

## HIROC NEWS

Quinte Health Care zeroes in on improving hospital-to-home transition for patients  
Various initiatives target enhancing quality of life, reducing days spent in hospital  
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For each day patients spend in bed they lose five per cent of their ability to function.

That's what the rehabilitation therapists at Quinte Health Care report and they're taking initiatives to get people up and moving.

While daily recreation therapy in a group setting isn't generally offered in acute-care units, it's part of the hospital's plan to help patients staying longer than necessary in hospital maintain their agility.

"They become weaker and weaker," as they spend time in bed, says Katherine Stansfield, vice-president of patient services and chief nursing executive at the hospital.

"For those people on the cusp (of entering long-term care), if we can keep them at a functioning level there's a better chance they'll be able to go home."

The initiative, launched this spring at the Ontario hospital, is part of the hospital's plan to help send patients home sooner and in better health. People occupying acute care beds when their needs are no longer acute is a province-wide healthcare issue that stresses the system and reduces quality of life for patients.

In Ontario in 2005-2006, there were 600,000 days patients spent in hospitals when it was medically unnecessary for them to be there, according to research by The Change Foundation. That rate for South East Ontario exceeded 20 per cent during 2006, while the provincial rate was 14 per cent.

Quinte Health Care's Trenton Memorial site in conjunction with the South East Community Care Access Centre (SE CCAC) recently took part in a project funded by The Change Foundation and the Ontario Association of Community Care Access Centres (OACCAC) aimed at making the transition from hospital to home smoother and timelier for Ontario patients.

Phase one of the project, involving this southeast region, began in February and was aimed at pinpointing problems in the transition and finding solutions.

Project participants worked with consultants to map out the steps and decisions patients and caregivers

make during the transition with the different service providers, whether the patient is returning to his or her home, a retirement home, long-term care home or supportive housing.

They consulted patients and caregivers about their needs, perspectives and placement preferences to help develop recommendations for changes to processes, policies and practices.

Stansfield says the hospital and CCAC are already working together on projects, like the recreation therapy, as a result of what the [study results revealed](#).

"We are making some inroads," says Stansfield, noting a full two months of data showed there was a slightly higher number of people heading home as opposed to long-term care.

The hospital is also working on ensuring patients who enter the hospital have a discharge plan initiated early on so care providers can establish the person's needs once they leave and begin working with the patient, family and other community providers on the transition. Stansfield says the hospital was doing this before but is now bolstering that support with the addition of social workers.

As well, the hospital and CCAC are now assessing patients from their point of entry into hospital through emerg. Through triage, care providers determine if the person is at high risk for an admission based on social reasons and make a referral to a CCAC case worker who is on site 12 hours a day, seven days a week.

The patient may need to be hospitalized and stabilized and then sent home or may not need to be admitted to hospital at all, explains Stansfield.

Results from phase one of the project ultimately show patients want a smoother, timelier transition from hospital to home.

"This has been a great opportunity to obtain client and caregiver feedback about the transition from hospital to home – wherever home may be," says Margaret Mottershead, OACCAC CEO.

"The CCACs, as navigators of the healthcare system, partner with clients and families to help them make the best decisions and then to implement those in a seamless manner. This study provides insights that our members will find valuable as they work to continually improve services."

The second phase of the project will involve the Toronto CCAC and an area hospital.

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