G022

Enhancing Clinical Services in Special Care Homes

Summary

- The Enhanced Clinical Services in Special Care Homes Pilot Project was implemented in New Brunswick to provide clinical support services and enhance collaboration around residents' care needs in Special Care Homes (SCHs).
- This pilot project introduced Extra-Mural Program (EMP) Community Liaison Nurses (CLNs) into SCHs through a newly established unit within the EMP called the Special Care Home Unit. By providing clinical expertise within this new unit, the project aimed to enhance support for senior's aging in place and ensure timely access to care.
- The major roles and responsibilities of the CLNs included (1) assessing patient needs and appropriateness of admission to EMP, (2) facilitating the admission of residents to the local EMP unit as needed, (3) developing clinical care plans for residents, (4) leading patient care conferences, (5) communicating regularly with the SCH, and (6) providing education to SCH staff and care team members.
- The pilot project was evaluated across 16 SCHs to assess the impact of the CLNs and inform potential scale-up of this service in New Brunswick.
- The main aim of the evaluation was to assess whether the new enhanced clinical EMP role (1) strengthened coordination, effectiveness, and timeliness of resident care and collaboration among team members, (2) improved SCH residents' satisfaction with the care they were provided and (3) reduced unplanned or preventable health system use, including ER visits and hospitalization.
- Participants in the evaluation included 5 CLNs, 47 SCH staff, 26 SCH care team members, and 204 SCH residents.

HSPP Focus Area	Developing innovative care pathways
Project Start & End Date	May 1, 2021 – March 31, 2024
Organization/Agency	Extra-Mural Program/Ambulance New Brunswick (EM/ANB), Department of Health (DOH), Department of Social Development (SD) & the New Brunswick Special Care Home Association
Location	Various SCH locations across New Brunswick
Principal Investigator(s)	Diane Lirette

Indicator	Impact / Outcome / Result

Strengthened coordination, improved effectiveness and timeliness of resident care, and collaboration among team members	• Since the introduction of the CLN, most SCH staff and members of the care team noticed improvements in:
	  ○ how well they work together (coordination),
	  ○ providing care to residents, including improved knowledge and skill toward patient care (effectiveness),
	  ○ how quickly they provide care to patients, including processing referrals, initiating EMP services, and responding to patients' needs (timeliness), and
	  ○ Levels of collaboration between team members and overall satisfaction toward collaborating with other team members (collaboration)
	• Overall, SCH staff and care team members noted that working with the CLN was a positive experience.
	• During focus group discussions with the CLNs, educating SCH staff and communicating/liaising with PCPs emerged as two key ways in which they believed their role contributed to improved timeliness of resident care.

Indicator	Impact / Outcome / Result
SCH residents' satisfaction with the CLN	• Overall, 87% of residents who were surveyed indicated that they were 'very happy' with the way their health care needs were addressed. • Since the introduction of the CLN, on average, residents agreed that the SCH staff (1) knew their medical history (2) knew their health care needs, and (3) staff quickly informed others on their health care team when their health needs changed. Residents were also satisfied with the care provided by staff.
Reduced unplanned or preventable health system use	• Overall, encouraging trends were observed in some system-level outcomes (e.g., emergency 911 calls, ER visits, preventable ER visits, reassessments, needs assessments, and hospitalizations). However, due to limitations in the interpretation of administrative data, it was not possible to assess the impact of the CLN program on system-level outcomes.

Methods and Comparison

Data was collected from 16 special care homes that utilized a CLN. Self-report surveys were used to collect data from SCH residents, SCH staff, and SCH care team members. A focus group was conducted to capture the perspectives of CLNs. Aggregated administrative data that was provided by DOH and EM/ANB was also used to analyze system-level outcomes.

Conclusions and Lessons Learned

- Overall, the CLN program showed several positive benefits for the SCH residents health/well-being and their experience at the SCH.
- Since the introduction of the CLN into SCHs, SCH staff and care team members believed that the coordination, effectiveness, and timeliness of resident care and collaboration among team members had improved.
- SCH residents were satisfied with the care provided by the staff and the way their health care needs were addressed.
- CLNs found their role to be beneficial to SCH residents and staff, and the SCH staff were particularly satisfied with the training and education they received from the CLNs.

Recommendations

- Provide SCH staff with more formal/structured training opportunities from CLNs to help them better respond to the healthcare needs of residents.
- Facilitate greater collaboration between CLNs and EMP.
- Increase the frequency/duration of CLN visits in SCHs.
- Add more staff/resources to SCHs to help with administrative tasks associated with the CLN role.
- Continue to integrate processes that facilitate communication/collaboration between SCH staff, care team members, and the CLN.

Next Steps

The project was a part of the New Brunswick Provincial Health Plan and has secured funding from the Department of Health to assist with scale-up and sustainability. The project has been successfully scaled-up across the province.

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