Ontario Health atHome

Rapid Response Nurses

Physician and Practitioner Fact Sheet

Ontario Health atHome Rapid Response Nurses (RRNs) provide complex patients with an intensive level of assessment to ensure medications are taken as instructed; follow-up doctors' visits are made and kept, and ongoing clinical assessments continue through constant monitoring for up to 30 days after leaving hospital or after referral from a community service agency.

Partnering for Better Patient Care

We partner with your existing care team and community support services to identify patients who may benefit from one-on-one, intensive care coordination that our RRNs can provide.

RRNs help patients by:

- Keeping at-risk adults and seniors at home by providing support and education to patients and their caregivers.
- Ensuring patients are confident that their discharge from hospital will be successful.
- Helping patients understand and participate in creating a health care plan that works for them.

Eligibility Criteria

Our highly skilled, experienced registered nurses support adults and seniors who have:

- Complex care needs
- Poorly managed chronic diseases such as COPD, CHF, diabetes, cardiac disease
- Multiple admissions to hospital, or frequent visits to emergency departments or urgent care
- Difficulty managing medications
- Fragile care support

Scope of Practice

- RRNs visit each patient in their home within 24–48 hours of discharge from hospital or referral from community service agencies. They complete a full assessment, assist with medication management and work with each patient to educate them about their specific health issues.
- The RRN assists the patient for up to 30 days to reduce the risk of readmission to hospital or avoidable emergency department visits.
- The average length of service is two to three visits.
- Before discharge, the RRN will connect the patient with community supports, such as clinics, that they require to help them in with ongoing disease management.

How do I refer a patient or speak to a patient's care coordinator?

- Call our team voicemall at: 519-883-5581
- Speak to a care coordinator in your hospital
- Fax in a home and community care service referral form to Ontario Health atHome at: 519-883-5555

Contact Information

If you have any questions regarding this service, please contact: **310-2222** • **ontariohealthathome.ca**