Partnering for patients: Home care nurse in the emergency department

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Finding solutions to address the emergency overcrowding crisis due to the ongoing pressures of inpatient bed shortages are crucial. Emergency departments throughout Canada are reporting overcrowding and excessive wait times placing patients at risk (Canadian Association of Emergency Physicians, 2007; National Emergency Nurses Affiliation, 2004). Patients requiring admission are backlogged by a lack of inpatient beds (Canadian Association of Emergency Physicians, 2007). Older medical admitted patients are often the source of the most significant backlog.

At Red Deer Regional Hospital Centre, there is a bed utilization committee working actively on various strategies related to improving access to inpatients beds. One of those initiatives during 2006 was to establish a six-week improvement trial related to an idea presented by an emergency physician who suggested an innovative program that would allow a home care nurse to assess older patients in the emergency department. The theory behind this trial was to establish whether or not older patients actually required admission for management of chronic health care needs, or if management and support could be offered in the community. Ultimately, the goal was to offer a process for early intervention for older clients who present to the Red Deer Emergency Department. Early assessment has the opportunity to reduce unnecessary admissions to hospital and to offer clients access to a variety of health care services of which they may not have been otherwise aware.

Six-week trial

The Red Deer Emergency Department staff partnered with key members of home care for a successful six-week pilot project. One of two home care nurses was situated in the emergency department on a full-time basis for the trial period and provided assessment and recommendations for delivery of care options to any older patient who presented during regular working hours (Monday-Friday, 0800-1700). Two hundred and sixty-eight older medical clients were assessed by the home care nurse. Forty-six per cent of the patients who were assessed were discharged with the appropriate home care supports.

Qualifications and role of the home care nurse

Each of the two home care nurses who participated in this trial were staff members with expertise in home care. They were not only familiar with all of the home care services available in the health region, but were also able to access these services promptly and efficiently. Professional autonomy permitted the home care nurses the ability to make suitable and timely placement decisions.

When situated in the emergency department, the home care nurse was accessible and visible ensuring prompt and efficient intervention. Verbal referrals were made to the home care nurses by frontline staff, ER physicians, charge nurses, the ER case manager and case coordinators from home care. The home care nurse was able to see anyone in the emergency department (no official order or referral was required), however, priority was given to older patients over the age of 60. On a regular basis, the home care nurse would also check the ER tracker (electronic white board) to identify patients over the age of 60, or any other patients for reasons indicating that an assessment by the home care nurse may be appropriate. Assessments were completed on an average of 8.6 patients per day. The home care nurse had a cell phone, which enabled her to make and receive phone calls readily. The home care nurse was able to coordinate home care and community support services directly from the emergency department.

Examples of home care services provided

1. Support clients to remain independent and in their own homes as long as possible.
2. Provide services at home to clients who would otherwise require admission to hospital.
3. Arranged assessment for assisted living, supportive living and other residential care streams of living to clients.
4. Provide services that support people who are nearing the end of their life, and their families, at home or in a hospice.
5. Client focused communication between the home care case coordinators in the community and the emergency department caregivers.
6. Provide information to the client's home care case coordinator about the assessment completed by the home care nurse in the emergency department.
7. Arranged home care follow-up on admitted patients through community liaison coordinators (discharge planners) to reduce hospital stay.
8. Arrange direct referrals to rehab, MS Society, dietitians, Alzheimer Society, diabetic clinic, and other community resource groups.
9. Arrange home care based on the following needs: housing, personal care, meals, respite, medications, and mobility issues.
10. Encourage clients and ER physicians to access home parenteral therapy (HPT), wound care, and other existing community-based programs that are already available in the emergency department through home care.

Home care philosophy

Home and community care services promote well-being, dignity and independence of clients. Clients and families are given the information required to make their own decisions about lifestyle and care. Home care believes clients have the right to make their own care decisions.

During this trial, the ER case manager was partnered with the home care nurse on duty. Together, they endeavoured to put the patient's needs first, always assessing each situation on an

individual basis. The home care nurses were particularly knowledgeable about the needs of older patients and the services available to them, thereby educating emergency staff when admitting older patients with chronic medical problems about options for management in the community, more specifically, suggesting increased risk that once admitted to an inpatient bed the older adult frequently becomes dependent on the health care system – often ending up in a long-term care facility, which is not a desired outcome for older clients wishing to remain independent (Palmisano-Mills, 2007).

Patients with admission orders

Out of the 268 patients who were seen during the trial period, the home care nurse assessed 115 admitted medical patients waiting on emergency stretchers for inpatient beds. The home care nurse was able to discharge 33% of these patients by putting services in place to support patients in the home. A plan for home care was initially discussed with the patient and patient's family, and then this plan was presented to the admitting physician.

Emergency physicians

All emergency physicians evaluated the project as "excellent" in the satisfaction survey. Most specifically, this process allowed the efficient and safe discharge of older patients from the emergency department. Emergency physicians were able to send patients home who would have otherwise been admitted to an inpatient bed. Having an experienced home care nurse as part of the emergency team was of particular importance to the success of this trial. She was particularly credible with respect to her knowledge regarding accessible resources in the community and her expertise in managing the care of this patient population and their family members.

The home care nurse also assessed 93 "possible" admissions and was able to discharge 34% of these patients. These were patients with health care needs whom emergency physicians indicated that, if no other reasonable service options were readily available to support them, an admission to an inpatient bed would be necessary. Information regarding home care services was given to patients who had never sought home care support in the past. For new clients not requiring admission, home care services were arranged directly in the emergency department, potentially reducing subsequent emergency visits.

Discussion

This innovative project helped highlight one of the many issues that lead to emergency department overcrowding. The possibility of avoiding admissions or frequent ER visits by educating a certain patient population about the variety of services available outside of emergency care or inpatient admissions has benefits for system-wide improvements while offering patient-centred care alternatives. The home care nurse was able to coordinate support services directly from the emergency department. This process offered a more seamless integration of service delivery. This project prevented unnecessary medical admissions enabling elderly clients to be discharged home safely with the appropriate homecare supports. Ultimately, this project helped improve the wait times for medical admissions while supporting more streamlined patient care for older adults.

Conclusion

Development of successful interventions to prevent further health decline of older adults who are discharged from the emergency department is essential (Hastings & Helflin, 2005). More seamless and integrated services are needed. Collaboration and integration between home care and emergency staff will produce positive outcomes for older adults while decreasing medical admissions. The initial success of this pilot project was evident and clearly warrants further consideration. This partnership was tailored to local needs and designed to integrate to the services that are available within the David Thompson Health Region. The principles behind this pilot project have the potential for success in any emergency department across Canada. The problem of "overcrowded emergency departments" is one of national concern. New and innovative ideas and strategies for change must be considered.

References

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