Innovative geriatric care: Integrating the Transitional Care Bridge Program in a new Co-Management Model for Frail Elderly

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Outline presentation

- Zuyderland MC and older frail patients
- From Consultation to Co-Management
- Content of the Co-Management program
- Transitional Care in practice

Zuyderland MC and Older Frail Patients I

photo: Rince De Jong & Zuyderland MC Sittard-Geleen

- Hospitals face more and more older AND frail patients:

patients ≥65 years are responsible for 40-50% of all patient days

- Zuyderland Medical Centre
- 2006: 22% ≥ 70 years
- 2015: 36% ≥ 70 years

- 40% of admitted patients ≥ 70

can be regarded as frail: (N=2350 / year)

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Zuyderland MC and Older Frail Patients II

Foto: Rince de Jong, Zuyderland MC, Sittard-Geleen

- Frail older patients are vulnerable for adverse events such as:
- Functional decline or hospital associated disability
- At risk of (partly preventable) complications as delirium, falls, malnutrition
- Longer length of stay
- At risk of Institutionalization

Hospital stay in itself may be a risk factor for adverse events!

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Experiences of older people and their caring family / friends during acute hospital stay

Pettigrew, 2006; Bridges et al 2010; Dewar 2013; Sivertsen 2012; Lowson et al , 2012; Clisset et al, 2013; Meide van der, 2015

- Admission often **stressful**
- Difficulty to keep **grip and contro**l over what happens
- Especially if **cognitive or communicational problems**
- Need for **privacy, personal space and possessions**
- To keep **contected with family and social network**
  - **Preservation identity / Participation decision making**
  - **Using experience/skills, competence of caring family**
  - **Caring family: experience of a change of position:**
  - **Being central before /no impact during hospital stay**

A new approach:

preservation Identity and Function central concepts

Foto; Truus Groen

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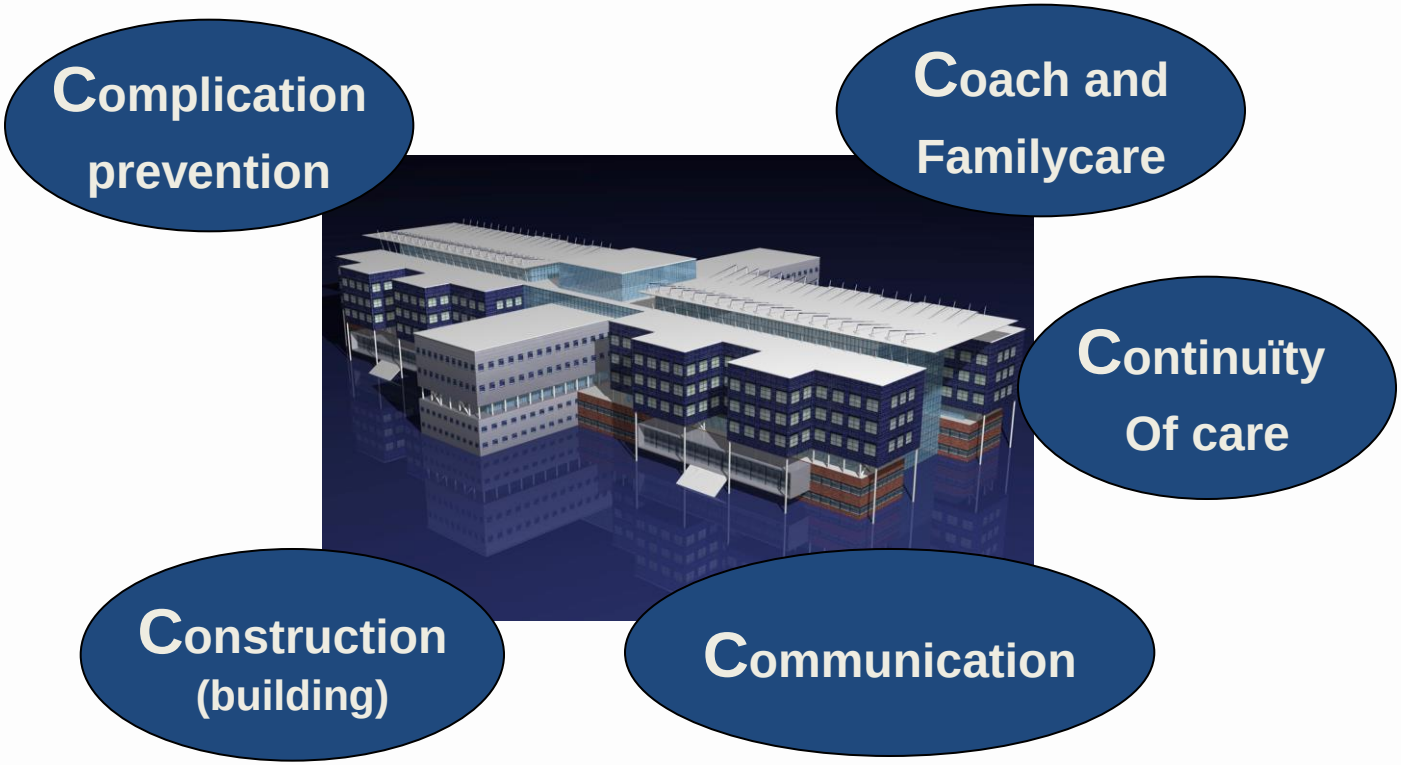
Ungoing development : integrating geriatric care model hospital and primary care

- Raak Program ‘Continuity of care for Frail Elderly’ 2008-2009 RAAK Award 2011
- NPO Program ‘ Zorg uit Voorzorg’ 2009 – 2014
- National Project Quality Mark Senior Friendly Hospitals 2011-
- Integrated 5-C model of Care (Habets, 2009)



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From Consultation to Co Management

(Winograd et al 1993, Deschodt et al, 2013)

- **Inpatient Geriatric Consultation Team**
- aims to share the core geriatric principles and multidisciplinary expertise to all medical staff and care teams and for all hospitalized persons with a geriatric profile who are admitted in not geriatric units.
- Non adherence to recommendations and lack of control to implementation inhibits effectiveness

- **Geriatric Co-Management**
- 'The most far reaching model of **shared care** between a general treating physician and a geriatrician. They **manage the patient together** from admission until discharge and are **both responsible** for the process and outcome of provided care' (Kammerlander 2010)

Comanagement program I

- **Objective;**

  To deliver effective, personalized geriatric care aimed at prevention of functional decline, prevention of medication mistakes and optimizing continuity of care to frail older patients admitted to Zuyderland MC
- **Target group**: older patients ≥ 70 years, frail profile + at risk complications (N=100)
- **Where:** Project on 3 wards : Internal Medicine, Lung Diseases, Surgery and primary care

Comanagement program II

- **Participants:** older patients, family, and professionals:

  Primary Care: General practitioner, primary care nurse or casemanager dementia and physiotherapist (with geriatric competencies)

  Zuyderland MC: Medical/Surgical staff, geriatric resource nurse and ward nurses, geriatrician, geriatric nurse, physiotherapist (with geriatric competencies), occupational therapist

- **Components:** Use of primary careplan at admission, comprehensive geriatric assessment, daily ward rounds en staff communication, participation in interdisciplinary team meetings, geriatric resource nurse, homevisit ≤ 48 hours, continuity of care after discharge

- **Design:** Before and After study

Ingredients of the program I

Nursing Assesment

- Within 24 hours after admission
- 70+
- Frail: Groningen Frailty Indicator (Frailty screening tool) ≥4 + ≥1 of the following risks (VMS):
- Falls
- Delirium
- Functional Decline

Detection of Frail Elders

- Daily, actual digital, hospitalbroad GFI / riskscores VMS
- Selection of patients

Comprehensive Geriatric Assessment

- Geriatric Nurse Geriatrician Physiotherapist
- **Goals patient**

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Ingredients of the program II

Information from primary care

- Telephone
- Future: digital
- Careplan/Priorities?

Systematic Medication Review

- Prevention Polyfarmacy
- Critical Review at admission and before discharge

Communicate with specialist / nurses ward

- **Daily rounds**
- **Participation in interdisciplinary Team Meetings**

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Samenvattingskaart Vallen

Risico

- Bent u in de afgelopen 6 maanden één of meerdere keren gevallen?
- Maakt u (of uw naaste) zich ongerust over het feit dat u wellicht zou kunnen vallen tijdens uw verblijf hier?
- Klinisch oordeel: heeft de patiënt een verhoogd valrisico?
- Minimaal éénmaal Ja: valrisico aanwezig
- Vragen in anamnese leiden tot overzicht risicofactoren (samenvattingstabblad)
- Arts neemt *anamnese SPLAT* af incl. z.n. aanvullend onderzoek

Preventie

- Meld valrisico aan arts
- Kies passende verpleegkundige preventieve interventies *(verpleegplan valpreventie)*
- Informeer patiënt en familie: verstrek *folder Valpreventie*
- Laat familie goed schoeisel meebrengen
- Icc fysiotherapeut o.v.v. 'valrisico'
- Icc VALTEAM: valincident als opname-indicatie, als er > 3 risicofactoren aanwezig zijn, bij een delirant beeld of cognitieve problematiek

Diagnose

- Diagnostiek m.b.t. valrisico / onderliggende oorzaak *(LINCFAL)*
- Diagnostiek m.b.t. valrisico en mobiliteit
- Noteer valrisico in medische voorgeschiedenis

Behandeling en begeleiding

- Multifactoriële behandeling
- Starten binnen 48 uur na opname en na 5 dagen evalueren
- Kies passende preventieve interventies *(verpleegplan valpreventie)*
- Kies specifieke interventies (infrarood, alarmmat in stoel)
- Arts start passende interventies *(MOBIEL)*

Nazorg

- Valrisico in ontslagbrief
- Verstrekkingenformulier ambulante paramedicus
- Evt. verwijzing Valpolikliniek
- Overdracht: informatie val(risico) en behandeling naar praktijkondersteuner, thuiszorgaanbieder, verzorgings- of verpleeghuis
- Overdracht met bewegings- en activiteitenadvies voor patiënt en familie
- Indien van toepassing overdracht

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Verpleegkundige preventieve interventies Vallen

Klinische factor	Preventieve Interventie
Duizeligheid / Hypotensie (DH)	• Transfer onder begeleiding (DH) • RR meten liggend, staand en na het eten (DH) • 1x per week evaluatie medicatie • Adviseer patiënt langzaam op te staan
Mictieproblemen (MC)	• Regelmatig ondersteuning bieden bij toiletgang (MC) • Maak gebruik van postoel naast het bed (MC) • Regelmatig bladderen (MC) • Analyseer toiletbehoefte (MC)
Mobiliteitsstoornis (MOB)	• Zorg voor stevig schoeisel (MOB) • Zet mob. hulpm. binnen handbereik (MOB) • Geef ondersteuning bij mobiliseren (MOB) • Schakel fysiotherapeut in (MOB)
Visusstoornis (V)	• Stimuleer gebruik van bril (v) • Zet benodigdheden binnen handbereik (V) • Zorg voor goede verlichting (V) • Positionering patiënt t.o.v. lichtbron (V) • Ondersteun bij mobiliseren (V) • Schakel evt. oogarts in (V)
Gehoorstoornis (G)	• Stimuleer gebruik gehoorapparaat (G) • Articuleer duidelijk (G) • Contact in gezichtsveld (G) • Inspectie gehoorgang, cerumen verwijderen (G)
Verwardheid (VW)	• Maak gebruik van infrarood (VW) • Bed laag zetten en tegen de muur plaatsen (VW) • Matras op de grond voor het bed leggen (VW) • Schakel naasten in (VW) • Centraal gelegen kamer (VW) • Verwijder gevaren uit de omgeving (VW) • Creëer een prikkelarme omgeving (VW) • Loop regelmatig even binnen (VW) • Geef onrustmedicatie op tijd (VW) • Geef dagstructuur (VW) • Fixatie als laatste redmiddel (VW)
Medicatie (MED)	• Inventariseer risicomedicatie (MED) • Attendeer arts op risicomedicatie (MED) • Wees alert op bijwerkingen (sufheid, stijfheid, verwardheid, duizeligheid) (MED)

Meer info? Zie: 'Kwetsbare ouderen in OMC' op intranet.

Ingredients of the program III

Geriatric Resource Nurse

- Overview Frail Elderly on ward
- Motivating colleagues/fine-tuning interventions
- Small scale projects on ward level to promote prevention functional decline and preservation identity and activating patients and facilitating family participation
- Early Mobilisation, wearing daily cloths, creating activating spaces, eating together, not in bed, rooming-in option for family

Intervention

- Mobilisation program (coordination physiotherapist specialized in geriatrics: personalised daily program and continued after discharge (8 wks)
- Nutritional program
- Evidence Based Interdisciplinary Protocols

Transition to home

- Preparation and central role of geriatric nurse
- Careplan: Goals patient AND geriatric AND specific medical
- Meeting with patient and family before discharge
- Communicating care plan with primary care professionals
- Home visit within 48 hours
- Handle over to nurse in primary care practice or casemanager dementia

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Follow up in primary care

- Primary care team:

  General practitioner,
- Nurse in primary care/ general practice OR
- Casemanager dementia
- Physiotherapist in primary care
- During 3 months after discharge: proactive visits (2,6,12 weeks) continuing individualized careplan

Final remarks;

- October 2016 – January 2017: implementing intervention
- Spring 2017: results

Important issues:

- Start co-management in hospital as early as possible
- Continuity of care: Integrate essential aspects of ongoing careplan general practice team in hospital care plan at admission
- Interprofessional team meetings: process /content can be improved

Overall so far:

intensive collaboration, learning/respecting expertise of each other, leading to small but important improvements in care

‘ In our hospitals, creating a cultural shift, shifting thinking involves changing people’s points of views, shifting their paradigms. More than one strategie is needed all the time. Small gains add up to big solutions’

Belinda Parke

Photo: An Sofie Kesteleyn

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