

## CONFERENCE ABSTRACT

# Evaluation of a transitional care programme for frail older adults and the effectiveness for the oldest old

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Wilma van der Vlegel-Brouwer

IJsselland hospital, The Netherlands

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**Introduction:** Older adults with multimorbidity, aged 70 years and older, experience a complex of both medical and social problems and frequently require continuous care in multiple settings. They move between acute and non-acute care settings, such as hospitals, home, intermediate care unit, primary care center, nursing home and hospice. It is within that context, that the transitional care programme for this group has been developed in the IJsselland hospital in the Netherlands, and will be evaluated. In this programme the Transmural Care Bridge is incorporated.

**The programme:** The identification of seniors at risk starts at the Emergency Department with the ISAR- HP, the identification of seniors at risk- hospitalized. Patients at high risk for functional decline will fill out a triage questionnaire with their informal caregivers developed by the Geriatricians of the hospital. In all cases a registered nurse on the ward where the patient is admitted will start with screening on delirium, malnutrition, ADL functions, mobility and fall risk. If necessary the geriatric consultation team will visit the patient and a systematic comprehensive geriatric assessment (CGA) will be done. The geriatrician will develop a care plan.

In the programme one day before discharge from hospital a community nurse (CN) visits the patient inside the hospital and within 48 hours after discharge from hospital and after 2, 6, 12 and 24 weeks. Main issues during these visits are medication safety, appropriateness of care arranged during hospital admission resources, social network and support for the informal caregiver. The CN will discuss the care plan with the General Practitioner (GP) of the patient.

In a prospective cohort study 100 older patients, 50 patients before and 50 patients after the start of this programme, are asked to fill out a questionnaire at the start of the program in the hospital, and after one and three months after discharge from hospital, to measure morbidity, functional limitations, cognitive functioning, social functioning, self-perceived health, self-perceived quality of life, experiences, GP visits and admissions. Also the effectiveness of the program on self-management abilities will be measured by the CN through the Self Sufficiency Matrix.

30 professionals inside and outside the hospital who provide care for this group of older adults, specialist, nurses, general practitioners and community nurses will be asked to provide their perspectives on the programme and on inter-professional collaboration.

**Effectiveness for the oldest old:** Because preliminary research findings showed that many people aged 85 years and older, who we consider in this study as the oldest old, said they felt lonely, useless, lost spouses, friends and sometimes children and sometimes were waiting to die, an additional question arose about how the oldest old would perceive this care programme and if this would meet their needs. This question will be addressed by in depth interviews with the oldest old.

**Aim:** This research project aims to contribute to changes in transitional care for older adults who are admitted to the hospital and add to the current body of knowledge of the perspectives of the oldest old on their care.

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**Keywords:** oldest old; self-management; transitional care

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