RN Solutions in the Care of Older Adults

Transitions across the continuum of care

This is the second of a series of four profiles of emerging roles for nurses who work with older adults. Each of the stories follows "Mr. Smith and his wife" as they try to meet the multiple challenges of his complex care needs. In response to these challenges, we highlight innovative solutions that arise from nurses' keen recognition of the gaps in care and their commitment to finding ways to address them.

ISSUE

Registered nurses are in the best position to provide the care older adults need to (1) manage successful transitions of care across the continuum, (2) provide better care overall and (3) reduce the costs associated with complications and readmission.

After three days in hospital, Mr. Smith and his family are informed that he will be discharged that evening. Until recently, he was receiving treatment for a deep vein thrombosis to his leg and was functioning well in his own home as an independent 85-year-old. Mr. Smith has a complex history and multiple chronic conditions that require monitoring and periodic intervention.

If you were related to Mr. Smith, how would you expect his caregivers to ensure he receives effective nursing support that keeps him at home?

Did you know . . .

With the right education, referral information and resources, Mr. Smith and his family can be better prepared for the future.

RN solutions address gaps in care transitions

Nurses who practise to their full scope can ensure seamless transitions between care settings. Exemplars of such practices exist in emerging nursing roles across the country. In these roles, nurses liaise with interdisciplinary professionals and patients to better coordinate and improve their transition of care, either during or immediately after discharge from an inpatient unit.

Transitions of care facts

- People who were discharged from acute care and sent into residential care accounted for more than 5 million total alternate level of care (ALC) days* (CIHI, 2012).
- Frail seniors have a good chance of being readmitted to hospital within 30 days of their discharge (Mississauga Halton CCAC, 2013).
- 54 per cent of seniors who were admitted to acute care were discharged to a residential care facility (CIHI, 2012).

* In CIHI's report, ALC refers to a population (whose numbers are expected to grow in step with aging Canadians) waiting in acute care beds for more appropriate home or residential care that no longer requires acute care.

Nurse navigators, now at work in many parts of Canada, address complex health needs and improve patient experiences by easing transitions across the continuum of care (CNA, 2011). Not only do they help their patients navigate the health-care system, they work with other health-care team members to ensure timely followup, monitoring and treatment.

RN monitoring leads to a sustainable return home

The Rapid Response RN (RRRN) program, a 2012 Ontario Community Care Access Centre initiative, ensures successful transitions, from acute care to home and community care, for medically complex children and adults. Each RRRN offers in-person support during patient transitions and careful monitoring for 30 days after their discharge.

By making connections with primary care partners, reconciling medications and connecting patients and families to community services, the nurses support a sustainable release from hospital. The success and savings of the RRRN program have resulted in its continuation across the province, the most recent in Mississauga Halton in February 2013 (Mississauga Halton CCAC, 2013).

> Registered nurses are in the best position to provide the care older adults need

RN leadership results in better outcomes

Having patients without acute care needs waiting in hospital is costly to the system, and it can also lead to a decline in people's health (Graf, 2006). Nurse-led, interprofessional, timely transition care would improve these inadequacies and is essential to good results (Covinski et al., 2006; Walker, 2011).

For more than a quarter of a century, a growing body of credible evidence has linked nursing leadership with positive patient, provider and organizational outcomes. Nurses who insist on practising to their full and legal scope and who push practice boundaries to new levels make a difference to successful transitions for older adults who require varied levels of access to care.

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