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Acute Care of the Elderly Column




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Reorienting ourselves to the reality of hospitalization

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"Hey, how's it going?"

"Good night?"

"Mmmm, steady busy - we got three admissions from the E.D. since 2 am - all of them are old and pretty sick."

"Let me go get ready and I'll meet you back here for report. We can go in together and you can introduce me to them and their families before I see our other patients."

Many hospital shifts begin with this sort of exchange, nurses feeling calm and aiming to set a pace for a good day for them and the patients in their care. Inpatient nursing care for older patients is intense, often more complex than for younger patients. Pressed hospital timelines add to that complexity and intensity. The pace of hospitalization often makes fully empathizing with what hospitalization represents for our patients difficult.

Our older patients and their loved ones feel far less calm, trying to exert some sort of control if they are able. Most often, though, acutely or critically ill elders wheel up to an unfamiliar place, surrounded by people they do not know, telling them things they are likely unable to process from delirium or other cognitive concerns.[1,2] Our older patients are more likely to think and sometimes say "where am I?", "what is going to happen to me?" and "will I ever be able to go home again?".

Our responses to our patients' questions are predicated on compassion but are generally predictable: 'you are in the hospital', 'we are going to take care of you', and 'let's see how you do' or some phrases to that effect. Having been here before with other ill elders, we gain a strong sense of patterns by which their hospitalization is likely to progress. Returning home feels like a hope rather than a goal, given increasing reliance on skilled nursing facilities (SNF) as a halfway point in acute care transitions.[3,4] The meaning of hospitalization for the individual is easily lost while processes put in place to expedite discharge take precedence. Two interconnected realities drive a wedge between our patients' goals and our efforts to help them attain those goals.

The first reality is that hospitalization often represents a crisis for the older person, for family, and even for our healthcare system. The rising attention to hospital readmission rates is testament to the seriousness with which clinicians, scientists, and policy makers all scrutinize hospitalization today. For many elders, especially those with chronic conditions and clinically advanced disease, hospitalization may occur when support at home is insufficient to meet their needs as well as when their medical condition worsens. More fully attending to that sense of crisis enables us as nurses to advance our care for acutely and critically ill elders.

The second reality is that social support and resources appear key in preventing hospital admission. Evidence suggests social factors distinguish those who are able to avoid hospitalizations from those who incur readmissions.[5] Yet social assessment and referrals for social care remains optional instead of being a mandatory element in any hospital admission. Healthcare views medical care alone as necessary. Hospitals offer those patients with clear needs a range of supportive, rehabilitative, and palliative services. The result disconnects medical care from the other domains of care, effectively creating two separate systems of care that may – or may not – intersect in the plan of care for individual patients. However, if social support and resources play an important role in avoiding hospitalization and keeping people at home, then these separate systems of care require integration. We, as nurses, possess power and skills to begin that integration right from the bedside.

Framing our interactions with older patients and their loved ones with an understanding of the crisis of hospitalization in mind enables us to act accordingly. Acknowledging the crisis in our own minds allows for adjustment in care patterns. For example, when we expect rather than react to delirium, as a common element of many acute

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care admissions, our care becomes proactive. We adjust patient and family education and medication reconciliation with referrals for Medicare homecare and continuing care from a nurse. We similarly request physical and occupational therapy along with pharmacy and social work consultation at admission.

Proactive referrals and consultations aimed at managing the crisis of hospitalization link directly to back to social support and resources. Enacting supportive, rehabilitative, and palliative care as integral to effective care for our older patients creates integration from the ground – or bedside – up. When we see hospitalization for the crisis it is, resulting at least in part from social and other concerns at home, we avoid the disconnection of using different triggers and instead pursue comprehensive interdisciplinary care for our patients. The premise of healthcare becomes medical need mandating some plan for individualized supportive, rehabilitative, and palliative care using proactive referrals instead of specific justification.

Making supportive, rehabilitative, and palliative care consultation and home care referrals routine for all patients is generally thought financial insupportable, clinically unfeasible, and managerially daunting. That view relies on short-term accounting, while losing sight of potential long-term costs, and prioritizing a system-centered over a person-centered approach. Success in achieving this goal and creating integrated social and healthcare relies on finding a starting point supported by evidence and corollary clinical success. For example, ambulatory programs serving an older population face a similar challenge in providing comprehensive geriatric assessment to all of their patients. Many programs are finding the ways and means to achieve this necessary element in their services lines despite limited human and other resources. They reshape care, use screening tools, and create interdisciplinary teams to make care processes more effective and satisfying for patients and families. Most paths to that sort of clinical success begin with a shift in the philosophy of care. The current trend in philosophies of care moves from the subspecialist thinking of geriatric models to age-friendly care.[6] The crossover from ambulatory to acute care is clear. The philosophical shift to make care age-friendly facilitates integrated social and healthcare protocols.[7,8] It also makes those protocols easier to design, implement, and evaluate

Frailty screening along with interdisciplinary models of care, sometimes now referred to as bundled care; provide concrete means to achieve more age-friendly care. Frailty screening and bundled care become tools to help put the four M's – what Matters, Mentation, Medications, and Mobility – into practice.[7] As an example, screening for frailty allows for better identification of those in need of comprehensive geriatric assessment and subsequent intervention within ambulatory care. Care coordination by nurses in navigator or similar roles shows real promise in process and outcomes metrics.[9,10] Moreover, using a bundled care approach to nurse-led interdisciplinary care coordination enables a group of age-friendly 'first responders' to lead proactive assessment and intervention. An age-friendly team of a social worker, a physical therapist, and a gerontological practice nurse offers complementary expertise in completing initial assessments and follow-up.

Advancing age-friendly care on our units as a way of mitigating the crisis hospitalization represents for some many of our patients need not wait for large-scale institutional initiatives. My favorite nursing strategies to change the reality of hospitalization include:

- Advocating for including frailty screening as part of nursing admission assessment. The choice of instrument requires some deliberation, as does the use of surrogate respondents.[11] Nonetheless, benefits are well worth these efforts. Several frailty-screening tools, congruent with inpatient nursing practice, are available and substantiated by good quality evidence.
- Making consultations for social work, nutrition, pharmacy, and physical therapy and referrals for home care routine for all at risk older patients (e.g. those who screen positive for frailty). Shifting your thinking from 'why is this consultation or referral necessary for this patient?' to 'is there any reason why we should not request this consultation or make this referral for this patient?' makes this practice easier to achieve. Importantly, moving from an 'opt in' approach to an 'opt out' approach avoids missed opportunities to support older patients and their loved ones.
- Asking colleagues in supportive, rehabilitative, and palliative care services to generate shared studies of quality and quality improvement projects in age-friendly care. Your unit council, if you practice in a Magnet facility, is generally the right group to lead such projects. Examining screening criteria, timely referrals, and patient experience to support early efforts and integrating nurse-sensitive indicators as part of person-centered approaches are good places to start.
- Finally, establishing ongoing dialogue with your nurse leadership team generates momentum for institutional investment in age-friendly care. Age-friendly care, and structures and processes to provide that care, are the contemporary way to overcome the crisis of hospitalization and integrate social factors into truly comprehensive care for older patients.

Challenging times lie ahead as hospitals and healthcare systems work to realign mission, vision, and operations to meet health and social needs in our aging society. As nurses, we can offer leadership from the bedside, reflecting the realities of hospitalization for our older patients and showing a better way forward through age-friendly care.

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