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Conference abstract

Home at last

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Abstract

Introduction: Our practice-oriented question was 'how can the community sector work with their local hospitals to smooth the patient's transition home from hospital'. Our answer was Home At Last, an innovative hospital-community collaboration in the Greater Toronto, Ontario, Canada.

Objective: To ensure that when seniors have had a hospital stay or emergency department visit, they are discharged in a timely manner and transitioned back to the community quickly with the right supports.

The program: The hospital changes its discharge processes to achieve a pre-determined discharge time, usually 11:00 am, at which time transportation arrives along with a community worker who rides home with the patient and then stays to get them settled until a family member arrives home or 9:00 pm at the latest. The worker can pick up groceries and prescriptions if necessary, prepare small meals, perform light housekeeping, do laundry, and provide toileting assistance. The Home At Last Care Coordinator follows-up with the patient the next day, and designs and arranges a package of community services and follow-up visits.

Results: The program has enabled participating hospitals to achieve expected discharge time for patients; increase patient satisfaction with the discharge process and greater compliance with discharge plan orders. In addition, patient throughput has been improved by at least 6 hours and social readmissions have decreased.

Keywords

hospital discharge, home care, Canada

Presentation slides available from:
http://www.integratedcarenetwork.org/Sweden2008/slides/02-06-gordon.ppt