

Bridging the Gap for Clients from the LHO G4 Cardio-Pulmonary Unit to the Community

Introduction

At the time of discharge, clients often leave the hospital with information they have received in an unsystematic way. This information needs to be contained in one place so that the client can feel organized about what will take place at home and what is set up for them. Knowledge is power for the client and this will help the client to feel like they have a handle on the next step.

The goal of this project was to provide an individualized solution such as a portable folder to organize the array of information that the client receives from admission through to discharge (i.e. med sheet, CCAC services required, brochures for community services, physicians notes for the client, LTCH information or documentation that has been done, discharge sheet with prescriptions and appointments to be made as an outpatient, dietary information, etc.)

This folder would be provided to the client upon discharge to start his/her client-centred care in the community. It would be suggested to the client that this folder could be used to add to at home and take with the client to all appointments either in the community or if there are follow-up appointments at the hospital. As the client's history would be in the folder, this could be provided by the client to the primary care provider who could learn what has been happening to the client in the home setting.

This folder would also serve as a communication tool for the CCAC and other members of the health care team as services the client would be getting would all be documented and provided in the folder.

Actions

- ✓ Collected all information given out on discharge to clients
- ✓ Researched options for the best tool while keeping the cost low (binder, clipboard, folder, etc.)
- ✓ Collected phone numbers of most use to the patient on discharge
- ✓ Reviewed the brochures on G4 and at a CE LHIN symposium
- ✓ Called various providers and asked questions to determine what they provided
- ✓ Met with the Director of Medicine re the project to get input and guidance-loved the idea, was supportive and wanted to see it completed...possibility for this to be applied more broadly
- ✓ Met with Susanne Babic to discuss what would be feasible within the allotment of time for the project
- ✓ Explored various aspects as the idea was originally to trial it and gather feedback; Planned to make a CD for the patient explaining the folder but the value of adding this was questionable; Upon further discussion it was determined that these elements would be challenging to complete within the scope of this project
- ✓ Decision made to scale back and to go with the folder at this time
- ✓ Spoke to Allied Health for opinion re the folder and the services at home and what that involves
- ✓ Spoke with other units in medicine and they felt it was a good idea as they had similar issues with information going missing with their discharged clients
- ✓ Decided that the folder should have separate sections for the different types of information to make it easier for the patient

Results



A package containing all relevant information has been completed.



The information folder looks good and is organized which should assist the patient with navigating through his/her healthcare encounters.



Challenges

- ✓ When a patient is being discharged from hospital there is not a lot of time to explain the information package.
- ✓ Taking on a bigger project was too much with the allotted time so it was helpful to determine the scope before starting. It was disappointing however not to be able to trial this before the end of the project.
- ✓ There are too many brochures to choose from which can be confusing and somewhat overwhelming.
- ✓ Time is a factor when working full-time and managing other conflicting demands.
- ✓ It will be challenging to determine if a patient will use this to its full potential post-discharge once they have returned home or if they will continue to use it at all.



Lessons Learned

- ✓ Thinking smaller and doing it well makes a project successful keeping in mind that eventually it could be expanded
- ✓ Recognition that others share similar issues and there may be opportunities to share solutions; Other areas in the hospital are having the same problems with patients not having their information contained upon discharge and needing to call back into an area post discharge with questions
- ✓ Sufficient resources must be allocated to any venture
- ✓ It is possible that with the baby boomer generation of seniors, that the folder won't be needed as they will be increasingly computer savvy however the trend now with giving older patients web sites, etc. is not very helpful
- ✓ Separate sections to organize the folder helps the patient with managing their information
- ✓ Providing the folder to the patient on admission and then encouraging the person to use it during their stay to make it very individualized makes sense
- ✓ Creating a sample or 'mock up' of a folder to experiment with what could potentially be contained in it was useful

New Evidence/Best Practices

In discussions about this project with other internal hospital areas such as the PASS program it was agreed that it was useful to provide a mechanism for patients to contain all of their important information in one place. This would be easy and accessible for the person to take to appointments, and the patient would have the ability to continuously add content as needed. (i.e. if CCAC services were added, etc.)

If a client is in the process of applying for LTCH placement and has selected options, a copy of this information would be useful to keep in this folder and it may be helpful when seeing health providers.

It is helpful for a patient to have their medication list in the folder upon leaving the hospital as this may decrease drug discrepancies.

If the patient is clear about information and next steps at the time of discharge this could decrease the calls back to the hospital with unanswered questions. Providing the folder while in hospital gives the patient and family time to read, process, and ask questions in an unhurried manner; It empowers patients to take charge of their health.

Next Steps

- ✓ Prepare additional packages
- ✓ Trial the folder on G4 LHO
- ✓ Get buy in and support from staff
- ✓ Determine how to track who gets packages and how to do post discharge calls to see how it is working
- ✓ Present project to Director of Medicine
- ✓ Explore opportunities to expand the idea across the organization as other units have expressed interest

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