Nursing-Led Geriatric Interdisciplinary Team Pilot

Inpatient Medical Unit

Abstract Topic: Interdisciplinary Geriatric Clinical Quality Improvement Initiatives: Nurses at the Frontline Driving Results

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Introduction: The care of vulnerable, older adult inpatients is often fragmented and can result in unintended, costly consequences requiring higher levels of care, longer hospital stays, and readmissions. Our NICHE team was concerned with medication management, falls, malnutrition, delirium and dementia, so we reached out to key stakeholders to form an interdisciplinary team (IDT). Weekly meetings began as a pilot on two units where experts from several disciplines shared evidence-based protocols targeting the unique needs of select geriatric patients. As a team, we saw positive results in our goal to educate, build awareness, and commit to delivering better outcomes in our older adult population.

Needs Assessment Results:

- 75% of patients admitted to two complex Medical Surgical and Pulmonary Units are aged 65+
- 4-5 days increased lengths of stay/per admission
- High patient falll rates in identified Medical Surgical and Pulmonary Units

Implementation Steps:

1. Implement IDT on units with at least 60% of patients ≥ 65 years of age
2. Identify and assemble interdisciplinary team
    a. Pharmacy, Nursing, Case Management, Rehab Representative, Dietitian, Geriatrician or Geriatric Provider/NP/RN, NICHE Coordinator, Chaplain, Wound Care Nurse, Internal Medicine Physician, Patient Care Technician
    b. Inform and include management who these disciplines report to
3. Locate an accessible area to meet that does not interfere with patient care
4. Schedule weekly or bi-weekly meetings
5. Select the patients to be reviewed at the meeting at least one day prior the meeting
    a. Notify the disciplines involved through email or the Electronic Medical Record (EMR)
6. Plan, as a group, on interventions to place in the electronic medical record (EMR) for acceptance by providers

Barriers:

- Inconsistent attendance from internal medicine physician and social work attendance
- Shorter lengths of stay for some patients prevent adequate IDT communication, planning, and intervention
- Hesitance to adjust medications prescribed by other physicians
- Inconsistent attendance by direct care nurses due to competing patient care priorities

Results:

- 60% physician acceptance of pharmacy recommendation for medication adjustments
- During 2016, we reviewed 750 patients and made 400 recommendations to improve the quality of patient care.
    - Recommendations include but were not limited to medication adjustment, physical therapy evaluation orders, and dietary recommendations.
- 90% increased referrals to chaplain or support services for seniors
- 10% reduction in falls since pilot implementation (2015-2017)
- Decreased length of stay through interdisciplinary collaboration
- Began as a pilot and is now adopted as an initiative for the unit
- Increased nursing geriatric knowledge and communication skills (Pre/Post GIAP)

NICHE Interdisciplinary Team

Patient Review 2016

Ms. Jackson's Case Study

Ms. Jackson is a 65 year old female who presented to the hospital by Emergency Medical Services (EMS) with pain "all over" and altered mental status. The patient reported she moved a lamp three days ago and has since been in severe pain. She is oriented only to name, with no family present at the bedside. Ms. Jackson is unable to provide any medical history. She did state she has been off her psychotropic meds for months, because of her inability to pay for them. Ms. Jackson was found to have a thoracic spine epidural abscess, septic arthritis, complicated by Clostridium Difficile infections, renal failure, and septic shock.

Barriers to Wellness and Discharge

- Non-funded patient and unable to discharge to a Long Term Acute Care (LTAC) Facility or Skilled Nursing Facility (SNF)
- Complicated medical course requiring extended antibiotic therapy
- Psychological concerns - decreased motivation and increased need for pain medications / behaviors
- Impulsiveness and frequent attention-seeking behaviors
- Urinary retention resulting in catheterization
- Poor intake, prefers to drink only Coke (severe protein calorie malnutrition)
- Depression and history of mental illness
- Polypharmacy - multiple psychotropic medications on regimen: Lithium toxicity (Bipolar history); increased use of intravenous (IV) pain medication; refusal of oral pain meds
- Inability to walk despite multiple physical therapy (PT) sessions
- Severe infections requiring isolation in room for eight months (duration of admission)
- Lost apartment while hospitalized as inpatient and became homeless upon discharge
- Spent Thanksgiving, Christmas, New Year's, and her birthday in the hospital
- Adult children in jail and estranged from the patient

Ms. Jackson's Case Study Interventions

Pharmacy-worked with physician to order a long-acting pain medication and address drug-abuse history. IV pain medication no longer needed, patient less drowsy and able to perform in therapy.

Dietary-educated on proper diet, allowed patient to personally order food, as options became mundane. Maintained adequate nutrition, preventing need for non-oral nutrition.

Rehabilitation Services–encouraged efforts to mobilize at least twice daily: set goal allowing patient to leave room and leave the hospital for fresh air.

Pastoral Care-made daily visits to the patient and prayed, as the patient was depressed and alone due to isolation precautions and no family presence.

Geriatric NP-visited with patient, discussed plan of care, needs, and provided psychosocial support

NICHE Coordinator-arranged gift package for the holidays and weekly perks, as the pt was homeless. Visited the patient with NP, and geriatric ambassador, weekly.

Nursing-moved patient closer to nurse's station and provided frequent support. Rotated nursing staff to prevent burn out.

WOCN - educated on impact of dietary intake on bladder irritation and retention, encouraged bladder diary and voiding trials, ultimately patient able to void independently.

Case Management assisted patient in obtaining Medicaid, found patient a SNF, ensured a seamless transition to the outpatient setting. Also assisted in state funding for home assistance, after discharge.

Clinical Nurse Leader-worked with team to identify barriers for discharge needs.

Psychiatry-received referral for medication management. Provided competency/capacity evaluations for decision-making capability.

Palliative Care/Hospice-placed on Hospice Services in a "charity bed." Improved, was sent to SNF, and now lives well in an apartment with her children.

Interdisciplinary Team Intervention Worksheet

Discipline: _____ **Date:** _____

	Problem	Intervention
Patient Name		
Patient Name		

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1. Disciplines receive notification of selected geriatric patients - a minimum of one day before the IDT meeting
2. Disciplines review selected patient's electronic medical record (EMR) for problems or barriers that may complicate or increase the patient's hospital length of stay (deconditioning, poor appetite, polypharmacy or potentially inappropriate medications for seniors, cognitive impairment, etc.) and record on this worksheet
3. The Geriatric Nurse Practitioner or Team Lead records recommendations in the EMR