Ontario Health atHome

Rapid Response Nursing (RRN) Program

Patient Information Sheet

Effective transitions between hospital and home are recognized as critical to achieving good outcomes for individuals and avoiding re-hospitalization. The RRN Program is committed to providing services that help to ensure your transition from hospital to home is successful.

Key Responsibilities of the Rapid Response Nurse (RRN)

Ontario Health atHome's RRN program is a dedicated team of Registered Nurses providing a variety of intensive in-home services to patients and their families. Patients with complex care needs and their families are professionally assisted to support smooth and safe transitions from hospital to home.

The RRN is responsible for:

- Confirming the patient's hospital discharge care plan including follow-up appointments
- Initiating communication with the patient's primary care provider, ensuring everyone has the necessary information for follow-up and continuing care
- Reviewing the patient's medications and helping them understand how to take them
- Helping the patient and their caregiver(s) to understand the care plan, treatments, how to manage symptoms and when/who to ask for help
- Identifying individuals requiring accelerated assessment by an Ontario Health atHome Care Coordinator

An RRN assessment serves as the foundation for the delivery of ongoing integrated care provided through Ontario Health atHome and it's service providers.

The RRN Program helps achieve positive outcomes for patients and assists with avoiding re-hospitalization, while promoting effective transitions between hospitals and home.

Philosophy Statement

Through our compassionate and collaborative approach to care, we believe in building connections, bridging gaps, and increasing health literacy for patients and their families as they transition from hospital to home.

Important Facts About Care Transitions

Increasingly, effective transitions between hospital and home are recognized as critical to achieving good outcomes for individuals and avoiding re-hospitalization

Research into care transition demonstrates that the risk of readmission to hospital, when people receive their first home care nursing visit within 24 hours of discharge, is significantly lower. Similarly, findings indicate post-discharge individuals who have a primary care visit within seven days from discharge have a significantly lower probability of readmission back to hospital

Who the RRN Program Serves:

The RRN Program accepts referrals for patients in hospital who:

- Live at home or in a retirement residence;
- Have multiple complex medical issues;
- Have multiple medications or changes in medication routine;
- Have difficulty with disease management; and
- Have a limited support network

To be referred to the RRN Program please speak to the hospital-based Ontario Health atHome Care Coordinator.

Hours of Service

7 days a week by appointment

For urgent situations outside of regular business hours call:

1. Your community agency nurse
2. Your physician
3. Ontario Health atHome Extended Hours Team

You can also call 911 or visit the emergency department of your local hospital.

Ontario Health atHome Central East Offices

- **Campbellford Branch**
  119 Isabella Street, Unit 7
  Campbellford ON K0L 1L0
  705-653-1005
- **Haliburton Branch**
  73 Victoria Street, Haliburton ON
  K0M 1S0 705-457-1600
- **Lindsay Branch**
  370 Kent Street West, Unit 11
  Lindsay ON K9V 6G8 705-324-9165
- **Peterborough Branch**
  700 Clonsilla Avenue, Suite 202
  Peterborough ON K9J 5Y3 705-743-2212
- **Port Hope Branch**
  151A Rose Glen Road, Port Hope ON
  L1A 3V6 905-885-6600
- **Scarborough Branch**
  100 Consilium Place, Suite 801
  Scarborough, ON M1H 3E3
  416-750-2444 / 416-701-4806 Chinese Line
- **Whitby Branch/Head Office**
  920 Champlain Court
  Whitby ON L1N 6K9
  905-430-3308

Your Rapid Response Nurse (RRN)

is _____

Who visited you on _____
(Date)

Toll-free: 1-800-263-3877