Guest Lecture

# Inter Disciplinary Management of Hospitalized Elderly

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Hospitalization poses a risk for altered functional status for geriatrics due to acute illness, decreased mobility, the negative effects of bed rest such as pressure ulcers, pain, dehydration and/or malnutrition, medication side effects, and associated hospital treatment measures such as invasive lines and catheters that limit mobility.

Research has shown that older adults who are admitted to a hospital have a much higher risk of hospital-related health issues such as falls, pressure ulcers, incontinence, delirium, and malnutrition.

Hospitalized elders with multiple and complex medical issues, requires comprehensive assessment and close attention by a well-coordinated treatment team. Furthermore, hospitalization for the frail elderly can pose a significant risk for a decline in general function.

The geriatric care requires the expertise of many professional disciplines- Physicians, nurses, pharmacists, social workers, therapists, dieticians, counsellors - and that those needs are best served by the professionals working together as a team.

This multidisciplinary model of care has been shown to significantly improve the clinical outcomes of hospitalized elderly patients, improve their functional status at discharge and reduce the rates of transfer to nursing homes.

The model based system generally manages to reduce the average hospital stay, complications, readmissions and mortality rates generated at geriatric units. In addition, these procedures have been shown to save costs to the health system.

Low levels of mobility and bed rest are common occurrences during hospitalization for older adults. Of great significance is that de conditioning and functional decline from baseline have been found to occur by day two of hospitalization in older patients.

The Acute Care for the Elderly (ACE) Unit, is specifically designed to address the needs of geriatrics and to prevent functional decline in acutely ill, hospitalized, community dwelling elders and assist them and their families with the transition back into the community.

Studies have shown that ACE units reduce the average length of a hospital stay, better preserve a patient's ability to function normally and increase patient and staff satisfaction.

Under ACE the 'whole' person and their unique circumstances are managed by a multidisciplinary team.

The team focuses on:

- Providing the right care at the right place at the right time
- Patient function
- Patient safety.

The ACE Model of Care has provided a range of benefits to patients, carers and staff at

- Improved journey for patients and carers.
- Improved performance in key areas including: reduced length of hospital stay; reduced access block; reduced readmission rates; and improved patient and staff satisfaction.
- Allows specialists to concentrate on their speciality area with the ACE team providing the holistic care, management of co-morbidities and discharge planning.

The American Academy of Nursing's Expert Panels on Acute and Critical Care, Aging and Quality Health Care developed a framework based on the theme: **Healthy Care Environments for Older Adults – Creating a Culture of Care**. Within this framework, eight specific goals identify ways to address prevention of functional decline and the promotion of a culture of caring. These goals include: (1) Promoting Recovery (2)

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Optimizing Reserve (3) Maximizing Safety (4) Supporting Independence (5) Upholding Dignity (6) Maintaining Vigilance (7) Cultivating Responsiveness (8) Improving Access.

Care coordination unites a team of providers to meet individual needs, improves health care access and outcomes, and synchronizes the variety of long-term services and supports. In these models, a care coordinator works closely with the individual, family caregivers, primary care provider, and other health care professionals to improve communication, resulting in improved individual well-being and outcomes.

Elements of care coordination models found to be effective in improving quality of care and coordination of social supports. When care coordination is team-based, interdisciplinary and maintains open communication, individuals feel most supported and quality of care improves.

In India, most hospitals do not have a special geriatric facility. At present most elderly patients are still being treated in general medical wards. Similarly the nursing and other para-medical staffs are not formally trained in providing care for elderly patients. However, a sense of awareness and urgency is beginning to come in both in Government and the private sector and hopefully such set ups will become a reality in the near future with the burgeoning increase in geriatric population in our country.

**Key Take home messages**

- With the population ageing and especially the rapid rise in the 'old-old' segment expected in the next few decades, health and social policy issues related to the care of older persons are posing an urgent challenge in most developed countries.
- While the care of all older people should be managed appropriately and effectively, the most vulnerable elderly often require fuller assessment and more intensive forms of care management.
- The important requirement of geriatric care management is to differentiate the level of case management response according to the need i.e. target appropriately, devolve of budgets, ensure continuity of case manager with service user involvement, and provide appropriate links with specialist health care expertise.

**References**


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