Reducing Emergency Department Visits – Shalom Village

“It’s an overall recognition that it’s an important thing to pay attention to for various levels, for resident comfort, and as part of the broader health care system.”

– Jeanette O’Leary, CEO at Shalom Village

Shalom Village CEO, Jeanette O’Leary, shares with Health Quality Ontario her home’s experiences in reducing avoidable emergency department visits through quality improvement.

Background

<table>
<thead>
<tr>
<th>Home Name</th>
<th>Shalom Village</th>
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<tbody>
<tr>
<td>Home Type</td>
<td>Faith-based, not-for-profit long-term care home</td>
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<td>Home Size</td>
<td>139 beds, approximately 263 staff</td>
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<tr>
<td>Location</td>
<td>Hamilton, ON</td>
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<tr>
<td>First participated in Residents First</td>
<td>Early 2010</td>
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<td>QI Team</td>
<td>• Decision Support Analyst</td>
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<td></td>
<td>• Executive Coach, Long-Term Care</td>
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<td></td>
<td>• 2-3 Clinical Leaders (Registered Nurses)</td>
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Challenge

Emergency department (ED) visits can cause clinical risk, stress and anxiety for older, more vulnerable patients. Overcrowding and surging costs of hospital emergency departments have long been a concern in Ontario’s health care system, and there is a need to address this issue from all perspectives. Addressing avoidable emergency department visits from residents of long-term care homes is essential to ensuring good care and freeing up hospital resources for true emergencies.

“There’s the recognition that when long-term care residents go to the Emergency Department it’s not a pleasant experience and there’s lot of complications that can develop as a result. Long-Term care staff feel they should have done something more; that they failed somehow. And so by paying attention to this issue – by identifying the root causes and problem solving, using QI set of tools, Emergency Department use can be reduced and lead to improved outcomes for residents.”

Project Aims

- To decrease the prevalence of avoidable Emergency Department visits to zero.

Measures

Residents First Measures

| 1 | Outcome Measure | Number of visits to the ED each month by cause (i.e., fall, potentially preventable deterioration in condition, other) |
| 2 | Outcome Measure | Of the residents that went to the ED from the LTC home, percentage of residents who have multiple ED visits within a 30-day period. |
| 3 | Process Measure | Percentage of residents at high risk* for an ED visit who had a change in condition documented on the Shift-to-Shift Report (or progress notes) in the 24 hours prior to ED visit. |
| 4 | Process Measure | Percentage of residents with an ED visit in the previous month for whom a transfer package** accompanied the resident to the ED visit. |
| 5 | Process Measure | Percentage of residents readmitted to the LTC home in the previous month who have an ED or hospital discharge record*** that accompanies the resident back to the Long-Term Care home (or comes in a timely manner). |
| 6 | Process Measure | Percentage of residents readmitted to the Long-Term Care home in the previous month with follow-up care documented in the physician’s orders and care plan within a 24 hour period. |
| 7 | Process Measure | Percentage of all residents in the LTC home who have an up-to-date care plan (10% sample) |
| 8 | Balancing Measure | Percentage of residents with worsening mobility (i.e., locomotion, transfer, and walk in corridor ability, mid-loss activities of daily living) compared to the previous month. |

*High risk residents are defined as those admitted to the LTC home within the last 30 days; re-admitted to the Long-Term Care home from an ED visit or hospitalization within the last 30 days; those who have experienced a change in medication, change in treatment plan or significant change in condition (as per Resident Assessment Instrument-Minimum Data Set) within the last seven days

**Transfer package should include: Reason for initial transfer, any high risks identified with related care plan interventions, medication list, medical history, and most recent assessments

***ED discharge record should include: Record of care and services received, discharge diagnosis, medications administered, diagnostic test results, response of resident to treatments, recommendations for follow-up, and consultation reports

Quality Improvement Program

PLAN-DO-STUDY-ACT CYCLES

1. **Refined the notification process for home staff to be alerted of resident ED visits**
   - Identified that part of the process for notifying staff of ED visits was missing, which led to PDSA:
     - Developed and refined a tracking form for ED transfers/visits of residents
       - Refined the tracking form for ED visits through several tests - the form started in paper format, and has since moved to an electronic format.

2. **Conducted an inventory of the tools and resources available to the home to help prevent the need for ED visits**
   - Met with external groups, etc. to determine which tools/resources were available to the home as alternatives to sending residents to the ED.
3. Piloted methods to help increase awareness of this issue with staff, family and residents
   - Initiated conversations with staff, family, and residents to make them aware of the problem and how they can help.

CHANGE IDEAS

Formalized processes to educate staff, family, and residents about minimizing avoidable ED visits
- Established ongoing processes to create awareness (e.g., conversations, training during meetings) among physicians, nurses, and other staff regarding the alternative tools and resources available to manage residents’ acute care issues that will prevent an ED visit.
- Created a review and follow-up plan for ED visits, to determine whether anything could have been done better, determine whether they could have been prevented, and correct it for future incidences.
- Have conversations with families to create awareness of alternatives to going to the ED.

Results
- The home has seen a general decline in monthly ED visits, and has been able to reduce some avoidable visits through their change ideas.
- Their effort to reduce the rate continues.

Impact

Resident and Family Satisfaction
- The home now follows-up with families after each ED transfer to determine whether alternative resources or decision-making could have prevented the visit, families recognize that the home has the best interest of the residents at heart and that they care.

“Families were glad to know that we cared, we were following up and that we were concerned about them and the residents.”
Staff Satisfaction
• With the new tools and awareness of alternative solutions, staff feel more confident in their ability to critically problem-solve and provide solutions for helping residents avoid ED visits.

Lessons Learned
• Clearly define the change idea before implementing the project throughout the home. The change idea of education and creating awareness ultimately found its footing, but it could have been clearer at the beginning.
• There is a need to continuously maintain the progress and hold the gains achieved.

“This is a change process that doesn’t end; it’s a continuous effort because we have new staff, new residents and families, and new physicians joining the home.”

Next Steps
• Continue with the same aim of having zero avoidable ED visits.
• Identify and develop new priorities for 2012-2013 Quality Improvement Plan.

“When you can tie your quality improvement project to something that is very relevant to your day-to-day work and continues to be relevant all the time, it’s worth spending effort on it.”

About HQO
On April 11, 2011 the Ontario government announced the formation of Health Quality Ontario (HQO). HQO is a government agency that combines the expertise of the Ontario Health Quality Council, the Medical Advisory Secretariat, the Ontario Health Technology Advisory Committee, the Ontario Health Technology Evaluation Fund, the Centre for Healthcare Quality Improvement and the Quality Improvement and Innovation Partnership.