Objectives

- Review the recommended baccalaureate competencies and curricular guidelines for the nursing care of older adults
- Provide two exemplars for integrating these competencies into nursing curriculum

Supplement

- Combined effort of the American Association of Colleges of Nursing and New York University College of Nursing
- Supplement to *The Essentials of Baccalaureate Education for Professional Nursing Practice*

Background

- Older adults are a majority – and growing proportion of people who receive nursing care
- Health status is diverse
- The focus is to maintain independence associated with functional decline and illness through health promotion
- Despite numerous efforts, the number of geriatric nurses remains very small

Background

- The majority of nurses practicing are, by default, geriatric nurses
- The field of geriatrics/gerontology has a recognized body of literature on care of older adults
- *The Essentials* provides a framework for developing, defining, and revising baccalaureate nursing curricula

Background

- The supplement provides a facilitates integration of geriatric content into curriculum
- It provides:
  - Gerontological nursing competency statements necessary for nurses to provide high-quality care to older adults
  - Divides the 19 gerontological nursing competency statements into the nine Essentials
The 19 Gerontological Nursing Competency Statements

- Incorporate professional attitudes, values, and expectations about physical and mental aging in the provision of patient-centered care for older adults and their families (Essentials VIII)
- Assess barrier for older adults in receiving, understanding, and giving of information (Essentials IV & IX)
- Use valid and reliable assessment tools to guide nursing practice in the care of older adults (Essentials IX)

Competency Statements Continued

- Assess the living environment as it relates to functional, physical, cognitive, psychological, and social needs of older adults (Essentials IX)
- Intervene to assist older adults and their support network to achieve personal goals, based on the analysis of the living environment and availability of community resources (Essentials VIII)
- Identify actual or potential mistreatment (physical, mental, or financial and/or self neglect) in older adults and refer appropriately (Essentials VII)

Essential Statements Continued

- Implement strategies and use online guidelines to prevent and/or identify and manage geriatric syndromes (Essentials IV & IX)
- Recognize and respect the variations of care, then increased complexity, and the increased use of healthcare resources inherent in the care of older adults (Essentials IV & IX)
- Recognize and respect the complex interactions of acute and chronic co-morbid physical and mental conditions and associated treatments common in older adults (Essentials IV & IX)

Essentials Statements Continued

- Compare models of care that promote safe, quality physical and mental health care for older adults such as PACE, NICHE, Guided Care, Culture Change, and Transitional Care Models (Essentials II)
- Facilitate ethical, non-coercive decision making by older adults and/or families/caregivers for maintaining everyday living, receiving treatment, initiating advanced directives, and implementing end-of-life care (Essentials VIII)

Essentials Statements Continued

- Promote adherence to the evidence-based practice of providing restraint-free care (both physical and chemical) (Essentials II)
- Integrate leadership and communication techniques that foster discussion and reflection on the extent to which diversity (among healthcare professionals) has the potential to impact care of older adults (Essentials VI)

Essentials Statement Continued

- Facilitate safe and effective transitions across levels of care, including acute, community-based, and LTC for older adults and their families (Essentials IV & IX)
- Plan patient-centered care with consideration for mental and physical health and well being of informal and formal caregivers of older adults (Essentials IX)
- Advocate for timely and appropriate and hospice care for older adults with physical and cognitive impairment (Essentials IX)
Essentials Statements Continued

- Implement and monitor strategies to prevent risk and promote quality and safety (e.g. falls, medication mismanagement, pressure ulcers) in the nursing care of older adults with physical and cognitive needs (Essentials II and IV)
- Utilize resources/programs to promote functional, physical, and mental wellness in older adults (Essentials VII)

Where to begin?

- Essential II: Basic organizational and systems leadership for quality care and patient safety
  - (10) Compare models of care that promote safe, quality physical and mental health care for older adults such as PACE, NICHE, Guided Care, Cultural Change, and Transitional Care Models
  - (17) Implement and monitor strategies to prevent risk and promote quality and safety (e.g. falls, medication mismanagement, pressure ulcers) in the nursing care of older adults with physical and cognitive needs

NICHE

- Nurses Improving Care for Healthsystems Elders
  - National program designed to help hospitals improve the care of older adults
  - Extensive resources and tools
  - Models to incorporate change

NICHE

- [http://www.nicheprogram.org/](http://www.nicheprogram.org/)
- NICHE is a component of a larger program
  - [http://www.hartfordign.org/](http://www.hartfordign.org/)
  - More resources
    - [http://consultgerirn.org/](http://consultgerirn.org/)
    - [http://consultgerirn.org/resources](http://consultgerirn.org/resources)
    - [http://www.hartfordign.org/education/webinars/](http://www.hartfordign.org/education/webinars/)

Try This series

- Fulmer SPICES Tool
  - [http://consultgerirn.org/resources/media/?vid_id=4200873#player_container](http://consultgerirn.org/resources/media/?vid_id=4200873#player_container)
OPTIMAL TRANSITIONAL CARE

- Entails a broad range of time-limited services designed to coordinate and continue health care as patients transfer:
  - Between different locations
  - Between different levels of care
- Contains elements of care coordination, discharge planning, and disease or case management
- Focuses on highly vulnerable and chronically ill populations

COMPONENTS OF OPTIMAL TRANSITIONAL CARE

(1 of 2)

- Accurate and timely transfer of information to the next set of providers
- Empowerment of the older adult to assert his or her preferences
- Comprehensive assessments of older adult and caregiver needs
- Comprehensive medication review and management
- Logistical arrangements related to executing the transition

COMPONENTS OF OPTIMAL TRANSITIONAL CARE

(2 of 2)

- Education to prepare older adults and caregivers for what to expect at the next site of care
- Support for self-management of medical conditions
- Coordination among medical and community resources
- Follow-up and support after discharge

3 STEPS TO IMPROVE TRANSITIONS

1. **Set expectations** for both the sending and receiving provider teams
   - The National Transitions of Care Coalition recommends shifting from the concept of “discharge” to that of “transfer with continuous management”

2. **Tailor communication strategies** to the type of information being communicated and the type of transition

3. **Target specific processes or outcomes** for improvement, using established QI methods
   - Begin by focusing on 1 or 2 measures, then expand once initial goals are achieved

STEP 1. SET EXPECTATIONS

- Based on the information available at admission, what needs will this older adult have after transfer?
- What are the patient’s and caregiver’s preferences?
- How will the patient care for himself or herself after transfer?
- What other clinicians need to evaluate the older adult to formulate an effective care plan?
- Do the older adult and caregiver understand the purpose of the transfer and what to expect at the next site of care?
- Has the next site of care received, understood, and clarified discrepancies about the care plan?

STEP 2. TAILOR COMMUNICATION

- What is the most relevant information about this older adult’s current episode of illness to communicate to the next site of care?
- How should this information be communicated?
  - **Electronically** — for notification of admission, discharge, or nonurgent issues
  - **Verbally** — for situations of urgency or uncertainty, or those with complex social dynamics
  - **In writing** — for information that must be a part of the medical record or used as a reference by the older adult, caregiver, or clinician
- Should the information also be given directly to the older adult and caregiver?
STEP 3. SELECT QI MEASURE

Examples:
• Communication with PCP before older adult’s transfer
• Medication reconciliation at the time of transfer
• Older adult’s, caregiver’s, or receiving clinician’s satisfaction with the quality of the transition
• Timeliness of arrival of transfer summaries
• Inclusion of various components in transfer summaries (eg, documentation of cognitive and functional status)
• Ease of scheduling follow-up appointments
• Frequency of health care usage after transfer

Transitional Care


Further Resource

• http://www.aacn.nche.edu/geriatric-nursing/gnec
  — Geriatric Nursing Education Consortium

Questions