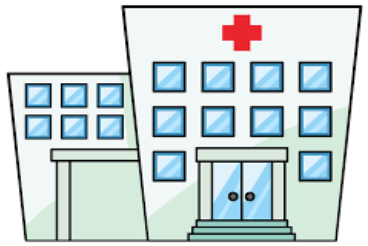
Outreach NP supporting rural general practice

Healthy Aging Plan



f/u acute weekend or surgical high risk patients

Neighbourhood concern

Falls

Overdue screening

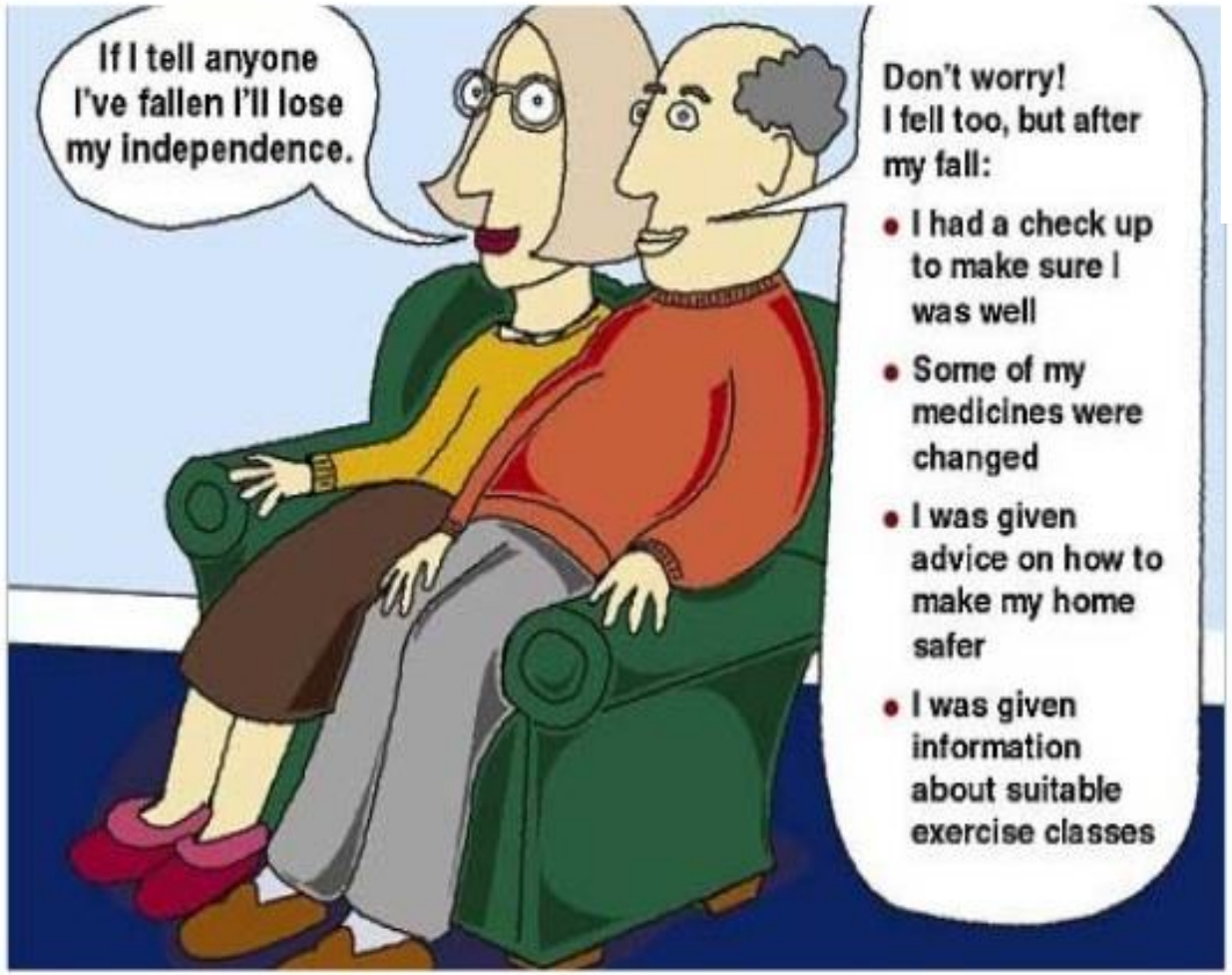
non attendance

Home assessment

Meds reconciliation

Advanced care planning 2/3 senior population

What we don't see in general practice



Benefit of Home Visits by NP

Improved independence and community connectedness

Enhanced clinician team support

Ensuring timely assessment and diagnosis with prescribing ability

Supporting respite, recovery to baseline health status

Reducing admissions/readmission

Reducing disparity Improving health targets

- Clinic nurse identified overdue DAR but not responding to recalls and one house visit on her way to work
- 71 yr old Pacifica man with known Type 2 diabetes. Last Hba1C 105 mmol, 2016. No rx for medication for over a year.
- Identified weight loss and fatigue, high risk feet, hypertension, hyperglycaemia.
- Plan- relationship established, information given in a manner that was understood. This led to the screening being achieved with the gentleman agreeing to see his G.P. and diabetes nurse to restart medication. He set his own goals and plan remaining the key person in his health care plan.
- ACP introduced and completed . Shared with permission to St John, Health Centre and hospital, Falls risk performed due to high risk feet

The Future - Risk Assessment to identify those at high risk of admission

- Undertake home visit for elderly identified as High Risk of admission and provide comprehensive needs assessment, undertake care planning in partnership with the patients and undertake agreed interventions

  Care Plan to be written as part of G.P. record so follow up can be ongoing