Keeping the frail and elderly out of emergency rooms

The Challenge: Poor coordination of care contributes to illness in older adults

Transitioning from the hospital back to home can be problematic for older adults in the Saskatoon Health Region (SHR), especially those who suffer from multiple medical conditions and, as a result, take multiple medications. Many older adults return from acute care to their homes in far poorer physical condition than before the initial illness and therefore find it difficult to live independently. These realities, combined with gaps in discharge planning, poor coordination of care and insufficient communication, can create potentially adverse events for older patients—events that lead to frequent visits to emergency departments and readmission to hospital.

The Improvement Project: Filling care gaps to improve patient health

In a literature review, EXTRA Fellow Gaylene Molnar, Director of Nursing Professional Practice and Education for SHR, confirmed service gaps and challenges specific to older patients transferring from hospital to home. The literature revealed that by combining discharge planning with ongoing discharge support—including in-home follow up—patients experience reduced health problems once they are discharged.

Molnar launched a pilot project in which she tested a standard set of transition support interventions to be carried out by “transition” nurses specifically assigned to support older adults at high risk of readmission. Support included written personal health information, communication to care providers and in-home follow up. Molnar used the LACE screen—length of stay, acuity of the admission, comorbidity of the patient, and emergency department use in the last six months—to identify such adults. Older patients identified as high risk on LACE were randomly selected to receive the intervention.

The most significant impact has been an increased awareness of the gaps and lack of care coordination in our current discharge processes. The patient perspective of their transition highlighted many improvement opportunities to ensure the safety and quality of every transition.
The Result: Specially assigned nurses reduce emergency room visit rates

Results indicate that the establishment of transition nurses had no effect on readmission rates, however they did reduce emergency room visits, and improved the experience for patients, families and care providers. More specifically, the control group had a 33 percent higher 90-day emergency room visit rate when compared to the intervention group. Transition nurses were also able to identify several factors within the system that contribute to transition problems for all patients, not just older adults. The LACE screen proved to be effective in identifying patients at risk of readmission. Patients with a LACE score of <10 had 44 percent less readmissions at 90 days than the control group.

The Impact: First step in the implementation of a region-wide intervention and improved patient flow

This project was a prototype, the next step will identify the feasibility to spread and implement the EXTRA intervention on a larger scale. The project’s findings will be communicated through Geriatric Grand Rounds and with other stakeholder groups within the region. The question remains as to whether hospitals need to add specially assigned transition nurses or if existing nurses have the time and ability to carry on this important work. Meanwhile, SHR is well positioned to focus on improving quality, placing the patient and family at the center of all they do with the province-wide implementation of the LEAN management system.

To learn more about the EXTRA program, please visit cfhi-fcass.ca/EXTRA or email us at info@cfhi-fcass.ca.