

Mobile Nurses Improve Emergency Care for Older Patients

Many elderly residents in Toronto's long-term care facilities are being spared the stress and inconvenience associated with a trip to the emergency department (ED) thanks to teams of specially trained mobile nurses who are resolutely focused on keeping them well and comfortable in their own bed and home.

Reducing unnecessary, and sometimes traumatic, visits by elderly patients to hospital EDs was the goal when Toronto Western Hospital (TWH) received funding from the Nursing Secretariat of the Ministry of Health and Long-Term Care for a pilot project in 2009, explains Mary Jane McNally, TWH director of nursing and the project's first administrator. That pilot established the foundation for the mobile nursing program of the West Hub of the Toronto Central Local Health Integrated Network (LHIN) and subsequently created a profound bond between a team of hospital-based mobile nurses and staff nurses working in several local long-term care homes (LTCH). The TWH program is now permanently funded and has been extended to the East Hub of the Toronto Central LHIN. Evidence has proven its positive impact on patient care, ED wait times, nursing practice and cost savings. Ontario's provincial chief nursing officer, Debra Bournes, reports that because of the success of the initial pilot, each LHIN in Ontario now has funding to support a similar outreach team initiative.

Inspiration for the pilot came during a sabbatical to Europe by Dr. Mary Ferguson-Paré – then vice-president, professional affairs and chief nurse executive at University Health Network (UHN) – who witnessed models that provided a simple and caring way to divert elderly patients with non-life-threatening conditions from the frantic pace of an overloaded ED. The European example proved that many cases of delirium, urinary tract infections, wound care and breathing issues, for example, did not necessitate a trip to the ED.

Toronto's mobile nurse pilot was launched after extensive consultations involving myriad stakeholders and partners. Seven local LTCHs, their family council groups and directors of care, Community Care Access Centre (CCAC) representatives, and various union groups, psychiatric and emergency management services were all consulted and involved in the pilot. The program also benefited from strong leadership and data support from the Regional Geriatric Program of Toronto, which ultimately supported the governance model for the program. Today, ongoing partnerships, buttressed by formal contracts, are characterized by mutual respect and trust. And initial concerns that seriously ill patients might be held back from the care they need have been allayed: in serious cases, patients are transferred to the ED.



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Mary Jane McNally

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Nurse-led Innovations

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“The most exciting thing about this program has been to witness nurses working at full scope and acting as leaders,” says McNally. “Their leadership has produced impressive system change.” McNally also notes that the program has attracted many mid-career nurses who have acquired specialized geriatric training. “This model allows our ED and gerontology-trained registered nurses to take their acute-care expertise directly to the LTCH resident’s bedside,” says McNally. “Along the way, the mobile nurses offer substantial peer-to-peer coaching and mentoring to the nurses based in the residence, building these nurses’ skills, confidence and capacity. Everybody wins – the patients, their families and the nurses on both sides of the equation.”

From the outset, the program has encouraged LTCH nurses and administrators to rethink their normal reflex to call 911 and get their ailing residents to the nearest ED. Today, those same nurses consult the mobile team first, getting advice about how to manage health requirements at the residence before considering a hospital visit. Meanwhile, the mobile nurses keep in regular contact, by phone and in person, with the care network – LTCH medical staff, residence staff nurses and directors of care, and geriatric emergency nurses – building knowledge of specific patient histories and needs. The mobile nurses also work behind the scenes to bridge the gap between acute-care and long-term care operations and their differing administrative protocols. There has been significant improvement in streamlining access to diagnostic and ambulatory procedures like interventional radiology and videofluoroscopy, thereby bypassing the ED and supporting residents’ direct access to these services.

High-level data collected in 2009 show that the formula works. Of the consultations made by the mobile RNs during the first year, the TWH pilot facilitated 1,000 patient visits and realized a 13 per cent decrease in ambulance transfers. An initial evaluation of the pilot found that 78 per cent of clients whose health situation would normally have prompted a 911 call to get them to the local ED received their care right in their LTCH. (The remaining 22 per cent were determined to require the trip to the ED.) The same analysis estimated that a mobile nurse visit costs 21 per cent less than an ED visit for a 75-year old patient.

In addition to the hard data, anecdotal evidence strongly suggests that the mobile nurse approach contributes to improved quality of life for residents, while also building nursing capacity, knowledge and scope of practice.

The mobile nurse program continues to evolve, and McNally predicts future enhancements that will see other professionals (e.g., speech language pathologists) engaged in the network, increased use of telehealth options, and a capacity to support families regarding pain management and end-of-life protocols.

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Web links:

<http://theconference.ca/acute-care-house-calls-to-long-term-care-homes>

<http://www.nursingchannel.ca/programs.html>

<http://www.longwoods.com/content/22335>

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