FACILITATING THE TRANSITION OF HIGH RISK SENIORS FROM HOSPITAL TO HOME

Renfrew Victoria Hospital
Assisted Living Program
March 2015
LOCAL HEALTH INTEGRATION

• Identified need for innovative programs to support high risk seniors in the Champlain Region.

• Decrease ALC rates, hospital admissions, ER visits and premature admission to LTC.

• HSIP for Assisted Living Services across Champlain fall of 2010
Client population with poorer health overall of Champlain.

Senior population in the town of Renfrew per capita (24.3% in 2011)

Low socioeconomic (17.6% of the population in 2000)

Higher risk factors
- smoking
- overweight/obesity
ASSISTED LIVING PROGRAM
CLIENT PROFILE IN 2015

18 high risk seniors:

- 9 Dementia – mild to moderate
- 3 ABI/Spinal Cord Injury
- 1 Mental Health
- 2 Hemodialysis
- 2 Visually Impaired
- 1 ALS
ASSISTED LIVING PROGRAM TEAM

• Care Coordinator – Registered Nurse
• 9 Personal Support Workers
• 24/7 on call urgent care service
• Scheduled shifts from 0700 – 2230
Registered Nurse:
- Geriatric Nurse Certified
- Emergency Nursing background
- Community Care Coordination Nursing background
- Diabetes Education Certificate
ASSISTED LIVING PROGRAM
PRIMARY CARE NEEDS 2015

• Cuing for medication, meals and personal care
• Assistance with meal planning
• Medication reconciliation
• Monitoring for changes
• Care Coordination facilitating care:
  - primary care physician
  - local pharmacy
  - geriatric services – day hospital, mental health
  - transitioning care from hospital to home
IMPROVING TRANSITIONS IN CARE FROM HOSPITAL TO HOME

- Discharge planner notifies ALS Coordinator

- ALS Coordinator meets with client, family/caregivers, multidisciplinary team to identify possible barriers to discharge

- ALS Coordinator provides a comprehensive care plan to the client, caregivers and the multidisciplinary team prior to discharge

- ALS Coordinator meets client at home within 24 hours of discharge to review care plan and perform medication reconciliation
LESSONS LEARNED

• Clients and their families and caregivers are more receptive to discharge from hospital

• Multidisciplinary team is able to identify possible barriers to a successful discharge

• Primary care physicians are more receptive to discharge with proven decreased hospital LOS
CASE REVIEW

• 77 year old female.
• Diagnosis – Type 2 diabetic (MDI), alcohol abuse, dementia, chronic dizziness.
• Lives alone.
• Unreliable with medications
• High fall risk
• Psychosocial risks – strained relationship with daughter and son d/t negative influence of a distant relative who visits almost daily.
Case Review continued ...

- 4 hospital admissions within 4 months
- Family physician advocates for ALS services
- Discharged home on ALS
  - 4 visits daily (insulin/meal cuing)
  - assist with personal care
  - Daily monitoring for changes
  - Devices in place
Case Review continued……

- Physician visited biweekly and as required
- Regular communication with RN Coordinator to titrate insulin to achieve optimal blood sugar control
- Condition deteriorated after 4 months at home
- Admitted to hospital “Failure to Cope”
- Discharged home after 15 days in hospital
- Urgent referral from home to PCS with transfer to respite facility to await crisis placement
REFERENCES


http://www.champlainlhin.on.ca/