Review of Current Discharge/Transition Planning Practices in the Champlain LHIN and Recommendations for Enhancement

Author: Elizabeth Lynch, M.Psych.

Submitted by the Family Advisory Council to the Addictions and Mental Health Network of the Champlain LHIN, November, 2010

Introduction

The Family Advisory Council (FAC) has, from its inception, looked for opportunities to promote enhanced collaboration and communication between consumers, caregivers and mental health service providers. Formed in 2004, the FAC has representation from many organizations including: Schizophrenia Society of Ontario, Ottawa Region; Mental Illness Caregivers Association; Mood Disorders Ottawa Mutual Support Group; Family Advisory Group of the Mental Health Commission of Canada; Provincial Centre of Excellence for Child and Youth Mental Health; Hopewell Eating Disorder Support Centre; NAMI; Parent's Lifeline of Eastern Ontario; Ottawa Network - Borderline Personality Disorder; Family Council, Royal Ottawa Mental Health Centre; Ontario Ministry of Community and Family Services Planning Body; and Community Advisory Board, Education and Social Action Committees to Lanark County Mental Health.

The FAC recognized early on the need to document the issues family members have with discharge planning and the system changes required to promote enhancement. In March 2007 FAC produced a position paper entitled *"Transitional Planning for Individuals with Mental Illness"* which has been widely distributed through mental health networks. Continuing our work in this area, in June 2009, the FAC sought and received an endorsement from the Council of the Mental Health Network of the Champlain LHIN to support our Discharge/Transition Planning Task Group. In addition, The Task Group made a presentation to the Schedule 1 Mental Health Inter-Hospital Committee for the Champlain Region and received further support. The Committee offered hospital staff members as representatives and the Task Group subsequently embarked upon a process for gathering information from the Champlain Region hospitals that have inpatient mental health units. Although they are not Schedule 1 facilities, the Pembroke Regional Hospital participated, and the Royal Ottawa Mental Health Centre was also included, given its status as a specialized centre.

Task Groups Guiding Principles:

- Mental illness can impair many factors in the quality of life of an individual and their family members, often on an ongoing basis. Consequently, admission to and discharge from hospital are recognized as part of a continuum in overall care and support.
- Family members and caregivers should be recognized as partners in care, with hospital practices reflecting this.
- Comprehensive discharge/transition planning is essential for ensuring the safe and successful return to home and community for the patient/consumer.
- Effective discharge planning acknowledges the importance of involving the patient/consumer, their family members and hospital outreach and community mental health services.
- Development of the discharge plan, as well as information and education, should be provided to consumers and family members prior to discharge.

Task Group Primary Objectives:

1. Enhancing existing discharge/transitional planning efforts.

   Over 50% of persons with mental illness are discharged from hospital to their family's home[1]. Families oftentimes are burdened with post-discharge issues, some of which could be avoided with adequate information-sharing and pre-discharge planning for patient follow-up. The experience of families can help to inform the discharge/transitional planning process to ensure a positive transition back into the community.

   Tasks: To review existing practices, identify gaps and make recommendations for improvement.

2. Exploring privacy issues that can negatively affect caregivers.

   Families repeatedly identify privacy issues that interfere with their inclusion in the circle of care. Caregiver engagement, pre- and post-discharge, may be enhanced by having families inform the system partners about these issues and explore options to address them.

   Tasks: To review existing hospital-based forms/literature on privacy for patients and propose recommendations for improvement where necessary.

3. Enhancing communication among health care system and family/caregiver partners.

   Inconsistencies in the nature and extent of caregiver and consumer engagement exist across the region. To better support meaningful engagement of all parties, ongoing communication amongst health care system partners, consumers and family/caregivers is vital.

   Tasks: To facilitate communication over the course of the Task Group's term and beyond.

This report provides a brief overview of the information that was gathered by the Task Group and contains the recommendations for the implementation of cost-effective system changes which will help create the necessary conditions in our community to support the optimal health and well being of caregivers and their loved ones with mental health issues.

[1] Looper, K, Fielding, A, Latimer & Amire, E. Improving access to family support organizations: A member survey of the AMI-Quebec Alliance for the Mentally Ill. Psychiatric Services, 1998, 19:1491-1492.

Acknowledgements

It is important to note that this project would not have been possible without the participation and cooperation of staff from various regional hospitals. The FAC Task Group would like to extend their sincere appreciation to the following professionals for their expertise, good humour and kind assistance despite their daunting workloads:

Hazel Alexander-Tate, R.N., BscN.
Nurse Manager
Mental Health Program
Queensway-Carleton Hospital

Gabrielle Burnham, M.S.W., R.S.W.
Acute Mental Health
Pembroke Regional Hospital

Claude Caron, R.N., BscN.
Team Leader
Mental Health Inpatient Unit
Montfort Hospital

Josianne Chartrand, M.S.W., R.S.W.
Social Worker
Mental Health Program
Montfort Hospital

Melody Crites, R.N., CPMHN(C)
Manager,
Psychiatric Care Unit
Cornwall Community Hospital

Julie Devecseri, R.N., CPMHN(C)
Clinical Manager, Mental Health
Civic Campus, The Ottawa Hospital

Jennifer Gray, R.N., BscN.
Acute Mental Health
Pembroke Regional Hospital

Karen Poole M.A., M.S.W. (equiv), R.S.W.
Chief, Social Work
Royal Ottawa Mental Health Centre

Lydia Ritchie, BScN, MScN, CPMHN(C),
Certified Affiliate, Academy of Cognitive Therapy
Clinical Nurse Consultant, Anxiety Disorders Program
Royal Ottawa Mental Health Centre

Cherri Sleeth, M.S.W., R.S.W.
Mental Health Program
Queensway-Carleton Hospital

Lea St. Louis, M.S.W., R.S.W.
Mental Health Program
General Campus
The Ottawa Hospital

Susan Trotter, M.S.W., R.S.W.
Psychiatric Care Unit
Cornwall Community Hospital

Finally, the FAC Task Group extends its sincere thanks to the members of the Client Empowerment Council of the Royal Ottawa Mental Health Centre, and the other clients/consumers who attended our Focus Group on September 30, 2010. Through sharing their discharge experiences from hospital, they greatly added to our knowledge base.

Overview of Current Practices in Hospital Mental Health In-Patient Units:

The Task Group conducted three meetings with Social Work staff from the above noted hospitals in Champlain Region to obtain literature, forms, policies and practices related to caregiver information sharing and interaction. *(NOTE: Pembroke Hospital participated via teleconferencing, with both social work and nursing staff participating. Individual meetings were held with Cornwall Community Hospital staff later in the project as they were unable to participate earlier).*

During this part of the process, the Task Group realized that in many instances individuals admitted to inpatient mental health units often did not interact with members of the social work department and the bulk of the discharge planning work was done by the nursing staff. Consequently, the Task Group also held individual, on-site meetings with the nurse managers of the Ottawa Hospital, the Queensway-Carleton, the Montfort and Cornwall Community Hospitals for further information gathering around discharge/transition planning practices.

Pembroke Regional Hospital

Pembroke Regional Hospital has a 15 bed inpatient Mental Health Unit (MHU). A social worker is involved with almost every case as well as a resource nurse. Hospital staff also works in concert with their Community Mental Health Team gathering information on the MHU resources patients have used. If patients have been involved with the Community Team, their information is sent, with the patient's consent, to the Community Team upon discharge. MHU staff routinely tries to involve families/caregivers in discharge/transition planning and act upon verbal consent of the patient, following up with written consent. The hospital provides patients with specific MHU information, as well as generic hospital information. Typically, nursing staff review any hospital literature, unit rules and do any necessary behavioural contracting with patients, as well as filling out any discharge plan documentation.

The Task Group was struck by the outstanding collaboration between hospital staff and their community partners to ensure follow-up on the needs of the individual patient prior to discharge.

Montfort Hospital

Montfort Hospital In-patient Mental Health Unit has 28 to 30 beds and it is not unusual to have several patients waiting off service daily. A social worker is not always involved with each patient (that request is made by the treating physician). It is the social worker who is most often called in when there is an identified need for a meeting with the family. Weekly meetings are held where physicians, nursing, recreology and social work staff gather to review patient progress and plan for discharge. At this time, no discharge protocols or specific literature exists for mental health patients; however, there are plans to develop them. A generic hospital information booklet is provided to all patients. Nursing staff review any admission and discharge documentation with patients. When speaking to families/caregivers the nursing staff act upon verbal consent by the patient, but also follow up to obtain written consent.

Recently, the Montfort has embarked on a number of projects to improve care and communication practices. In the Mental Health Unit, nursing staff are participating in a research project headed by Dr. Ginette Rodger to enhance the present model of care. As well, the Unit has been piloting a "Synergy" Project which has been very positive. It includes, among other things, a board and color-coding system which informs staff as to patient status regarding discharge and has improved their ability to plan for the patient's discharge.

The Ottawa Hospital (TOH)

The **Ottawa Hospital Civic Campus** has an Inpatient Mental Health Unit with 42 beds and 5 beds in Psychiatric Emergency Services (in the ER, providing a short stay, which offers assessment, crisis intervention and stabilization). The Civic Campus also has a waiting area specifically designated for psychiatric emergencies. The **General Campus of the Ottawa Hospital** has an Inpatient Mental Health Unit with 45 beds, 6 of which are designated beds for the Eating Disorders Program. The First Episode Psychosis Program is attached to this unit as well and has some designated beds. By October/November 2010, the General site will have 4 beds in Psychiatric Emergency Services (in the ER). Both Units offer short-term care with the average length of stay of 14 days. On both campuses, there are 2.5 social workers assigned to the Unit. Nursing staff review admission material and literature specific to the rules and functions of the Unit with patients. Written consent is obtained prior to speaking to families/caregivers. Discharge planning is done by a social worker, if a social worker has been consulted. Consults to social workers are typically generated when: safety concerns are identified; a patient's care or discharge is identified as being complex or problematic; when there are concerns about a patient's family/community support or lack thereof. Many patients, however, go through their stay and have no contact with social work. Consequently, nursing staff and psychiatrists also play a significant role. The nurses spend a lot of time in discussion with families, as do physicians, especially on evening shifts during visiting hours.

The Task Group is cognizant that the Ottawa Hospital is a major provider of emergency mental health services and there is tremendous pressure for beds at both sites of TOH (e.g., on a regular basis there can be five or more persons waiting off-service for a bed on the mental health unit). Despite this significant systemic problem, the Units do their utmost to enhance communication regarding patient progress through regular patient review meetings between physicians, nursing staff and allied health professionals. Each physician has multidisciplinary team round one morning each week to discuss progress and plans for each of their patients. At the Civic site, the Clinical Manager meets with physicians and all allied health each morning to determine discharges and discuss any related barriers.

Queensway-Carleton Hospital

The Queensway-Carleton Hospital has 24 to 25 beds and 1.4 social workers cover the In-Patient Mental Health Unit. Staff noted that in the past two years referrals to the Unit have increased by a staggering 121% and on a regular basis, patients are waiting off-service for a bed. Patients are provided with generic hospital information as well as a booklet specifically covering information about the Unit rules, functioning and programs. The discharge planning sheet is typically completed by the nursing staff. Most often, communication to families is done through the psychiatrist if there is no social worker involved. Social workers are not involved with all cases but can become involved through weekly case conferences. Should a family meeting be needed, a referral is made to the social worker to conduct it. Written consent of the patient is required for families/caregivers to be given information, but staff also act upon verbal patient consent and note it in the patient chart.

It is noteworthy that the QCH perspective is that discharge planning begins at admission. This principle is borne out in practice by the comprehensive daily programming offered to patients on the In-Patient Mental Health Unit. For example, weekly group meetings are held on topics such as stress management; relaxation techniques; anger management; community resources which offer support, and patients also have the opportunity to meet weekly with the hospital pharmacist to discuss any issues/concerns regarding medication. The aim of such ongoing programming is to better prepare individuals for a successful return to their home community.

Cornwall Community Hospital

The Cornwall Community Hospital Mental Health Inpatient Unit has 16 to 17 beds, recently cut back from 22. The reason for the cut back was the result of the partnership between the Unit and the Community Mental Health Crisis Team, which has been very successful in treating people though community outreach, consequently lowering re-admission rates. There is a .5 social worker assigned to the Unit and, similar to Pembroke, the social worker is involved with the admission and stay of every patient and is vital to the continuity of patient care. All staff are involved in weekly case reviews with physicians and nursing staff work as a team with the social worker regarding discharge planning. They routinely involve community partners, families/caregivers in discharge/transition planning and will act upon verbal consent of the patient, following up with written consent. The hospital provides patients with literature specific to the mental health unit, as well as generic hospital information. Unit staff attend bi-weekly meetings with community-based programs (i.e., Crisis Team, Tri-County Mental Health, and ACT) to ensure discharge follow up and to keep each other updated on any changes to programs.

The Task Group was impressed with the team approach utilized in Cornwall, with nursing staff often going above and beyond their regular duties to take patients to view residences prior to placements.

Royal Ottawa Mental Health Centre

As the Royal Ottawa Mental Health Centre (ROMHC) is a specialty hospital, all beds are MH beds, all patient literature contains an MH perspective and all patients are provided with an information booklet about their rights, hospital rules and programming. Although it varies by program, there is an approximate ratio of one social worker for 22 beds. Social workers are assigned to programs, but do not become involved with a case unless requested by the physician. When involved, they routinely and actively try to involve families in care and will speak to family members with the verbal consent of the patient, but only provide client specific information with written consent. Efforts are made to provide generic information to family members, although there is no specific literature for families/caregivers. There is, however, a Family Council which meets regularly and acts as a conduit for involvement, having representation on the ROHMC Board, and the ROHMC regularly runs family information sessions and support groups. As well, the Client Empowerment Council meets monthly and has representation on various internal ROMHC committees.

Currently, a pilot project, utilizing a new discharge form, is being undertaken. It shows promise in adding to the information which must be documented for discharge and so far, appears to have improved collaboration and communication in discharge planning.

Perspectives from Clients/Consumers

All of the clients/consumers who attended our Focus Group on September 30, 2010 had experienced stays in the inpatient mental health units of the Montfort, General and Civic Campuses of TOH, QCH and ROMHC within the last 2 years. It was the unanimous feeling of the group that practices in discharge planning had improved in recent years. It was noted that community resource information was now more routinely given upon discharge and that efforts made to match individuals to "peer-to-peer" support groups were very valuable. There was also praise from the group about the ROMHC Ambulatory Care Program, and they expressed the strong desire to see it extended to cover the weekends.

There were, however, numerous concerns raised by the group suggesting that there was still much room for improvement. Examples included:

- The interminable wait for services at both campuses of TOH when they sought assistance though the ER, and the chaos of having to wait alongside those needing treatment for non-mental health related illnesses and physical injuries.
- Individuals who were admitted to TOH but were active patients at the ROMHC expressed a feeling of being in a "holding pattern" regarding their care while they awaited a bed at the ROMHC.
- At the ROMHC, involvement in discharge planning and information given to patients seemed to vary greatly by program (i.e. in the Mood Disorder Program, discharge planning sheets were filled out collaboratively with the patient, nurse and social worker and upon discharge a patient satisfaction survey was given to the patient to fill out. These practices were not adhered to in some other programs).
  All members of the group could cite times in the past when they were discharged but did not feel ready for it, primarily because although a change in medication was going to occur, it would not take place until after discharge. This was highly anxiety provoking for people and negatively affected their confidence in being able to cope with such change on their own. There was unanimous agreement that whenever a change in medication was necessary, it should be done while the individual is in hospital so that any problems/side effects can be addressed at that time. There was a very strong feeling that inpatient treatment provided the kind of safety net essential for patients to have a comfort level in accepting such an important change to their treatment plan. It was apparent that this is happening, in part, due to systemic problems (i.e. in one case an individual was to be discharged and her change of medication was not going to occur until 3-4 weeks after that because she required a screening at the Thrombosis Clinic prior to being put on her new medication, and could not get the Clinic appointment until 3 weeks after her discharge, despite being referred by her physician during the first week of her hospitalization).

Conclusions and Recommendations

It is apparent that the biggest barrier to effective discharge/transition planning is due to structural and capacity problems within the healthcare system. These systemic problems (added to by factors such as the closing of the Brockville Mental Health Facility and Rideau Regional, lack of access to long term care beds) have resulted in an increase in referrals to most mental health inpatient units in Schedule 1 hospitals in the Champlain District. Despite this growing demand, nursing and social work staff have been cut, and in some instances, mental health beds have been lost as there were insufficient staff to cover them. This has resulted in increased pressure for existing beds and a has a negative impact on discharge planning in that staff are frequently not given enough notice prior to the discharge of an individual to complete comprehensive plans. Consequently, discharge from local Inpatient Mental Health Units was often unplanned with little collaboration with the patient, their family and community services. At times, patients can be discharged with little or no information. Follow up appointments and information on community resources are not routinely given and, in many instances, family members remain external to discharge planning.

In addition, systemic changes have served to further constrict access to specialized beds at mental health facilities. For example, a patient can be admitted through psychiatric emergency at the Ottawa Hospital, yet they are an active patient at the ROMHC but cannot be transferred in a timely way as the ROMHC has no bed available.

The Task Group's resulting recommendations for the enhancement of discharge/transition planning in the Champlain are intended to:

- aid in supporting the Champlain LHIN priority of ensuring there is a recovery-based mental health system through enhanced and comprehensive transition planning from hospital to community.
- demonstrate in a tangible way that individuals and their support systems are key participants in any recovery-based system, and that self-management is a core component within a chronic disease prevention and management model.
- highlight the potential for reducing the burden on emergency rooms, i.e. enhanced, comprehensive transition planning which involves family support may positively affect recovery in the return to the community, consequently reducing the number of re-admissions or visits to the emergency room. In March of 2006, the Canadian Health Services Research Foundation highlighted the fact that *"…enhanced discharge plans help reduce re-admission rates, both for the original problem that sent the patient to hospital and for all other reasons. By ensuring patients are properly cared for at home, discharge planning can reduce hospital re-admissions"*[2]. Consumers and family members who have received education about medication, treatment plans and resources available in

[2] Canadian Health Services Research Foundation Staff, Evidence Boost. "Enhance Discharge Planning to End the Revolving Door of Hospital Care". March 2006

the community may utilize services more appropriately, whereas in the past, they believed ER services to be their only option.

- highlight the potential of a cost-effective component to comprehensive discharge/transition planning though the possible reduction in a patient's length of stay. In 2005, study conducted at the Faculty of Health Sciences at the University of Western Ontario found that utilizing an innovative discharge planning model as a new way of *"helping people with mental illness make the difficult transition from hospital to community saved more than $12 million through shorter hospital stays while improving how patients function. The savings were achieved through the early discharges of patients on 13 wards, in four cities, over the period of one year"*[3].

Recommendation #1

Once the individual is admitted and their condition is stabilized, hospital policy should dictate that every effort must be made to obtain consent for a family meeting with the patient prior to discharge, in all cases where the individual will be discharged to return to the familial home, and/or where the family has ongoing involvement.

Rationale: When an individual is being discharged to a group home or referred to a community program, every effort is made to obtain consent for releasing information to that resource. In cases where the resource is considered part of the circle of care for the individual, such as in hospital outreach programs, the information is always made available and can help to ease the transition for the patient. Sharing information with consumers and their families about mental illness and its treatment has been demonstrated by Keller and his colleagues to aid in preventing non-adherence to a prescribed drug regime[4]. Better compliance may translate into reduced morbidity, hospital admissions and health care costs[5]. In addition, affiliates with the Douglas Hospital in Montreal noted that *"Outcome factors demonstrate the benefits of family involvement in hospital treatment. These include: the improvement of patient social functioning, increasing the amount of time spent out of hospital, reducing family conflicts and reducing perceived family burden, as well as the attainment of a feeling of increased effectiveness among relatives"*[6].

[3] Forchuk C et al. 2005. "Therapeutic relationships: from psychiatric hospital to community." Journal of Psychiatric and Mental Health Nursing; 12(5): 556-564.

[4] Keller, M.B., Hirschfeld, R.M.A., Demyttenaere, K. & Baldwin, D.S. Optimizing outcomes in depression: focus on antidepressant compliance. Int. Clin. Psychopharmacology 2002, 17: 265–71.

[5] Desplenter, F.A., Simoens, S. & Laekeman, G. The Impact of Informing psychiatric patients about their medication: a systematic review. Pharmacy World & Science, 2006, 28 (6): 329-341.

[6] Perreault, M., Tardif, H., Provencher, H., Paquin, G., Desmarais, J. & Pawliuk, N. The role of relatives in discharge planning from psychiatric hospitals: the perspective of patients and their relatives. Psychiatric Quarterly, 2005, 76 (4): 297-315.

Recommendation #2

That a standardized "Release of Information Form" be developed and utilized by hospitals in the Champlain Region.

> **Rationale:** It is evident from our review of the current hospital literature that each facility is using a different form which can create unnecessary confusion. These forms also do not appear to be readily available when a family member/caregiver requests them.

Recommendation #3

Hospitals with mental health inpatient units should formally review their practices regarding which documents can be distributed without compromising the Personal Health Information Protection Act (PHIPA).

> **Rationale:** Literature which is specific to a mental health inpatient unit (e.g., program schedules for groups and activities, any literature regarding rules and privilege levels, behavior contracting, community resources, information sheets regarding psychotropic drugs, patient and nursing station telephone numbers) is generic for that unit and not the individual patients within it. Providing such material to family members would not breech PHIPA and would be extremely helpful for families to review as they await the return home of their loved one. As well, this recommendation is consistent with that made in the recent Final Report of the Select Committee on Mental Health and Addictions of the Legislative Assembly of Ontario*, "Navigating the Journey to Wellness: The Comprehensive Mental Health and Addictions Action Plan for Ontarians".*[7]

Recommendation #4

When a referral is made to a social worker to conduct a meeting with the patient's family, it should be established as a regular practice that a member of the nursing staff is scheduled time to participate.

> **Rationale:** In the great majority of cases, it is nursing staff that are interacting with individual patients daily, not social work staff. Frequently, individuals admitted to hospital in-patient mental health units do not see a social worker, whereas nursing staff have had one to one contact with them throughout their stay. Consequently, they are in an excellent position to assist in meetings when families/caregivers are seeking help in supporting their loved one in the transition home.

Recommendation #5

Whenever a change in medication is necessary for an inpatient, all efforts should be made to navigate systemic barriers to accomplish this while the individual is in hospital.

> **Rationale:** Consumers of inpatient mental health services we spoke with during this project clearly did not feel ready for discharge in cases where a change in medication was going to occur but would not take place until after discharge. This was highly

[7] Ontario Legislative Assembly Select Committee on Mental Health and Addictions. Final report, August 2010. *"Navigating the Journey to Wellness: the comprehensive mental health and addictions action plan for Ontarians*", page 17.

anxiety provoking and eroded their self-confidence in being able to successfully cope with such change on their own, given any problems/side effects that might arise. Inpatient treatment provided the kind of safety net essential for compliance and for individuals to have a comfort level in accepting such an important change to their treatment plan.

Recommendation #6

Hospitals in the Champlain region that have Inpatient Mental Health Units would benefit from studying the "Discharge Planning Policy: Adult Mental Health Services", Department of Health, New South Wales, Australia, available to download at:
http://www.health.nsw.gov.au/policies/pd/2008/pdf/PD2008_005.pdf

Rationale: Our lack of a national homecare system makes it even more important for us to develop a comprehensive discharge planning protocol that looks at the biological, psychological and social needs of the individual in an organized and comprehensive way.

Recommendation #7

Hospitals with mental health inpatient units should begin meeting on a regular basis to develop common elements to a comprehensive discharge plan.

Rationale: Inconsistencies in the nature and extent of caregiver and consumer engagement in discharge planning exist across the region. To enhance existing practices, better ongoing communication amongst system partners is vital, and necessary for the implementation of Recommendations 1 - 5.

Recommendation #8

That the Champlain LHIN requests the MOHLTC formally review the legislation for the United Kingdom, Australia and New Zealand relating to family members and "carers" as part of the circle of care.

Rationale: In Ontario, individuals who have been admitted to inpatient mental health units go from the structured environment of the hospital to home, where they may have a mix of formal and informal care and support, some subsidized and some, paid for by the consumer and their families. Ontario would benefit from studying The National Health system in the UK, which relies upon and supports the appropriate involvement of caregivers (referred to as "carers") in discharge planning and homecare. This model has been found to save the National Health Care System money while providing better support for individuals and families[8,9].

[8] U.K. Department of Health. January 1999. *"Caring About Carers: A national strategy for carers"*

[9] U.K. Department of Health. June 2008 *"Carers at the Heart of 21st Century Families and Communities: A caring system on your side, a life of your own*".