Nursing Initiatives at the Hartford Institute: Nurses Making a Difference

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NIH Award 1R25CA183723-01A1

City of Hope

National Cancer Institute

Focus of My Remarks

- Hartford Institute products for individual practicing nurses
- Hartford Institute products to help create age friendly health care settings
- The Hartford Institute web site ConsultGeri
- Examples of how you might use these products

A Public Health Imperative : Drawing Care of Older Adults into the Mainstream of Nursing Practice

- All nurses should be educated to care of older adults
- All nurses should be competent to deliver evidence-based care to older adults
- All health care environments (primary care; hospitals; home care; nursing homes) should be configured as “elder-friendly”

Geriatric* Competence *Improves Outcomes* for Older Adults

- Care by health care professionals with geriatric preparation:
  - Decreases mortality
  - Reduces disability & illness
  - Improves patient & family satisfaction
  - Improves quality of life, including at the end of life
  - Decreases health care costs

**Geriatrics denotes geriatrics/gerontology throughout presentation*

Functional and Cognitive Status of Community Residing Adults ≥ 80

- 22% of adults >85 need help with personal care
- 30% of adults >80 have dementia
- Older adults with dementia have:
  - 3 times more hospital stays
  - 2.8 times higher hospital costs
  - 3+ times higher home health costs

Geriatric Syndromes

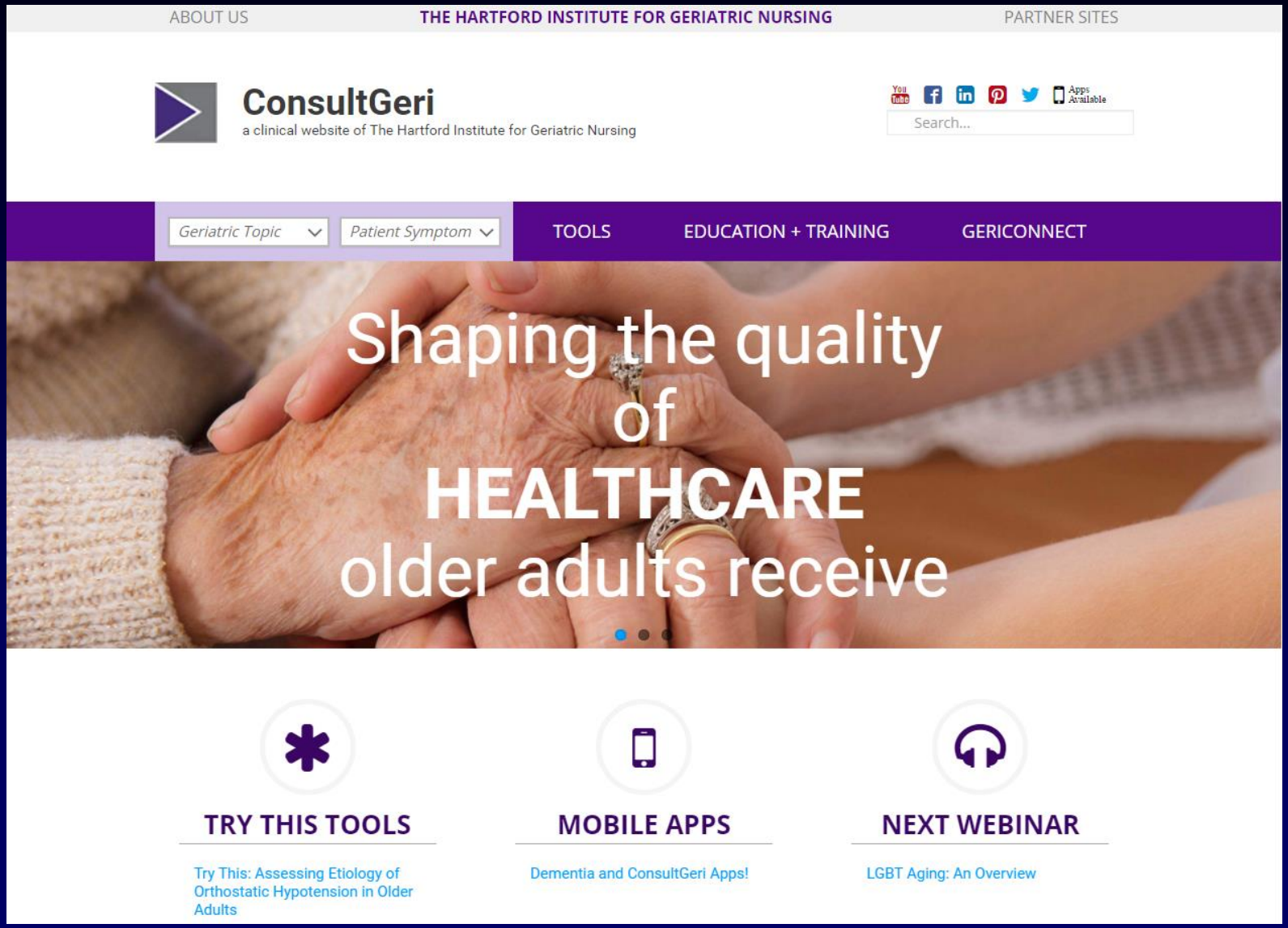
- Clinical syndromes that occur more frequently in older adults, especially those >80, e.g.:
  - Dementia
  - Delirium
  - Urinary Incontinence
  - Falls
  - Depression

Geriatric Syndromes in Older Adults with Cancer

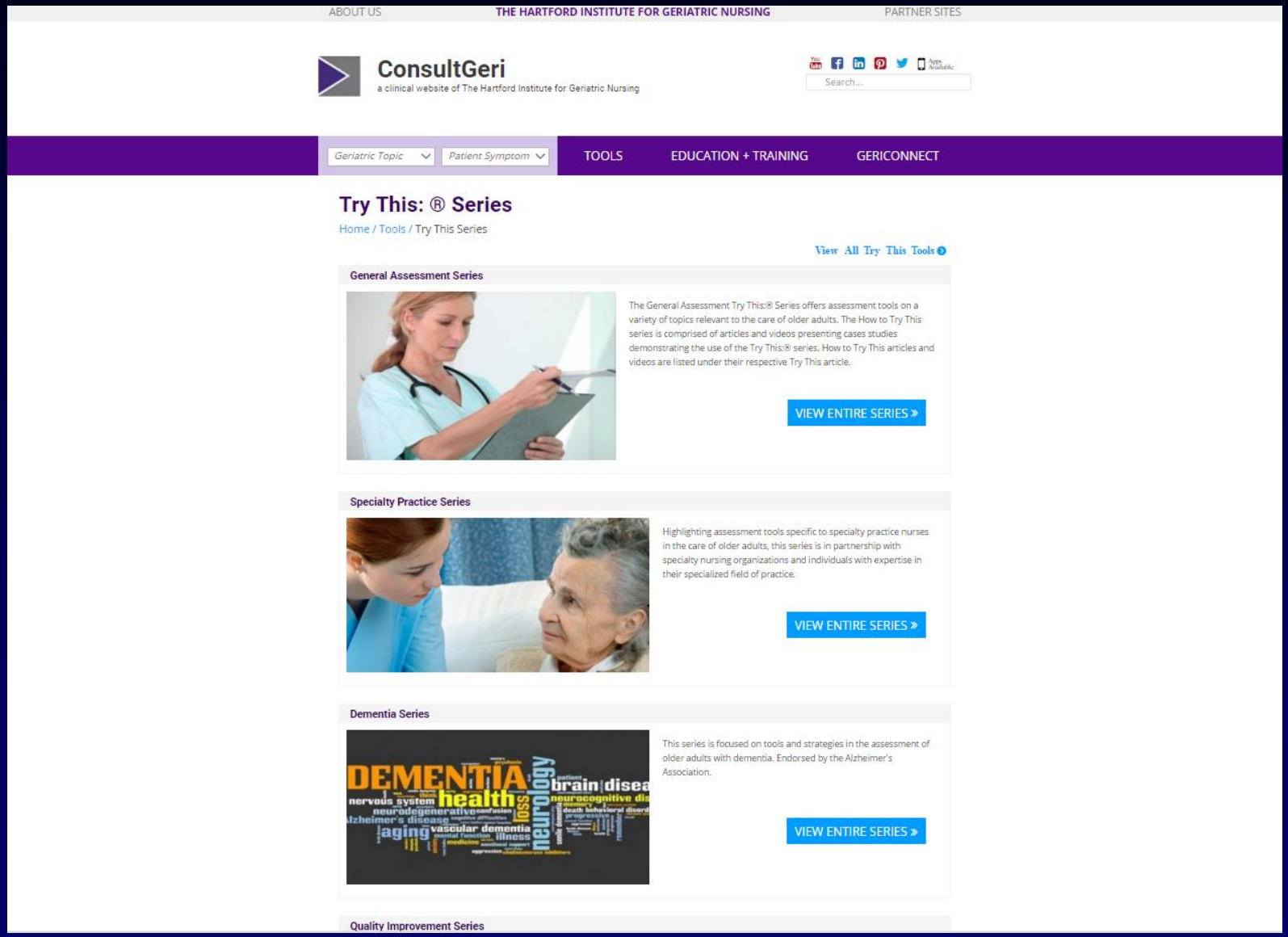
- Prevalence as high as
  - 34% of older adults with breast cancer
  - 50% of older adults with prostate cancer
  - 14% of older adults with colorectal cancer

- 10+% of older patients have a geriatric syndrome, a disability and a co-morbidity (e.g. DM, CHF, COPD) and disability)

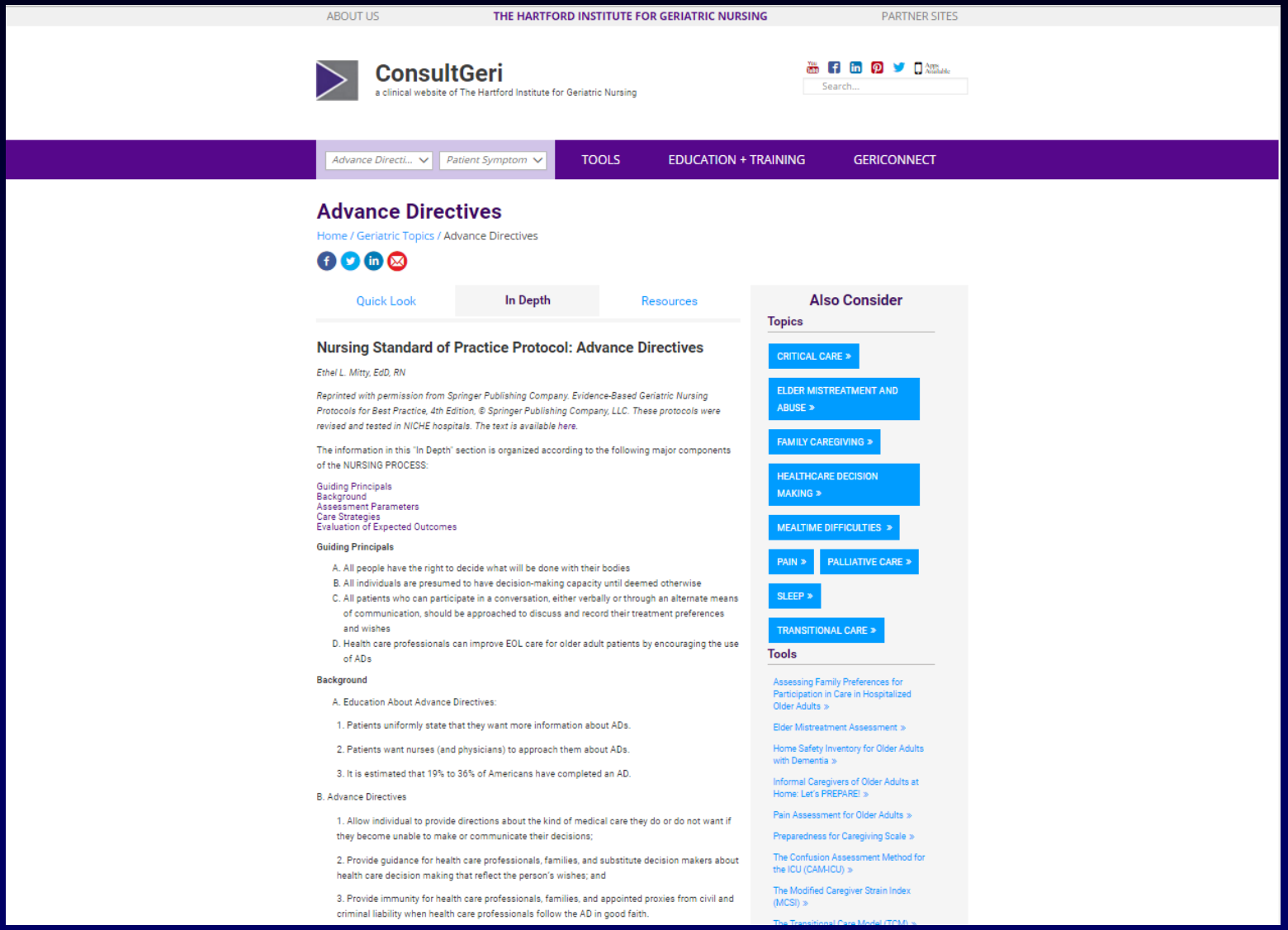
ConsultGeri: Resource for Practicing Nurses



Consult Geri Try This Series



Consult Geri Protocols



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Advance Directives

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Quick Look | In Depth | Resources

Nursing Standard of Practice Protocol: Advance Directives

Ethel L. Mitty, EdD, RN

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The information in this "In Depth" section is organized according to the following major components of the NURSING PROCESS:

Guiding Principals
Background
Assessment Parameters
Care Strategies
Evaluation of Expected Outcomes

Guiding Principals

A. All people have the right to decide what will be done with their bodies
B. All individuals are presumed to have decision-making capacity until deemed otherwise
C. All patients who can participate in a conversation, either verbally or through an alternate means of communication, should be approached to discuss and record their treatment preferences and wishes
D. Health care professionals can improve EOL care for older adult patients by encouraging the use of ADs

Background

A. Education About Advance Directives:

1. Patients uniformly state that they want more information about ADs.

2. Patients want nurses (and physicians) to approach them about ADs.

3. It is estimated that 19% to 36% of Americans have completed an AD.

B. Advance Directives

1. Allow individual to provide directions about the kind of medical care they do or do not want if they become unable to make or communicate their decisions;

2. Provide guidance for health care professionals, families, and substitute decision makers about health care decision making that reflect the person's wishes; and

3. Provide immunity for health care professionals, families, and appointed proxies from civil and criminal liability when health care professionals follow the AD in good faith.

Also Consider

Topics

CRITICAL CARE »
ELDER MISTREATMENT AND ABUSE »
FAMILY CAREGIVING »
HEALTHCARE DECISION MAKING »
MEALTIME DIFFICULTIES »
PAIN » | PALLIATIVE CARE »
SLEEP »
TRANSITIONAL CARE »

Tools

Assessing Family Preferences for Participation in Care in Hospitalized Older Adults »
Elder Mistreatment Assessment »
Home Safety Inventory for Older Adults with Dementia »
Informal Caregivers of Older Adults at Home: Let's PREPARE! »
Pain Assessment for Older Adults »
Preparedness for Caregiving Scale »
The Confusion Assessment Method for the ICU (CAM-ICU) »
The Modified Caregiver Strain Index (MCSI) »

Hartford Institute web sites

- www.conultgeri.org
- www.hartfordign.org
- www.nicheprogram.org

Geriatric Assessment

- Comprehensive geriatric assessment is seen as the cornerstone of care of older adults
- It involves assessment of function, mental status, and assessment of geriatric syndromes
  - Delirium
  - Falls
  - Pain
  - Continence

Hartford Institute Assessment Resource: *Try This*

- One page, back-to-back authoritative resource for assessment of older adults
- Provide quick review of the topic, assessment process and additional resource
- Includes the actual instrument or approach
- On web (www.ConsultGeri.org) & mobile compatible

Try This Example

general assessment series

try this:®

Best Practices in Nursing Care to Older Adults

From The Hartford Institute for Geriatric Nursing, New York University, College of Nursing

Issue Number 33, 2016

Editor-in-Chief: Sherry A. Greenberg, PhD, RN, GNP-BC
New York University College of Nursing

Assessing Etiology of Orthostatic Hypotension in Older Adults

By: Elizabeth B. Esstman, MSN, GNP-BC, AGPCNP-BC,
Hebrew Healthcare, West Hartford, CT

WHY: Orthostatic hypotension is a drop in systolic blood pressure of at least 20 mm Hg or a drop in diastolic blood pressure of at least 10 mm Hg within 3 minutes of standing from a supine or sitting position (Feldstein & Weder, 2012). It is common in at least 30% of older adults and may lead to falls, diminished function and decreased quality of life (Feldstein & Weder, 2012; Irvin & White, 2004; Lee, 2013; Ricci, De Caterina, & Fedorowski, 2015). Assessing for the etiology of orthostatic hypotension may help identify reversible causes and expedite possible treatment.

BEST PRACTICE APPROACH: Nurses and other health care professionals should gather information to help determine the etiology of orthostatic hypotension by obtaining orthostatic pulses while concurrently obtaining orthostatic blood pressures. If possible, blood pressure AND pulse should be recorded in the lying, sitting, and standing positions. However, if a person reports dizziness or lightheadedness when lying or sitting, they should not be instructed to stand.

If the pulse rises over 20 beats per minute while blood pressure drops, this suggests hypovolemia (e.g. dehydration, acute blood loss) or an adverse effect from a medication (e.g. anti-hypertensives, psychotropic medications) (Gupta & Lipsitz, 2007; Irvin & White, 2004).
If the pulse stays constant or rises less than 10 beats per minute while blood pressure drops, this suggests autonomic dysfunction (e.g. Vitamin B12 deficiency, Parkinson's disease, diabetic neuropathy) (Gupta & Lipsitz, 2007).

Mental Status Assessment

general assessment series

try this:®

Best Practices in Nursing Care to Older Adults

From The Hartford Institute for Geriatric Nursing, New York University, College of Nursing

Issue Number 3, Revised 2013

Editor-in-Chief: Sherry A. Greenberg, PhD(c) MSN, GNP-BC
New York University College of Nursing

Mental Status Assessment of Older Adults: The Mini-Cog™

By: Deirdre M. Carolan Doerflinger, CRNP, PhD, Inova Fairfax Hospital, Falls Church, Virginia

WHY: Five and a third (5.3) million Americans of all ages have Alzheimer's disease
One in ten individuals over 65 and nearly half of those over 85 are affected. A new c
seconds according to the *2010 Alzheimer's Disease Facts and Figures; Older Ameri*
availability of successful treatments for dementia and dementia-related illnesses me
identification of cognitive impairment, particularly in the geriatric population. Usir
implement facilitates early identification and allows the person to receive prompt tr
form of medication and behavioral therapy may slow disease progression, delay fun
nursing home placement.

BEST TOOL: The Mini-Cog™ is a simple screening tool that is well accepted and ta
be used to detect cognitive impairment quickly during both routine visits and hospi
tool to identify patients in need of more thorough evaluation. The Clock Drawing T
to quickly assess numerous cognitive domains including cognitive function, memo
executive function and provides a visible record of both normal and impaired perfor

TARGET POPULATION: The Mini-Cog™ is appropriate for use in all health care se
various heterogeneous language, culture, and literacy levels.

VALIDITY AND RELIABILITY: The Mini-Cog™ was developed as a brief screening
without dementia. Depending on the prevalence of dementia in the target populati
and specificity ranging from 89-93% with 95% confidence interval. A chi square te
other dementias ($p<0.001$). This tool has strong predictive value in multiple clinica
that a 5-point numerical scoring system based on the original algorithm may be eas
drawing distractor (CDT) (0-2 points), and recall of the earlier three items after the

The Mini Cog™

Administration:

1. Instruct the patient to listen carefully to and remember 3 unrelated words and then to repeat the words. The same 3 words may be repeated to the patient up to 3 tries to register all 3 words.

2. Instruct the patient to draw the face of a clock, either on a blank sheet of paper or on a sheet with the clock circle already drawn on the page. After the patient puts the numbers on the clock face, ask him or her to draw the hands of the clock to read a specific time. The time 11:10 has demonstrated increased sensitivity.

3. Ask the patient to repeat the 3 previously stated words.

Scoring: (Out of total of 5 points)
Give 1 point for each recalled word after the CDT distractor. Recall is scored 0-3.
The CDT distractor is scored 2 if normal and 0 if abnormal.
(Note: The CDT is considered normal if all numbers are present in the correct sequence and position, and the hands readably display the requested time. Length of hands is not considered in the score.)

Interpretation of Results:
0-2: Positive screen for dementia
3-5: Negative screen for dementia

Sources:

Borson, S., Scanlan, J., Brush, M., Vitaliano, P., & Dokmak, A. (2000). The Mini-Cog: A cognitive 'vital signs' measure for dementia screening in multi-lingual elderly. *International Journal of Geriatric Psychiatry, 15*(11), 1021-1027.

Borson, S., Scanlan, J.M., Watanabe, J., Tu, S.P., & Lessig, M. (2006). Improving identification of cognitive impairment in primary care. *International Journal of Geriatric Psychiatry, 21*(4), 349-355.

Lessig, M., Scanlan, J., Nazemi, H., & Borson, S. (2008). Time that tells: Critical clock-drawing errors for dementia screening. *International Psychogeriatrics, 20*(3), 459-470.

Try This - Delirium

general assessment series

try this:®

Best Practices in Nursing Care to Older Adults

From The Hartford Institute for Geriatric Nursing, New York University, College of Nursing

Issue Number 13, Revised 2012

Editor-in-Chief: Sherry A. Greenberg, PhD(c) MSN, GNP-BC
New York University College of Nursing

The Confusion Assessment Method (CAM)

By: Christine M. Waszynski, MSN, APRN, BC, Hartford H

WHY: Delirium is present in 10%-31% of older medical inpatients upon hospital admission and develop delirium during hospitalization (Siddiqi, House, & Holmes, 2006; Tullmann, Fletcher, & associated with negative consequences including prolonged hospitalization, functional decline, i physical restraints, prolonged delirium post hospitalization, and increased mortality. Delirium n effects including the development of dementia within two years (Ehlenbach et al., 2010) and the home care (Inouye, 2006). Predisposing risk factors for delirium include older age, dementia, se morbidities, alcoholism, vision impairment, hearing impairment, and a history of delirium. Prec acute illness, surgery, pain, dehydration, sepsis, electrolyte disturbance, urinary retention, fecal risk medications. Delirium is often unrecognized and undocumented by clinicians. Early recogn outcomes. Therefore, patients should be assessed frequently using a standardized tool to facilitat management of delirium and underlying etiology.

BEST TOOL: The Confusion Assessment Method (CAM) is a standardized evidence-based tool th trained clinicians to identify and recognize delirium quickly and accurately in both clinical and r includes four features found to have the greatest ability to distinguish delirium from other types is also a CAM-ICU version for use with non-verbal mechanically ventilated patients (See *Try This*

VALIDITY AND RELIABILITY: Both the CAM and the CAM–ICU have demonstrated sensitivity 89-95% and high inter-rater reliability (Wei, Fearing, Eliezer, Sternberg, & Inouye, 2008). Sever validate clinical usefulness.

STRENGTHS AND LIMITATIONS: The CAM can be incorporated into routine assessment and h languages. The CAM was designed and validated to be scored based on observations made during testing, such as brief mental status evaluations. Training to administer and score the tool is nece The tool identifies the presence or absence of delirium but does not assess the severity of the cor detect clinical improvement or deterioration.

FOLLOW-UP: The presence of delirium warrants prompt intervention to identify and treat unde supportive care. Vigilant efforts need to continue across the healthcare continuum to preserve a

MORE ON THE TOPIC:
Best practice information on care of older adults: www.ConsultGeriRN.org.
The Hospital Elder Life Program (HELP), Yale University School of Medicine. Home Page: www.hospitalelderlifeprogram

The Confusion Assessment Method Instrument:

1. ***[Acute Onset]*** Is there evidence of an acute change in mental status from the patient's baseline?

2A. ***[Inattention]*** Did the patient have difficulty focusing attention, for example, being easily distractible, or having difficulty keeping track of what was being said?

2B. ***(If present or abnormal)*** Did this behavior fluctuate during the interview, that is, tend to come and go or increase and decrease in severity?

3. ***[Disorganized thinking]*** Was the patient's thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?

4. ***[Altered level of consciousness]*** Overall, how would you rate this patient's level of consciousness? (Alert [normal]; Vigilant [hyperalert, overly sensitive to environmental stimuli, startled very easily], Lethargic [drowsy, easily aroused]; Stupor [difficult to arouse]; Coma; [unarousable]; Uncertain)

5. ***[Disorientation]*** Was the patient disoriented at any time during the interview, such as thinking that he or she was somewhere other than the hospital, using the wrong bed, or misjudging the time of day?

6. ***[Memory impairment]*** Did the patient demonstrate any memory problems during the interview, such as inability to remember events in the hospital or difficulty remembering instructions?

7. ***[Perceptual disturbances]*** Did the patient have any evidence of perceptual disturbances, for example, hallucinations, illusions or misinterpretations (such as thinking something was moving when it was not)?

8A. ***[Psychomotor agitation]*** At any time during the interview did the patient have an unusually increased level of motor activity such as restlessness, picking at bedclothes, tapping fingers or making frequent sudden changes of position?

8B. ***[Psychomotor retardation]*** At any time during the interview did the patient have an unusually decreased level of motor activity such as sluggishness, staring into space, staying in one position for a long time or moving very slowly?

9. ***[Altered sleep-wake cycle]*** Did the patient have evidence of disturbance of the sleep-wake cycle, such as excessive daytime sleepiness with insomnia at night?

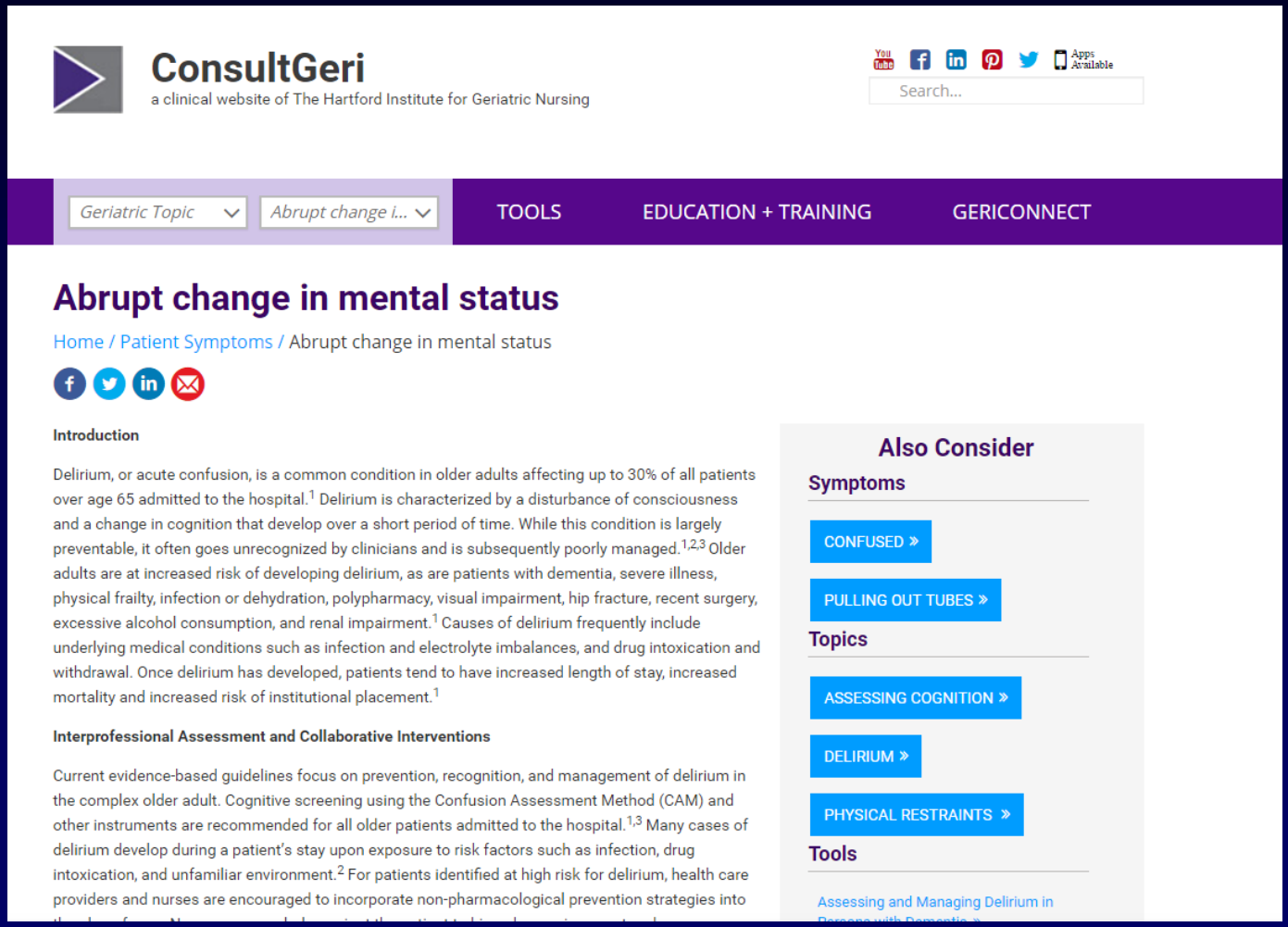
The Confusion Assessment Method (CAM) Diagnostic Algorithm

Feature 1: ***Acute Onset or Fluctuating Course***
This feature is usually obtained from a family member or nurse and is shown by positive responses to the following questions: Is there evidence of an acute change in mental status from the patient's baseline? Did the (abnormal) behavior fluctuate during the day, that is, tend to come and go, or increase and decrease in severity?

Feature 2: ***Inattention***
This feature is shown by a positive response to the following question: Did the patient have difficulty focusing attention, for example, being easily distractible, or having difficulty keeping track of what was being said?

Feature 3: ***Disorganized thinking***
This feature is shown by a positive response to the following question: Was the patient's thinking disorganized or

Importance of mental health assessment and co-morbidities



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Abrupt change in mental status

Home / Patient Symptoms / Abrupt change in mental status

Introduction

Delirium, or acute confusion, is a common condition in older adults affecting up to 30% of all patients over age 65 admitted to the hospital.[1] Delirium is characterized by a disturbance of consciousness and a change in cognition that develop over a short period of time. While this condition is largely preventable, it often goes unrecognized by clinicians and is subsequently poorly managed.[1,2,3] Older adults are at increased risk of developing delirium, as are patients with dementia, severe illness, physical frailty, infection or dehydration, polypharmacy, visual impairment, hip fracture, recent surgery, excessive alcohol consumption, and renal impairment.[1] Causes of delirium frequently include underlying medical conditions such as infection and electrolyte imbalances, and drug intoxication and withdrawal. Once delirium has developed, patients tend to have increased length of stay, increased mortality and increased risk of institutional placement.[1]

Interprofessional Assessment and Collaborative Interventions

Current evidence-based guidelines focus on prevention, recognition, and management of delirium in the complex older adult. Cognitive screening using the Confusion Assessment Method (CAM) and other instruments are recommended for all older patients admitted to the hospital.[1,3] Many cases of delirium develop during a patient's stay upon exposure to risk factors such as infection, drug intoxication, and unfamiliar environment.[2] For patients identified at high risk for delirium, health care providers and nurses are encouraged to incorporate non-pharmacological prevention strategies into

Also Consider

Symptoms

CONFUSED »

PULLING OUT TUBES »

Topics

ASSESSING COGNITION »

DELIRIUM »

PHYSICAL RESTRAINTS »

Tools

Assessing and Managing Delirium in

Hartford Institute Clinical Practice Protocols

- Evidence-based protocols
- Focus on common geriatric care syndromes
  - delirium, urinary incontinence, falls, nutrition
- Accessible and usable by direct care nurses
- On ConsultGeri web site

Use of Geriatric Assessment and Protocols in Patients with Cancer

- In older patients with cancer, especially people >75:
  - Anticipate geriatric syndromes (dementia; delirium after use of chemo)
  - Screen for geriatric syndromes using validated instruments
  - Apply evidence based protocols

Age Friendly Practice Environments

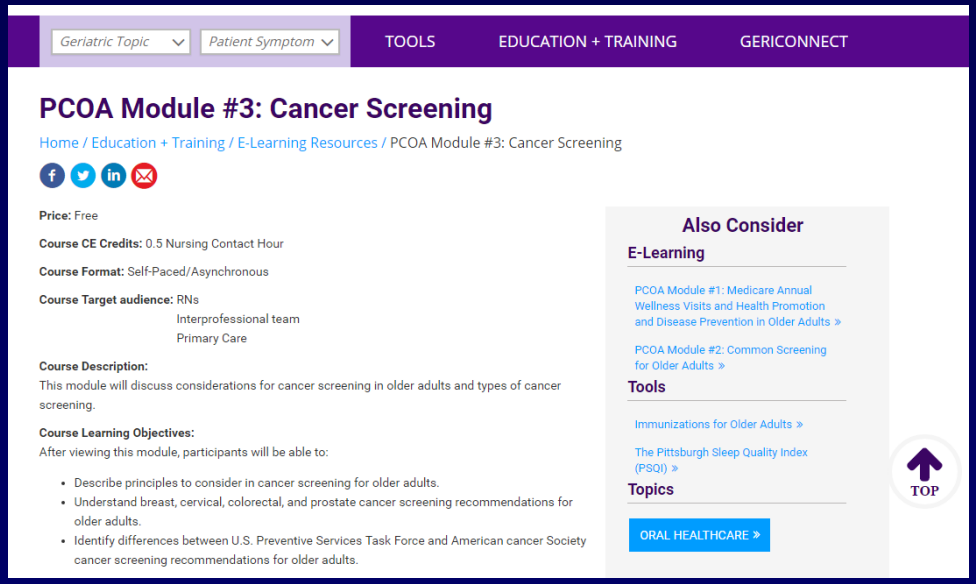
- Creating elder friendly primary care practices (PCOA)
- Creating age friendly hospitals: NICHE and beyond
- Fostering geriatric excellence among specialty nurses
- Improving interdisciplinary communication
- Strengthening nursing home care

- 11 modules focused on age appropriate care for older adults in primary care
- PCOA-Interprofessional: Testing models to educate personnel throughout a health system on care of older adults
  - Emphasizes wellness and chronic disease management
  - Emphasizes interdisciplinary team training

Examples of PCOA Modules

- PCOA Module #3 – Cancer Screening
- PCOA Module #6 – Advanced Directives
- PCOA Module #7 – Palliative and Hospice Care
  PCOA Module #9 – Persistent Pain

Visit https://consultgeri.org/education-training/e-learning-resources



Older Adults in Hospitals

- Account for 35% of hospital admissions
- Account for 48% of admissions to ICUs
- $17.5B in avoidable readmissions to hospitals annually

nicheprogram.org

NICHE

Nurses Improving Care for Healthsystem Elders

NICHE: Reaching Hospitals to Create System Change

NICHE: Nurses Improving Care to Health Systems Elders

- **>600 hospitals nationwide**
- Median of 400± beds
- Hospitals undertaking system change to improve geriatric care

NICHE Framework

NICHE PRINCIPLES

Evidence-based geriatric care at the bedside

Patient/family -centered environments

Healthy and productive practice environments

- Values: older adult and staff autonomy
- Interdisciplinary collaboration
- Access to geriatric -specific resources

Multi-dimensional metrics of quality

NICHE Hospitals Nationally (Nicheprogram.org)

- In almost all states
  - Large numbers in CA, FL, IL, MA, MI, NJ, NY,OH, PA, TX, VA, WI
- All types of hospitals involved, e.g. academic health centers, community hospitals
- NICHE hospitals vary as to their level of implementation: Early, Progressive, Elder Friendly, and Exemplar Implementation

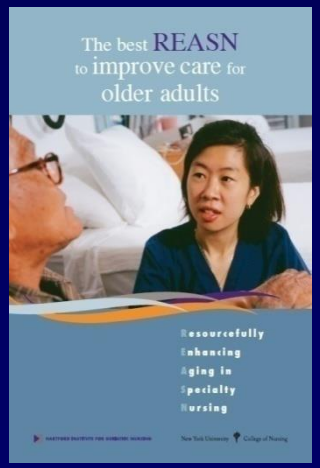
NICHE Resources for Patients with Cancer

The educational series, Nursing Care of the Older Adult with Cancer, provides the nurse clinician with practical information regarding the complexities and special considerations associated with caring for older adults with cancer, in all practice settings. The completed course provides 6 contact hours. Available for NICHE member organizations

- Cancer and the Aging Population
- Cancer and Age-Related Changes
- The Older Adult Receiving Radiation: Nursing Considerations
- The Older Adult Receiving Chemotherapy: Nursing Considerations
- The Older Adult Receiving Cancer Treatment: Symptom Management
- The Older Adult with Cancer: Psychosocial Considerations

Specialty Nurses and Care of Older Adults

- REASN – Reaching >500,000 specialty nurses
  - Introducing geriatric language into the Scopes and Standards and certification exams for specialty nurses
  - Assuring a geriatric capacity in specialty nursing associations
    - Geriatric special interest groups
    - Web-based resources



Geriatric Resources from ONS

- Caring the Older Adult with Cancer in the Ambulatory Setting book: https://www.ons.org/products/caring-older-adult-cancer-ambulatory-setting
- An Evidence Based Approach to the Treatment and Care of the Older Adult with Cancer:https://www.ons.org/products/evidence-based-approach-treatment-and-care-older-adult-cancer
- The NCCN has Clinical Practice Guidelines for the Older Adult in Oncology - you can register for free and access them: http://www.nccn.org/professionals/physician_gls/f_guidelines.asp#age

Creating Age Friendly Environments

- Look at your practice environment with a new “lens”
  - Is your physical responsive to an older patient’s needs?
  - Are your written and electronic materials appropriate for older patients?
  - Is your workforce prepared to work with older patients?
  - Do you assure that family members of older adults fully involved in their care?
  - Does someone on your staff monitor the geriatric literature or belong to a geriatric group in your professional organization?

Re-conceiving Interdisciplinary Practice

- Interdisciplinary (inter-professional) practice no longer a “fad”
- Employers **expect** interdisciplinary skills & competencies
- Interdisciplinary models **dominate** care delivery
- Interdisciplinary models **rewarded** in payment structures and regulations
- Interdisciplinary models **cut across systems of care**

Geriatric Interdisciplinary Systems of Care

- Quality Cost Model of Transitional Care
- PACE programs
- The Care Transitions Program
- Project Boost
- Geriatric Resources for Assessment and Care of Elders (GRACE)
- Guided Care
- Elder Friendly Hospital Initiative

Creating Interdisciplinary Care for Older Adults with Cancer

- Where does your setting stand in terms of interdisciplinary care?
- Do you have the right members on your team?
  - GNP, geriatrician, geriatric social worker, geriatric pharmacist
- How strong are your liaisons with your home care agencies and nursing homes?

Geriatric Cancer Nurses Are Not Born – They Are Made

www.ConsultGeriRN.org