysis to help determine why the “other” reason is being used and whether an adjustment to the provincial ALC Form, definitions or Work Standard is required. This may potentially be determined by an increase in use of other codes not available on the ALC Form.
3.	Quarterly Review of Services Required: eHealth will conduct a review of the ALC Form specific to “Services Required”. The use of “other” services/consultations will be monitored. If there is increased utilization the “other” section in a particular facility/region eHealth will initiate a detailed root cause analysis to help determine why the code is being used and whether an adjustment to the provincial ALC Form, definitions or Work Standard is required. This may potentially be determined by an increase in the use of other codes not available on the ALC Form.
4.	Monthly ALC Data Quality Dashboard: eHealth will monitor ALC under reporting and on a monthly basis provide an ALC Data Quality Report back to each Region that will identify charts that could potentially be an ALC patient but were not coded as such.

Supplies:

Work Standard 5: Placement of Alternate Level of Care Form in Patient's Chart at Health Records

 	Name of Activity: Placement of Alternate Level of Care Form in Patient's Chart at Health Records		
	Role performing Activity: Chart Assembly		
	Location:		Department:
WORK STANDARD	Document Owner:		Region/Organization where this Work Standard originated: eHealth
	Date Prepared: 29-Jan-2015	Last Revision:	Date Approved:

Work Standard Summary:

Essential Tasks:	
1.	When the ALC form is triggered it will be sent to Health Records Department upon discharge with patient's chart.
2.	During assembly, place ALC form directly after the discharge summary.

Audit Tool for Alternate Level of Care Form

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T										
Audit tool for Alternate Level of Care (ALC) form																	Turn around time (Should be within 2 business days.)		Final Status										
Basic information to be filled out for all rows						Initial Status		What is incomplete? We may not need to audit every field on the form. Perhaps just the critical ones like the date of ALC and the reason declared ALC.																					
Name of person who Medical Record Discharge Date						Missing Incomplete Complete		Any inaccuracies? Yes/No		ALC designation date		ALC designation time		Date reverted to acute status (if applicable) by		Reason declared Service required		Consult requested date		Assessment completed date		Accepted to program date		Date sent to unit		Date returned from unit		Not ALC Form completed Form incomplete	
Region	Facility	Unit	out form	Number	Discharge Date	Complete	Yes/No	date	time	by	ALC	required	date	date	date	date	to unit	from unit											

A	B	C	D	E	F	G	H
Audit tool for Alternate Level of Care (ALC) form							
Basic information to be filled out for all rows						Initial Status	
Name of person who Medical Record Discharge Date						Missing Incomplete Complete	
Any inaccuracies? Yes/No						ALC designation date	
ALC designation time						Date reverted to acute status (if applicable) by	
Reason declared Service required						Consult requested date	
Assessment completed date						Accepted to program date	
Date sent to unit						Date returned from unit	
Not ALC Form completed Form incomplete							

I	J	K	L	M	N
What is incomplete? We may not need to audit every field on the form. Perhaps just the critical ones like the date of ALC and the reason declared ALC.					
ALC designation date		ALC designation time		Date reverted to acute status (if applicable) by	
Reason declared		Service required			

O	P	Q	R	S	T
Turn around time (Should be within 2 business days.)			Final Status		
Not ALC Form completed Form incomplete					
Consult requested date		Assessment completed date		Accepted to program date	
Date sent to unit		Date returned from unit			

Note: The Audit Tool is an Excel document included in the toolkit.

Introduction

Alternate Level of Care (ALC) is a system classification used in Canada that is applied when there is a mismatch between the intensity of care needs in relationship to the intensity of services/resources in that setting. This can occur in acute inpatient, mental health, rehabilitation, and chronic, or complex continuing care. It has been recognized that there is a need for a standardized approach in considering patient status in ALC designation.

Definitions

Alternate Level of Care (ALC): When a patient is occupying a bed in a facility and does not require the intensity of resources/services provided in that care setting.

Contextual information

Why: The consistent use of ALC designation facilitates measurement of the access gap from one care setting to another. These gaps, once defined, inform system level planning to improve access.

Where: This guideline applies specifically to acute inpatient care.

Who designates: The patient must be designated ALC by the most appropriate care team member, which may be a physician, long-term care assessor, patient care manager, discharge planner or other care team member. The decision to assign ALC status is a clinical responsibility.

When: The ALC time frame starts on the date and at the time of designation as documented in the patient chart or record. The ALC time frame ends (1) on the date and at the time of departure from the ALC setting or (2) on the date and at the time the individual's care needs change such that the ALC designation no longer applies. For a patient who is ALC and reverts to acute status and then becomes ALC again, the patient's total count of ALC days should resume and not start again from 0. **Note: The discharge or transfer destination need not be known at the time of ALC designation.**

How: The ALC status is clearly documented in the patient record by clinical staff, preferably on an approved ALC Designation form. **Acute care patients require daily assessment; therefore, the assessment for ALC designation takes place daily.** The Health Information Management Professional will record the pertinent ALC information in the Discharge Abstract Database (DAD) abstract. In order to enter the ALC service in the abstract, the duration of the ALC portion of the

Acute inpatient care: An active, short-term care episode including facility-based overnight stay and the presence of 1 of the following:

- The need for active treatment of serious injury or illness, urgent medical or mental health condition or during initial recovery from surgery
- Care/monitoring provided 24/7 by a multidisciplinary team, which may include physicians, nurses (registered or practical), nurse practitioners, and other allied health professionals (pharmacist, physiotherapist, occupational therapist, registered dietitian, social worker, etc)
- Services provided at a minimum level of certain frequencies and intensity levels:
 - Attendance and charting by a physician or delegate at least once per day
 - Close clinical monitoring at least 3 times daily based on delegated functions by the physician
- Access to diagnostic tests required to stabilize plan of care

Acute inpatient care encompasses a range of clinical health care functions and treatments, including emergency medicine, trauma care, acute medicine, acute care surgery, critical care, obstetrics, gynecology, acute pediatric care, acute mental health, acute rehabilitation, acute palliative care and inpatient stabilization.

Guidelines to support ALC designation by clinicians

The following table is intended to support clinical decision-making to determine whether an individual's inpatient status should be designated ALC. **The guidelines are intended to prompt questions for clinicians to consider for ALC designation. In all cases, application of clinical judgment and adherence to best practice is expected judgment for final designation decisions.**

	Acute inpatient care (if any 1 of the following criteria is met)	ALC
Patient characteristic		
Clinical status	<ul style="list-style-type: none"> Unstable and/or deteriorating Anticipated risk for rapid decline Actively under investigation and diagnoses under revision 	<ul style="list-style-type: none"> Stable and/or patient's status has plateaued Low risk for rapid decline No longer searching for new additional diagnoses
Safety risk: Self and others	<ul style="list-style-type: none"> Progressive acute behavioural or neurological difficulties requiring acute inpatient care Evidence of actual or potential danger to self or others Requires protection for self and/or others from aggression/self-injurious behaviour Requires 1:1 observation 	<ul style="list-style-type: none"> Cognitive impairment including dementia, with stable treatment plan, not requiring acute care services Behavioural or neurological difficulties that can be managed with interventions in the community as specified in the care plan
Team requirements		
Activity tolerance	<ul style="list-style-type: none"> Activity level markedly below baseline or new baseline; requires assistance Anticipated to require access to the full range of professional therapies to achieve client goal Altered cognition or physical symptoms impair rehabilitation services If dominant treatment plan is rehabilitation, can tolerate intensity of 2 professional therapeutic services (e.g., nursing, occupational therapy [OT], physical therapy [PT]) 	<ul style="list-style-type: none"> Baseline independence recovered or new baseline established Can receive activity support in a different setting Assisting patients in returning home or moving to another level of care (e.g., waiting for specialized rehabilitation care beds)
Clinical practice and process	<ul style="list-style-type: none"> ≥2 professional therapeutic services are required daily (e.g. any combination of nursing, OT, PT, etc.) Close monitoring at least 3 times daily (e.g., vital signs) Plan actively changing Clinical status or need requires ≥1 daily doctor visit 	<ul style="list-style-type: none"> Required professional therapeutic services and monitoring can be provided in a different setting (e.g., in specialized rehabilitation care beds/facilities) Stable treatment plan Requires <1 daily doctor visit
Clinical interventions		
Medication and fluid administration	<ul style="list-style-type: none"> Requires multiple assessments and/or titrations Requires special routes of administration that must be performed in hospital (e.g., IV, epidural, intrathecal) 	<ul style="list-style-type: none"> Frequency of assessment and/or titration per administration can be accomplished in another setting Route of administration could be done on an outpatient basis (e.g., IV medication) regardless of service availability in the community
Diagnostics and therapeutics	<ul style="list-style-type: none"> Requires access to diagnostics/procedures and results or pre-/post-testing care 	<ul style="list-style-type: none"> Service as well as pre-/post-care available in a setting other than hospital No immediate results requirement

	Acute inpatient care (if any 1 of the following criteria is met)	ALC
Specialized care or scenarios		
Palliative care	<ul style="list-style-type: none"> • Medically unstable with potentially reversible conditions requiring diagnostics and treatments not available outside the hospital setting. The goal is life prolongation. • Complex symptom control issues and required support for imminent death within the acute care environment (e.g., a patient on a medical ward, palliating without a plan to move to another level of service) • End-of-life care focused on comfort only, with unstable complex symptoms that require the support of the interdisciplinary team and specialist palliative care services 	<ul style="list-style-type: none"> • Medically stable with gradual progression of non-reversible illness; stable treatment plan may be supported outside of acute inpatient care • Care requirements may be delivered in another setting (e.g., chronic or complex continuing care, home with home care, hospice care) • Comfort care can be supported within the community setting • Patient-centred care can be creatively planned to support dying at home
Mental health	<ul style="list-style-type: none"> • Suffers from sudden and severe psychiatric symptoms; can include patients who are suicidal, or who have hallucinations, extreme feelings of anxiety, paranoia or depression • Progressive acute behavioural or neurological difficulties requiring acute clinical or psychiatric care • Therapeutic pass to inform clinical readiness for discharge 	<ul style="list-style-type: none"> • Can be managed with individual or group therapy, or relapse prevention services • Clinically stable or has plateaued and is able to participate in recovery plan in the community, including in designated non-acute- mental health treatment facilities • Overnight or >24-hour trial discharge where treatment plan supports care in an alternate setting
Respiratory care	<ul style="list-style-type: none"> • On a ventilator with a new tracheostomy (cuffed), requiring ≥ 3 assessments/day 	<ul style="list-style-type: none"> • On a ventilator, chronic respiratory care
Companion		<ul style="list-style-type: none"> • Companion — well baby/adult (if registered)

Appendix 4 – Patient Brochure Text for RHAs

Patient Information on Alternate Level of Care

What is Alternate Level of Care (ALC)?

When you're in hospital, a health care team of professionals are involved in your care and recovery. As you know, recovering from an illness or surgery takes time. Recovery is different for every one of us. How you recover also affects the kind of ongoing care you require. Most patients are sent home – or discharged – to recover.

Many people still need to receive some kind of care, just not the same kind of care a hospital offers. This type of care is called Alternative Level of Care, or ALC for short.

Your health care team has recognized that you no longer require the care that comes from an acute care hospital setting. They will discuss your specific care requirements with you, but this pamphlet provides a quick overview of what ALC means.

An ALC patient is a patient who is occupying a bed in a health facility or hospital and does not require the intensity of resources/services provided in that care setting. This does not mean you don't need care. It just means the care you need could be provided outside the hospital setting.

What does ALC mean for you?

ALC options are different for each patient. They may also change over time as you recover. Every attempt will be made to let you recover where you are most comfortable – your home. Your health care team will want to know important information about you or your family situation to help them plan your discharge:

- Will your family be available to help?
- Do you live with someone who can help with things like going to the bathroom and making meals?
- Are you or your family willing to having community services help you at home?
- Are home care services available where you live?
- What services or programs are available in your community?

The answers to these questions will help determine how your care needs could be met at home.

Sometimes, your recovery may make it difficult to be discharged home right away. Perhaps a chronic illness becomes worse, complications after surgery occur, or you have a sudden onset of another illness. These changes can be even more challenging for someone who is very elderly. If it's been determined that you no longer need to be in a hospital setting, then your health care team will help determine options in planning your discharge from hospital.

How is ALC determined?

When you entered the hospital, your health care team already started to plan for your discharge. This is normal. We know that no one likes to stay in hospital longer than required. It takes time and preparation to plan for discharge. The health care team continually assesses your condition. At some point, they may identify you are now “alternate level of care.” Many factors go into this, for example:

- Do you need further medical testing?
- Do your medical treatments still have to be carried out in hospital?
- Do you require full-time nursing care?
- Do you need to see a doctor every day?
- Do you require close monitoring of your medications?
- Do you require the intensive therapy services that are offered in the hospital?

These are a few examples of questions that will be asked, and if the answers are “no,” it's possible you may be considered ALC.

What happens after you are designated ALC?

Your health care team has assessed you as being ALC. So now what?

The first thing that will happen is your health care team will discuss with you what options are available to you. The goal is to continue providing the right care in the right setting. Options may include, but are not limited to:

- home (with or without any additional services);
- a non-acute type of setting such as a convalescence unit or transition unit. The availability of these programs varies across the province; or
- care homes. The availability and variety of care homes also varies from region to region.

Module 2: Alternate Level of Care

You may have heard of some of the following facilities: [each RHA to regionalize with examples and language appropriate for your area – not an exhaustive list, just one that makes sense to the community/ies of the patient]

It is not necessary to determine where your care is going to take place before being assessed as ALC.

How will transfer occur?

XXXX

What do I need to do?

XXXX

Appendix 5 – Family Brochure Text for RHAs

Family Information on Alternate Level of Care

What is Alternate Level of Care (ALC)?

When a patient is in the hospital, a health care team of professionals is involved in their care and recovery. As you know, recovering from an illness or surgery takes time and each person's recovery is different. Families play a key role. How a patient recovers affects the kind of ongoing care he/she requires. Most patients are sent home – or discharged – to recover. Many people still need to receive some kind of care, just not the same kind of care a hospital offers.

The health care team looking after your family member has recognized that he/she no longer requires the type of care provided in an acute care hospital. Instead your family member needs what's called alternative level of care, or ALC for short. The health care team will discuss specific care requirements with the patient, but this pamphlet provides a quick overview of what ALC means. We encourage you to discuss this information together, provided your family member is willing to do so.

An ALC patient is a patient who is occupying a bed in a health facility or hospital but does not require the intensity of resources/services provided in that care setting. This does not mean the patient no longer needs care. It just means the care he/she needs could be provided outside the hospital setting.

What does ALC mean for the patient?

ALC options are different for each patient. They may also change over time as the patient recovers. Every attempt will be made to allow patients to recover where they are most comfortable – their home. A patient's health care team will want to know important information about him/her, or their family, to help plan the patient's discharge:

- Will you or other family members be available to help?
- Does the patient live with someone who can help with things like going to the bathroom and making meals?
- Are you or other family members willing to having community services help the patient at home?
- Are home care services available where the patient lives?
- What services or programs are available in the patient's community?

Module 2: Alternate Level of Care

The answers to these questions will help determine how a patient's continuing care needs could be met at home.

Sometimes, the speed at which a patient is recovering makes it difficult for him/her to be discharged home right away. Perhaps a chronic illness becomes worse, complications after surgery occur, or he/she has a sudden onset of another illness. These changes can be even more challenging for an elderly patient. However, if it's been determined the patient no longer needs to be in hospital, then that patient's health care team will help determine the best options for meeting their care needs after discharge.

How is ALC determined?

Shortly after a patient enters the hospital, his/her health care team is already starting to think about discharge to home. This is normal. We know that no one likes to stay in hospital longer than required. It takes time and preparation to plan for discharge. The health care team continually assesses a patient's condition, even before the patient has completed his or her recovery. At some point, they may determine the patient is now "alternate level of care." Many factors go into this, such as:

- Does the patient need further medical testing?
- Does the patient's medical treatment still have to be carried out in the hospital?
- Does the patient require full-time nursing care?
- Does the patient need to see a doctor every day?
- Does the patient require close monitoring of their medications?
- Does the patient require the intensive therapy services that are offered in the hospital?

These are a few examples of questions that will be asked, and if the answers are "no," then the patient may be considered ALC.

What happens after a patient is designated ALC?

After a patient is designated ALC, his/her health care team will discuss what options are available. The goal is to continue providing the right care in the right setting. Options may include, but are not limited to:

- Home (with or without any additional services);
- A non-acute setting such as a convalescence unit or transition unit. The availability of these programs varies across the province; or,
- Care homes. The availability and variety of care homes also varies from region to region.

You may have heard of some of the following facilities: [each RHA to regionalize with examples and appropriate wording – not an exhaustive list, just one that makes sense to the community/ies of the patient]

It is not necessary to determine where the patient’s care is going to take place before he/she is assessed as ALC.

How will transfer occur?

XXXX

What do I need to do as a family member?

XXXX

Appendix 6 – Alternate Level of Care Patients – Designation, Measurement and Management

Memorandum of Understanding

Of

All Saskatchewan Regional Health Authorities

This Memorandum of Understanding (MOU) sets forth the terms and understanding between all Saskatchewan Regional Health Authorities (RHAs) related to the designation, measurement and management of Alternate Level of Care (ALC) patients.

Purpose

In the spirit of a health system that thinks and acts as one, this MOU will outline agreed upon principles related to identification and management of ALC patients. Agreement on these principles will reflect a shared commitment to patient centered care and the provision of the care in the right place at the right time by the right provider.

Standardized processes based on agreed upon principles will also ensure that the resources and capacity of the provincial health system are efficiently and maximally utilized.

Background

The Emergency Department (ED) Waits and Patient Flow Initiative (the Initiative) has identified understanding and managing the ALC population as a system level priority. ALC patients utilizing acute care beds are one of the contributing factors to long waits within the ED. The prolonged presence of this population within acute care is reflective of the system's inability to meet their care needs within the community. A goal of patient centered care should be to prevent avoidable hospital admissions for this vulnerable population and if an admission is required, successfully transition those individuals back into the community after acute care is no longer required.

Currently a common definition is not used provincially to identify and manage this patient population. Regions have primarily been capturing ALC data on patients waiting for a long-term care (LTC) bed while in hospital. As a result, ALC patient days are underreported provincially.

For 2013-14, 7.8% of total patient days were reported as ALC by all the regions. By using the additional CIHI discharge destinations of General Rehabilitation Facility; Chronic Care Facility; Nursing Home; Special Rehabilitation Facility; or Home for the Aged; CIHI estimated the actual percentage for 2013-14 at 8.9%.

This historic practice of only reporting patients waiting for LTC placement has also contributed to the practice of requesting LTC assessment before community options are explored. This may result in patients being discharged to an inappropriate setting and receiving an inappropriate level of care.

By using this provincial definition for ALC, the goal of the system to have the right patient in the right place at the right time receiving the right care in a cost effective and safe environment will occur. In addition, the system will begin to see that this group of patients is not just waiting for LTC placement.

Early results from recent improvement work on ALC designation, using the new provincial definition in two regions, (Sunrise and Saskatoon) has demonstrated that the actual ALC patient days may be significantly higher than 8.9%. Accurate data on the ALC population is essential to inform the system on potential investments in community based care that will provide safe, accessible, cost effective options for this population. This will also decrease the utilization of acute care beds; thereby positively impacting patient flow and reducing ED wait times.

Regional stakeholders want to standardize and improve the processes on designation, measurement, and management of ALC patients. This has included identifying and addressing the barriers affecting this work.

The Initiative's ALC working group has found that the current designation of ALC results in several misunderstandings in the management of these patients. Examples of these care breakdowns include:

- Reduced or withdrawn professional services, even though the patient's care may be negatively impacted;
- Implementation of bed charges for patients after the ALC designation, even though there is no other care option available for that patient; and,
- Confusion over allowable provider billing policies.

Module 2: Alternate Level of Care

These situations may provide a disincentive to identifying patients as ALC and further compromise the ability to collect accurate data necessary to drive future planning. Education regarding this provincial ALC process is required for administrators, care providers, patients and families.

Principles

When designing policy; procedures; processes; guidelines or work standards related to ALC patients, the following principles will be incorporated by the parties that are signatory to this MOU:

1. The following definition of ALC will be used provincially: ***An ALC patient is a patient who is occupying a bed in a facility and does not require the intensity of resources/services provided in that care setting.***
2. Common provincial ALC designation and data collection forms, which have been tested and validated through a provincial replication process, will be used by all regions.
3. ALC data will be reported to CIHI by individual regions as per normal processes.
4. The care provided to patients should be driven by the needs of that patient, not their designation as ALC. Appropriate services for that patient will be determined by the potential for improvement, care goals and the impact on the patient's health status if service is reduced.
5. A level of care assessment (the Minimum Data Set tool) will be utilized to determine an appropriate service/program/location to meet the needs of the ALC patient.
6. Community based options should be considered first; a LTC assessment should be completed, if appropriate, only when all other care options have been explored.
7. Parties of this agreement will use standardized maximum bed charge guidelines as developed by the Joint Committee on Acute and Emergency Services (JCAES).
8. Standardized provincial education material for patients and families on what ALC is and what an ALC designation means will be developed and utilized by all regions. Regional context may be required in the materials developed.

Duration

This MOU is at-will and may be modified by mutual consent of authorized officials from (CEOs). This MOU shall become effective upon signature by the authorized officials from the (CEOs) and will remain in effect until modified or terminated by any one of the partners by mutual consent. In the absence of mutual agreement by the authorized officials from (CEOs) this MOU shall endure.

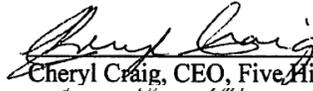
Contact Information


 Jennifer Conley, CEO, Athabasca Health Authority

September 29/15
 Date


 Beth Vachon, CEO, Cypress Health Region

10 Sept 2015
 Date


 Cheryl Craig, CEO, Five Hills Health Region

September 1, 2015
 Date


 Greg Cummings, CEO, Heartland Health Region

29.9.15
 Date


 Jean-Marc Desmeules, CEO, Keewatin Yatthe Health Region

September 28 2015
 Date


 Shane Merriman, CEO, Kelsey Trail Health Region

SEPT - 2/2015
 Date


 Andrew McLetchie, CEO, Mamawetan Churchill River Health Region

Aug 31/15
 Date


 David Fan, CEO, Prairie North Health Region

September 23, 2015
 Date


 Cecile Hunt, CEO, Prince Albert Parkland Health Region

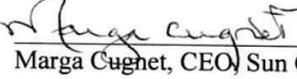
Sept 23, 2015
 Date


 Dan Florizone, CEO, Saskatoon Health Region

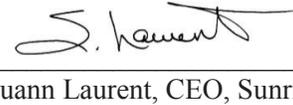
Sept. 3, 2015
 Date


 Keith Dewar, CEO, Regina Qu'Appelle Health Region

Sept 3/15
 Date


 Marga Cugnet, CEO, Sun Country Health Region

September 2, 2015
 Date


 Suann Laurent, CEO, Sunrise Health Region

August 31, 2015
 Date

Patient Flow Toolkit



Module 3:

Transfers of Care

Reference guide for operational leaders, managers and point-of-care staff

January 2016

Table of contents

Module objectives	1
Background	1
Foundational elements	2
Process flow map	4
Work standards and documents to support process	6
Documentation for patients and families.....	13
Physician-to-physician communication.....	14
Dispute resolution process	16
Appendices	
Appendix 1 – Memorandum of Understanding.....	20
Appendix 2 – Work standard for medication reconciliation (to come)	23
Appendix 3 – References	24

For more information about this toolkit, visit www.hqc.ca and select the Emergency Department Waits and Patient Flow Initiative in the Improving Quality of Health Care menu. If you need further help, contact the Initiative at edwaits@hqc.sk.ca or 306-668-8810.

Module objectives

This module is intended to be a guide for operational leaders, managers, and point-of-care staff in Saskatchewan health regions to implement new provincial standards for coordinating safe and timely patient transfers throughout the provincial health care system. In the spirit of a health system that thinks and acts as one, this module outlines principles and processes that will be applied by all health regions when they are transferring patients within or between regions. A standardized process for transferring patient care reflects a shared commitment to patient-centered care and to providing care in the right place, at the right time, by the right provider.

Note: In most instances in this document, the word patient could be replaced with resident, client or person, depending on the individual's preference and/or care setting.

The objectives of this module are to:

- Provide background and rationale for the development of a standardized provincial process for transfers of care.
- Provide a process flow map and related work standards to help regions implement the new provincial process.
- Share provincially agreed upon principles for all inter- and intra-regional transfers of care (Memorandum of Understanding).

Background

In Saskatchewan, many patients require visits in more than one facility for both planned and unplanned episodes of care. As part of their care journey, patients often need to transition between facilities within their region or in and out of facilities in adjacent regions to have their care needs met.

Coordinating timely and safe transfers not only enables patients to move smoothly throughout Saskatchewan facilities, but also ensures patients receive the right care, by the right provider, at the right time. Effective transfers of care also enable patients to return to their home communities and support networks once it's safe for them to do so.

Several process improvement events related to patient transfers have been completed in Saskatchewan, which have generated important learnings and promising results. As well, stakeholders from across the system have provided input to inform work processes and work standards for a provincial approach to inter- and intra-regional transfers of care.

This work led to a Memorandum of Understanding with Principles for all Inter- and Intra-Regional Transfers of Care in Saskatchewan, attached as Appendix 1. This Memorandum of Understanding has been recognized and endorsed by all of Saskatchewan's regional health authorities.

Module 3: Transfers of Care

Through the transfer-related improvement events, a number of individuals across the province have developed considerable knowledge about transfers of care; these people are available to help mentor regions as they begin to implement the new processes. To request assistance for your health region, contact the ED Waits and Patient Flow Initiative at (306) 668-8810 ext 108, or edwaits@hqc.sk.ca.

The process flow maps, principles, and work standards included in this module are intended to serve as the foundation for achieving our desired future state: safe and efficient patient transfers.

Foundational elements

While there is room for some flexibility and customization by regions, there are key elements all regions must apply to ensure we have a consistent transfer process provincially:

Patient- and family-centered approach

In Saskatchewan, patient and family advisors have provided important feedback that the health system must provide a seamless care experience for patients and families. Patients and families want to experience consistent care regardless of where they receive it, and they want smooth transitions when they transfer between regions. The tools and standard work provided in this module are intended to help regions involve patients and their families in decisions about transfers.

While regions may not always be able to transfer a patient to their location of choice or at a time of their choosing (due to system constraints), we can work with patients and families to give them choices about many other aspects of transfers. These choices may include how they would like to be transferred, who will be present to support them during transfer, and what services or supports they may be provided with prior to, during, and following the transfer (e.g., translator). Early communication with, and involvement of, patients and families can also help alleviate stress and anxiety associated with transfers.

Estimated date of transfer

Setting an estimated date of transition for patients as early in their stay as possible can help care team members coordinate patient care toward achieving this common goal. It is recommended that the need to transfer be established early on in the patient's stay. To ensure a smooth transfer, this should be identified at least three days prior to transfer day whenever possible (ie. Transfer day minus 3: T-3). Having a predicted date of transfer is critical for improving the patient experience, patient flow and safety.

Identifying those patients who are likely to require a transfer three days prior to their actual transfer will allow early communication to occur with the receiving unit or hospital. This gives everyone adequate time to plan and prepare for safe transitions. Research has shown that the risks associated with patient transitions (such as unsafe or delayed transfers) increase when there is not effective

communication or when there are challenges in coordinating care. (Waring, Marshall, Bishop, Sahota, Walker, Currie, 2014)

Risks to patient safety include medication errors, falls, errors in care procedures, necessary equipment or supplies not being available, and risk of infection. Early notification and communication on patient care needs can mitigate these risks by allowing receiving units to prepare the needed medications, staff, and equipment.

This module incorporates standard processes for communicating between sites about a patient's transfer needs and their estimated date of transfer.

Centralized intake

Due to the complex nature of transfers, regions must establish a central point of contact to coordinate transfers into and out of their facilities. Centralizing this function allows facilities to monitor their regional capacity, minimizes rework, improves safety, and ensures that patient needs are met. A key aspect of this role will be to coordinate provider-to-provider dialogue and ensure receiving sites are prepared to meet patient care needs.

Information handover

To support safe transitions, the following information sharing must occur:

Communication with patients and families:
Discussion with patients and families

regarding transfer needs should occur as early as possible in the episode of care. It is critical that patients and their families are involved in the planning of their transfer and informed at each step in the process. This includes early communication on the need to transfer and when they can anticipate their transfer will occur (T-3). This will allow patients and families to make the necessary arrangements so that support is available for the transition. Patients and their family members should have information about their care explained clearly to them, with essential information also provided in writing. The Patient Transfer Summary Sheet attached on page 13 could be used to share this information.

Physician-to-physician communication: Both verbal handover and written communication must occur. Information should also be shared with the patient's family physician to ensure continuity of care. It is the work of the central point of contact to ensure that this sharing takes place. A work standard and sample discharge note to support this communication are included on page 14.

Region-to-region: This communication needs to occur well in advance of the patient transfer. Ideally it should happen three days prior to the transfer (T-3), which will require care teams to estimate a transition date as early as possible in a patient's stay. This dialogue allows the receiving region and unit to prepare for the patient's care needs and determine whether they have the capacity to safely meet a patient's care needs. The work standards included in this module provide the foundation to support inter-region communication.

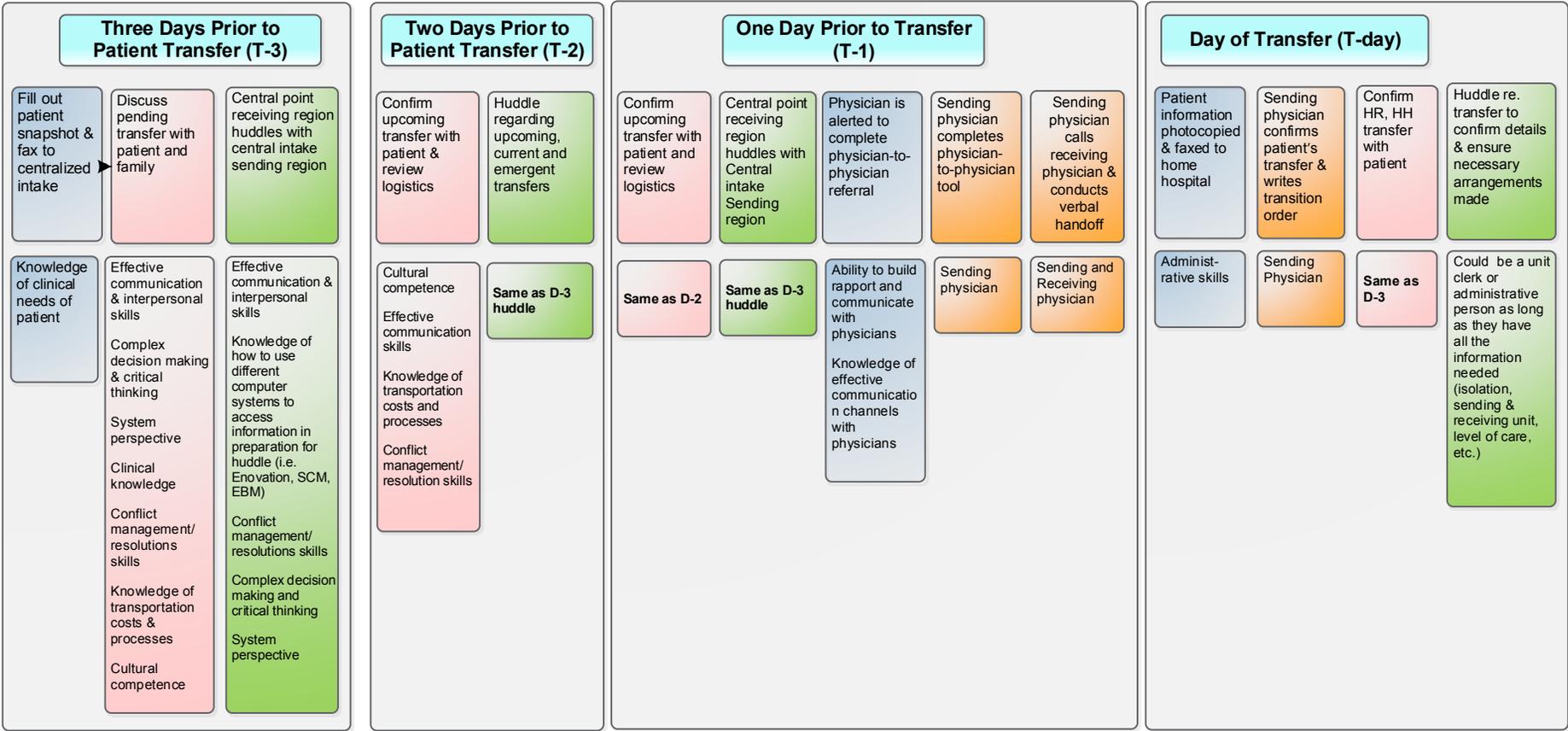
Module 3: Transfers of Care

Documentation: In addition to the region-to-region verbal communication necessary to prepare for patient transfers, written documentation must also be completed as part of the transfer process. A checklist for required documentation has been created and is included on page 11. Patient medication reconciliation is an essential part of safe patient transfers. Provincial Standard Work for medication reconciliation is currently being developed and will be included in future versions of this module.

Process flow map

The transfer of care process flow map (next page) shows the desired future state for all inter- and intra-region transfers of care in Saskatchewan. While there is currently variation across the province in how regions carry out and resource this work, this map is intended to guide regions in achieving the future state. It is recognized that there will be many interim steps in achieving the desired state; staff of the ED Waits and Patient Flow Initiative will help support regions to implement the new transfer processes. The map identifies the required steps on each day of a patient's care episode leading up to their transfer. In light of the fact that the staffing complement and workflow processes vary by region, the map identifies the suggested skill set for each step. This information is intended to help regions align available resources with the tasks required.

Provincial Patient Transfers of Care Future State Process Map



Administrative tasks
 Region-to-region communication
 Communication with patients and family
 Physician tasks

Work standards and documents to support the transfer process

Through improvement events in Saskatchewan health regions and provincial planning events, a set of work standards has been created to support the process flow outlined above. Each step in the process has been standardized, with related tools developed to support each step. Regions will need to determine how best to implement the standards so that all fundamental elements are addressed. As we learn from each region across the province, updates will be made to the module and standards, and rolled out in a coordinated manner.

Regions should use these work standards to create their own implementation plans and to align resources to support processes on the flow map. Full implementation includes creating more detailed standard work that aligns with the work standards and recognizes unique regional characteristics.



WORK STANDARD				Name of Activity: Region-to-Region communication for transfers (Transfer day -3)		
				Role Performing Activity: Central Point of Contact, sending and receiving region		
	Location: Repatriation/transfers office		Department: Transfers of care central intake			
	Document Owner: EDPKOT		Region/Organization where this Work Standard originated: EDPKOT - Rural and Remote Working Group			
Date Prepared: June 26, 2015		Last Revision: Aug. 26, 2015		Date Approved:		

Work Standard Summary: These are the steps sending and receiving regions must complete to facilitate **T-3 patient** transfers of care.

Essential Tasks: Sending Region	
1.	In discussion with the patient/family complete Hospital Transfer – Patient Snapshot form, which includes a complete identification of all variables connected to patient transfer for patients identified as T-3 in their transportation process. Ensure communication has occurred with patient and family.
2.	Ensure communication occurs with patients and their family members: <ul style="list-style-type: none"> • Reason for anticipated transfer • Plan for care at receiving site - Provide information and answer questions from the patient/family about the care they will receive at the receiving site. • Transportation options and costs - Offer choice - how will the patient be transferred? Will the family participate/ be present during the transfer? • Other supports required – What supports does the patient and family feel they need? • Obtain consent to proceed
3.	Include the name of the primary nurse, so the receiving region knows who to contact for patient care information.
4.	Collate patient snapshots by region and send to the central point of transfer for those regions with identified T-3 patients.
5.	Central point of contact participates in the regional huddle validating existing snapshots on T-2/T-1 patients. Identify any changes in patient information.
Essential Tasks: Receiving Region	
1.	Receive snapshot of T-3 patients. Identify any potential barriers to providing care for the patient to be transferred and alert sending site of any concerns through daily huddle.
2.	Update local physicians of impending transfers. Identify the potential MRP. Notify patient’s family provider of pending transfer and to which site.
3.	Participate in the region-to-region huddle, updating T-2/T-1 snapshots. Discuss any care changes.

Module 3: Transfers of Care

HOME HOSPITAL TRANSITION-PATIENT SNAPSHOT

Sending: Region: _____ Site: _____ Unit: _____

Receiving Site: _____

--

Admission Date: _____		Predicted Transition Date: _____	
Service	<input type="checkbox"/> Medical <input type="checkbox"/> Surgical <input type="checkbox"/> Palliative <input type="checkbox"/> OBS Other: _____	Mar Attached	
Admitting Diagnosis		Reason for Transfer to Home Hospital	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Convalescents <input type="checkbox"/> LTC Assessments Other: _____
Transfer Diagnosis		Surgery Date/Type (if known)	
Sending Physician		TLR	<input type="checkbox"/> Independent <input type="checkbox"/> Supervised <input type="checkbox"/> Sit/Stand Lift <input type="checkbox"/> Total Lift <input type="checkbox"/> Assist X1 <input type="checkbox"/> Assist X2 <input type="checkbox"/> Assist X3
Receiving Physician (if known)		Family Physician	
Isolation Precautions	<input type="checkbox"/> Yes <input type="checkbox"/> No Why: _____ Was Swab done: <input type="checkbox"/> Yes <input type="checkbox"/> No Why: _____ <input type="checkbox"/> Contact <input type="checkbox"/> Droplet <input type="checkbox"/> Airborne <input type="checkbox"/> Contact Droplet Other: _____		
Equipment Requirements	<input type="checkbox"/> Mattress _____ <input type="checkbox"/> Wheelchair <input type="checkbox"/> Commode	<input type="checkbox"/> VAC Dressing <input type="checkbox"/> Walker <input type="checkbox"/> Pneumatic	<input type="checkbox"/> Tracheostomy <input type="checkbox"/> Compression
Special Care Needs	<input type="checkbox"/> Bariatric <input type="checkbox"/> Tube Feed <input type="checkbox"/> Therapy OT PT SLP <input type="checkbox"/> O2 _____ <input type="checkbox"/> Fall Risk <input type="checkbox"/> Aggression <input type="checkbox"/> Dressing Change <input type="checkbox"/> IV <input type="checkbox"/> Confusion/Wander Risk <input type="checkbox"/> Behaviors _____ Other: _____		
Special Medication/Care Requirements	(Supply, order process, preparation, administration, monitoring)		

Form Completed By

Name: _____ Position: _____ Ward: _____

Contact Number: _____

For Use by Receiving Facility Only	Please fax completed form to:
Receiving Physician Name: _____	306- -
<input type="checkbox"/> Contacted <input type="checkbox"/> Accepted <input type="checkbox"/> Paper Faxed	Contact: 306- -

WORK STANDARD				Name of Activity: Region-to-region communication for transfers (Transfer day -2)		
	Role performing Activity: Central Point of Contact sending and receiving regions					
	Location: Repatriation/transfers office			Department: Transfers of care central intake		
	Document Owner: EDPKOT			Region/Organization where this Work Standard originated: EDPKOT - Rural and Remote Working Group		
Date Prepared: June 26, 2015		Last Revision: Aug. 26, 2015		Date Approved:		

Work Standard Summary: These are the steps sending and receiving regions must complete to facilitate **T-2 patient** transfers of care.

Essential Tasks: Sending Region	
1.	Collate any information updates on T-2/T-1 patients destined for the receiving region.
2.	Engage with receiving region in region-to-region huddle.
3.	Discuss and update on T-2/T-1 patients destined for the receiving region.
4.	Confirm any receiving barriers / issues affecting individual transfers.
5.	Confirm impending transfer and location information with sending physician / ward. Collect contact information for sending provider.
6.	Determine transportation method required with patient, family and care team and advise ambulance, if required, of upcoming transport needs for T-2/T-1 patients. Begin filling in the Provincial Patient Transfer Checklist .
7.	Review progress of transfer plan and logistics with patient and family.
Essential Tasks: Receiving Region	
1.	Gather regional facility/capacity information that relates to anticipated T-2/T-1 patient needs. Advise/update the potential receiving facility of impending transfers. Confirm receiving facility and MRP, and share this information with sending site.
2.	Engage with sending region, in region-to-region huddle.
3.	Confirm name of potential receiving physician and advise of potential T-2/T-1 transfers.

Module 3: Transfers of Care

	Name of Activity: Region-to-region communication for transfers (Transfer day -1)		
	Role performing Activity: Central Point of Contact sending and receiving regions		
	Location: Repatriation/transfers office	Department: Transfers of care central intake	
WORK STANDARD	Document Owner: EDPKOT	Region/Organization where this Work Standard originated: EDPKOT - Rural and Remote Working Group	
	Date Prepared: June 26, 2015	Last Revision: Aug. 26, 2015	Date Approved:

Work Standard Summary: These are the steps sending and receiving regions must complete to facilitate **T-1 patient** transfers of care.

Essential Tasks: Sending Region	
1.	Collate any information updates on T-1 patients destined for the receiving region. Send all documents on Transfer Document Checklist to receiving site.
2.	Engage with receiving region in region-to-region huddle.
3.	Provide update on status of T-1 patients destined for the receiving region.
4.	Confirm any receiving barriers / issues affecting individual transfers.
5.	Request sending physician or ward complete Physician to Physician Transfer Summary to verify physician/ward has completed it.
6.	Review progress of plan and logistics with patient and family. Provide the contact information of the receiving site and a point person to the patient/family.
7.	Advise transportation services of upcoming transport needs for T-1 cases if transfer is confirmed. Finalize the Provincial Patient Transfer Checklist .
Essential Tasks: Receiving Region	
1.	Confirm the facility for T-1 patient transfer. Advise/update the potential receiving facility of impending transfer.
2.	Confirm receiving physician information for T-1 transfer for physician -to-physician hand off. Share information with family provider if they are not the MRP.
3.	Attend region-to-region huddle with sending region.

Transfer Document Checklist

Documents Accompanying All Hospital Transfers

- Advanced Care Directive
- Intra/Inter/Agency Nursing Referral
- Doctor to Doctor Referral
- Physician Order to Transfer
- MAR 48 hour prior to discharge
- PIP med reconciliation from admission
- Medical Consults
- Therapy Consults (PT, OT, SLP, Dietician, SW, RT)
- Progress Notes for past 48 hours
- Last Lab Report
- Diagnostic Reports (i.e. radiology, ECG, CT, U/S, MRI etc.)
- Diabetic Record, VAC/Wound/Dressing Care, Ostomy/Stoma Care

Completed By: _____

Date: _____

Time: _____

Receiving Site: _____

Fax Number: _____

Module 3: Transfers of Care

	Name of Activity: Region-to-region communication for transfers (Transfer day T-day)		
	Role performing Activity: Central Point of Contact sending and receiving regions		
WORK STANDARD	Location: Repatriation/transfers office		Department: Transfers of care central intake
	Document Owner: EDPKOT	Region/Organization where this Work Standard originated: EDPKOT - Rural and Remote Working Group	
	Date Prepared: June 26, 2015	Last Revision:	Date Approved:

Work Standard Summary: These are the steps sending and receiving regions must complete to facilitate patient transfers of care on day of transfer (**T-day**).

Essential Tasks: Sending Region	
1.	Collate any information updates on transferring patients destined for the receiving region.
2.	Engage with receiving region in region-to-region huddle.
3.	Provide update on status of patients destined for the receiving region. Confirm transfers for day with receiving region (T-day patients).
4.	Confirm that any receiving barriers / issues affecting individual transfers are resolved.
5.	Confirm with sending physician / ward that Physician-to-Physician Transfer Summary has been completed.
6.	Confirm with transportation services that transfer will proceed today. Collate all documentation as per provincial list that will accompany transfer.
7.	Confirm final details of transfer with patient and family. Review Patient Transfer Summary Sheet with patient and family and provide them with a copy.
Essential Tasks: Receiving Region	
1.	Confirm transfer with receiving facility.
2.	Attend region-to-region huddle with receiving region. Confirm that all needed information about patient is documented.
3.	Confirm receiving physician-to-physician hand off. Confirm notification is sent to family physician, if different than receiving physician.

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(Example of documentation provided to patients and families)

Patient Transfer Summary Sheet

* To be reviewed and provided to patient and family prior to transfer

Planned date of transfer: _____

Patient Information (sticker)	
Patient Name: _____	HSN _____
Address: _____	Contact#: _____
Next of Kin: _____	

My Care Information	
Facility I am going to: _____	Who my physician will be: _____
Contact person at receiving hospital: _____	_____
Contact #: _____	After hours #: _____
Summary of my care and treatment at this hospital: _____	

Plan of care for me at the hospital I am going to: _____	

Medications I am taking: _____	

My special care needs: _____	

Follow up appointments arranged: _____	

Contact name and # for follow ups: _____	

Transfer Information	
Sending site: _____	Sending contact information: _____
I will be transported by: _____	Estimated cost for transportation: _____
My next of kin: _____	Has my next of kin been notified?:
	Yes <input type="checkbox"/> No <input type="checkbox"/>

Module 3: Transfers of Care

 WORK STANDARD	Name of Activity: Transfers of care physician-to-physician communication		
	Role performing Activity: Physicians at sending and receiving site		
	Location: Repatriation/transfers office	Department: Transfers of care central intake	
	Document Owner: EDPKOT	Region/Organization where this Work Standard originated: EDPKOT: rural and remote working group transfers of care module	
Date Prepared: July 2, 2015	Last Revision: August 26, 2015	Date Approved:	

Work Standard Summary: These are the communications related steps that must be completed by physicians in receiving and sending facility to facilitate patient transfers of care.

Essential Tasks: Sending Region Physician	
1.	Identify all patients on unit who could transfer in 3 days (T-3) and discuss with care team.
2.	T-1: Call accepting physician in receiving sites and conduct verbal handoff. Complete transfer/discharge note. Identify for receiving physician any barriers to transfer related to patient care.
3.	T-day: (Transfer day) Confirm that patient is safe and ready to transfer, write Transfer Order and finalize Discharge/Transfer Note . If barriers related to receiving site accepting patient's care have not been resolved by T-day, contact your SMO (or designate). (Follow steps outlined in dispute resolution Work Standard)
Essential Tasks: Receiving Region Physician	
1.	T-3: Receive alert of pending incoming transfer. Alert central point of contact in your region if there are any care concerns with transfer.
2.	T-1: Receive phone call for verbal handover from sending physician. If care concerns are identified, work with team to resolve, if possible.
3.	T-day: Accept patient transfer and complete admission. If there are unresolved barriers to accepting care, contact your SMO (or designate). (Follow steps set out in dispute resolution Work Standard)

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(Example of written documentation for physician-to-physician communication)

Patient Transfer/Discharge Note

Name: _____
DOB: _____
PHN#: _____
Address: _____
NOK: _____

Date Admitted: _____ Date Transfer/Discharge: _____

Reason for Transfer: _____

Most Responsible Physician (print): _____

Family Physician (print): _____

Final Diagnosis: _____

Investigations/Course in Hospital: _____

Check Box if Full Medication Reconciliation Summary **upon Discharge** is Attached; **OR**

List Discharge Medication(s): _____

Special Instruction(s)/Advice/Care Plan: _____

Follow up appointment(s):

Dr. _____ Date _____ Location _____

Dr. _____ Date _____ Location _____

With your family physician _____ Date _____

With other health providers _____ Date _____

Copy for Family Physician

Provide copy for Patient

Provide copy to the MRP listed above.

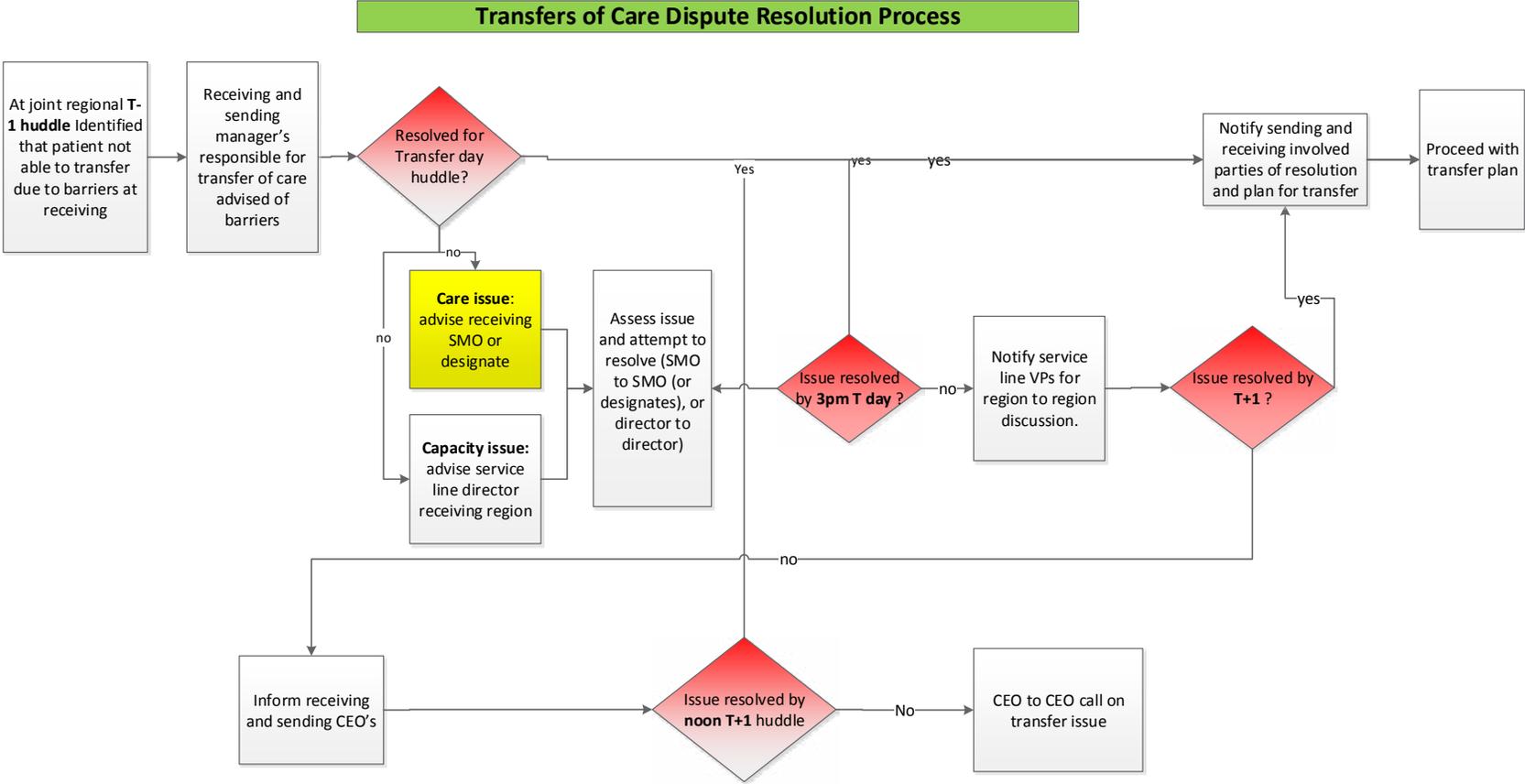
Destination of Transfer Confirmed. Location/Destination: _____

Fax Copy to physician that patient is being transferred to: _____ Physician Fax # Date & Time faxed

Form Completed By (print) Date Completed Signature

Dispute resolution process

A dispute resolution process has been developed, to help deal with instances where there are barriers to the receiving facility accepting a patient. This map illustrates how this process should work; related Work Standards explain the steps for escalating an issue.



WORK STANDARD				Name of Activity: Incoming transfers with unresolved barriers T-1		
				Role performing Activity: Central Point of Contact Sending and Receiving Regions		
	Location: Health Region		Department:			
	Document Owner: EDPKOT Rural and Remote		Region/Organization where this Standard Work originated: ED PKOT			
Date Prepared: October 30, 2015		Last Revision:		Date Approved:		

Work Standard Summary: These are the steps for sending and receiving regions to follow when there are **unresolved barriers** to receiving region accepting patient transfer **by Transfer day -1**.

Essential Tasks: Sending and Receiving Regions	
1.	After morning huddle on T-1, identify any barriers to accepting patient transfers and escalate to the managers responsible for transfers of care at sending and receiving regions.
2.	If barriers not resolved prior to T-day huddle, manager will escalate to receiving region SMO for care issues , and service line director of receiving region for capacity issues . SMO and/or service line director to assess issue and attempt to resolve. SMO-to-SMO or director-to-director call to occur if needed.
3.	If barriers not resolved by 1500 T-day by receiving region director and or receiving region SMO, VPs of service line responsible for transfers will engage in region-to-region discussion.
4.	T+1: If the barriers to transfer are not resolved by T+1.huddle, the CEO for the receiving and sending regions are advised by directors.
5.	T+1: If the barriers to transition are still not resolved by noon T+1,CEO -to-CEO discussion should occur.
6.	Once barriers resolved, proceed with transfer process and notify all involved parties.

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Module 3: Transfers of Care

	Name of Activity: Incoming transfers with unresolved barriers T-1		
	Role performing Activity: SMO or designate at sending and receiving regions		
WORK STANDARD	Location: Regional Health Authority		Department:
	Document Owner: EDPKOT Rural and Remote		Region/Organization where this Standard Work originated: ED PKOT
	Date Prepared: October 30, 2015	Last Revision:	Date Approved:

Standard Work Summary: These are the steps for the SMOs in sending and receiving regions to follow when barriers to transfers (related to patient care needs) have been identified.

Essential Tasks:	
1.	SMOs (or designates) in both sending and receiving region will be alerted by most responsible physician (sending) and accepting physician (receiving) of pending transfer with unresolved barriers related to patient care.
2.	Sending region's SMO (or designate) initiates phone conversation with receiving region's SMO (or designate).
3.	Each SMO to inform central point of contact of outcome of discussion. If issue is not resolved by 3p.m. on T-Day (transfer day), SMOs to notify service line VPs.

Appendices

Appendix 1 – Memorandum of understanding

Principles for all Inter and Intra-Regional Transfers of Care

Memorandum of Understanding

Of

All Saskatchewan Regional Health Authorities

Purpose

In the spirit of a health system that thinks and acts as one, this Memorandum of Understanding (MOU) will outline agreed-upon principles for transfers of patients to and from tertiary care (TC) home hospital (HH) or home region (HR) and all inter and intra-regional transfers of care. Agreement on these principles will reflect a shared commitment to patient centred care and the provision of the care in the right place at the right time by the right provider. A standardized process will also ensure that the resources and capacity of the provincial health system are efficiently and maximally utilized. This MOU represents a shared commitment that will be followed by specific actions to achieve the desired future state for safe patient transfers of care.

Background

Many patients move from rural settings to TC and or other regional facilities for both planned and unplanned episodes of care. Once a patient's needs are such that the level of care in that facility is no longer required, they are transferred to a receiving facility. While receiving facilities make best efforts to accommodate transfers, at the present time, there is no provincial standardized process related to these transfers of care. This leads to multiple issues and concerns for both staff and patients including but not limited to:

- Patient transfers occurring with very little time for preparation;
- Sending facilities waiting until a discharge order is written before communicating with receiving facilities;
- Receiving Facilities have very little lead time to prepare for the transfer resulting in challenges with medication, staff and/or equipment availability;
- Patients and families are not informed of transfer in advance leading to unnecessary stress and anxiety; and,
- Incomplete and inconsistent information is sent with the transfer.

All of this leads to poor patient and family experience and potentially compromised safety if receiving sites are not equipped with the appropriate medications, equipment, or skills for safe patient care. Several process improvement events have been completed by HRs related to patient transfers, with important learning's and promising results. There is a desire by region staff, physicians, and leaders to standardize and improve the processes related to all inter and intra-regional transfers of care. This has also been identified as a system level priority by the Provincial Kaizen Operations Team (PKOT) for the Emergency Department (ED) Waits and Patient Flow Initiative, as delayed transfers are one of the bottlenecks impeding patient flow across the continuum of care.

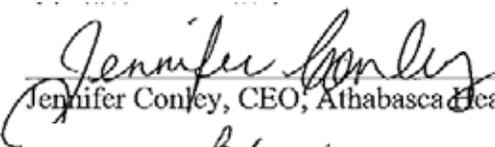
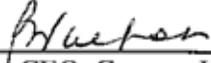
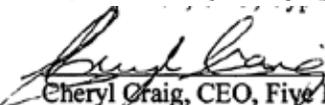
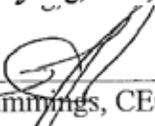
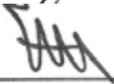
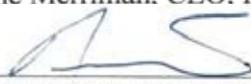
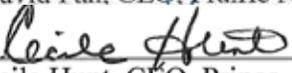
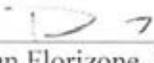
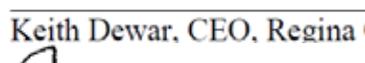
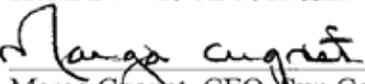
Policy and procedure related to all inter and intra-regional transfers of care for all patients will incorporate the following principles and processes to the best of the participating region's capability:

1. Transfers will be based on overall needs and safety of the patient. Any delays in the transfers of care from TC to HH or HR should consider the ability of TC to continue to provide safe care, understanding TC obligation to accept patients as defined by the Ministry of Health Critical Care Transfer and Transport Policy. In situations where the safest location for care is in question, a standardized dispute resolution process (to be developed) will be utilized.
2. For all transfers where a receiving region or facility has the appropriate services, and available transportation, to safely transfer and care for a patient, that region or site will not refuse the patient transfer. Regions or facilities which are not TC's will aim to accept transfer of a patient within a maximum 24 hours from the time the patient is ready, unless extenuating circumstances are present.
3. Transfers will occur seven days a week and where possible, be guided by patient and family preference.
4. Regions will work towards a centralized intake process and single point of contact for transfers.
5. Discussion with patients and family regarding transfers to and from TC or a regional facility will occur as early as possible during the episode of care. Ideally, these discussions will occur at the time of transfer to TC or a receiving facility, upon admission to the TC or a receiving facility and on transfer from the TC or sending facility.
6. Timely communication with the receiving HH, HR or receiving facility well in advance of the patient transfer will occur. Ideally, the TC or sending facility will alert the HH, HR or receiving facility of the pending or potential transfer at least 72 hours prior (T-3 or D-3) to the Estimated Date of Transfer or Discharge (EDT or EDD).
7. Transfers are made before 10 a.m. if possible. Where this is not possible, communication should occur with the HH, HR or receiving facility intake contact to insure patient needs will be met upon arrival.
8. Standardized information sharing: Based on a provincial standard (to be developed), regions will collaboratively follow a mutually agreed upon standardized checklist of information to be faxed/ emailed to the TC or HR or HH or receiving facility in advance of the transfer. The checklist will include a list of documents that will be transferred with the patient.
9. Once the appropriate bed in the HH, HR or receiving facility is determined by the central intake point, a physician to physician handoff will occur. This hand off **will** occur verbally for all transfers of care. In addition, a **legibly** completed written copy of a provincial transfer summary form (to be developed) will accompany the patient.
10. Each region will commit to utilizing the bed capacity in the entire region when facilitating a transfer of care.

Module 3: Transfers of Care

This MOU is at-will and may be modified by consensus of the Regional Health Authority CEOs. This MOU shall become effective upon signature by the authorized officials and will remain in effect until modified or terminated by the partners. In the absence of consensus for revisions by RHA CEOs this MOU shall endure.

Contact Information

 Jennifer Conley, CEO, Athabasca Health Authority	<u>9/18/15</u> Date
 Beth Vachon, CEO, Cypress Health Region	<u>29 July 2015</u> Date
 Cheryl Craig, CEO, Five Hills Health Region	<u>September 1, 2015</u> Date
 Greg Cummings, CEO, Heartland Health Region	<u>22.07.15</u> Date
 Shane Merriman, CEO, Kelsey Trail Health Region	<u>JULY 30/15</u> Date...
 Andrew McLetchie, CEO, Mamawetan Churchill River Health Region	<u>Aug 31/15</u> Date
 David Fan, CEO, Prairie North Health Region	<u>July 28, 2015</u> Date
 Cecile Hunt, CEO, Prince Albert Parkland Health Region	<u>Aug 18, 2015</u> Date
 Dan Florizone, CEO, Saskatoon Health Region	<u>Sept. 2, 2015</u> Date
 Keith Dewar, CEO, Regina Qu'Appelle Health Region	<u>July 24, 2015</u> Date
 Marga Cugnet, CEO, Sun Country Health Region	<u>August 11, 2015</u> Date
 Suann Laurent, CEO, Sunrise Health Region	<u>July 22, 2015</u> Date

Appendix 2 – Med rec work standard (to come)

Appendix 3 – References

Waring J, Marshall F, Bishop S, Sahota O, Walker M, Currie G, et al. An ethnographic study of knowledge sharing across the boundaries between care processes, services and organisations: the contributions to 'safe' hospital discharge. *Health Serv Deliv Res* 2014;2(29).