**Establishing a Standardized Discharge Process for Outpatient Clozapine Clinic Patients**

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**Description**

Humber River Health’s (HRH) outpatient Clozapine Clinic strives to support the growing needs and wellness of patients who require clozapine services. As the clinic continues to accept acute patients, a lack of a standardized discharge process resulted in a growing number of stable patients who remain reliant on the clinic’s services. To support the care needs of stable patients who require clozapine services, HRH initiated a standardized discharge process to transition stable patient care to community practitioners. Aligned with Accreditation Canada’s Required Organizational Practice for Transitions in Care, all pertinent information is communicated to the receiving provider through this process. By promoting interprofessional collaboration between clinicians in the acute care and community care sectors, a network of support is established for stable patients requiring clozapine services.

**Objective**

To optimize patient flow and care by establishing a standardized discharge process.

**Actions Taken**

- Physician lead built initial outflow process map, which was shared with the outpatient mental health clinical team and Medical Quality Improvement Committee.
- The Quality and Patient Safety team was consulted to identify barriers to discharge.
- Regular meetings were held to finalize process map and build associated templates.
- Senior leadership stakeholders were consulted for validation and feedback.
- Discharge process piloted for select physician users.

**Summary of Results**

By collaborating with various stakeholders, a refined discharge process was updated to include six templates to promote the standardization of information provided to community practitioners. After piloting a standardized Clozapine Discharge Process, one patient has been successfully discharged. Five patients have been progressing through the discharge process from the outpatient clinic. The creation of this discharge process also improved collaboration between interprofessional and community stakeholders when supporting patient transition into community care.