Reducing Potentially Avoidable Emergency Department Visits by Treating Residents in the Home

- **Organization:** The Pines Long-Term Care Home, District Municipality of Muskoka
- **Author(s):** Jennifer Ridgley, RN, BScN, Administrator

Overview

The Pines Long-Term Care (LTC) Home launched a multifaceted initiative to reduce potentially avoidable emergency department (ED) visits by building the home's capacity to assess and treat residents in place. The work focused on introducing new clinical technologies, upgrading nursing equipment and systematically reviewing ED transfer data through interdisciplinary committees. Key interventions included Jubo vital sign integration with PointClickCare, bladder scanning, computerized ambulatory drug delivery (CADD) pumps, telemedicine, portable diagnostics and enhanced nursing equipment, supported by stronger interdisciplinary review through the home's CORE Committee and collaboration with physicians and health care partners. These efforts reflect the home's philosophy of providing the right care, at the right time, in the right place, so residents can stay in familiar surroundings whenever clinically appropriate. The initiative addressed the Quality Improvement Plan (QIP) priority issues of access and flow, resident safety and quality of care, and was tied to the indicator: rate of ED visits for a modified list of ambulatory care-sensitive conditions per 100 LTC residents. The home's rate fell from 26.47 to 19.40 visits per 100 residents.

Key Elements of Initiative

Change Ideas Tested or Implemented

- **New technologies:** Implemented Jubo vital sign integration, bladder scanning, telemedicine and enhanced diagnostic capabilities to support treatment in the home.
- **Nursing equipment:** Updated and expanded equipment such as suction machines, air mattresses and CADD pumps so acute resident needs can be managed without a hospital transfer.
- **ED transfer review:** Introduced regular review of ED transfers through the interdisciplinary CORE Committee to identify trends, assess whether transfers were appropriate and put preventive strategies in place.

THE PINES LONG-TERM CARE HOME

Ontario Health

- **Partnerships:** Strengthened partnerships with physicians, the Muskoka and Area Ontario Health Team (MAOHT) and telemedicine providers to support care in place.

Objective of the Change Ideas

- Reduce avoidable ED visits by increasing the home's ability to safely assess, monitor, diagnose and treat residents in the LTC setting.
- Improve resident comfort and reduce the disruption that comes with hospital transfers.

Team Members Involved

- Administrator, Director of Care and nursing leadership team
- Registered staff and personal support workers (PSWs)
- Physicians and the CORE Committee interdisciplinary team
- MAOHT partners, telemedicine and specialist providers
- Community diagnostic providers (laboratory and portable X-ray services)

Target Population

- Residents of The Pines, particularly those at higher risk of avoidable hospital transfers due to falls, infections, dehydration, continence issues, skin and wound concerns, or pain management needs

How Progress Was Measured

- ED visit rate for ambulatory care-sensitive conditions
- Number of technologies implemented and equipment upgrades completed
- Review of ED transfers and transfer appropriateness at CORE Committee meetings
- Resident outcomes linked to in-home treatment options

Implementation Experience: Successes & Challenges

Results and Early Wins

- The ED visit rate for ambulatory care-sensitive conditions fell from 26.47 to 19.40 per 100 residents, surpassing the home's previous target.

- Residents now have access to more advanced assessment and treatment in the home, including vital sign integration, bladder scanning, telemedicine consultations and enhanced diagnostics.
- Teams reported greater confidence in managing complex resident needs on-site.

Enablers of Success

- Strong leadership support and commitment to quality improvement
- Engaged interdisciplinary teams
- Investment in new technologies and nursing equipment
- Collaboration with physicians and external health care partners
- Participation in MAOHT initiatives and Ontario Health tables
- Robust review and monitoring through the CORE Committee

Challenges and Solutions

- New technology required staff education, workflow changes and ongoing support. Introducing technologies and equipment in phases helped, but needed careful planning and monitoring.
- The home planned to use the Nurse Practitioner-Led Outreach Team (NLOT) for support, but this resource became unavailable. The team found other educational supports and relied on internal leadership and external partnerships to keep implementation moving.

Advice for Other Teams

- Start with a clear review of your ED transfer data to understand local trends and opportunities.
- Invest in technologies and equipment that directly address your most common reasons for transfer.
- Engage physicians and frontline staff early.
- Create a structured interdisciplinary process to regularly review transfers and identify preventive strategies.
- Build strong community health care partnerships.

Future Steps & Sustainability

Next Steps and Embedding the Work into Practice

- Continue implementing intravenous (IV) hydration and medication therapy programs.

- Expand the use of technologies that support in-home treatment.
- Review all ED transfers through the CORE Committee.
- Strengthen nursing competencies in acute care management.
- Continue working with MAOHT and Ontario Health partners to improve care transitions and reduce unnecessary transfers.
- **Embedded in practice:**
  - Review of high-risk residents and ED transfers is built into CORE Committee processes.
  - Technology integration and equipment reviews are now part of routine nursing leadership work.
  - Staff education continues through orientation, professional development, physician collaboration and committee review.
  - The initiative is part of the home's 2026/27 QIP and operational practices.

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