Editorial

Rural Practice Forum: Hospitalizing Older Adults

Bette Ide, PhD, RN, Editorial Board Member

Jeanie Niemoller, MS, RNc, Director of Extended Care at Ivinson Memorial Hospital in Laramie, WY, is a rural nurse who speaks from many years in community health and hospital nursing. She sends the following practice "tip." It encompasses useful advice for anyone, particularly an older adult from a rural area, who is planning on hospitalization or currently hospitalized: When a person spends time in the hospital, and has surgery or serious illness, it is not unlikely that they will need help at home after the hospitalization. Whenever possible, they or the nurse should find out about home care providers, the services offered by the local senior citizen center or area association for aging prior to the hospital admission. They can also talk to friends and neighbors about services they have used and what is available. A good question to ask home health agencies is "How often can you visit since I live 10, 30, or 50 miles from town?" If services are not available, the individual may need to plan to stay temporarily at a nursing home or assisted living center to get the aftercare they need. Asking questions beforehand will save lots of stress and possible longer stays in the hospital. Stephanie Christian RN, MS, CCRN, concurs with the above. She works and teaches nursing students in the acute care setting in Altru Hospital, Grand Forks, ND, a small city within a large rural area. She states that preplanning is great but not always possible, and it is essential to begin discharge planning on admission to the hospital. Prior living situations, support systems and availability of possible resources are important factors to assess. Family involvement is particularly important because, due to the acuity of care required on admission, discharge planning is not usually a priority for

the patient. As the patient recovers their involvement significantly increases, and family involvement is reinforcement for the patient. Education and plans upon discharge seem to be more successful when support systems are involved. Post discharge follow-up with a nurse, hopefully through a home visit, helps to ensure that the patient is doing well and the support following discharge is adequate. Ms. Christian collaborated with Ellen J. O'Conner, MS, RN, CS, a community health nurse in rural North Dakota and northwestern Minnesota for many years, in conducting a pilot Hospital-to-Home program at Altru Hospital during the summer of 2000. Most of the patients involved had multiple diagnoses such as COPD and a variety of cardiovascular problems, or had had a cardiac procedure such as CABG. The students functioned in leadership and primary care roles while their patient was hospitalized. They were able to observe what the patient and family were going through during and after a short but intense hospital stay. Patients loved the support and wanted it to continue. Thus, these rural nurses describe some ways to smooth the transition from hospital to home for rural residents.

Comments and questions should be directed to Bette_Ide@mail.und.nodak.edu.