Team Name: Regional PCH Program Team Meeting Team Lead: Director – PCH West/East Approved by: Regional Lead – Community & Continuing Care	Reference Number: CLI.6410.PL.025 Program Area: Personal Care Homes Policy Section: General
Issue Date: March 15, 2023 Review Date: Revision Date:	Subject: Discharge to Community from a Personal Care Home Setting

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POLICY SUBJECT:
Discharge to Community from a Personal Care Home (PCH) Setting

PURPOSE:
To assist the resident and/or their representative with discharge to community.

BOARD POLICY REFERENCE:
Executive Limitation (EL-2) Treatment of Clients

POLICY:
When a resident and/or their representative requests discharge to the community, he/she will be assisted with appropriate discharge planning.

Discharge will be considered when:

- Resident and/or their representative requests discharge; or
- The multi-disciplinary team assessment indicates a resident is able to live in the community.

IMPORTANT POINTS TO CONSIDER:

- The safety of the resident in the community needs to be the main consideration.
- Residents who are competent can make the decision to live at risk in the community.
- Residents could be discharged from an interim placement bed to wait for their preferred PCH placement, or they could be discharged to live in the community.

PROCEDURE:

1. Discussion with resident and/or representative:
   - reason for discharge;
   - feasibility of community living arrangement;
   - possible need for Home Care supports;
   - any medical concerns arising from move out of PCH; and
   - the opportunity for a social leave to trial the discharge.

   The discussion with resident and/or representative will be facilitated by Social Worker and/or Nurse Manager or designate. The Medical Practitioner may need to be involved in discussion regarding any concerns regarding management of medical issues. Document the discussion in the health record including the recommendation from the multi-disciplinary team and the final decision by the resident and/or representative. Some suggestions for documentation include:
   - Who was involved in making the decision (a competent resident, family members, professionals with the designation? and the date);
   - Suggested that consultation involve more than one discipline regarding the discharge including having a resident/family conference to ensure that the process is well thought out before the discharge took place;
   - That the inherent risks to the resident of being discharged are clearly explained in easy to understand lay terms to the resident and/or representative;
   - That the resident and/or representative communicate their understanding of these risks and that they are willing to accept possible negative outcomes should they occur;
   - The resident and/or representative are aware of “what to do” should a situation arise where nursing and/or medical care is needed;
   - Who was involved in the decision-making process.

2. Based on discussion with resident and/or representative, appropriate referrals are to be made to:
   - Home Care; and
   - other community supports (e.g. meal delivery, Lifeline)

3. If Home Care is required, discharge plans are to be coordinated with resident and/or representative and Case Coordinator to ensure appropriate Home Care supports are in place prior to discharge.
   - Home Care Referral and Intake Process (CLI.5410.PL.003.FORM.02) will be completed and forwarded to Home Care Case Coordinator
   - Residents and/or their representatives need to be advised that there may be a delay in Home Care services, and they are responsible to provide all required care if the resident is discharged before the Home Care plan can be established.

4. If resident and/or their representative declines Home Care services, this is noted in the health record. The contact information for the Home Care Program will be provided for future reference.

5. The PCH will provide a copy of the most recent Medication Administration Record (MAR) to Home Care (if applicable) and to the resident's community pharmacy of choice.
   - This should be provided at least 2 business days in advance of the resident being transitioned, when possible. Order changes occurring in the interval after the MAR is sent will have to be communicated to Home Care (if applicable).
   - Education will be provided to the resident and/or their representative on the discharge medications by the most appropriate qualified healthcare professional (e.g. nurse, pharmacist or prescriber).

6. Discharge order to be written by prescriber.

7. If resident and/or their representative is choosing to be discharged from an interim bed to await placement in the community for their preferred PCH bed, complete Change of Circumstance form (CLI.6410.PL.019.FORM.01) and submit to Administrative Assistant – Long Term Care. The resident will remain on the waitlist for their preferred PCH until a bed is obtained.

8. If resident and/or their representative proceed with discharge against advice of medical practitioner and/or the multidisciplinary team, the discussion regarding risks and concerns will be clearly documented in the health record prior to discharge. Documentation should include that the resident and/or representative were advised that discharge is contrary to their professional advice.

   An occurrence report is also completed. Consider whether referral to Public Trustee and Protection for Persons in Care (*PPCO)* is required if resident safety is a concern.

9. The process to assist the resident and/or representative in making the decision to discharge is often an ethical situation. Staff should complete the Record of Ethical Decision-Making Discussion (ORG.1810.PL.005.FORM.02) to document this process.

10. Notify appropriate departments of discharge

REFERENCES:

CLI.6410.PL.019.FORM.01	Change of Circumstance form
CLI.5410.PL.003.FORM.02	Home Care Referral and Intake Process
ORG.1810.PL.005.FORM.02	Record of Ethical Decision Making Discussion