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Optimal Care for Elderly in Transition...Lessons Learned

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Introduction

The elderly population in the Netherlands is expected to increase from 2.5 million in 2010 to 4.1 million in 2030. Of these, a quarter is frail. Since the proportion of older elderly is expected to increase more dramatically from 2025 onwards, demographic analyses predict that the number of frail elderly will increase more rapidly than the number of elderly of 65 years and over. In 2030 we expect to have just over 1,000,000 frail elderly [1].

The rapidly ageing population with associated complex care requirements-in combination with the nationwide cutbacks-provide a challenge for organizing elderly care effectively and efficiently. In addition, there are too few dedicated teams and limited interdisciplinary collaboration. This situation leads to unfavourable outcomes for the frail elderly and their care givers, as demonstrated in the disappointing results of the National Care for the Elderly Program (cost 80 million Euro). Although the program aimed at 'coherent care provision that is better suited to the individual needs of the elderly', outstanding positive results were lacking.

Prevention and Reactivation Care Program

I was involved in the process evaluation of the Prevention and Reactivation Care Program, which was one of the programs within the National Care for the Elderly Program. The particular program is an intervention aimed at reducing hospital related functional decline among elderly patients by offering evidence based intervention components that are multidisciplinary, integrated and goal-oriented. Given that just over a quarter of the hospital patients is 70 years and older, the hospital plays an important role in the treatment and care for the elderly [2]. However, as a result of hospital admission, 35% of this group experiences functional decline in comparison with the situation before the illness. This percentage increases dramatically with age [3,4]. Functional decline, also as a result of hospital admission, and frailty go hand in hand, and is defined as a new loss of independence in self-care activities or as deterioration in self-care skills, measured on an activities of daily living scale (such as bathing, dressing, transferring from bed to chair, using the toilet) and on an instrumental activities of daily living scale (such as shopping, housekeeping, and preparing meals).

Taking a closer look at the performance of the Prevention and Reactivation Care Program, we observed and measured low intervention fidelity. In this case, a year into the implementation of the intervention, only 50% of the components were delivered. Also, other projects within the national program, both in primary care and in hospitals demonstrate low intervention fidelity and minor positive results [5-9].

Intervention Fidelity

First of all, what is intervention fidelity? In outcome research intervention fidelity, has been described as the confirmation that the manipulation of the independent variable occurred as planned. In other words, the work was done as planned. Or doing the right things right! Intervention fidelity enables researchers to determine how adequately a program has been implemented; it also enables researchers to assess conformity with prescribed components and absence of non-prescribed components; and intervention fidelity enables researchers to provide assurances to policy-makers that services are being implemented as intended and are reaching the target audience. Without documentation or measurement of adherence to the intended intervention, it is impossible to determine whether unsuccessful outcomes reflect failure of the intervention or failure to implement the intervention as intended, or even the influence of moderating factors. Yet, intervention fidelity is seldom measured in geriatric health services research.

Intervention fidelity has two core components: protocol adherence and competence. Adherence is the most basic and entails the extent to which the interventionists' behaviour conforms to the intervention protocol in terms of content, frequency and duration. The competence component is more complex and focuses on the interventionist's skillfulness in the delivery of the intervention.

Mechanisms causing low intervention fidelity

The literature shows us that intervention fidelity issues are caused by various factors. In the Prevention and Reactivation Care Program, the absence and unavailability of a detailed protocol was considered to be one of the factors contributing to the low intervention fidelity. How can we expect that professionals implement a new way of treating and caring for the frail elderly without a proper protocol available? Organizational constraints and the rapid patient flow resulted in the fact that the essential component 'Medication use review by pharmacist' was not executed. Furthermore, the insufficient planning of the multidisciplinary meetings resulted in delayed presentation, discussion and treatment of newly admitted patients [10].

Apparently, it is not easy to realize care for our frail elderly in hospitals. Yet, it is not that professionals don't want to care for the elderly appropriately. On the contrary, within the research context the professionals were performing at their best level. Yet, it is the lack of skills and knowledge that caused the inability to provide adequate geriatric care. In the Dutch language, this concept is called 'Handelingsverlegenheid' or performance apprehensiveness.

The ineffective implementation obviously played a major role in the low intervention fidelity of the Prevention and Reactivation Care Program. The results of three other projects within the National Care for the Elderly Program, in the clinical setting as well as in primary

care, also demonstrate that multidisciplinary 'evidence based' interventions for frail elderly were executed with limited intervention fidelity and few minor positive effects. In general, these results are caused by various factors, including the complexity of the intervention and limited attention for the implementation. These results are frustrating for the care professionals, as we have observed during the interviews with care professionals, who worked in these projects.

Both professionals and the elderly experience three main causes for the limited intervention fidelity and the few positive results from multidisciplinary interventions for the frail elderly:

1. Professionals (doctors, nurses and allied health professionals) have difficulty in executing multidisciplinary interventions for frail elderly and their informal care givers in a structured and effective way. In daily practice, multidisciplinary team meetings and the resulting interventions take place in an random fashion with relatively low continuity of team members. As a result, the required patient information is often not or only partly available. Professionals point out that they don't realize to what extent continuity of care and collaboration between involved professionals determine the effective implementation of indicated interventions.
2. Professionals experience a high level of performance apprehensiveness and indicate to have problems with multidisciplinary collaboration, since tasks and responsibilities are insufficiently defined.

In their work with frail elderly patients professionals are confronted with complex and unpredictable problems, for which they feel insufficiently equipped. Professionals realize that they do not have acquired the core competences to effectively care for this high-risk population. In particular nurses explicitly express the need for education and Inter-Vision.

These factors were observed both in primary care and in the hospital with transitions, such as admission and discharge, as particular challenging moments. These factors may explain the low intervention fidelity and few positive results from the national research projects, such as the fact that on average only 50% of the indicated interventions for the frail elderly were executed [10]. Obviously, low intervention fidelity contributes negatively to the quality of care for this vulnerable group of patients.

Another concern is that hospital directors as well as managers, have increasingly less expertise in the field of geriatric care and treatment, resulting in lack of control in both the content and the implementation. This becomes a problem when new interventions require adequate implementation.

Consequences of ineffective geriatric care

So, what are the consequences of ineffective care for the elderly? We found that ineffective care has serious consequences for both clients and informal care givers. For example, the lack of a care plan, as a consequence of the delayed identification of the frail elderly results in gaps and overlaps in the care and to failing decision making with regard to treatment or no treatment. Or it leads to a delayed consultation of the physiotherapist or the occupational therapist, insufficient information at the handover and discharge. Finally, ineffective chain care leads to increased burden for informal caregivers or care givers left in the dark about their relative's care situation.

Professional education…. the key to success?

Lecturers as well as teachers and students affiliated with health care universities experience a lack of knowledge and experience in the field of geriatric care. They indicate that the content of current medical and nursing curricula lack specific content and expertise with regard to the frail elderly. Also, multidisciplinary collaboration skills are usually not taught in these programs. They acknowledge and agree that there is a need for innovative education in the field of geriatric care with regard to content as well as training for teachers.

National research into Nursing programs in the Netherlands presented similar conclusions. In particular, there appears to be knowledge gap in the area of essential care aspects for frail elderly, multi morbidity and multi-function problems, identification of the frail elderly and shared decision making [11,12]. In addition, there is a lack of motivated teachers and role models in the geriatric field, and Dutch schools of Nursing do not offer Geriatrics as a standalone subject within the Nursing curricula, as in other countries, such as the United States, Sweden and Belgium. Also, international studies into the geriatric content of Nursing education point out that that students lack motivation and knowledge with regard to geriatric care [13-16]. As a result, professionals are not adequately prepared and equipped for the care for the elderly in the future, despite the evident demographic transition.

These factors add up to an inadequate base for sustainable quality of geriatric care, regardless of the amount of love, warmth and energy care professionals put into their work. Fortunately, there is plenty of the latter, yet it masks the fundamental inadequacies, which we would not accept in, for example children's health care. Irrespective of the type of program, the optimal implementation requires adequate professionals with dedicated knowledge, skills and attitude, in order to provide the right care with 100% intervention fidelity.

Optimal care for frail elderly through improved education

Education should be expanded with gerontological and geriatric content. More specifically, gerontology and geriatrics should be taught as stand alone subjects, such as the case is with for example pediatrics. In addition, the education system should invest in more and improved teaching materials, and in role models/ambassadors in nursing schools and trainee units [12,13,17].

Reports from the Dutch Health Care Inspectorate also recommend more educated professionals. Unfortunately, health care providing organizations are not keen to spend their valuable resources on educating their staff. In the Rotterdam region for example, a dedicated post-Bachelor program in geriatric care had to be cancelled in 2014 due to a lack of post-Bachelor students working in elderly care. Nevertheless, a subsequent quick scan among regional providers of geriatric care clearly revealed the need for acquiring in-depth knowledge in the field of geriatric care. Given these results, we are restarting this program in 2017, but now for nurses on both level 4 and 5.

But there is more good news: The national Bachelor of Nursing 2020 education profile, including the CanMEDS roles and competences, has specific attention for the elderly patient and his care requirements. As a result, the Dutch Schools of Nursing are currently reviewing and updating their curricula to match the Bachelor of Nursing 2020 profile.

Finally, the national campaign 'There is more to it than meets the eye' is very successful in promoting working in elderly care by

showcasing ambassadors and role models by bloggers and vloggers. There is even a Facebook page, which is extremely popular given the number of followers.

Conclusion

The effective implementation and evaluation of interdisciplinary programs for the elderly require professionals, who are demonstrably trained and equipped in order to ensure evidence based practice with regard to the essential care aspects for the frail elderly in transition.

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