MSH CARE@HOME

Information for patients, families and caregivers

Eastern York Region North Durham

EYRND ONTARIO HEALTH TEAM

CONNECTING CARE FOR CLIENTS, FAMILIES AND CAREGIVERS | EYRND.ca

What is MSH Care@Home?

MSH Care@Home was created to better coordinate the care that you need when you are discharged from Oak Valley Health (formerly Markham Stouffville Hospital) through one team, one record. Our goal is to make your transition home as stress-free and smooth as possible and to help you recover and become more independent.

We will continue to support you for up to 16 weeks after discharge from the hospital. Your home care services will be provided in partnership with Oak Valley Health, SE Health, CHATS and ProResp, and will continue to be coordinated through your primary nurse.

You will meet your Transitions Care Lead during your hospital stay who will:

- Work closely with all members of your health care team
- Help make the transition from hospital to home smooth
- Manage your home care services
- Connect with your family doctor or health care provider and specialists
- Identify services that may be needed for support at home, including nursing, physiotherapy, occupational therapy, speech language therapy, dietitian and personal support workers
- Connect you with community resources to support independent living

How does MSH Care@Home work?

Before you leave the hospital, your Transitions Care Lead and a member from the MSH Care@Home team will meet with you, your family and your hospital team to create your home care plan for the first 72 hours that you are home. This plan will be shared with everyone involved in your care after you are discharged from the hospital.

We will provide you and your caregiver with a list of items you would need for your care at home and will explain to you how we get the items delivered to your home.

When will my Care@Home start?

Your first home visit will be within 24 hours of your discharge from the hospital.

What if I don't have someone to take me home?

If you do not have someone who can take you home on the day of discharge, MSH Care@Home will arrange for transportation to drive you home and help you get settled in your home. We will also help with getting your medications from your pharmacy. Please note this service excludes ambulance transport.

What can I expect from MSH Care@Home?

Once you are home, your MSH Care@Home team will:

- Visit you within 24 hours of your discharge from the hospital
- Check in with you daily for the first week that you are home
- Work with you, your family and your whole health care team to understand your health goals
- Support arranging for a visit with your primary care provider to inform him/her of the changes in your care
- Work with you to update your home care plan to help with your recovery
- Keep your doctor, nurse practitioner and Oak Valley Health, up-to-date on how you are doing to ensure you meet your health goals

How is care provided?

We will check in and care for you in the following ways:

- Home visits
- Telephone calls
- Technology like telemonitoring

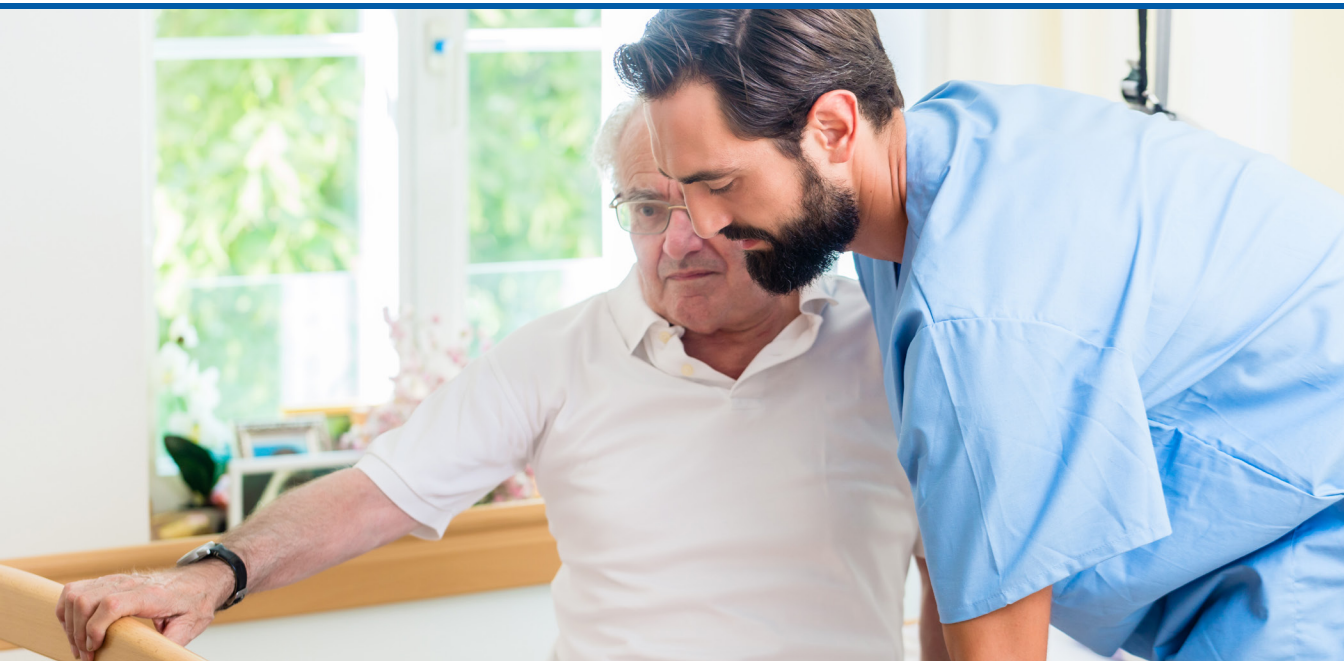
We will also work with other partners, like CHATS and ProResp, to make sure that you have the supports you need like:

- Caregiver support programs
- Transportation (rides)
- Day programs
- Respiratory Services

As your needs change, we will work with you and the team to update your home care plan and your services. Our goal is to help you improve and need less services.

What happens if I need to be readmitted to Oak Valley Health?

If you need to be readmitted to Oak Valley Health, your MSH Care@Home team will be kept informed of how you are doing. When you are ready to go home again, a Transitions Care Lead will work with you to reassess your needs and plan for your transition back into the program if appropriate to ensure the program still meets your needs.



What happens if I still need care once I have completed MSH Care@Home?

You and your MSH Care@Home team will be talking often, together and with you, about the services you may need at the end of the program.

Two important points are:

- At approximately 10 - 12 weeks, you and your MSH Care@Home team will sit down to talk about how you are all doing with meeting your goals. Your home care plan will be updated with a focus on adding the services that you may need at the end of the MSH Care@Home program.
- Then at approximately 12 - 14 weeks, we will be calling Home and Community Care Support Services (HCCSS) to make a referral for home care if you need these services. HCCSS will do an assessment and plan your ongoing care.

What if I don't have a family doctor or nurse practitioner?

MSH Care@Home team will work with you to find you one.

What are my Rights?

As MSH Care@Home patient, you, your family and your caregiver(s) have the right to:

- Receive care in a courteous and respectful manner and be free from mental, physical and financial abuse
- Receive care in a manner that respects your dignity, privacy and promotes independence
- Receive care regardless of your ethnic, spiritual, language, lifestyle and cultural preferences
- Receive a clear explanation of the services you will receive and who will provide them
- Actively participate in care assessment/planning and determine your service requirements including any revision to your service plan
- Give or refuse consent to treatment of any service
- Express concerns about your care and decisions affecting your care without fear of retribution
- Be informed in writing how to initiate a concern regarding a service provider
- Confidentiality of your personal health record

Privacy and your health information

If you would like access to your personal health information, please call: **1-833-991-1969**

Patient Relations – complaints, concerns, compliments

MSH Care@Home partners are committed to listening to patients and learning from your experiences. We therefore believe that your feedback, whether it is a compliment or complaint, is an opportunity for us to learn and to improve the quality of care that we provide to our patients. If you have any compliments, comments, and/or concerns please do not hesitate to speak with your primary nurse, a member of the health care team involved in your care, or contact us at:

1-833-991-1969

patientrelations@msh.on.ca

How do I contact my MSH Care@Home team?

You can contact a member of the care team, **7 days a week, 24 hours at day at:**

1-833-991-1969

When you call this number, your call is answered by one of our coordinators who can:

- Answer questions about changes to or cancelling a visit
- Transfer you to a nurse to answer health-related questions
- Connect you with the Oak Valley Health Patient Relations office to share compliments, comments, and/or concerns about the program

Proud members of the EYRND Ontario Health Team

Oak Valley Health | ProResp Community Respiratory Therapy | Health | CHATS Community & Home Assistance to Seniors | Ontario Central Local Health Integration Network

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