QUINTE HEALTHCARE CORPORATION

Alternate Level of Care (ALC)

Title: Alternate Level of Care (ALC)		**Policy No:**	**3.18**
		Original Issue Date:	October 1, 2005
Manual:	**Clinical**	**Last Review/Revision Date:**	September 2017
Department:	**Corporate**	**Policy Lead:**	Manager Patient Flow
Approved By:	**Operations Committee**		

1. PURPOSE:

Timely and appropriate designation of patients who no longer require the level of resources/services provided in the current care setting occurs regardless of whether the appropriate services are available in the community. Appropriate designation and documentation of ALC patients across the Southeast is achieved through a multidisciplinary approach aimed at risk screening and identification of potential ALC patients as early as possible. Activities are aligned with a patient centered proactive approach focusing on maintenance of functional and cognitive status supporting discharge planning time to exhaust options for home support or alternative care settings.

2. POLICY:

Quinte Health Care (QHC) accepts the Provincial definition for Alternative Level of Care. The definition (see below) applies to all patient populations waiting in all patient care beds in an acute or post-acute care hospital.

On the day that a patient is deemed to meet the Provincial definition for ALC, the physician or delegate writes the order indicating ALC and works collaboratively with the team to identify the discharge destination. The designation of ALC is independent of discharge destination and occurs regardless of whether a discharge plan is in place.

ALC DEFINITION:

When a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting (Acute, Complex Continuing Care, Mental Health or Rehabilitation), the patient must be designated **ALTERNATE LEVEL OF CARE (ALC)** at that time by the physician or her/his delegate. The ALC wait period starts at the time of designation and ends at the time of discharge/transfer to a discharge destination (or when the patient's needs or condition changes and the designation of ALC no longer applies).

The definition does not apply to patients:

- waiting in an acute care bed/service for another acute care bed/service (e.g. surgical bed to medical bed at any site)
- Waiting in an acute care hospital bed for transfer to another acute care hospital bed (e.g. repatriation to community hospital)

Delegate: Will be defined by the individual organization

3. PROCESS:

When appropriate, the Physician or MRP will write medically stable and ready for discharge on the patient record. Each discipline involved in the care of the patient will indicate on the bullet round board once the patient's care goals have been met or when progress has reached a plateau or her/his potential in the program optimizing functional and cognitive status. On the day that all disciplines indicate patient readiness **and** the patient is medically stable and ready for discharge; the patient is deemed to meet the Provincial definition for ALC. The physician or delegate writes the order indicating ALC and works collaboratively with the team to identify the discharge destination.

Any changes in patient condition whereby the patient requires an acute level of care necessitates suspension of the ALC designation and must be documented within 2 business days. Re-designations when the patient condition stabilizes and they again meet the Provincial definition. Re-designations must also occur within 2 business days.

1. A physician or MRP writes medically stable and ready for discharge in the patient record

2. Prior to an ALC designation, the multidisciplinary team will identify when patients are approaching goals that have been set out in the plan of care.

3a. The physician or delegate designates the patient ALC when the patient no longer requires the level of resources/services provided in the current care setting, or has reached their potential in that program or their progress has reached a plateau.

3b. The physician or delegate is responsible to advise the patient/SDM that the active medical treatment is complete and that the health care team will continue to work with them/their family to assess the best options for discharge from hospital

4. The physician or delegate will write an order to suspend ALC designation should the patient subsequently require an acute level of care.

5. Re-designation documented by the physician or delegate will occur once the patient stabilizes and meets the Provincial ALC definition. Designation and re-designation must occur within two business days of the change in status.

6. The multidisciplinary team will conduct a regular review at a minimum of every two days of the complex needs and discharge status of patients designated ALC to ensure that the plan of care reflects the mental, social and physiological needs of the individual. This is aligned with the provincial requirement to document changes in patient status within two business days.

APPLICABILITY:

This policy applies to all hospitals, and the CCAC within the SELHIN.

APPENDICES AND REFERENCES

Appendices:

Appendix A Alternate Level of Care (ALC) Long Term Care (LTC) Sign off
Appendix B Letter to Patients and Families about Long Term Care and Discharge

References:

Access to Care
https://www.accesstocare.on.ca/cms/One.aspx?portalId=120513&pageId=121468

Cancer Care Ontario Alternate Level of Care Definition
https://www.cancercare.on.ca/cms/One.aspx?portalId=1377&pageId=43214#def

Cancer Care Ontario WTIS (Wait time information system)
https://www.cancercare.on.ca/ocs/wait-times/wtio/

Ontario Ministry of Health and Long Term Care
http://www.health.gov.on.ca/en/pro/programs/waittimes/edrs/alc_definition.aspx