FACILITATING THE TRANSITION OF HIGH RISK SENIORS FROM HOSPITAL TO HOME

Renfrew Victoria Hospital
Assisted Living Program

March 2015

RENFREW VICTORIA HOSPITAL

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

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RENFREW COUNTY

- 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

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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

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ASSISTED LIVING PROGRAM TEAM

- Care Coordinator – Registered Nurse
- 9 Personal Support Workers
- 24/7 on call urgent care service
- Scheduled shifts from 0700 – 2230

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CARE COORDINATOR

Registered Nurse:

- Geriatric Nurse Certified
- Emergency Nursing background
- Community Care Coordination Nursing background
- Diabetes Education Certificate

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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

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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

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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

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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.

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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

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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 15days in hospital
- Urgent referral from home to PCS with transfer to respite facility to await crisis placement

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REFERENCES

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