

## **NPs Making a Difference for Long Term Care Residents, Interprofessional Teams and the System**

A resident in a long-term care home (LTCH) has begun to deteriorate. He has developed a high fever and he's not eating or drinking. The staff is worried and makes a phone call.

In the past, the phone call would have been to an on-call doctor who may not have been available to assess the resident, in person, at that time. The staff would have been left with only one option, call an ambulance and send the resident to hospital.

The resident might spend 20 or more hours in the emergency department waiting to be assessed. During this time, their level of consciousness decreases, and they often become delirious and afraid. Because they lie on a stretcher for hours, they can also develop skin ulcers and pressure wounds. By the time the emergency room (ER) staff assesses the patient, the residents' mental and physical health has deteriorated. In the Mississauga-Halton Local Health Integration Network (MH LHIN), this scenario is a thing of the past. Now, the LTCH staff call nurse practitioners like Lori Brown who prevent transfers to local hospitals by diagnosing and treating residents in the comfort of their home.

Lori is the coordinator, and an NP, of the NPSTAT (Nurse Practitioners - Supporting Teams and Averting Transfers) program. This program strives to reduce hospital transfers of the elderly in long-term care facilities. Lori is one of 7 NPs working in 27 long-term care facilities in the MH LHIN. Together, NPSTAT provides acute, episodic care to more than 4100 residents.

"We provide comprehensive assessments on a variety of acute, episodic symptoms, wound care, post-fall assessments, palliation, comfort care, and pain management. We also write prescriptions to treat acute conditions and consult on end of life care and management," said Lori. She also performs procedures in the LTCH, orders diagnostic tests and makes referrals to ensure the residents receive comprehensive care.

The program is part of the MOHLTC Aging at Home Strategy with leadership and support from Credit Valley Hospital. Since its inception three years ago, the program has been recognized for reducing resident transfers to hospital by more than 85 per cent.

Each nurse practitioner is responsible for the management of a number of LTCHs in the MH LHIN. Lori is personally responsible for 8. A typical day begins around 8:30 am when the staff from all the homes begin calling her about resident concerns. Lori triages the cases based on their acuity and heads to the most serious resident first. When she arrives to the LTCH, she receives report from the staff and then reviews the resident's chart to ascertain a full understanding of the pertinent issues and background. She then takes a history and performs a physical assessment to develop a plan of care. She also engages the LTCH team to enhance communications regarding her prescribed plan of care.

"We're mentors of the team and try to enhance the knowledge and skills of the staff we collaborate with," she said. "We've also developed and defined a consultative and collaborative network with each of our physician partners in the homes, ensuring optimal levels of care for our patients." Once the team is comfortable with the plan and Lori has documented her visit, she makes her way to the next resident, confident in the knowledge that an unnecessary hospital transfer was avoided.

A family member describes the impact that Lori had on her mother's health by averting a recent hospital transfer. "It was such a relief to our family when we found out the NPs were working in my mother's home," the family member said. "The last time she fell ill, she went to hospital and spent many hours in the ER and came back in worse condition. With Lori being there, I know my mother will be cared for and won't end up in the hospital unnecessarily."

Lori's days are unpredictable, and calls often come in throughout her shift. Her Primary Health Care specialization allows her to work to her full scope of practice and beyond. She said her physician partners also see the benefits of the role.

"The physicians rely on the fact we can be at the home to make an assessment in a timely manner and determine whether the resident requires transfer to hospital," she said. "The residents are getting more comprehensive care and we're also saving the patients and families unnecessary stress while helping build that collaborative model with the team. It's a win-win for everyone."

While Lori admits her role can be stressful, the satisfaction she feels from helping both the residents and team members is worth every phone call. "After 25 years of nursing, this is by far the most satisfying role for me. Helping make a patient comfortable in their advanced years is a privilege and seeing the impact we have on residents and their families by preventing transfers to hospital is empowering."