Communauté de pratique du leadership des maillons santé

19 juillet 2016

Volet de transition des congés et littératie en santé

Conférencière : Kelly O’Halloran

Qualité des services de santé Ontario

Le conseiller de la province en matière de qualité des soins de santé en Ontario

Ontario

Qualité des services de santé Ontario

	ORDRE DU JOUR
9 h - 9 h 05	Accueil et introduction
9 h 05 - 9 h 15	Communauté de pratique du leadership des maillons santé : préparer le contexte
9 h 15 - 9 h 25	Pratiques innovantes
9 h 25 - 9 h 55	Conférencière : Kelly O'Halloran « Volet de transition des congés et littératie en santé »
9 h 25 - 10 h 05	Histoire du patient
10 h 05 - 10 h 20	Discussion : application pratique dans votre maillon santé
10 h 20 - 10 h 25	Sondage pour les sujets futurs et évaluation des webinaires
10 h 25 - 10 h 30	Mots de la fin

Objectifs d'apprentissage du webinaire

- **Comprendre les outils de prise de décision des volets de transition des congés pour le personnel, ainsi que les outils d'autogestion pour les patients**
- **Décrire les composants de la bronchopneumopathie chronique obstructive (BPCOD) et les méthodes de retransmission pour l'insuffisance cardiaque**
- **Partager les expériences et les apprentissages avec les autres collègues de la province**

Communauté de pratique des maillons santé

Les communautés de pratique se définissent comme étant des groupes de personnes ayant une préoccupation ou une passion commune pour leur vocation et qui apprennent comment s'améliorer à mesure qu'ils interagissent régulièrement

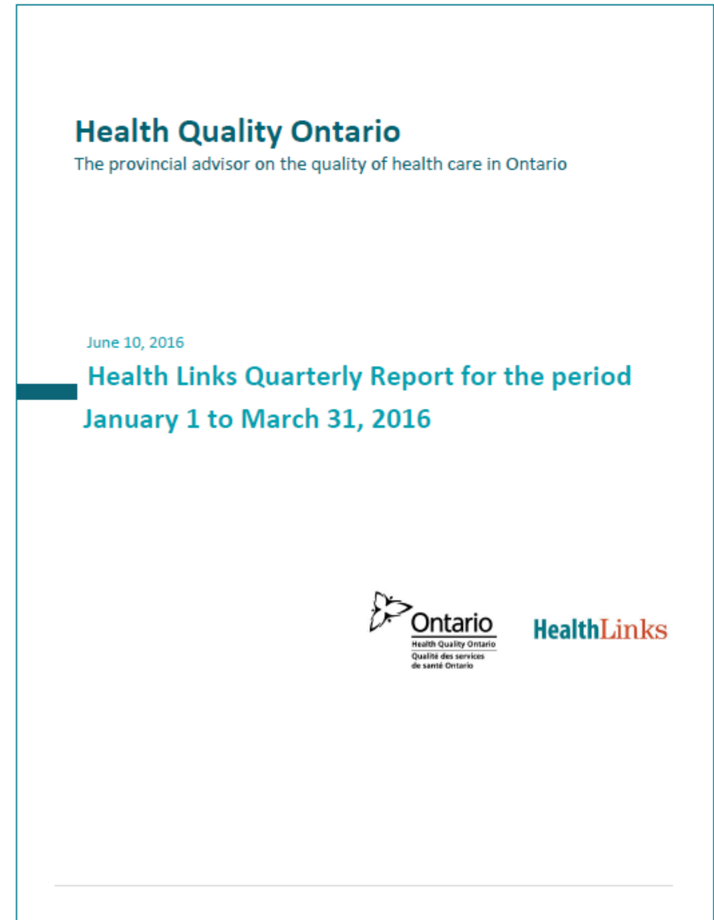
Communauté de pratique des maillons santé

Il s'agit d'une occasion de rencontre (en ligne et en personne) avec les autres pour le réseautage, le partage et l'apprentissage :

- Apprenez des leaders afin de mieux comprendre ce qui est nécessaire pour favoriser le changement dans un environnement de maillons santé
- Être inspiré à propager les approches novatrices dans votre maillon santé
- Contribuer à l'apprentissage collectif sur ce qui fonctionne le mieux dans une approche de maillon santé.

Rapports trimestriels

- Distribués à grande échelle avec une transparence complète au sein des maillons santé
- Comprend :
  - Données présentées sur deux mesures clés (plans de soins coordonnés et envoi aux fournisseurs de soins primaires)
  - Objectifs locaux et provinciaux
  - Sommaires de discussion des approches des maillons santé
  - Témoignages de patients
- Les rapports futurs comprendront une utilisation à plus grande échelle des pratiques innovantes appuyées par le groupe de référence clinique



Répercussions des maillons santé – Mise à jour du T4

Plans de soins coordonnés

Plans de soins coordonnés (PSC)
Total cumulatif
Avril 2013 à juin 2016

Nombre de patients avec un plan de soins coordonnés, élaboré par le maillon santé

18 926 patients aux besoins complexes ont reçu des plans de soins coordonnés par l'entremise de maillons santé

Accès aux soins primaires

Accès à un fournisseur de soins primaires (FSP)
Total cumulatif
Avril 2013 à juin 2016

Nombre de patients ayant bénéficié d'un accès régulier et rapide à un FSP

29 946 patients de maillons santé ont eu accès à des soins primaires périodiquement et rapidement

Source de données : Plateforme de rapports et d'analyse d'amélioration de la qualité de Qualité des services de santé Ontario - présentée par les maillons santé

Évaluer les pratiques innovantes

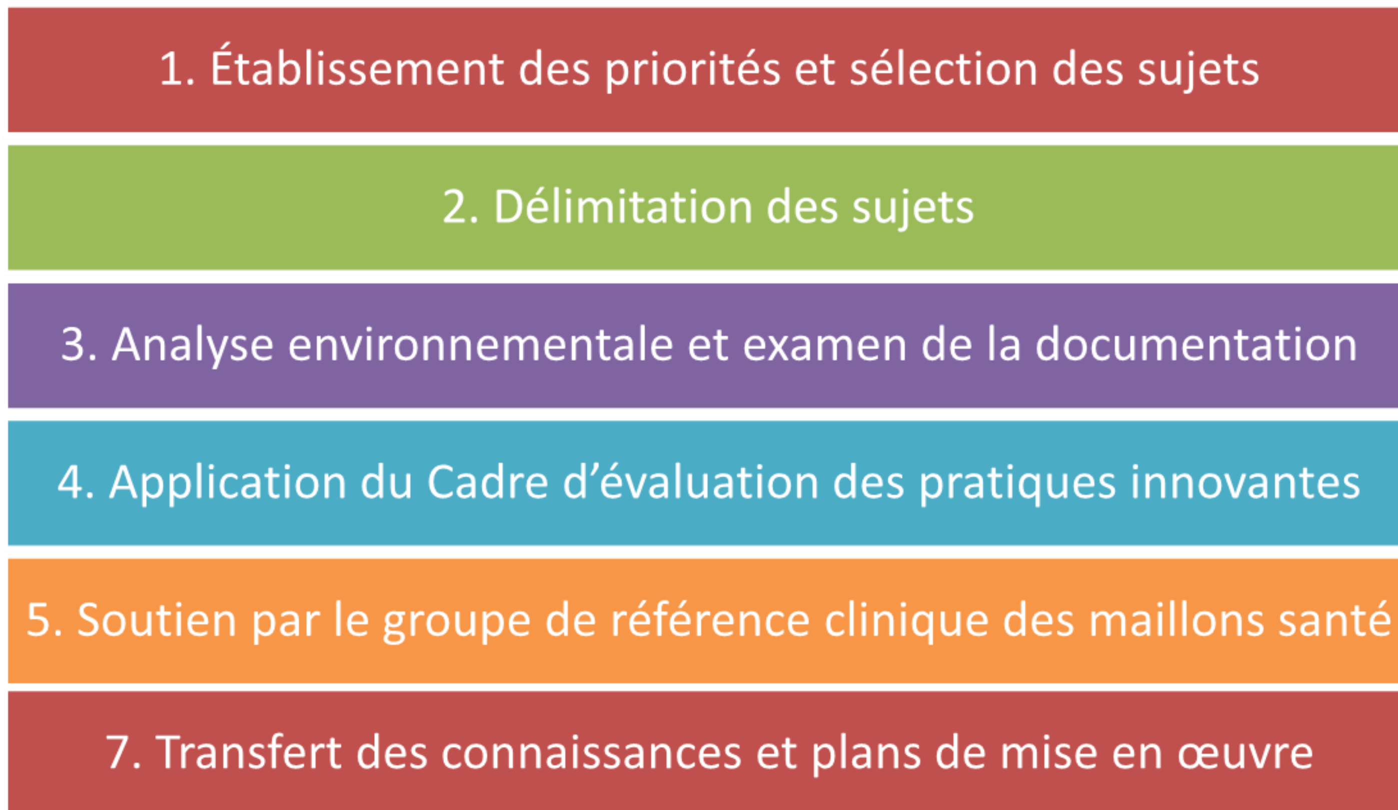


Figure 1 : Sommaire du processus du Cadre d'évaluation des pratiques innovantes

Cadre de référence d'évaluation des pratiques innovantes

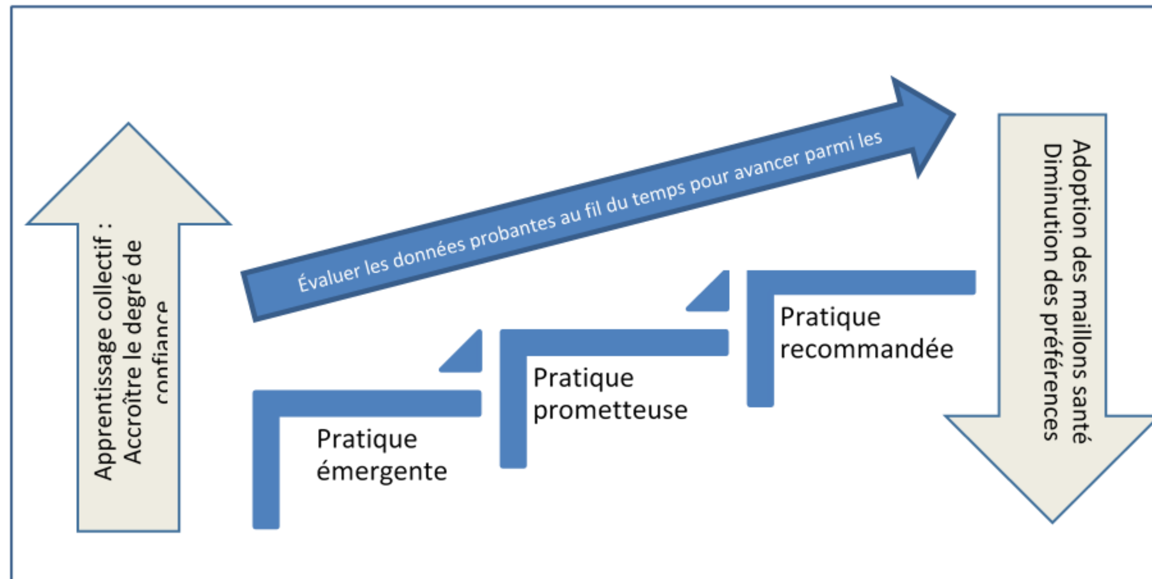


Figure 3 : Progression des pratiques innovantes

Ontario
Qualité des services
de santé Ontario

Transitions entre l'hôpital et la maison

Au début de l'admission à l'hôpital

- Effectuer le bilan comparatif des médicaments à l'admission
- Évaluer le risque de réadmission du patient
- Évaluer la littératie en santé
- 1. Aviser les fournisseurs communautaires de l'admission du patient à l'hôpital
- 2. Collaboration entre les fournisseurs communautaires pour élaborer/mettre à jour le plan de soins coordonnés

Tout au long de l'hospitalisation et du processus de transition

- Utiliser la retransmission de l'information lorsqu'on crée la capacité du personnel soignant et du patient
- Améliorer les communications avec le patient et le personnel soignant à l'aide d'outils visuels

À l'approche du congé

- Garantir un transfert personnel de clinicien à clinicien
- Effectuer le bilan comparatif des médicaments au congé
- 3. Identifier un responsable pour effectuer un bilan comparatif des médicaments dans la collectivité
- 4. Prévoir une visite de soins primaires avant le départ de l'hôpital

Dans la collectivité après un séjour à l'hôpital

- 5. S'assurer que le sommaire de congé est disponible dans les 48 heures
- 6. Assurer un suivi dans les 48 heures suivant la transition à la maison
- 7. Désigner une personne dans la communauté pour répondre aux besoins non cliniques dans la période suivant le congé d'hôpital

Meilleures pratiques fondées sur les données probantes

Pratiques innovantes

Pratiques innovantes

SE CONCENTRER SUR LA GESTION DES SOINS COORDONNÉS ET DES TRANSITIONS EN SANTÉ

Conférencière : Kelly O’Halloran

VOLET DE TRANSITION DES CONGÉ ET LITTÉRATIE EN SANTÉ

Littératie en santé, retransmission et volet de transition des congés du RLISS HNHB

Rx
-COLEMAN-
" TAKE WITH MEALS ? NO PROBLEM !
I EAT ALL THE TIME ! "

Littératie en santé

Selon l'Association canadienne de santé publique (2006),

La littératie en santé est la capacité à accéder, à comprendre, à évaluer et à communiquer l'information de manière à faire la promotion, à maintenir et à améliorer la santé dans une multitude d'environnements tout au long du processus de vie.

L'Organisation mondiale de la santé (1998) indique que

…..*la littératie en santé est essentielle pour prendre le contrôle et gérer sa santé. Cela signifie bien plus qu'être capable de lire des dépliants et de prendre des rendez-vous. En améliorant l'accès des gens à l'information sur la santé et leur capacité à l'utiliser efficacement, la littératie en santé est essentielle à leur autonomie.*

Association canadienne de santé publique (2008). Vision d’une culture de la santé au Canada : Rapport du Groupe d’experts sur la littératie en matière de santé
Organisation mondiale de la santé (1998). Glossaire de promotion de la santé

Certains faits sur la littératie en santé

- Les données démontrent que 60 % des adultes et 88 % des aînés au Canada ne possèdent pas de connaissances en santé.

- Les gens de plus de 65 ans, les immigrants arrivés récemment, les gens à faibles revenus, à faible niveau d'éducation ou possédant peu de connaissances en anglais ou en français sont plus enclins à posséder peu de connaissances en santé.

- Les études ont démontré que 40 à 80 % des renseignements médicaux que reçoivent les patients sont oubliés immédiatement et que près de la moitié des renseignements retenus sont incorrects.

Association canadienne de santé publique (2008). Vision d'une culture de la santé au Canada : Rapport du Groupe d'experts sur la littératie en matière de santé

Agence de la santé publique du Canada : http://www.phac-aspc.gc.ca/cd-mc/hl-ls/index-fra.php

A Vision for a Health Literate Canada

Report of the Expert Panel on Health Literacy

Irving Rootman and Deborah Gordon-El-Bihbety

WHO/HPR/HEP/98.1
Distr.: Limited

Health Promotion Glossary

CPHA ACSP

The Impact of Low Health Literacy on Chronic Disease Prevention and Control

Canadian Public Health Association

2006

Review

THEMED ARTICLE | Pediatric & Geriatric Cardiology

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EXPERT REVIEWS

The older patient with hear failure: high risk for frailty cognitive impairment

Expert Rev. Cardiovasc. Ther. 10(6), 779–795 (2012)

...der heart failure (HF) patients can be complic... care for HF patients h... particular,...

Karen Harkness[1,2], George A Heckm... and Robert S McKelvie*[2,5,6]

[1]Faculty of Health Science... University, Hamilton, ON... [2]Heart Failure Program, ... Health Sciences, Hami... [3]Schlegel-UW Researc... Aging, Kitchener, ON... [4]Faculty of Applied... University of Wate... ON, Canada [5]Division of Card... of Medicine, Mc... Hamilton, ON, ... [6]Cardiac Heal... Program, Ha... Hamilton, O... *Author fo... robert.mc...

Cognitive Decline among Patients with Chronic Obstructive Pulmonary Disease

William W. Hung[1,2], Juan P. Wisnivesky[3], Albert L. Siu[1,2], and Joseph S. Ross[1,2]

[1]Department of Geriatrics and Adult Development, and [3]Department of Medicine, Divisions of General Internal Medicine and of Pulmonary, C... Care, and Sleep Medicine, Mount Sinai School of Medicine, New York, New York; and [2]Health Services Research and Development Service Rese... Enhancement Award Program and Geriatrics Research, Education, and Clinical Center, James J. Peters Veterans Administration Medical Center... Bronx, New York

Rationale: Prior research has suggested an association between chronic obstructive pulmonary disease (COPD) and the development of cognitive decline; however, these studies have been cross-sectional or small case series.

Objectives: To determine whether COPD increases the risk of cognitive decline among older adults surveyed in a large, population-based longitudinal cohort.

Methods: We included data from the 1996 to 2002 waves of the Health and Retirement Study, a biennial nationally representative survey. We studied respondents who completed cognitive testing in 1996 and at least one subsequent survey, and excluded th... unknown history of COPD. Clinical history... self-report; severity was cate... disease-related...

AT A GLANCE COMMENTARY

Scientific Knowledge on the Subject

Although prior cross-sectional and clinical studies have suggested a relationship between chronic obstructive pulmonary disease and cognitive decline, longitudinal evidence of this relati... ...g.

...e chronic obstructive ...r cognitive performance ...over time.

...quality of life (6). ...rate of cognitive ...larly among those ...). Some studies ...re COPD may ...onsequence of ...ized to affect ...airment (11). ...ay cause, or ...ive impair... ...tia. How... ...r rates of ...nable to ...cline in ...igns (7, ...: case-... ...ching ...dent

Better Transitions: Improving Comprehension of Discharge Instructions

Amita Chugh, Mark V. Williams, James Grigsby, and Eric A. Coleman

The project that this article is based on was conducted with the support of the Aetna Foundation.

SUMMARY • Discharge out of the hospital is a time of heightened vulnerability for our patients. The combination of shorter lengths of stay and increased clinical acuity results in increased complexity of discharge instructions and higher expectations for patients to perform challenging self-care activities. Yet, the amount of time and resources available for patient and family

Retransmission de connaissances

La retransmission est une méthode utilisée pour confirmer que vous avez expliqué au patient tout ce dont il a besoin d'une manière lui permettant de tout comprendre.

Clinical Best Practice Guidelines

SEPTEMBER 2010

Strategies to Support Self-Management in Chronic Conditions: Collaboration with Clients

INTERNATIONAL AFFAIRS & BEST PRACTICE GUIDELINES

TRANSFORMING NURSING THROUGH KNOWLEDGE

Clinical Best Practice Guidelines

SEPTEMBER 2012

Facilitating Client Centred Learning

Volet de transition des congés du RLISS HNBH

Outil d'apprentissage sur le BPCO pour le personnel

COPD Teach-back

Please begin Teach-back when patient able. If patient unable to Teach-back please attempt to do this with caregiver (living with patient). Please document whether patient or caregiver is able to Teach-back on reverse and make referral to CCAC RRTT if patient or caregiver is not able to Teach-back for Teach-back # 1 or 2 or 3 or 4.

Please Document Who You are Completing Teach-back With: ☐ **Patient** ☐ **Caregiver (living in home) Name:** ___________________________

Teach-back #1 : I would like to talk to you about what you can do when you are feeling more short of breath than what is normal for you.

If you feel/have:	Actions:
• Stressed or have been exposed to things that make your breathing worse. • More short of breath than usual. • Coughing or wheezing more than usual. • More sputum than usual.	• Take your medications, especially your quick relief or rescue inhaler (Bronchodilator - Ventolin). • Use oxygen as prescribed. • Try to avoid or stay away from what is making your breathing worse (e.g. stress, cigarette smoke, dust). • Breathe from your diaphragm or with pursed-lips. When sitting, lean forward, relax your neck, shoulders and arms. • Call your doctor or nurse practitioner if you feel you are getting more short of breath.

I want to make sure I have explained everything clearly to you. Can you please tell me what you will do when you feel more short of breath than what is normal for you?

Teach-back #2 : I would like to talk to you about your COPD Medications.

COPD Medications:	Actions:
• HandiHaler (Spiriva) • AeroChamber with an Aerosol Inhaler (Ventolin, Atrovent, Advair, Flovent) • Diskus (Flovent, Advair, Serevent, Ventolin)) • Turbuhaler (Symbicort, Pulmicort, Bricanyl)	• Take your medications as prescribed (right med, right time, right technique). • Understand which inhaler is your relief or rescue inhaler (Bronchodilator - Ventolin). • Understand purpose of all COPD medications.

I want to make sure I have explained your COPD medications clearly to you. Can you please tell me what each of your COPD medications are for and show me how you will take each of them?

Teach- back #3 : I would like to talk to you about what you can do when you feel your shortness of breath is getting worse and when you need to call your doctor or nurse practitioner. I would also like to talk about when you may be in danger.

If you have:	Actions:
• Increasing shortness of breath. • More sputum than usual. • Green or yellow sputum with or without a fever.	• Call your doctor or nurse practitioner. • Take your medications, especially your quick relief or rescue inhaler (Bronchodilator - Ventolin). • Use oxygen as prescribed. • Start any new medications prescribed. • If your symptoms do not improve within 48 hours call your doctor or nurse practitioner again. • If you cannot contact your doctor or nurse practitioner go to a Clinic, Urgent Care or Hospital.

You may be in DANGER and need to go to the Hospital if you are/have:

If you feel/have:	Actions:
• Extremely short of breath. • Not able to do any activity because of breathing. • Not able to sleep because of breathing. • Fever or shaking chills. • Feeling confused, drowsy or agitated. • Sudden chest pain.	• Call 911 or have someone take you to the hospital. • Take your medications, especially you quick relief or rescue inhaler (Bronchodilator - Ventolin). • Use oxygen as prescribed.

I want to make sure I have explained how you can stay safe when you are at home. Can you please tell me when you will call your doctor or nurse practitioner and when you may need to go to a Clinic, Urgent Care or the Emergency Department?

Teach-back #4: You are being discharged from the hospital today. I would like to talk to you about your discharge instructions and how to manage your COPD at home.

- Review Teach-back # 1, 2, 3.
- Review Discharge prescription, specifically review COPD medications including purposes, doses, and frequencies. Discuss patient's ability to fill prescription without delay. Review relief or rescue inhaler (Bronchodilator - Ventolin). Have patient demonstrate use of inhalers. Instruct patient to take all medications with new prescription to their pharmacy.
- Review follow-up appointments and ensure appointments are made. Discuss patient's ability to get to all appointments.

We have talked about your COPD and what the hospital doctor would like you to do when you go home. To make sure I have explained this clearly, can you tell me what you will do when you are discharged today? Do you have any questions or concerns?

Plan d'action du patient pour le BPCO

COPD Signs & Symptoms	Action Plan
I feel well • My breathing problems have not changed (normal shortness of breath, cough and sputum). • My appetite is normal. • I have no trouble sleeping. • I can exercise and do my daily activities as usual.	**What should I do?** • Take my medications as prescribed. • Use oxygen as prescribed. • Continue my regular exercise and diet. • Avoid cigarette smoke, dust and other allergens.
I feel different • I am more short of breath than usual. • I am coughing or wheezing more than usual. • I have more sputum than usual. • I feel stressed or have been around things that make my breathing worse.	**What should I do?** • Take my medications, especially my quick relief or rescue inhaler (Ventolin) as prescribed. • Use oxygen as prescribed. • Avoid things that make my breathing worse such as cigarette smoke, dust and stress. • Breathe from my diaphragm or with pursed-lips. • When sitting, lean forward, relax my neck, shoulders and arms.
I feel I am getting worse • I have increased shortness of breath. • I have increased sputum. • I have green or yellow sputum with or without a fever.	**What should I do?** • Call my doctor or nurse practitioner. • Take my medications, especially my quick relief or rescue inhaler (Ventolin) as prescribed. • Use oxygen as prescribed. • If there is no improvement after 48 hours, call my doctor or nurse practitioner again. • If I cannot contact my doctor or nurse practitioner, go to a clinic, urgent care or hospital.
I am in danger • I am extremely short of breath. • I cannot do any activity because of breathing. • I am not able to sleep because of breathing. • I have fever or I am shaking (chills). • I feel confused, drowsy or anxious. • I have sudden chest pain.	**What should I do?** • Call 911 or have someone take me to the hospital. • Take my medications, especially my quick relief or rescue inhaler (Ventolin) as prescribed. • Use oxygen as prescribed.

The facts about COPD
(Chronic Obstructive Pulmonary Disease)

What is COPD?

COPD is a chronic disease that slowly damages your lungs and makes your breathing difficult. There is no cure but you can manage your COPD in many ways.

How do I stay healthy:

- Take your medications properly.
- Get a pneumonia shot.
- Eat well.
- Wash your hands regularly to prevent infection.
- Quit smoking (very important).
- Get an annual flu shot each fall.
- Exercise regularly.
- Follow your COPD action plan (on reverse).

What is a flare-up?

A flare-up is what happens when your COPD starts getting worse. You may have one or more of these signs for 48 hours or longer:

- More shortness of breath than usual.
- More sputum than usual.
- More coughing.
- Your sputum color is different..

What causes a flare-up?

- Stress or infections.
- Air pollution, dust or other allergens.
- Weather changes (cold, hot or humid air).
- Smoke.
- Strong fumes or odours.

What should I do if I start to have a flare-up?

- **Manage your flare-up as early as possible (see reverse side).**
- **Contact your doctor or nurse practitioner if your symptoms do not improve after 48 hours.**

Need more information?

Get the information and support you need from a Breathworks COPD educator:
- 1-866-717-COPD (ext. 2673) or www.lung.ca/breathworks

If you are still smoking and would like help to stop please phone the Smoker's Helpline:
- 1-877-513-5333 or www.smokershelpline.ca

Adapted from The Canadian Lung Association – Breathworks (2013) http://www.lung.ca/diseases-maladies/copd-mpoc_e.php

Autres outils de transfert des connaissances

Aimant de réfrigérateur sur le BPCO

Signs of a COPD flare-up

You are having a flare-up when you have one or more of these signs for 1 to 2 days:

- Increased shortness of breath compared to normal.
- Increased amount of coughing and sputum compared to normal.
- Your sputum changes from its normal colour to a yellow, green or rust colour.

When you have a COPD flare-up:

- Take your relief or rescue inhaler (ventolin) as prescribed.
- Call your doctor or nurse practitioner right away.

Call 911 or have someone take you to the hospital if you are extremely breathless, anxious, confused, agitated, fearful, drowsy or you have chest pain.

Éléments audiovisuels

- Les vidéos sur le BPCO et l'insuffisance cardiaque diffusées à différents moments pendant 24 heures sur la télévision de chevet des patients
- Vidéo sur la littératie en santé produite localement pour le personnel et les médecins

The facts about Heart Failure

at is Heart Failure?
- Heart failure means the heart does not pump enough blood throughout the body.
- Heart failure is a serious medical condition that can range from mild to severe.
- Heart failure cannot be cured but medications can make it easier for your heart and may help you feel better.

ake your Heart Failure medications as prescribed:
- Some medications may prevent your heart failure from getting worse.
- It may take months for your medications to help you feel better.
- Talk to your doctor or nurse practitioner before stopping any of your medic

Paying attention to change is a very important part of managing your
- Sudden weight gain can be an early sign of fluid build-up.
- Sudden weight loss can be a sign that you are losing too much fluid.
- Call your doctor or nurse practitioner right away if you notice sudden or any of the signs of worsening heart failure (listed on the back of th
- Your doctor or nurse practiti ... change your medicat

Choose the right diet:
- Eat foods that are low in salt food.

Limit salt (or sodium) in you
- Salt (or sodium) acts like a
- Extra fluid may cause swe

Limit the amount of fluid y include: water, soup, coffee,
- When you have heart fai
- Extra fluid may cause sw

Exercise as instructed by
- Staying active makes y
- Walking is one of the b
- Rest when you feel mo

Talk to your doctor if y
- Alcohol can make yo
- Smoking is one of th

Heart Failure Signs and Symptoms — Action Plan

I feel well if:
- My weight has not changed.
- My appetite is normal.
- I have no trouble sleeping.
- I can exercise and do my daily activities as usual.
- I don't have any new swelling in my stomach, feet, ankles or legs.

What should you do?
- Weigh yourself daily in the mornin after using the bathroom. Keep a re
- Take your medications as prescribed
- Continue your salt restricted diet as
- Do not drink more than 6-8 cups of fl
- Balance activity with rest periods.

I feel different if:
- I have gained or lost 2 pounds (1 kg) in a day.
- I have gained or lost 5 pounds (2 to 3 kg) in a week.
- I have swollen feet, ankles or legs.
- I feel more short of breath than usual.
- I feel short of breath ...

What should you do?
- Call your doctor or nurse practitioner right your symptoms.
- Take your medications as prescribed.
- ...ications or make changes to

...gh yourself every morning be ... bathroom. Record your weig

...icted diet and fluid restriction ...se practitioner.

...ou feel more short of breath, ...illows when laying down.

... rest periods.

...o not improve within 24 ho ...ctitioner again.

...t your doctor or nurse prac ...re or the Emergency Depar

...one take you to the hospi

daily weights and your me

Signs of Worsening Heart Failure

Your heart failure may be getting worse if you have:

- Gained more than 2 pounds (1 kg) in one day.
- Gained more than 5 pounds (2 to 3 kg) in one week.
- An increase in swelling in your feet, ankles, or legs.
- Fullness or bloating in your stomach.
- More shortness of breath than usual.
- More difficulty breathing when lying flat.

When you have any of the symptoms listed above:

- Call your doctor or nurse practitioner right away because your medications may need to be changed.

Go to the Emergency Department if you are extremely short of breath, have chest pain that is not relieved with nitrospray, feel like your heart is "racing", or you are coughing up frothy or pink sputum.

Normaliser la communication

Outil de documentation électronique

Teach-back COPD   16/10/15 1530 KLB   X

===============Teach-back Assessment for COPD===============

Teach-back completed with (G+):	Patient
1. Able to teach- back symptoms of COPD (G):<>	Partially able
2. Able to teach- back COPD medications (G):<>	Partially able
3. Able to teach back about worsening symptoms (G):<>	Partially able

*************Document on day of discharge only*************

4. Able to teach- back review, discharge instructions and management (G):<>

Hamilton Health Sciences

Discharge Order Set for Patients with COPD or Heart Failure

Instructions

- Prior to discharge, please schedule an appointment with the Family Doctor 7 business days from the date of discharge. Please document the date/time in the follow-up section of the Discharge Orders and discuss appointment date/time with patient/caregiver. If unable to reach the Family Doctor by telephone, please complete the **Discharge Alert – Hospital Request for Follow-up Appointment** form and fax this to the Family Doctor.

- If an appointment is required with the Family Doctor in less than 7 business days from the date of discharge, please contact the Family Doctor to discuss this request. If unable to reach the Family Doctor by telephone, please complete the **Discharge Alert – Hospital Request for Follow-up Appointment** form and fax this to the Family Doctor.

- Please **ONLY sign original pages** of the Discharge Orders including the Medication Reconciliation/Prescription and make photocopies of the original pages. **Only the original signed Medication Reconciliation/Prescription will be accepted/filled by pharmacy.**

- Please give original signed Discharge Orders including Medication Reconciliation/Prescription to the patient/caregiver. Also, provide 1 photocopy for the patient/caregiver to take to their appointment with the Family Doctor and place 1 photocopy on the hospital chart.

- Please fax a copy of the Discharge Orders to the Family Doctor's office including the Medication Reconciliation/Prescription.

- Please request permission from the patient to fax a copy of the Medication Reconciliation/Prescription to their pharmacy. Document on original copy in writing or with stamp, date faxed, pharmacy prescription faxed to and initials

Hamilton Health Sciences

ADDRESSOGRAPH

Patient's Name:

Discharge Orders for COPD or Heart Failure Patients

Date of Admission: ____________ (dd/mm/yyyy) Date of Discharge ____________ (dd/mm/yyyy)

Hospital Physician: ____________ Patient Discharged From: ____________

Primary Diagnosis: ____________

Other Diagnoses Affecting Hospitalization: ____________

Recommended Follow-up by Family Doctor/Nurse Practitioner: ☐ CBC ☐ Na,K,Cl ☐ Urea

☐ Creatinine ☐ INR ☐ X-Ray Chest Reason: ____________

☐ Additional Investigations: ____________

☐ ____________

Follow-up Appointments Arranged by Hospital Physician/Nurse Practitioner:

If patient needs to be seen by Family Doctor in less than business 7 days call to discuss. If unable to contact complete Discharge Alert on page 4 and fax.

Appointment With	Date & Time	Phone #	Address
Family Dr:			

Above appointments scheduled and documented by: ____________

Referrals Completed:

CCAC ☐ Yes ☐ No **CCAC Rapid Response** ☐ Yes ☐ No CCAC contact # (905)523-8600

Original & one photocopy given to patient by: ____________

Copy faxed to Family Doctor by: ____________

Hamilton Health Sciences

ADDRESSOGRAPH

Patient's Name:

Discharge Medication Reconciliation & Prescription (only original signed copy) for COPD or HF Patients

☐ McMaster & McMaster Children's, 1200 Main St. W. Hamilton ON L8N 3Z5
☐ General, 237 Barton St. E Hamilton ON L8L 2X2
☐ Juravinski, 711 Concession St. Hamilton ON L8V 1C3
☐ St. Peter's, 88 Maplewood Ave Hamilton, ON L8M 1W9
☐ Juravinski Cancer Center, 699 Concession St Hamilton ON L8V5C2
☐ Chedoke, Sanatorium Rd Hamilton ON L8C7N4

Phone (for all sites): 905-521-2100

☐ No Allergies ☐ Allergies (attach hospital allergy record) Height ________ cm Weight ________ kg

Medication Reconciliation Include Pre-admit medications				No prescription required Place X in applicable boxes			New Prescription Place X in applicable boxes				
Medication (generic name preferred)	Dose (include units)	Route	Frequency (note if PRN)	Unchanged Meds to be continued	Discontinued Pre-Admit Meds	Discontinued Narcotics or Benzodiazepines used in hospital	New	Changed Meds dose or frequency	Quantity/unit	Repeats	Limited Use Code
				☐	☐	☐	☐	☐			
				☐	☐	☐	☐	☐			
				☐	☐	☐	☐	☐			
				☐	☐	☐	☐	☐			
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				☐	☐	☐	☐	☐			
				☐	☐	☐	☐	☐			
				☐	☐	☐	☐	☐			

Medication Reconciliation completed by: ______________________________

Signature/printed name/ designation

This is your Prescription when signed – Original Copy Only

Take this prescription to your pharmacy along with all medications in your home

Signature: ______________________________ **Pager #** ____________ ☐

Signature/Printed Name/Designation

Hamilton Health Sciences

Discharge Alert

Hospital Request for Follow-Up Appointment

Date: ___________________________________

Dear Dr.____

I am discharging your patient ____
Patient's Name

on __________________________________and I am requesting a follow-up appointment in

_________ business days from the date of discharge. I am recommending that the following be

addressed at this appointment :

____

____

____

Please note a copy of the Discharge Orders which includes Medication Reconciliation/ Prescription will be faxed to your office on the day of discharge.

Prior to discharge from the hospital we would like to provide the patient with an appointment to see you. If your office is not able to contact the hospital to provide an appointment prior to the patient's discharge, please contact the patient directly and provide the appointment.

Thank you!

____
Physician's name (please print) and Pager # and Service

__________________________ __________________________
Hospital Name/Telephone # Unit patient being discharged from/Extension

Please fax this form to the Family Doctor as soon as possible

Apprendre à gérer le BPCO : Le succès de Carl

Carl has Chronic Obstructive Pulmonary Disorder (COPD) and didn't fully understand how and when to take his medications. He ended up at the Emergency Department many times. Now he's part of a program called Health Links, which sees HHS and its partners team up to provide care and support outside of the hospital. Carl receives home visits and has been taught how to better manage his condition. He's doing fine at home and rarely goes to the Emergency. See his story at

Questions

Discussion

APPLICATION PRATIQUE DANS VOTRE MAILLON SANTÉ

Sondages

Communauté de pratique du leadership des maillons santé

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