Preventing Potentially Avoidable Emergency Department Visits for Long Term Care Residents

(This case study has been adapted, with permission, from the work of The Perley and Rideau Veteran's Health Centre (Ottawa, Ontario). Modifications were made to the original work to facilitate learning in the IDEAS Program).

The QI Project Examples offered have been written based on real life experiences, modified to facilitate learning in the 1 Day Workshop of the IDEAS Foundations of Quality Improvement Program.

The QI Project Examples vary in their completeness and each raise different questions to the participant across a range of QI topics. They all have been written with the Model for Improvement in mind to guide the participant through the QI project journey with the ultimate goal of enabling the participant to become an effective member of the QI project team.

A well-designed QI project will include a frontline, inter-professional team that is empowered to:

1. Set goals for improvement,
2. Identify causes of poor system quality,
3. Conduct tests of change, and
4. Collect and analyze data to determine whether a change led to an improvement.

From various viewpoints of our complex health care system, we offer these to you for teaching purposes. All project examples have data sets provided as background for the QI Tools. We welcome your feedback.

Background

Bob, a 90-year-old retired Veteran, is transferred to the Emergency Department (ED) from Sunnyvale Home. This was the second trip to the emergency department in the month. During his stay at the ED, he experienced an eight-hour wait while he lay on a stretcher. The hectic environment caused Bob to be more confused and he tries to get off the stretcher and leave. He is physically restrained to the stretcher for his safety and medicated to decrease his anxiety. A urinary catheter is put in place to assist with incontinence needs. When Bob returned to the Home he was extremely sedated and had not had anything to drink in some time. He soon developed a pressure ulcer on his sacrum related to being on his back and not repositioned during his ED experience.

Unfortunately, the story of Bob is not an isolated case. Across the province, recent CIHI reports state that 1 in 3 seniors living in LTC visit the ED annually (1). 25-33% of these visits

are classified as being potentially avoidable and 24% of the visits are for potentially avoidable conditions (CIHI Report, 2014). Studies show that 25% of residents are re-admitted to the hospital within 30 days of discharge from hospital (Enderlin et al (2013) and Ouslander et al (2011). These avoidable hospital transfers result in increased wait times for patients on visit to the ED, which associated increased healthcare costs.

In 2014, an average of 10 per 100 residents per month were transferred to the ED from Sunnyvale Home. Extrapolating from published data (above), it was reckoned that a significant proportion of these transfers could have been avoided. It was believed that for the many reasons of transfer, the resident's needs could be adequately met in the LTC environment if the appropriate supports (clinical expertise, diagnostic equipment, etc.) were available in the homes.

Upon return from the hospital, the Sunnyvale Home staff does not always have the information or the clinical capacity to adequately meet the changing care needs of the resident. This often results in another transfer to ED and re-admission to hospital. This results in further increasing ED wait times, puts the residents at risk of hospital-acquired complications, and decreasing their quality of life.

The Chief Operating Officer at Sunnyvale and the Vice President of Clinical Programs at the hospital came together to consider the problem. It was agreed that there was an opportunity for improvement. They formed an improvement team comprised of members from both organizations. From the home: the Director of Nursing, a Performance Improvement Consultant, a registered nurse, a physician and a resident. From the hospital: an ED RN, a RN from the medicine unit and an ED physician were invited to join the team. As the change ideas were developed, a Nurse Practitioner (NP) from the Nurse Led Outreach Team (NLOT) at the hospital was invited to join the QI Project Team.

The team quickly came together and had a brainstorming session during which they tried to articulate the opportunity for improvement.