Reducing Potentially Avoidable Emergency Department Visits

- **Organization:** Cummer Lodge, City of Toronto
- **Author(s):** Cummer Lodge Multiprofessional Team

Overview

Cummer Lodge's initiative to reduce potentially avoidable emergency department (ED) transfers began in 2016 and has grown into a sustained quality improvement effort. It aims to improve residents' quality of life and experience during acute changes in health while reducing strain on the health care system. The home focused on understanding residents' wishes and treatment preferences, building the clinical decision-making skills of registered nursing staff, improving communication and care coordination with physicians and partners, and expanding access to nurse practitioners and external specialists who can support care in the home. Through these ongoing efforts, the home reduced potentially avoidable ED visits to 11.56%, down from 19.28% the previous year. The initiative addressed the Quality Improvement Plan (QIP) priority issue of access and flow and was tied to the indicator for potentially avoidable ED transfers.

Key Elements of Initiative

Change Ideas Tested or Implemented

- **Monthly ED transfer reviews:** An interprofessional team reviews ED visits each month to identify transfers that may have been avoidable. Findings are shared with units for staff discussion and education, and the care team is prompted to review the resident's goals of care with the resident and substitute decision-maker (SDM) or power of attorney (POA) as appropriate.
- **Early recognition education:** Ongoing education helps frontline staff identify clinical changes early, in collaboration with the Nurse Practitioner-Led Outreach Team (NLOT), the Palliative Care Coach from North York Toronto Health Partners, Nurses Specialized in Wound, Ostomy and Continence (NSWOC) and other partners.
- **SBAR communication:** Regular refresher education on Situation, Background, Assessment, Recommendation (SBAR) communication for registered nursing staff, supported by an SBAR progress note template for ED transfers.

TORONTO Ontario Health

- **Goals of care conversations:** Ongoing conversations help residents and families make informed decisions. With the Palliative Care Coach, the home hosted an Advance Care Planning workshop for family members and caregivers.
- **Access to clinical supports:** Improved access to internal and external resources, including NLOT, palliative care specialists and SCOPE, for time-sensitive clinical support.

Objective of the Change Ideas

- Involve residents and SDMs in reviewing care plan goals and preferences so every resident has up-to-date care directives to guide decisions during acute changes in health.
- Reduce unnecessary hospital transfers by supporting timely, appropriate care in the home.

Team Members Involved

- Physicians and nurse practitioner
- Frontline nursing staff and nursing management
- Residents, families and caregivers
- Other interprofessional team members
- External partners: NLOT, SCOPE, palliative care specialist, NSWOC, Palliative Care Coach and other community partners

Target Population

- All residents of Cummer Lodge

How Progress Was Measured

- Percentage of residents reviewed who have up-to-date care directives
- Percentage of residents reviewed who have updated care plan goals and preferences, particularly for end-of-life care

Implementation Experience: Successes & Challenges

Results and Early Wins

- Potentially avoidable ED visits fell to 11.56%, down from 19.28% the previous year.
- The home reports improved resident outcomes and quality of life alongside fewer potentially avoidable hospital and ED visits.

Enablers of Success

- **Culture shift:** A team effort to support residents during acute decline and raise concerns with physicians and the nurse practitioner, with the shared understanding that a decline in health does not automatically mean a transfer.
- Proactive use of external services, such as intravenous (IV) therapy, NLOT follow-up and palliative care specialist referrals
- A comprehensive monitoring tool that supports analysis and strategies to reduce reliance on the ED
- A positive team approach to reviewing ED transfers after they occur
- **Strong physician involvement:** Physicians start appropriate medical interventions before acute decline and discuss ED transfer when medically appropriate, in line with the resident's goals of care.

Challenges and Solutions

- **Differing wishes:** Resident or family wishes did not always align with the resident's clinical condition, including some cases where the care team felt a transfer would not help. The team kept communicating with residents and SDMs, explained the resident's condition, risks and care options, and engaged external specialists where appropriate. Early, consistent goals of care conversations with clear education and interdisciplinary support built trust and supported shared decision-making.
- **Staff turnover:** Turnover creates ongoing learning needs. Flexible education planning based on identified needs helps maintain staff competency and confidence.
- **After-hours access:** A physician is always on call overnight and after hours, but access to NLOT, SCOPE, the nurse practitioner and mobile imaging is limited. The team continues to focus on proactive interventions.

Advice for Other Teams

- Involve the full interdisciplinary team, including physicians, in reviewing transfers, so care gaps are addressed early in the illness and interventions can start before a transfer is needed.

- Treat reducing ED transfers as a culture shift toward providing care in the home whenever possible, rather than automatically sending residents to the ED.
- Begin goals-of-care conversations early and revisit them as health needs change. Clear education and interdisciplinary support can strengthen trust and shared decision-making during complex situations.

Future Steps & Sustainability

Next Steps and Embedding the Work into Practice

- Continue promoting meaningful advance care planning by building staff capacity and offering education and support to residents and SDMs or POAs.
- Continue exploring partnerships with community organizations to support residents' needs.
- **Embedded in practice:**
    - Monthly interprofessional ED transfer reviews
    - An SBAR progress note template for ED transfers
    - Regular SBAR refresher education
    - Goals of care reviews at admission, after significant health changes, after hospital returns and at care conference

Need this information in an accessible format? 1-877-280-8538, TTY 1-800-855-0511, info@OntarioHealth.ca
Document disponible en français en contactant info@OntarioHealth.ca

TORONTO Ontario Health