Supporting You in Your Return Home

We are committed to providing you with the best care – both while you are in the hospital and upon your return home. We start planning for your discharge as soon as possible so that we are able to meet your needs on the day of discharge.

If you are acutely ill, injured, or having surgery, the hospital is the right place to be. For the health of our community, it is important that hospital beds are available for people who need them for acute medical, surgical or rehabilitation services. Once your physician determines that you no longer require the services only a hospital can provide, home is the best place to be.

Home First

A new approach to planning your care, called ***Home First***, is a patient-centred care philosophy focused on keeping patients safe in their homes for as long as possible with the right community health supports. *Home First* focuses on what is needed to go home, to make decisions about future care and to live as safely and as independently as possible.

- Home provides the most comfort for recovery and continued healing with the support of family and friends.
- Home gives you the time you need to make informed and thoughtful choices about your future in the dignity of your own environment.
- Home helps to decrease the chance of catching a hospital infection.
- Home helps to prevent the loss of strength and physical ability that can come from a prolonged hospital stay.
- Home is a familiar environment especially for persons with confusion or dementia.

A **CCAC Care Coordinator** will meet with you while you are in the hospital to create a unique plan of care to ensure you have all the proper supports in place to settle back at home or in the community. As part of *Home First*, you may receive enhanced services from the Erie St. Clair CCAC for a period of time after your discharge home.

A **Substitute Decision Maker (SDM)** has an important role in planning for discharge from hospital. If you are an SDM for a person who has been deemed not capable of making their own care decisions, it is important that you work closely with the healthcare team. Under the *Substitute Decisions Act* you are required to be available and willing to make decisions that respect the values and wishes of the patient.

Other Care Settings May be More Suitable

When your physician deems that you no longer require the level of acute care or services that a hospital provides, your care needs will be designated as *Alternate Level of Care (ALC)*. This means that you could safely receive care in another setting other than the hospital. The interdisciplinary team will work with you or your SDM to arrange safe discharge options to choose from. Once arrangements are in place, your physician or nurse practitioner will complete a Discharge Order. *The Public Hospitals Act* requires that you leave the hospital on the discharge date set out in the Discharge Order.

Most people can wait safely at home or in the community, rather than the hospital, while waiting for their next care setting to become available. Your healthcare team will work with you to help you decide your best options. These may include a short stay in a Convalescent Care Program or one of the hospital's Continuing Care units in Sarnia or Petrolia while you continue to heal. You may also decide to move to a retirement home.

Moving to Long-Term Care

Should a move to a long-term care home be needed, our goal will be for you to access long-term care from the community by returning home first. Admission to long-term care is a complex process and it is better to make these types of life-changing decisions from a comfortable, familiar environment such as home. Even when you are making arrangements to move to a long-term care home, our team will continue to work with you on a safe discharge plan.

Your Healthcare Team

Your Doctor or Nurse Practitioner will:	The Erie St. Clair CCAC will:	Your Healthcare Team will:
• Work with the hospital team, the Erie St. Clair CCAC and you or your SDM to guide you through a plan of care focused on your specific needs both in hospital and upon discharge home. • Write an order for discharge when your acute medical needs have resolved and you are medically stable.	• Work with you to arrange the care that you will receive when you are discharged home or to the community. This may include nursing care, personal support, etc. • Link you with other community support service agencies to assist with your ongoing care. • Process and complete long-term care assessments, if requested.	• Work with you to develop your care plan, including goals that help you to return home. • Provide you with updates on your progress towards discharge. • Ensure you receive the information you need to actively participate in your discharge plan. • Identify any challenges to discharge and involve people who will provide safe discharge options for you to choose from.

BLUEWATER HEALTH

Erie St. Clair CCAC Community Care Access Centre / CASC Centre d'accès aux soins communautaires d'Érié St-Clair

www.bluewaterhealth.ca

www.healthcareathome.ca/eriestclair