Nursing Presence Bridging Care for Geriatric House Call Patients

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Objective

The learner will be able to identify ways to enhance caring relationships with homebound geriatric patients/family caregivers.

Background

The vulnerability of geriatric patients is a constant consideration for any practice, but in particular those patients who frailty confines them to their home setting with limited outreach access. In an effort to meet this particular need, the Geriatric Clinic at Wake Forest Baptist Health provides ongoing geriatrician primary care support via home visitation to approximately 20 patients.

Purpose

As we seek to better engage these patients and their support system within the continuum of care, we observed an underutilized opportunity in the consistent presence of nursing interaction and support.

Implementation

To enhance nursing presence, a clinic nurse has transitioned to more efficiently coordinate the House Call Team. The House Call Team meets quarterly to review recent patient visits, current patient status, and scheduling of future visits. Additionally, each patient is being tracked by an ongoing nursing care plan. The nursing care plan is the foundation of tracking specific patient needs and identifying any unmet needs. Finally, to more fully connect and cultivate the care team connection with the patient and their support system, the nurse makes check-in telephone calls between provider visits.

Conclusion

By implementing this more coordinated nursing effort with our House Call Team, we believe we will be able to more fully meet the ongoing needs of this unique patient panel. Ultimately, we expect this process will lead to an enhanced patient-centered approach leading to reduced admissions.

References

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