LA DIMISSIONE OSPEDALIERA "RITARDATA":

Complicanze intraospedaliere e criticità gestionali

5-6 Ottobre 2017

IX EDIZIONE

Giornate Mediche di anta Maria Nuova 2017

L'Ospedale dei Fiorentini

CURE INTERMEDIE, UN BISOGNO CRESCENTE?

Dr. Enrico Benvenuti

REGIONE TOSCANA
UFFICI REGIONALI GIUNTA REGIONALE

ESTRATTO DAL VERBALE DELLA SEDUTA DEL 07-08-2017 *(punto N 65)*

Delibera *N 909* *del 07-08-2017*

CURE INTERMEDIE:

comprende una gamma di servizi integrati, rivolti per lo più alle **persone anziane**, per **supportare la dimissione tempestiva**, favorire il recupero dopo un evento acuto o riacutizzato, **evitare ricoveri ospedalieri inappropriati** e ridurre l'utilizzo della lungodegenza e dell'istituzionalizzazione.

Sono prevalentemente servizi:

- a breve termine,
- erogati in un ambiente residenziale,

Maximising Recovery, Promoting Independence:

An Intermediate Care Framework for Scotland

The Scottish Government

The **Reshaping care for Older People programme's** public engagements collected clear messages about what people want for their future care.

REGIONE TOSCANA

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ESTRATTO DAL VERBALE DELLA SEDUTA DEL 07-08-2017 *(punto N 65)*

Delibera *N 909* *del 07-08-2017*

OBIETTIVI:

- garantire alla persona fragile o anziana una **presa in carico sanitaria** nella fase di dimissione ospedaliera a seguito di evento acuto, tenendo conto dell'evoluzione della malattia e della necessità di coordinare gli interventi sanitari e assistenziali per il rientro al proprio domicilio;
- assicurare a livello di ogni singola zona **l'appropriata risposta clinico – assistenziale in continuità** con il livello di ricovero ospedaliero, e in **forma integrata** con le **risorse territoriali**;
- attivare un modello di **transitional care** attraverso la condivisione della pianificazione clinico assistenziale e la responsabilizzazione del MMG;

REGIONE TOSCANA

UFFICI REGIONALI GIUNTA REGIONALE

ESTRATTO DAL VERBALE DELLA SEDUTA DEL 07-08-2017 *(punto N 65)*

ALLEGATO B - TABELLA RIEPILOGATIVA SETTING CURE INTERMEDIE RESIDENZIALI

Definizione setting	*Tipologia bisogno del paziente*	*Criterio accesso*	*Intensità assistenziale*	*Interventi/attività erogati*	*Assistenza Medica*	*Durata degenza*	*Tariffa giornaliera*	*N° min p.l. per modulo*	*Riferimenti normativi regionali*
LOW CARE	Assistenziale Clinico	Alto rischio instabilità clinica NEWS 3-4	Alta intensità di tipo residenziale	Assistenza clinica Assistenza infermieristica Riattivazione / Riabilitazione estensiva	Medico di struttura	Max 20 gg	€ 154,00 comprensiva di prestazioni specialistiche e terapia farmacologica	8	Regolamento 79/R DPGR del 17/11/16, allegato A, strutture D. 6 Strutture residenziali destinate ad accogliere i pazienti nella fase post-acuta alla dimissione ospedaliera
RESIDENZIALITA' SANITARIA INTERMEDIA	Assistenziale Clinico	Basso rischio instabilità clinica NEWS 2-3	Media intensità di tipo residenziale	Assistenza clinica Assistenza infermieristica Riattivazione / Riabilitazione estensiva	Medico specialista di struttura in stretto raccordo con la medicina generale	Max 20 gg	€ 132,00 comprensiva di prestazioni specialistiche e terapia farmacologica	8	Regolamento 79/R DPGR del 17/11/16, allegato A strutture D. 7 Strutture residenziali extraospedaliere a bassa complessità assistenziale (C.I.)
RESIDENZIALITA' ASSISTENZIALE INTERMEDIA	Assistenziale	Criticità assistenziali NEWS 0-1	Bassa intensità di tipo residenziale	Assistenza infermieristica Riattivazione / Riabilitazione estensiva	MMG che si avvale della consulenza specialistica programmata e medico di continuità assistenziale	Max 20 gg	€ 119,00	8	sperimentazione in atto fino al 31-12-2018 con riferimento agli aspetti funzionali e organizzativi previsti nell'allegato A

National Early Warning Score (NEWS)

Misurazione standardizzata della gravità della malattia

Tradotto e adattato dalla linea guida originale della Royal College of Physicians
da Giancarlo Berni, Cesare Francois e Luigi Tonelli

LINEA GUIDA
Consiglio Sanitario Regionale

REGIONE TOSCANA

SNLG Regioni 24

Data di pubblicazione: 2014
Data del primo aggiornamento: 2016

Carta 1: National Early Warning Score (NEWS)

PARAMETRI FISIOLOGICI	3	2	1	0	1	2	3
Frequenza del respiro	≤8		9 - 11	12 - 20		21 - 24	≥25
Saturazione d'ossigeno	≤91	92 - 93	94 - 95	≥96			
Ossigeno supplementare		Sì		No			
Temperatura corporea	≤35,0		35,1 - 36,0	36,1 - 38,0	38,1 - 39,0	≥39,1	
Pressione sistolica	≤90	91 - 100	101 - 110	111 - 219			≥220
Frequenza cardiaca	≤40		41 - 50	51 - 90	91 - 110	111 - 130	≥131
Stato di coscienza				Vigile			Richiamo verbale, dolore provocato, coma

Carta 2: Soglia di allarme NEWS

Punteggio NEWS	Rischio clinico
0	Basso
1 - 4 di somma	
ALLARME ROSSO* (quando un solo parametro raggiunge 3)	Basso
1 - 4 di somma	
≥7	Alto

D - REQUISITI STRUTTURALI, ORGANIZZATIVI E TECNOLOGICI SPECIFICI
PRESTAZIONI A CICLO CONTINUATIVO E DIURNO IN FASE POST-ACUTA

D.6 STRUTTURE RESIDENZIALI DESTINATE AD ACCOGLIERE I PAZIENTI NELLA FASE POST-ACUTA ALLA DIMISSIONE OSPEDALIERA

LOW CARE

Questa tipologia di strutture identifica un livello intermedio tra la degenza ospedaliera per acuti e le strutture territoriali, offrendo una modalità di assistenza infermieristica avanzata, pur essendo caratterizzata da una componente diagnostico terapeutica significativa per la quale è richiesta una residuale dotazione tecnologica all'interno della struttura. Inoltre è necessaria una adeguata assistenza medica giornaliera. Questa attività è rivolta a soggetti in dimissione da reparti per acuti che necessitano di assistenza medica sulle 24 ore non ad alto contenuto tecnologico, in ambiente sanitario, per la gestione della fase immediatamente successiva alla fase di stabilizzazione in ospedale per acuti, assicurando la continuità terapeutica e assistenziale e, qualora necessario, riabilitativa estensiva e/o di counseling riabilitativo.

REQUISITI ORGANIZZATIVI

D.6.14 Assistenza medica (geriatra o internista, o fisiatra o equipollenti): sulle 24 ore in funzione della tipologia e della complessità delle attività svolte

D.6.15 Assistenza infermieristica e assistenza OSS continuativa sulle 24 ore.

D.6.16 Personale di riabilitazione tale da garantire l'assistenza riabilitativa estensiva in misura adeguata alla tipologia e alla complessità delle attività svolte

D.6.17 Le attività di analisi chimico-cliniche possono essere garantite anche attraverso il ricorso a rapporti con strutture autorizzate all'esercizio di tali attività. Deve comunque essere presente l'attività di prelievo

REQUISITI IMPIANTISTICI

D.6.18 Nelle camere di degenza è presente la seguente dotazione minima impiantistica:

D.6.29 Apparecchio radiologico per RX standard

disponibile nella struttura

D.6.30 Deve essere garantita nell'arco delle 24 ore, la disponibilità nel presidio di attività diagnostiche correlate alla tipologia e complessità dell'attività svolta. In ogni caso devono essere presenti:

D.6.31 Apparecchio per saturimetria trans-cutanea

disponibile nella struttura

D.6.32 Ecografo

disponibile nella struttura

D.6.33 Elettrocardiografo (può essere a comune fra più articolazioni organizzative, ma in tal caso devono essere presenti istruzioni operative per assicurarne l'utilizzo efficace)

D.7 STRUTTURE RESIDENZIALI EXTRAOSPEDALIERE A BASSA COMPLESSITÀ ASSISTENZIALE (CURE INTERMEDIE)

RESIDENZIALITA' SANITARIA INTERMEDIA

Questa tipologia di strutture assicura un livello di intensità intermedio tra la degenza ospedaliera per acuti e le strutture territoriali, offrendo una modalità di assistenza infermieristica avanzata, pur essendo caratterizzata da una componente diagnostico terapeutica significativa, per la quale è richiesta una residuale dotazione tecnologica all'interno della struttura, senza necessità di assistenza medica sulle 24 ore.
Questa attività è rivolta a: soggetti in condizioni di buon compenso clinico, in dimissione da reparti per acuti in fase immediatamente successiva alla fase di stabilizzazione o provenienti dal territorio con riacutizzazione di cronicità, che richiedono, per assicurare la necessaria continuità assistenziale e terapeutica, un'assistenza continuativa di tipo infermieristico sulle 24 ore in ambiente sanitario e, qualora necessario, eventuali trattamenti riabilitativi di tipo estensivo e/o di counseling riabilitativo con l'obiettivo principale di mantenere e/o recuperare il massimo potenziale di autosufficienza residua; soggetti con riduzione non stabilizzata delle capacità funzionali riferite alla mobilità e alla cura del sé recuperabili con intervento assistenziale e di rieducazione estensiva ma non gestibili a domicilio per condizioni prevalentemente sanitarie (es. sindrome da immobilizzazione, procrastinata indicazione al carico dopo intervento ortopedico ecc.) che richiedono interventi assistenziali continuativi per la mobilità e la cura della persona.

REQUISITI ORGANIZZATIVI

D.7.15 Assistenza medica (specialista geriatra/internista o equipollente): almeno 30 ore settimanali

D.7.16 Assistenza infermieristica e assistenza OSS continuativa sulle 24 ore

D.7.17 Personale di riabilitazione tale da garantire l'assistenza riabilitativa estensiva in misura adeguata alla tipologia e alla complessità delle attività svolte

D.7.18 Criteri per l'accesso: N.E.W.S. < =3, diagnosi già definita e processo di stabilizzazione clinica non ancora consolidato, Programma di trattamento già pre-disposto e concordato con i medici ospedalieri e/o con i MMG in caso di dimissione da ospedale per acuti o con MMG appartenenti all'Aggregazione Funzionale Territoriale (AFT) in caso di accesso dal territorio

D.7.19 Le attività di analisi chimico-cliniche possono essere garantite anche attraverso il ricorso a rapporti con strutture autorizzate all'esercizio di tali attività. Deve comunque essere presente l'attività di prelievo

D.7.33 Deve essere garantita la disponibilità nel presidio di attività diagnostiche correlate alla tipologia e complessità dell'attività svolta. In ogni caso devono essere presenti:

D.7.34 Apparecchio per saturimetria trans-cutanea

▶ disponibile nella struttura

D.7.35 Ecografo

▶ disponibile nella struttura

D.7.36 Elettrocardiografo (può essere a comune fra più articolazioni organizzative, ma in tal caso devono essere presenti istruzioni operative per assicurarne l'utilizzo efficace)

Le Cure Intermedie

Nel corso degli anni '80 e '90 il National Health System esercitò una forte pressione per ***la riduzione del numero di posti letto nelle degenze per acuti e geriatriche****, che fu ottenuta come conseguenza dell' attivazione di letti a ciclo diurno e del* ***contenimento della durata di degenza.***

All'inizio degli anni '80 i posti letto erano 219.000, alle fine degli anni '90 erano diventati 137.000, ma nello stesso periodo la richiesta di ospedalizzazione era aumentata del 3,5% all'anno. ***Alla fine degli anni '90 ci si rese conto che la richiesta di ricovero era incontenibile.***

Fu promosso dal Department of Health uno studio nazionale – il "National Beds Inquiry" – che rilevò che questo aumento di richiesta proveniva dal riacutizzarsi delle malattie croniche nella popolazione anziana. Fu rilevato anche ***che il 20% delle giornate di degenza per questa popolazione erano da considerarsi inappropriate nell'Ospedale per Acuti****. Lo stesso documento mise anche il evidenza che il limite principale all'appropriato utilizzo delle degenze ordinarie era il* ***rallentato flusso in uscita per carenza di servizi intermedi fra Ospedale e domicilio****. Il Governo Laburista, che aveva tra gli obiettivi principali la modernizzazione dell' Assistenza Sanitaria,* ***avviò con il Piano Sanitario Nazionale 2000 la promozione delle Cure Intermedie.***

This report covers patients discharged from intermediate care services during 2011/12 and organisational level data relating to the period 2011/12 and, for comparison, 2010/11.

Document reference: NAIC2012

Figure 7.2.3: Location of beds commissioned

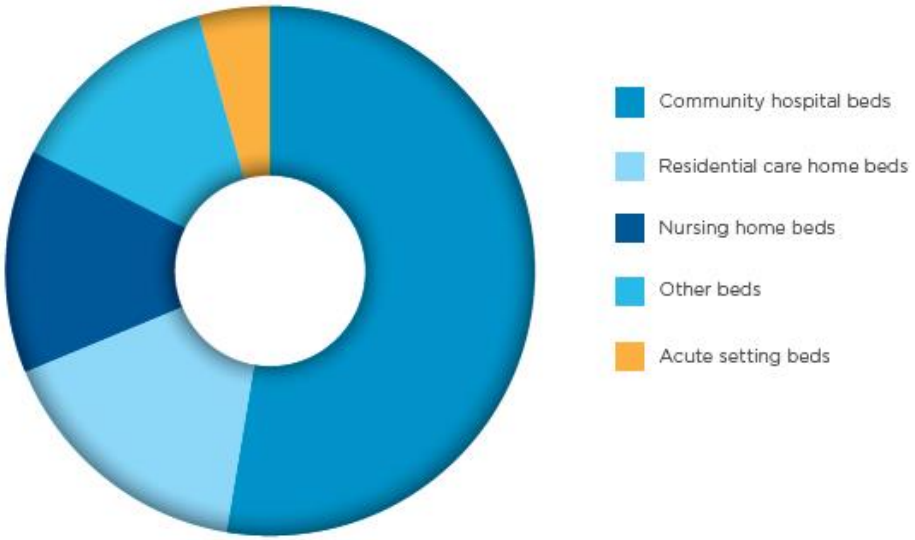
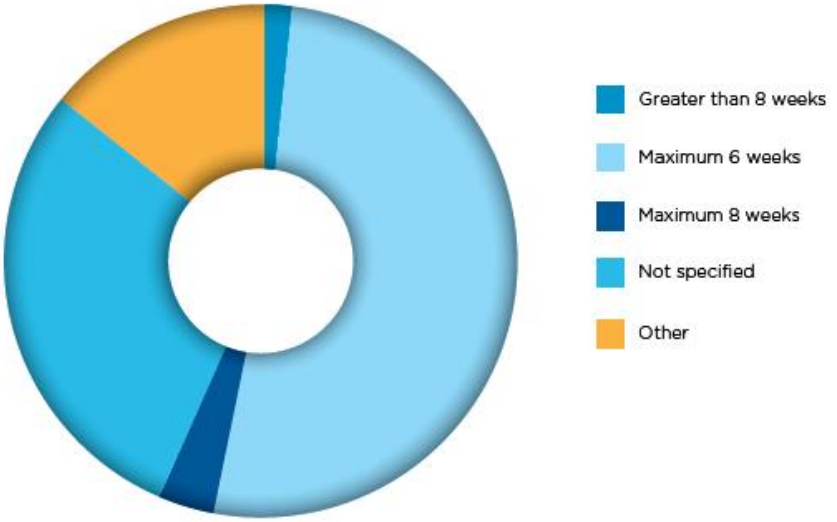


Figure 7.2.4: Maximum stay in intermediate care



This report covers patients discharged from intermediate care services during 2011/12 and organisational level data relating to the period 2011/12 and, for comparison, 2010/11.

Document reference: NAIC2012

Figure 7.2.5: Access criteria

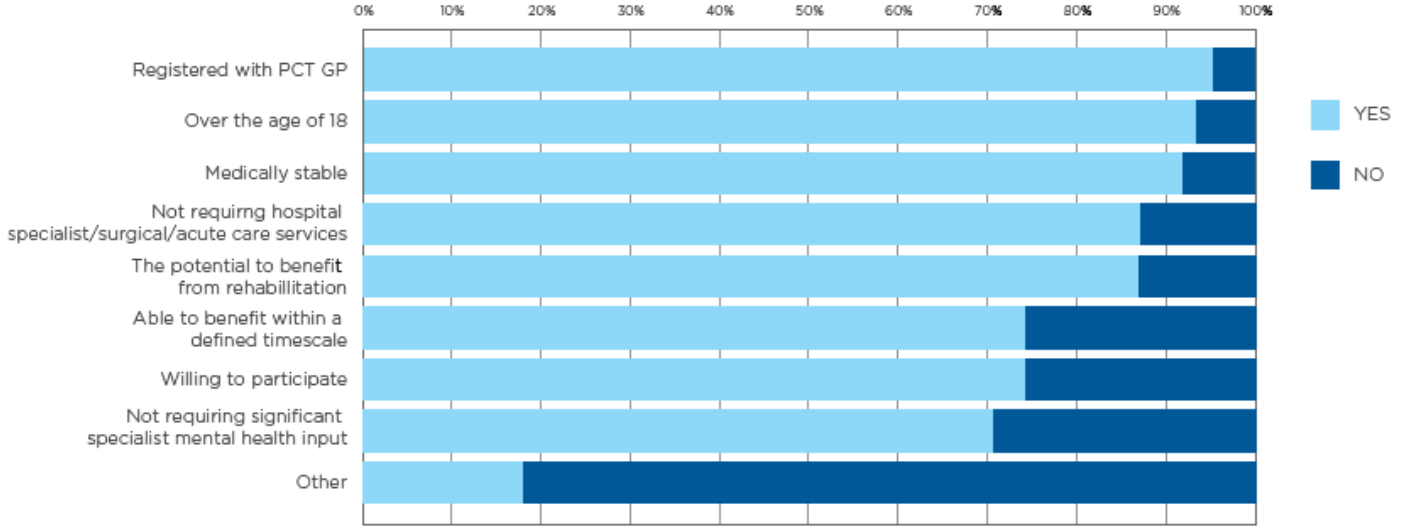
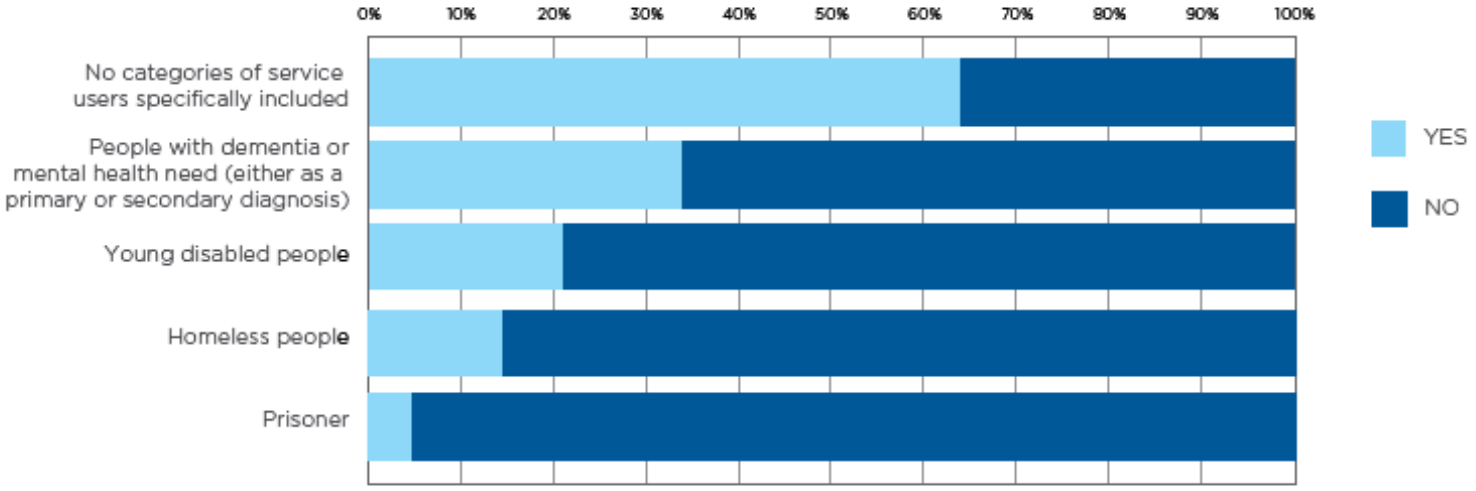


Figure 7.2.6: Access for vulnerable groups



This report covers patients discharged from intermediate care services during 2011/12 and organisational level data relating to the period 2011/12 and, for comparison, 2010/11.

Document reference: NAIC2012

Bed based services reported that, on average, the discharge destination of 66.5% of service users was home, 14.8% acute care, 9.5% went to a care home and 3.0% died (unknown 5.6%). For home based services, 68.5% remained at home, 8.4% were admitted to acute care, 3.1% to a care home and 2.4% died (unknown 15.2%).

Figure 8.5.1: Destination on discharge (% of bed based service users)

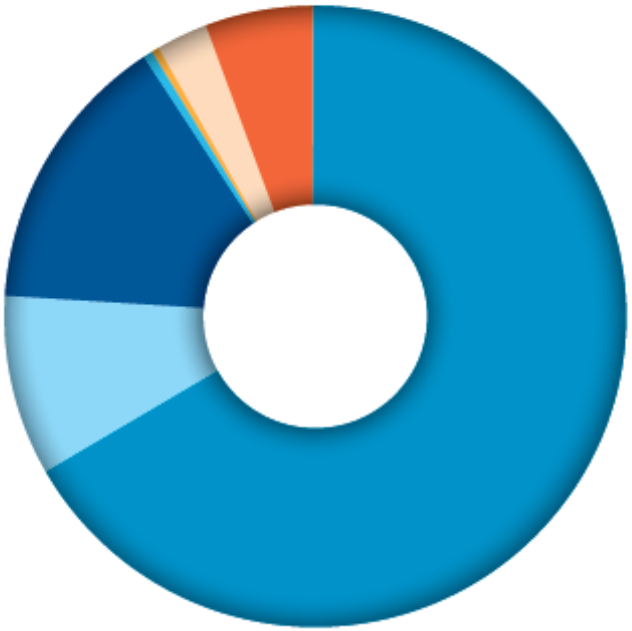
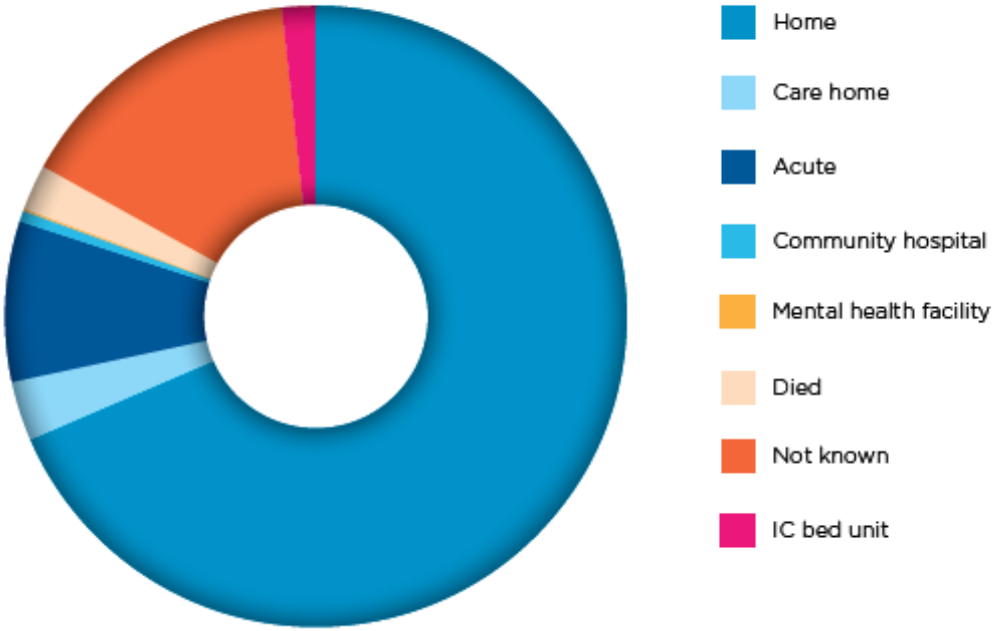


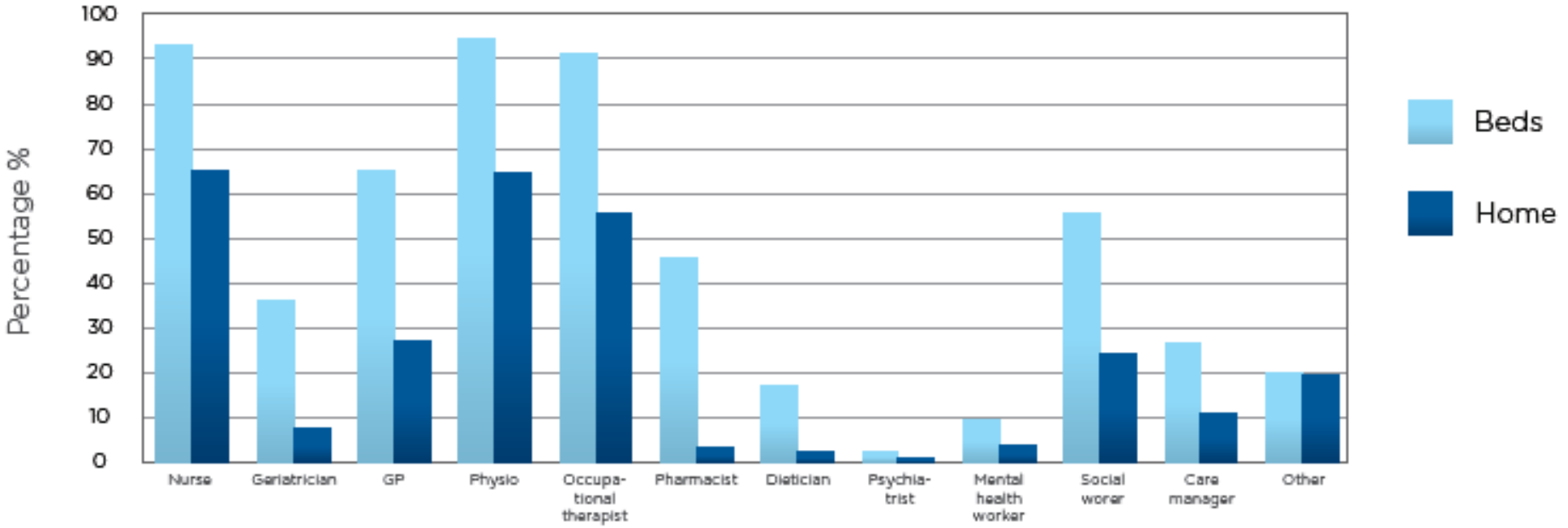
Figure 8.5.2: Destination on discharge (% of home based service users)



This report covers patients discharged from intermediate care services during 2011/12 and organisational level data relating to the period 2011/12 and, for comparison, 2010/11.

Document reference: NAIC2012

Figure 9.2.4: Patient assessments by staff discipline as % each IC service type



VOLUME 3 ISSUE 1 JANUARY 2015
ISSN 2050-4349

A key message from the literature review is that RCTs include older people with specific medical [stroke, COPD, congestive heart failure (CHF)] and surgical conditions (fractured neck of femur, CABG). Trials have not included the general population of service users. There is evidence that the rates of improvement in patients admitted to IC are often modest, with two studies showing that only around one-third of patients improve at all. Given the frailty of most of the patients admitted to IC, it could be that no decline in health status is also a positive outcome and perhaps the parameters for success of IC services need to be reconsidered.

The literature review showed evidence that age, cognitive impairment, living alone at admission and functional status at admission may all have an influence on the outcomes of patients using IC; however, the strength and direction of these findings were not consistent enough to draw conclusions for this study.

Analyses of data from our two studies focus on two main sets of characteristics: the assessed need of the subjects in receipt of IC services and the location of care. Age and sex are also included in the analysis but the effects, although statistically si

For each of the five measures, the higher scores at baseline tended to in all TOM scores, but the associat increase). When compared with fe activity, but lower improvements ir age or sex.

The overall outcomes of this study following an episode of IC. Rates c 43% of patients improved on the by TOM participation and 32% on EQ-5D score measurement after d

Factors that were statistically associated with a change in TOM scores were patient age (improvement declines with age), sex (females more likely to improve), LoC at admission, living in own home, receiving care in own home or IC facilities, referrals made by acute hospitals and having a lower score at admission.

With respect to all the outcomes (return home, TOM score and EQ-5D score), the analyses generally support the same conclusion: those patients who are more likely to have the most positive outcomes (return to home, large improvement in TOM parameters and EQ-5D score) are more likely to have been assessed as in need of rehabilitation (according to LoC need) by the admitting team.

Levels of care 3, 4 and 5 provide the springboard for most improvement and these represent an assessment that the patient is in need of slow-stream, regular or high-intensity rehabilitation.

Those patients who are likely to do best receive the IC service in their own home. This implies that those who do worst receive IC elsewhere, although it should be noted from the literature review that residential and nursing home settings are largely unevaluated.

However, there are clear indications from the secondary data analysis that place of care is important and that those who improve the least are those who receive care in residential/nursing homes and acute hospital settings. This finding is not surprising given that the level of impairment tended to be more severe for these patients, indicating a higher burden of chronic disease.

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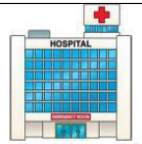
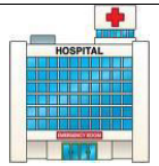
Level of acute need

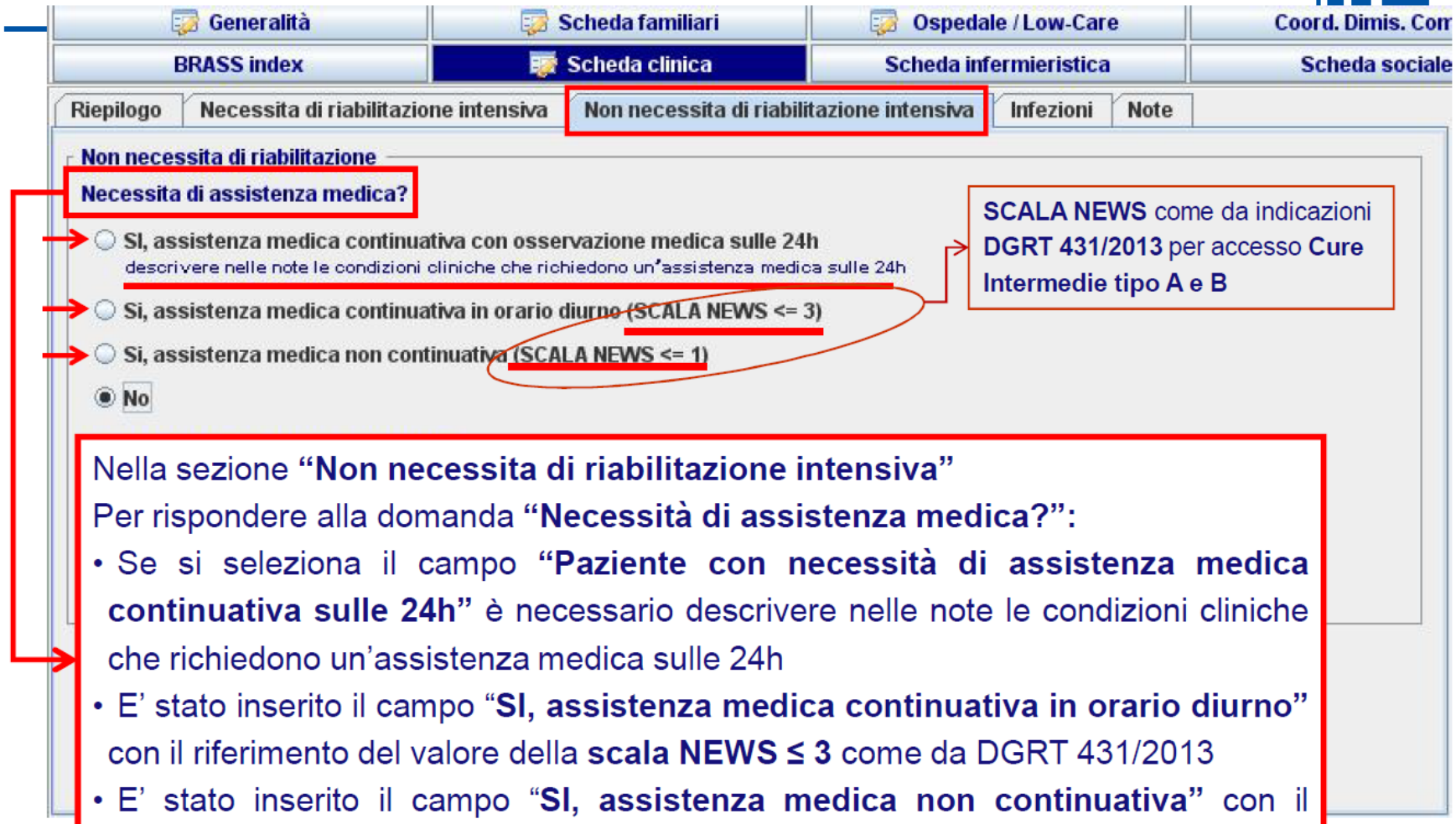
		
Individual becomes unwell. Primary care; District Nurse; Social Work; Home Care; NHS24; Ambulance practitioner; A&E attendance. Contact Single Point of Access Assessment Intervention as required: • Nursing • Therapy • Support Worker • Telecare Timely diagnosis by GP Specialist input by: • Geriatrician • Community diagnostics • Rapid Response Team	If too unwell to be cared for at home, step up to a care home, community hospital or other residential setting. History / Examination / Diagnostics. GP, Nurse practitioner or Consultant review within 24 hours. MDT input with principle of care delivery at home when appropriate (as it may be in a care home).	If too unwell to be cared for in a community facility, admit to acute hospital for comprehensive assessment. Transfer to community facility or home when medically stable and fit for transfer.

Level of need during recovery

		
Timely comprehensive multidisciplinary and multi-agency assessment : Rehabilitative need identified. Referral to Intermediate Care Single Point of Access. Individual is medically stable and fit for transfer. Individual transferred to the appropriate setting: • Own home • Community based facility (such as a care home or community hospital)	If the individual requires more care than can be delivered at home, step down from acute hospital to a care home, community hospital or other residential setting. Regular MDT and GP / Nurse / Consultant review with principle of care at home to continue rehabilitation when appropriate	Majority of users of Intermediate Care to receive their episode of care at home. MDT driven re-ablement to optimise recovery and promote independence.

CARIBEL – CENTRO DIMISSIONI COMPLESSE

MODIFICHE SCHEDA CLINICA



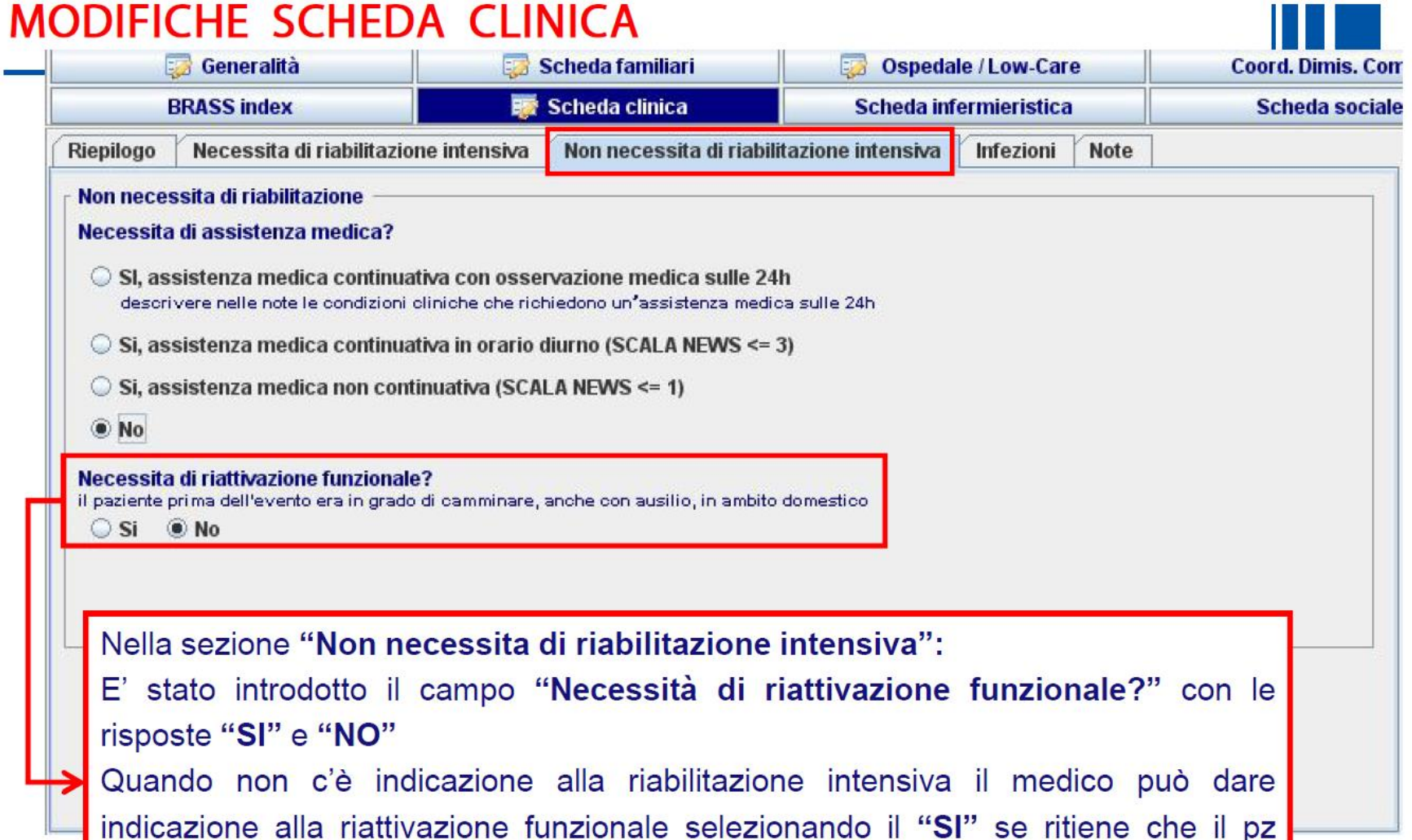
Nella sezione **"Non necessita di riabilitazione intensiva"**

Per rispondere alla domanda **"Necessità di assistenza medica?"**:

- Se si seleziona il campo **"Paziente con necessità di assistenza medica continuativa sulle 24h"** è necessario descrivere nelle note le condizioni cliniche che richiedono un'assistenza medica sulle 24h
- E' stato inserito il campo "**SI, assistenza medica continuativa in orario diurno**" con il riferimento del valore della **scala NEWS ≤ 3** come da DGRT 431/2013
- E' stato inserito il campo "**SI, assistenza medica non continuativa**" con il riferimento del valore della **scala NEWS ≤ 1** come da DGRT 431/2013

CARIBEL – CENTRO DIMISSIONI COMPLESSE

MODIFICHE SCHEDA CLINICA



Nella sezione **"Non necessita di riabilitazione intensiva":**

E' stato introdotto il campo **"Necessità di riattivazione funzionale?"** con le risposte **"SI"** e **"NO"**

Quando non c'è indicazione alla riabilitazione intensiva il medico può dare indicazione alla riattivazione funzionale selezionando il **"SI"** se ritiene che il pz possa beneficiarne perchè **"prima dell'evento erano in grado di camminare, anche con ausilio, in ambito domestico"**

Cure Intermedie Istituto P. Thouar

Pazienti ricoverati dall'inizio dell'anno fino ad Agosto

Tipologia di pazienti

N° pazienti:	262
Età media:	81,37
Età mediana:	84,00
Minimo:	32
Massimo	101
Femmine:	58%

Giorni di Degenza

Media:	16
Mediana:	13
Massimo	123
Minimo:	0

Cure Intermedie Istituto P. Thouar

Pazienti ricoverati dall'inizio dell'anno fino ad Agosto

Indicatori di stato clinico funzionale (%)		Indicatori di transizione (%)		Indicatori di esito efficacia (%)		Indicatori di esito performance (%)	
BI 41-80	39,7	**ACE generali**	26,3	**BI 41-80**	43,5	**Rientro a domicilio**	55,34
BI < 40	14,5	**ACE infettivi A**	8,0	**BI < 40**	31,3	**RSA**	26,71
Cammino Aut. Am	13	**ACE infettivi U**	14,5	**Cammino Aut.Dim**	**24,0**	**LDG**	1,9
Cattivo stato nutrizionale	25,6	**Contenzione farmacologica**	5,7			**Riabilitazione intensiva**	5,34
Infezione all'ammissione	8,0	**Contenzione fisica**	3,4			**Trasferimento DEA/UO**	10,68
Demenza con disturbo Comportamentale	11,1	**Delirium**	6,9				
Demenza senza disturbo comportamentale	25,2						
Fattori di rischio vascolare	50,0						
Fragilità sociale	62,0						
Instabilità clinica	9,9						

5. Key components of an effective Intermediate Care system

The following are key components of Intermediate Care:

- ***Clear, agreed scope,*** focused on ***prevention, rehabilitation, reablement and recovery;*** for those at risk of emergency admission, or re-admission, to hospital, or to avoid premature permanent admission to a care home.
- **Time limited,** linking and **complementing existing services**
- **Accessible, flexible and responsive** through a single point of access, 7 days a week, and 24 hours a day
- Based on **holistic assessment** to maximise independence, confidence and ***personal outcomes*** sought by the individual
- ***Co-ordinated***, able to draw on ***multi-professional and multi-agency skills*** and resources as required to meet complex needs
- **Managed for improvement,** gathering information on the impact of interventions and using this to inform service improvement.

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Partnership Example of Good Practice
Cumbernauld Re-Ablement Service

The aims of the Reablement programmes are to assess service users' functional ability within their homes, to maximise service users' independence with activities of daily living and if an on-going home care service is required at the end of Reablement to recommend an appropriate service based on evidenced need.

The Cumbernauld Reablement Team consists of:

1 FTE Occupational Therapist.	2 FTE Home Support Managers.
1.5 FTE administration workers.	15 Home Support Workers.

The Reablement team works with CARS team, North Lanarkshire hospital discharge team, to maximise service users' independence within their own homes. They are developing links with North East Rehabilitation Service, Glasgow hospital discharge team.

Upon receipt of referral OT and Home Support Manager visit service users at home to complete an initial Reablement Assessment, establish service users' outcomes and to set goals with service users. Weekly Reablement Team Meetings are held to discuss service users' progress and set new goals. The Reablement team also have twice weekly handovers to discuss any issues arising, discuss new service users etc.

Outcomes

- 118 service users completed the re-ablement programme between October 2010 and September 2011.
- No service users hours increased
- 21 service users (26%) hours decreased

Home Care Re-ablement

Initial research suggests that a home care service with a re-ablement philosophy is an effective and efficient alternative to the traditional model and is associated with improvements in health of the people using the services, with a high level of user satisfaction, staff involvement and commitment.

Re-ablement within Home Care services was first introduced by the City of Edinburgh Council in one area of the city in October 2008 and subsequently rolled out into other areas.

Chi può beneficiare di una riattivazione motoria

Assessment of recovery in older patients hospitalized with different diagnoses and functional levels, evaluated with and without geriatric assessment

Jenny Foss Abrahamsen[1*], Cathrine Haugland[2] and Anette Hylen Ranhoff[3,4]

Abstract

Background: The objective of the present study was to investigate 1) the role of different admission diagnoses and 2) the degree of functional loss, on the rate of recovery of older patients after acute hospitalization. Furthermore, to compare the predictive value of simple assessments that can be carried out in a hospital lacking geriatric service, with assessments including geriatric screening tests.

Methods: Prospective, observational cohort study, including 961community dwelling patients aged ≥ 70 years, transferred from medical, cardiac, pulmonary and orthopedic acute hospital departments to intermediate care in nursing home. Functional assessment with Barthel index (BI) was performed at admission to the nursing home and further geriatric assessment tests was performed during the first week. Logistic regression models with and without geriatric assessment were compared concerning the patients having 1) slow recovery (nursing home stay up to 2 months before return home) or, 2) poor recovery (dead or still in nursing home at 2 months).

Results: Slow recovery was independently associated with a diagnosis of non-vertebral fracture, BI subgroups 50–79 and <50, and, in the model including geriatric assessment, also with cognitive impairment. Poor recovery was more complex, and independently associated both with BI < 50, receiving home care before admission, higher age, admission with a non-vertebral fracture, and in the geriatric assessment model, cognitive impairment.

Conclusions: Geriatric assessment is optimal for determining the recovery potential of older patients after acute hospitalization. As some hospitals lack geriatric services and ability to perform geriatric screening tests, a simpler assessment based on admission diagnoses and ADL function (BI), gives good information regarding the possible rehabilitation time and possibility to return home.

Keywords: Geriatric assessment, Recovery, Post-acute care, Barthel index, Hospitalization

La valutazione multidimensionale geriatrica come elemento cardine nel determinare la potenzialità di recupero di un paziente

MOVE TO IMPROVE

Phys Ther. 2013 Feb;93(2):197-207. doi: 10.2522/ptj.20110400. Epub 2012 Sep 13.

Move to improve: the feasibility of using an early mobility protocol to increase ambulation in the intensive and intermediate care settings.

Drolet A[1], DeJuilio P, Harkless S, Henricks S, Kamin E, Leddy EA, Lloyd JM, Waters C, Williams S.

Author information

Abstract

BACKGROUND: Prolonged bed rest in hospitalized patients leads to deconditioning, impaired mobility, and the potential for longer hospital stays.

OBJECTIVE: The purpose of this study was to determine the effectiveness of a nurse-driven mobility protocol to increase the percentage of patients ambulating during the first 72 hours of their hospital stay.

DESIGN: A quasi-experimental design was used before and after intervention in a 16-bed adult medical/surgical intensive care unit (ICU) and a 26-bed adult intermediate care unit (IMCU) at a large community hospital.

METHOD: A multidisciplinary team developed and implemented a mobility order set with an embedded algorithm to guide nursing assessment of mobility potential. Based on the assessments, the protocol empowers the nurse to consult physical therapists or occupational therapists when appropriate. Daily ambulation status reports were reviewed each morning to determine each patient's activity level. Retrospective and prospective chart reviews were performed to evaluate the effectiveness of the protocol for patients 18 years of age and older who were hospitalized 72 hours or longer.

RESULTS: In the 3 months prior to implementation of the Move to Improve project, 6.2% (12 of 193) of the ICU patients and 15.5% (54 of 349) of the IMCU patients ambulated during the first 72 hours of their hospitalization. During the 6 months following implementation, those rates rose to 20.2% (86 of 426) and 71.8% (257 of 358), respectively.

LIMITATIONS: The study was carried out at only one center.

CONCLUSION: The initial experience with a nurse-driven mobility protocol suggests that the rate of patient ambulation in an adult ICU and IMCU during the first 72 hours of a hospital stay can be increased.

L'importanza di un Team Multidisciplinare: Non solo fisioterapisti ma anche terapisti occupazionali, infermieri, ecc…

L'importanza di protocolli sulla mobilità

Riattivazione motoria finalizzata

Physiother Theory Pract. 2017 Aug;33(8):611-621. doi: 10.1080/09593985.2017.1328721. Epub 2017 Jun 7.

The evaluation of a strength and balance exercise program for falls prevention in community primary care.

Hawley-Hague H Ba Hons Ma PhD[1], Roden A BSc Hons[2], Abbott J Rgn Ba Ma Ffph[3].

Author information

Abstract

We aimed to evaluate a strength and balance program delivered in the community. There is little evidence of implementation of evidence-based exercise in practice. The program was a step-down model, designed to encourage long-term exercise in community classes. The program consisted of a fully funded referral only evidence-based 12-week strength and balance (Community Otago) class, followed by an evidence-based continuous open-access community strength and balance class (Active Always). The program was offered to patients: 1) after formal falls rehabilitation (falls and fracture service); 2) after falls rehabilitation in intermediate care; and 3) referred by a GP who were not eligible for rehabilitation (preventative measure). Outcome evaluation used descriptive statistics to report changes in function, confidence in balance, hospital attendance/admission for falls/fractures and transition to community classes. Focus groups established participant experience/satisfaction. Seventy-nine participants were included, aged 56-96, and 53 (67%) were women. About 63.3% of patients transitioned to Active Always classes, demonstrating improvement in maintenance. Follow-up scores from baseline attendance at falls and fracture service to 12-weeks follow-up (24 weeks) in Community Otago showed the majority of patients improved their function (Timed up and Go), confidence (ConfBal) and lowered their falls risk (Tinetti). Follow-up of participants from Community Otago baseline to the end of 12-weeks showed improvement in function and confidence, but only a third of participants lowered their falls risk. Focus groups data suggest that continuity of delivery, the role of the instructor, health professional, and social and physical outcomes were essential for maintenance. A supportive environment can be created which encourages older adults' continued participation in group-based strength and balance, helping the delivery of evidence-based practice.

Riattivazione di gruppo - esercizi

Br J Sports Med. 2009 Aug;43(8):608-14. doi: 10.1136/bjsm.2008.049882. Epub 2008 Oct 16.

The effect of group-based exercise on cognitive performance and mood in seniors residing in intermediate care and self-care retirement facilities: a randomised controlled trial.

Brown AK[1], Liu-Ambrose T, Tate R, Lord SR.

⊕ **Author information**

Abstract

OBJECTIVE: To determine the effect of a general group-based exercise programme on cognitive performance and mood among seniors without dementia living in retirement villages.

DESIGN: Randomised controlled trial.

SETTING: Four intermediate care and four self-care retirement village sites in Sydney, Australia.

PARTICIPANTS: 154 seniors (19 men, 135 women; age range 62 to 95 years), who were residents of intermediate care and self-care retirement facilities.

INTERVENTION: Participants were randomised to one of three experimental groups: (1) a general group-based exercise (GE) programme composed of resistance training and balance training exercises; (2) a flexibility exercise and relaxation technique (FR) programme; or (3) no-exercise control (NEC). The intervention groups (GE and FR) participated in 1-hour exercise classes twice a week for a total period of 6 months.

MAIN OUTCOME MEASURES: Using standard neuropsychological tests, we assessed cognitive performance at baseline and at 6-month re-test in three domains: (1) fluid intelligence; (2) visual, verbal and working memory; and (3) executive functioning. We also assessed mood using the Geriatric Depression Scale (GDS) and the Positive and Negative Affect Schedule (PANAS).

RESULTS: The GE programme significantly improved cognitive performance of fluid intelligence compared with FR or NEC. There were also significant improvements in the positive PANAS scale within both the GE and FR groups and an indication that the two exercise programmes reduced depression in those with initially high GDS scores.

CONCLUSIONS: Our GE programme significantly improved cognitive performance of fluid intelligence in seniors residing in retirement villages compared with our FR programme and the NEC group. Furthermore, both group-based exercise programmes were beneficial for certain aspects of mood within the 6-month intervention period.

- Esercizi di gruppo con programmi di resistenza e rafforzamento dell'equilibrio
- Programmi di miglioramento della flessibilità e tecniche di rilassamento

J Am Geriatr Soc. 2017 Aug;65(8):1863-1869. doi: 10.1111/jgs.14889. Epub 2017 Apr 3.

Home- and Community-Based Occupational Therapy Improves Functioning in Frail Older People: A Systematic Review.

De Coninck L[1,2,3], Bekkering GE[2], Bouckaert L[3], Declercq A[4], Graff MJL[5], Aertgeerts B[1,2].

Author information

Abstract

OBJECTIVES: The objective is to assess the effectiveness of occupational therapy to improve performance in daily living activities in community-dwelling physically frail older people.

DESIGN: We conducted a systematic review and meta-analysis. We included randomized controlled trials reporting on occupational therapy as intervention, or as part of a multidisciplinary approach. This systematic review was carried out in accordance with the Cochrane methods of systematic reviews of interventions.

MEASUREMENTS: Meta-analyses were performed to pool results across studies using the standardized mean difference. The primary outcome measures were mobility, functioning in daily living activities, and social participation. Secondary outcome measures were fear of falling, cognition, disability, and number of falling persons.

RESULTS: Nine studies met the inclusion criteria. Overall, the studies were of reasonable quality with low risk of bias. There was a significant increase in all primary outcomes. The pooled result for functioning in daily living activities was a standardized mean difference of -0.30 (95% CI -0.50 to -0.11; P = .002), for social participation -0.44 (95% CI -0.69, -0.19; P = .0007) and for mobility -0.45 (95% CI -0.78 to -0.12; P = .007). All secondary outcomes showed positive trends, with fear of falling being significant. No adverse effects of occupational therapy were found.

CONCLUSION: There is strong evidence that occupational therapy improves functioning in community-dwelling physically frail older people.

KEYWORDS: frail older people; functionality; occupational therapy; primary care; social participation

World Federation of Occupational Therapists

Definition of Occupational Therapy

Occupational therapy is a client-centred health profession concerned with promoting health and well being through occupation. The primary goal of occupational therapy is to enable people to participate in the activities of everyday life. Occupational therapists achieve this outcome by working with people and communities to enhance their ability to engage in the occupations they want to, need to, or are expected to do, or by modifying the occupation or the environment to better support their occupational engagement.

(WFOT 2012)

Cosa condiziona il successo degli interventi in un sistema di cure intermedie?

Come il terapista occupazionale può aiutare la persona fragile e l'equipe nel processo di cura?

"suo bisogno"

"domiciliarità"

"reinserimento suo contesto di vita"

"care management"

"interventi specifici"

Archives of Gerontology and Geriatrics
Volume 54, Issue 3, May–June 2012, Pages e290-e293

Dose-dependent effect of rehabilitation in functional recovery of older patients in the post-acute care unit

Wei-Ju Lee [a, e], Yuan-Yang Cheng [b, e], Ching-Yi Liu [c], Li-Ning Peng [d, e], Li-Kuo Liu [d, e], Liang-Kung Chen [d, e]

Abstract

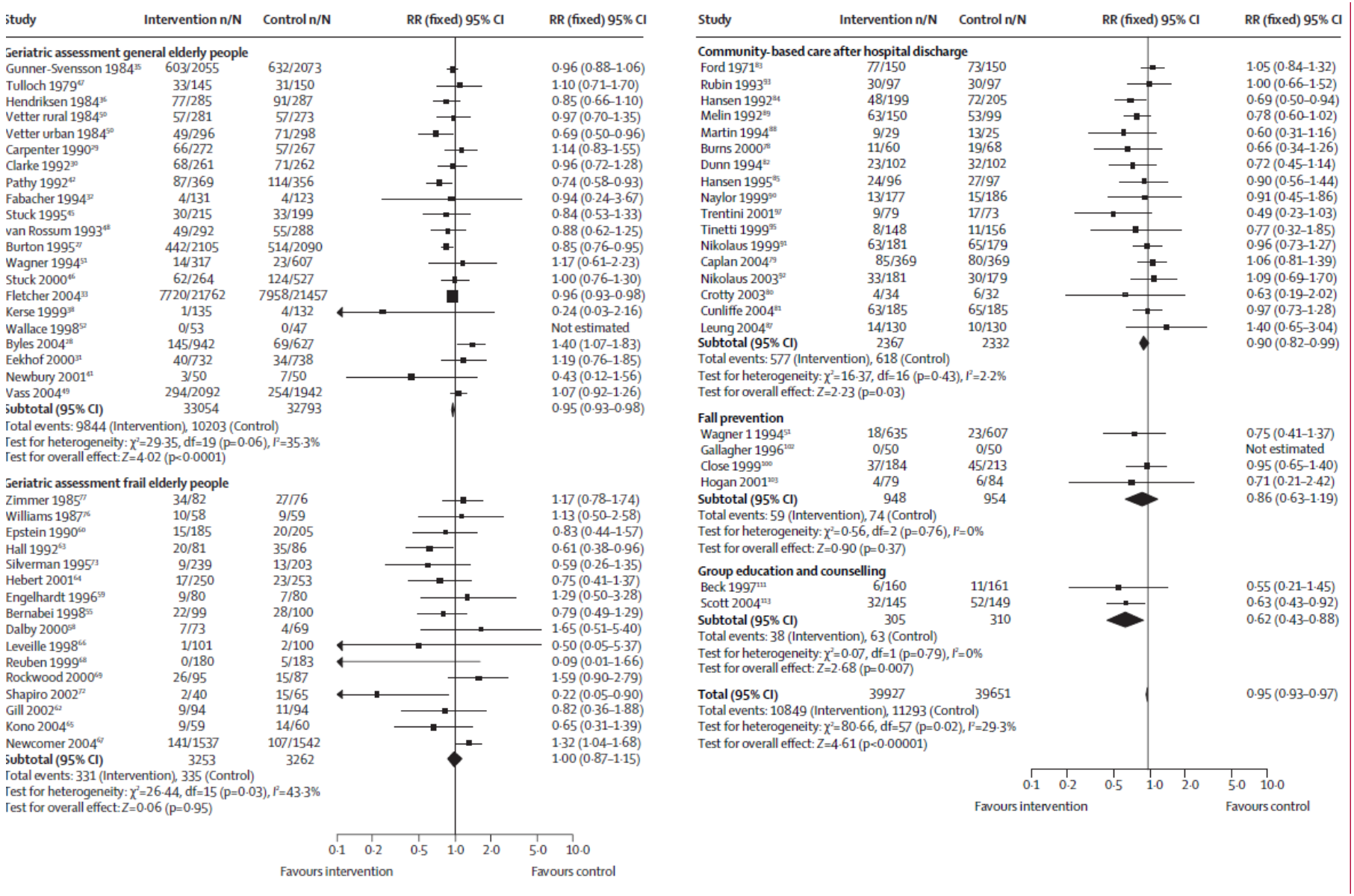
Post-acute care (PAC) is of great importance to promote functional recovery of older patients, which should be provided by the interdisciplinary team. In PAC services, rehabilitative therapy plays a key role, but the optimal intensity for rehabilitative therapy remained unclear. Between July 2007 and December 2010, all patients with functional decline after acute illness hospitalization admitted to the PAC unit of a community hospital in Taiwan were enrolled. Usual rehabilitation program, 40-min per day and five days a week, was provided to all patients before April 2009. After April 2009, the rehabilitative therapy was increased to 80 min per day. Functional improvement was measured by comprehensive geriatric assessment (CGA) at admission and 4 weeks after admissions to the PAC unit. Overall, 458 patients (mean age: 83.4 ± 5.5 years, all males) completed PAC services. Compared of all dimensions in CGA, increased dosage of rehabilitative therapy showed significantly better improvement in daily living activities (Barthel index (BI): 28.8 ± 18.4 vs. 20.0 ± 14.6, $p < 0.001$), depressive mood (geriatric depression score short form (GDS): −0.5 ± 1.0 vs. −0.1 ± 0.5, $p < 0.001$), and pain reduction (numerical rating scale (NRS): −2.0 ± 2.2 vs. −0.9 ± 2.1, $p = 0.01$); but not in cognitive function (mini-mental status examination (MMSE): 2.9 ± 3.3 vs. 3.3. ± 5.2, $p = 0.305$), and nutritional status (body mass index (BMI): 0.3 ± 0.9 vs. 0.3 ± 2.5, $p = 0.9$). In conclusion, intensive rehabilitative therapy significantly promote physical and psychological function with pain reduction, which deserves further investigations to evaluate whether there is a ceiling effect of rehabilitative therapy in PAC services.

La riattivazione motoria ha mostrato un incremento significativo nelle ADL, depressione e riduzione del dolore in un modo dose dipendente; scarso effetto sulle funzioni cognitive e stato nutrizionale

Complex interventions to improve physical function and maintain independent living in elderly people: a systematic review and meta-analysis

Andrew D Beswick, Karen Rees, Paul Dieppe, Salma Ayis, Rachael Gooberman-Hill, Jeremy Horwood, Shah Ebrahim

Lancet 2008; 371: 725–35



Trattamenti incentrati su mantenimento dell'attività funzionale residua da operatori sanitari anche in persone affette da demenza

Gerontologist. 2014 Dec;54(6):930-43. doi: 10.1093/geront/gnt108. Epub 2013 Oct 3.

Optimizing function and physical activity among nursing home residents with dementia: testing the impact of function-focused care.

Galik E[1], Resnick B[2], Hammersla M[2], Brightwater J[2].

⊕ **Author information**

Abstract

PURPOSE OF THE STUDY: The purpose of this study was to test the impact of Function-Focused Care for the Cognitively Impaired Intervention on nursing home residents with dementia and the nursing assistants who care for them.

DESIGN AND METHODS: This was a cluster-randomized controlled trial using repeated measures. A total of 103 cognitively impaired residents and 77 nursing assistants were recruited from four nursing homes. For residents, outcome measures included function, physical activity (survey and actigraphy), mood, behavior, and adverse events (falls and hospitalization). Main outcome measures for nursing assistants included knowledge, beliefs, and performance of function focused care.

RESULTS: There were significant improvements in the amount and intensity of physical activity (by survey and actigraphy) and physical function in the treatment group. In addition, there was a significant decrease in the number of residents who fell during the treatment period with those in the treatment sites having fewer falls (28% vs. 50% in the control group). Nursing assistants were also observed to be providing a greater percentage of function focused care during resident care interactions in the treatment group at 6 months following the completion of baseline measures.

IMPLICATIONS: This study provides some evidence that nursing home residents with severe cognitive impairment can safely and successfully be engaged in physical and functional activities.

- BAGNO
- UNITA' MOBILE
- CORRIDOIO
- GIARDINO SENSORIALE
- PISCINA

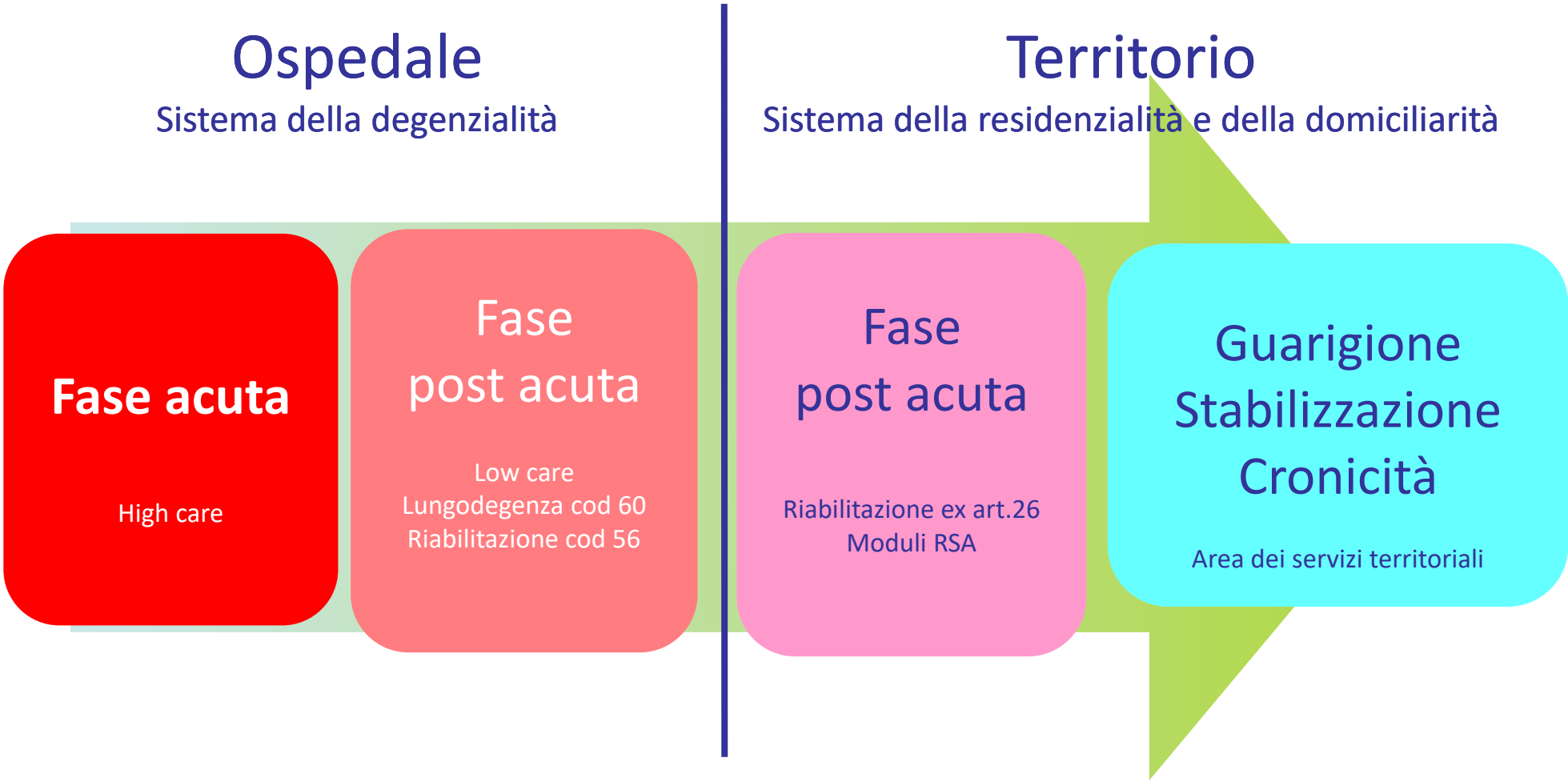
Pet theray.

Obiettivo: Favorisce l'interazione, la comunicazione interpersonale, aumenta la curiosità, la creatività, l' affettività, la calma, la capacità di osservazione la lucidità.

Metodo: contatto diretto con un animal svolgere tutte le attività di accudimer

Ada, una volta a settimana, entra in contatto con alcuni cani e gatti, che vengono portati nel salone . L'interazione con essi porta notevoli miglioramenti sui parametri fisici e sul tono dell' umore.

Foto Nucleo Alzheimer Arcobaleno- Suzzara (MN)



DALL'OSPEDALE ⟶ AL MEDICO DI BASE

Conclusioni

- Le cure intermedie fanno parte della rete del territorio
- Servono a dare una riposta diversificata secondo i bisogni del paziente con l'obiettivo del rientro a domicilio
- Riattivazione e terapia occupazionale, anche rivolta a persone con demenza, rappresentano la pietra angolare di questo tipo di sistema di cure
- Il bisogno sociale da solo non può rappresentare un criterio di trasferimento in cure intermedie

Cure Intermedie San Miniato

Pazienti ricoverati da Aprile a Settembre 2017

Indicatori di stato clinico funzionale (%)		Indicatori di transizione (%)		Indicatori di esito efficacia (%)		Indicatori di esito performance (%)	
BI 41-80	38,0	**ACE generali**	11,0	**BI 41-80**	13,0	**Rientro a domicilio**	60
BI < 40	51,0	**ACE infettivi A**	10,5	**BI < 40**	94,0	**RSA**	16
Cammino Aut. Am	1,2	**ACE infettivi U**	2,0	**Cammino Aut.Dim**	**3,0**	**LDG**	0
Cattivo stato nutrizionale	48,0	**Contenzione farmacologica**	6,0			**Riabilitazione intensiva**	4,0
Infezione all'ammissione	70,0	**Contenzione fisica**	2,0			**Trasferimento DEA/UO**	10
Demenza con disturbo Comportamentale	14	**Delirium**	22,0			**Mortalità**	10%
Demenza senza disturbo comportamentale	38						
Fattori di rischio vascolare	75,0						
Fragilità sociale	52,0						
Instabilità clinica	50,0						

Degenza Media: 11,14
Pazienti n° 84
età media: 80