University of Hertfordshire

AVOIDING BLACK HOLES: NURSING AND THE CARE OF OLDER PEOPLE AND THEIR CARERS LIVING AT HOME

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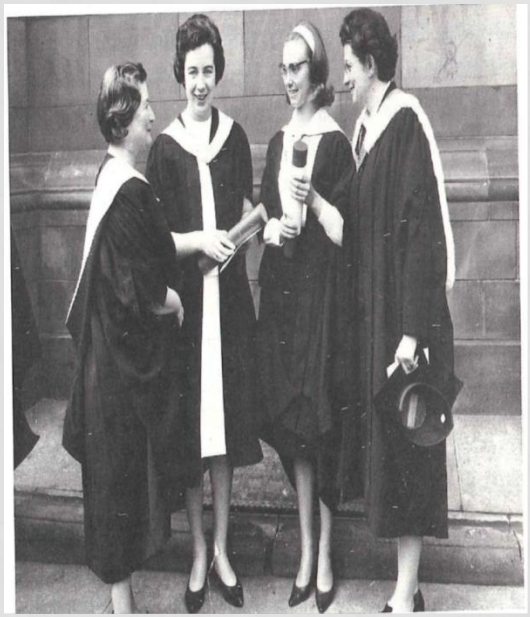
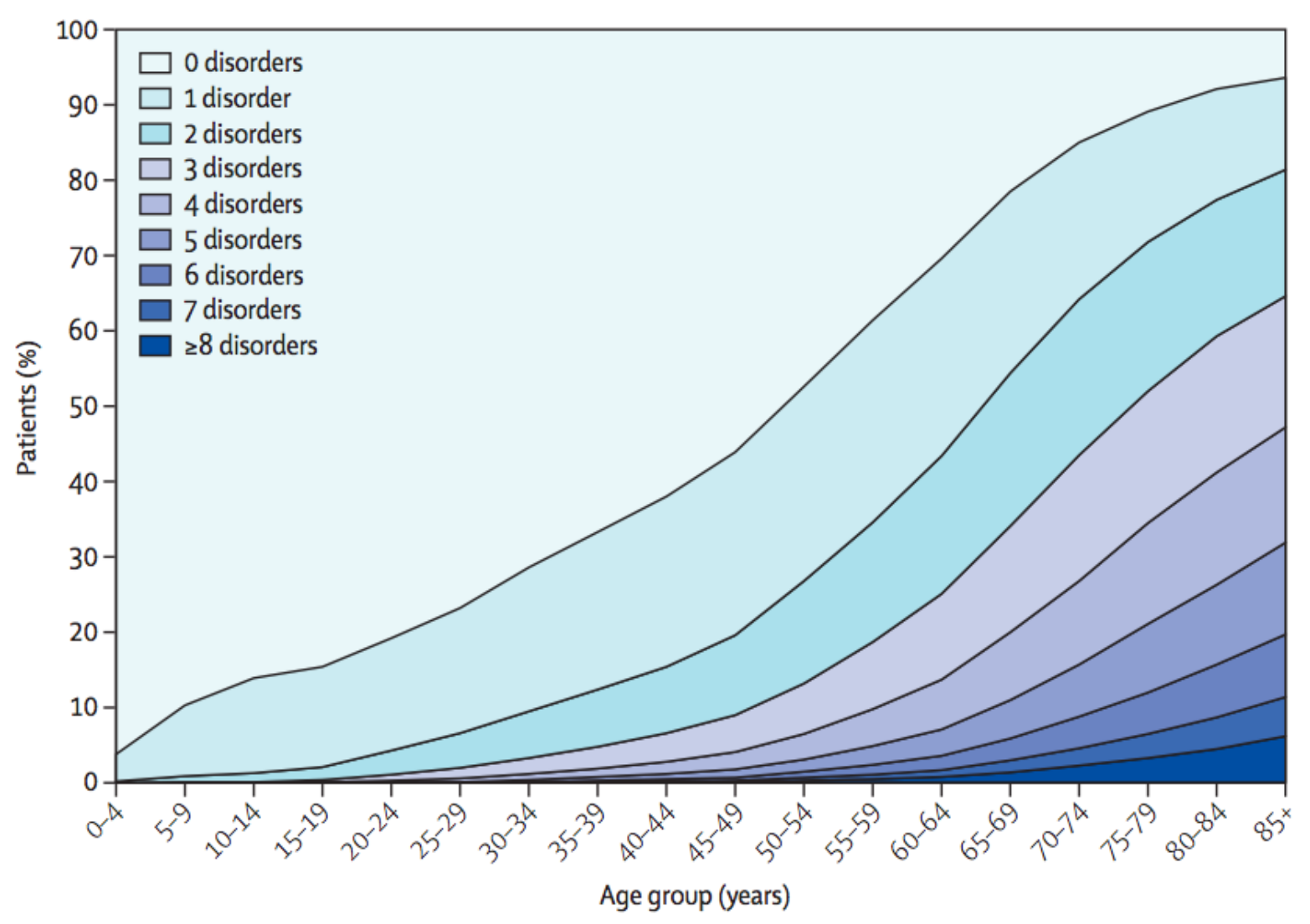
OUTLINE

- Black holes
- Elsie Stephenson
- Older people and their carers
- Nursing impact at the personal and organisational level
- Future response?

ELSIE STEPHENSON



MULTI MORBIDITY BY AGE BARNETT ET AL. LANCET 2012



More Exercise

Mobility problems

Son far away

Obese

Increasingly forgetful

Income reducing

warfarin

GP has retired, new appointment system

AF

neighbour moving away

High cholesterol

Avoid salt, fats, carbs

Multiple prescriptions

Diabetes

HbA1c 8.2%

Check sugars

Nurse-led clinic

Hypertension

Dizzy

Beta-blocker

Check his feet

Difficulty sleeping

Carer

Bad back

Getting her to the clinic

Neuropathy

Review in 12 weeks

Design adapted from Victor Montori, Mayo Clinic

CUMULATIVE COMPLEXITY

- Clinical and social factors accumulate over time
- Interact to shape health service use, self-care, and health

- Need to reduce the impact of **treatment burden**
- Need for patient centred approaches :**reconsider** disease centred approaches

Shippee, N.D., Shah, N.D., May, C.R., Mair, F.S. & Montori, V.M. Cumulative complexity: a functional, patient-centered model of patient complexity can improve research and practice. *Journal of Clinical Epidemiology,* ***65(10), 1041-1051.***

UNDERSTANDING FRAILTY (AKA CUMULATIVE TRIVIA?)

- **Fluctuating disability** day-to-day instability, resulting in patients with "good",independent days, and "bad" days on which (professional) care is often needed.

Clegg,Young, Iliffe et al 2013 Lancet

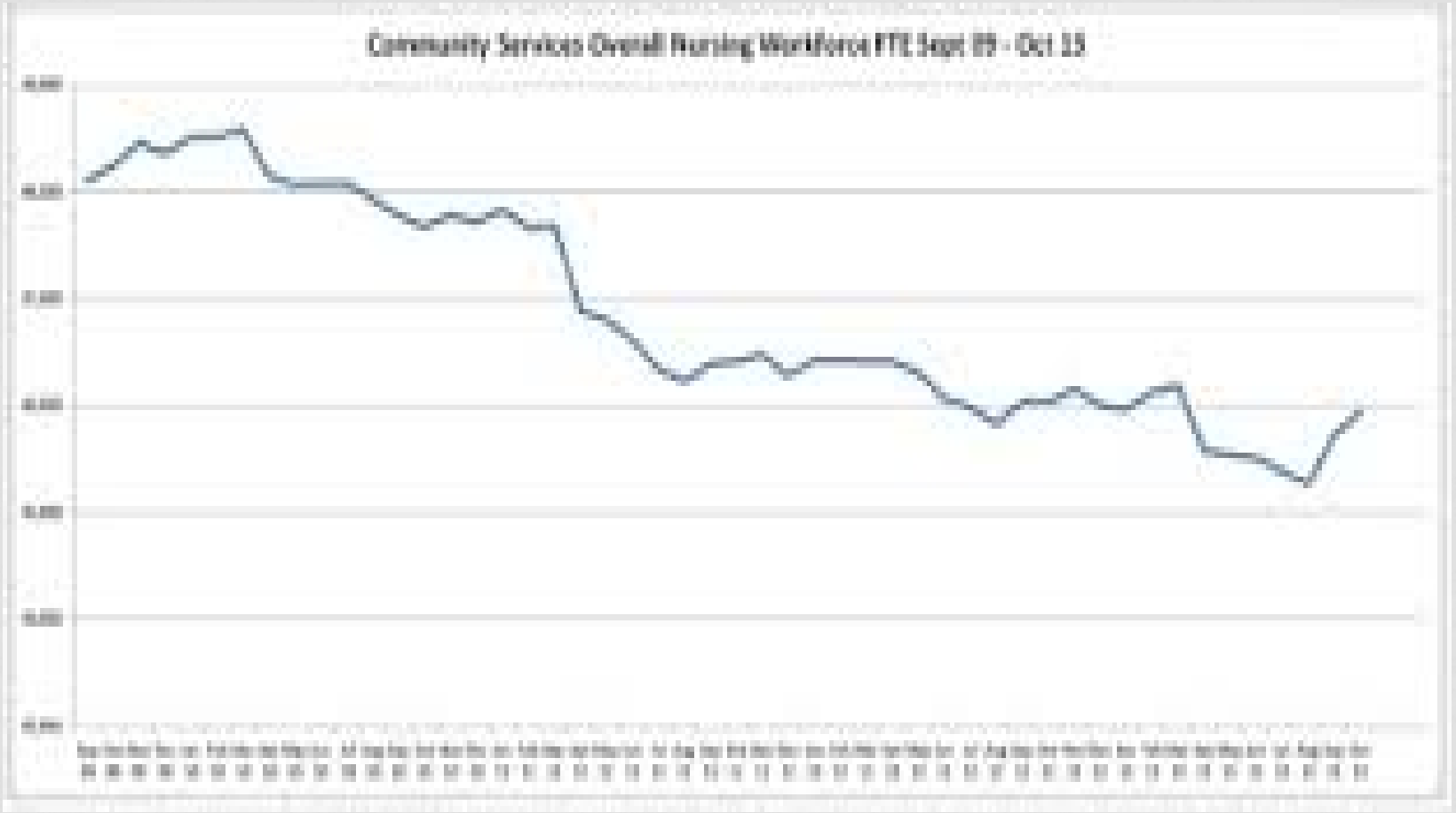
Poltawski, L., Goodman,C., Iliffe, s. et al 2011 Journal of Interprofessional Care 2011 25:4, 280-286

EVIDENCE IS MIXED

- Continuity of care with a family physician ☺
- Hospital at home instead of admission☺
- Self management☺
- Generic or disease specific case management☹☺
- Comprehensive Geriatric Assessment😐
- Telemedicine😐
- Integrated Care Pilots😐
- Pay for performance😐
- Structured discharge planning☹
- Pharmacist led medication review☹
- Partnerships for Older People Pilots ☹
- Virtual wards☹

WHAT IS THE NURSING IMPACT ?:

COMMUNITY SERVICES NURSING (FTE) 2009-2013 (ENGLAND) HSCIC



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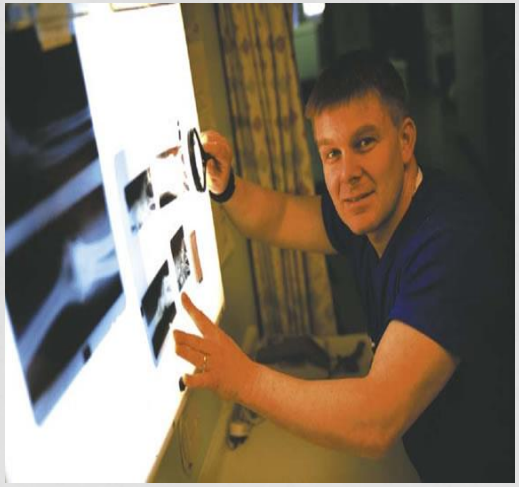
DIVERSE WORKFORCE



EVIDENCE?

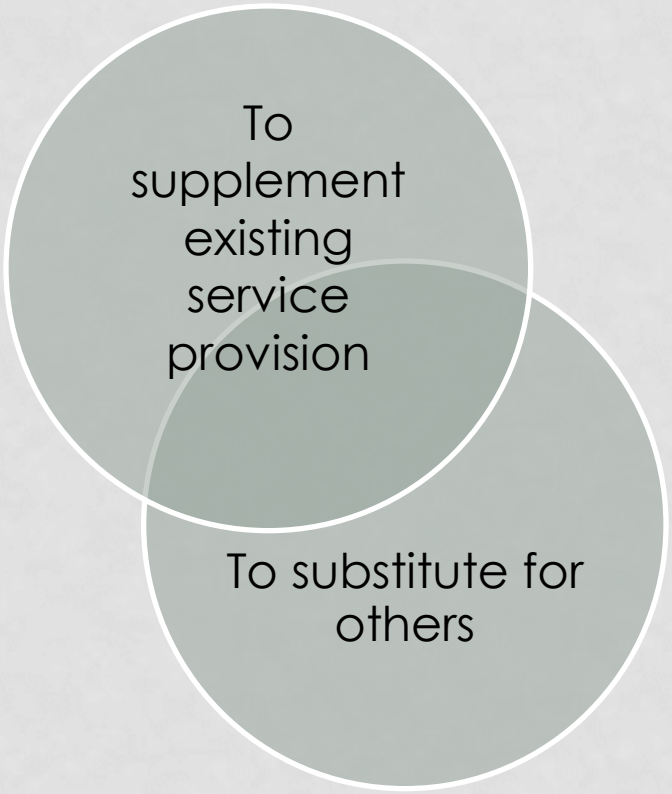
Integrative Review community nursing contribution to chronic disease management: Synthesis

Organisational and system influences on nursing contribution

To Substitute for others

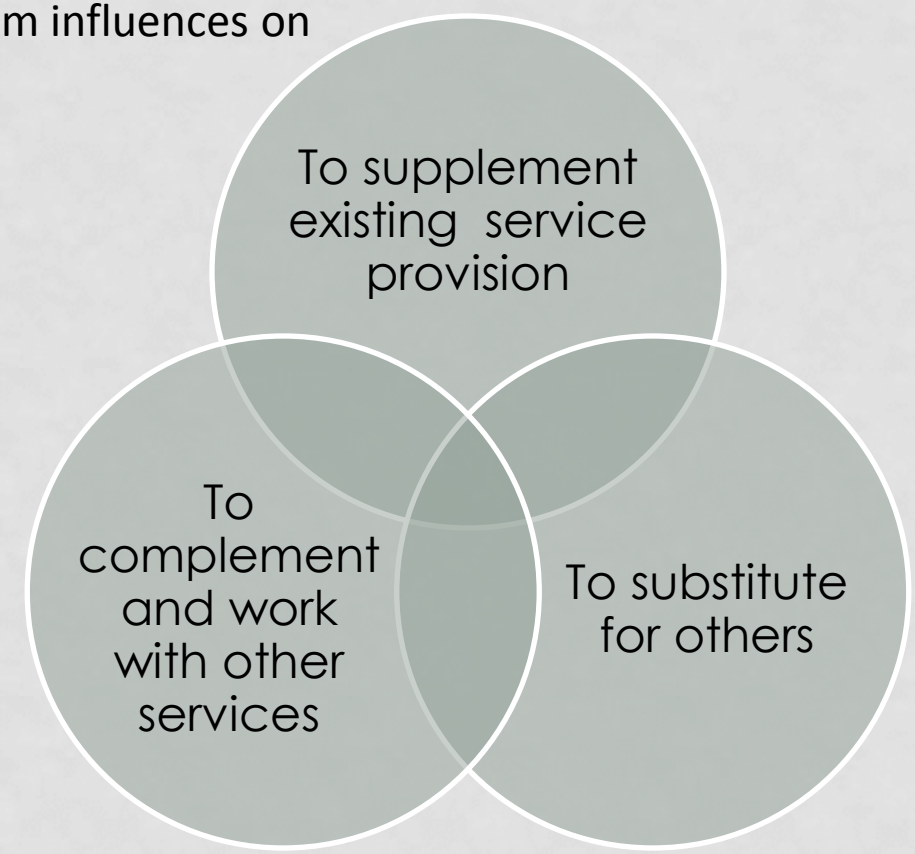
Integrative Review: Synthesis

Organisational and system influences on nursing contribution



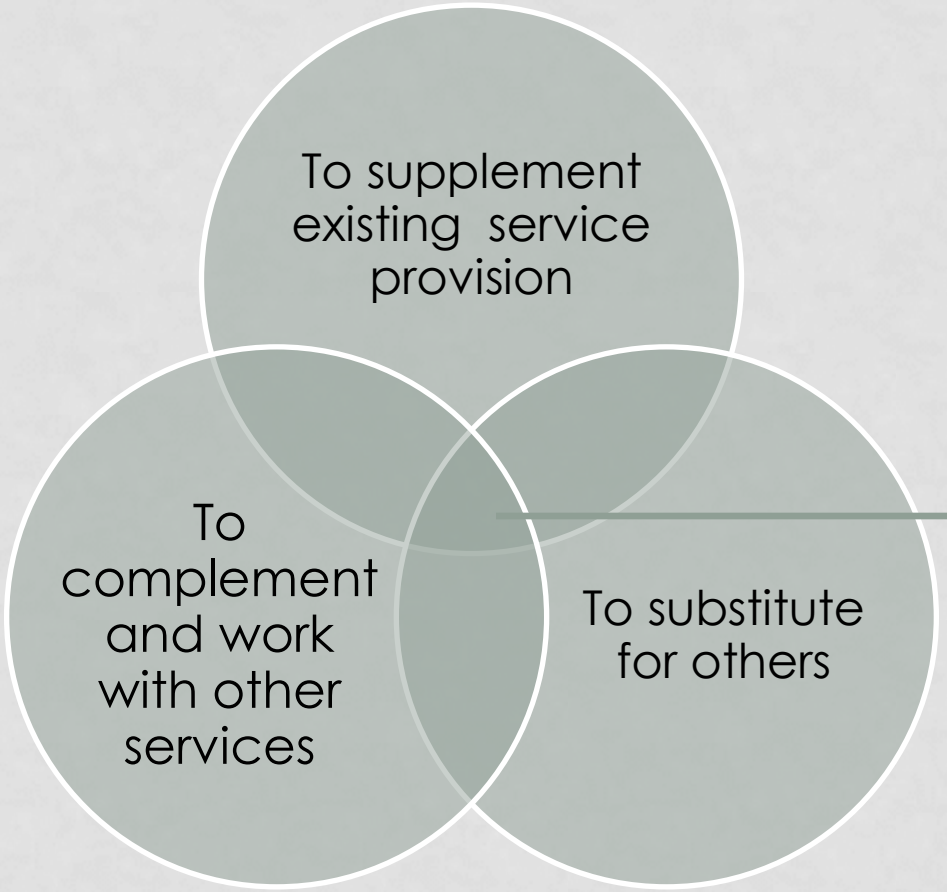
Integrative Review: Synthesis

Organisational and system influences on nursing contribution



Integrative Review: Synthesis

Organisational and system influences on nursing contribution



Dependent on education, expertise and organisational support, nurse achieves:

- Increased patient satisfaction and perceived quality of life
- Improved patient understanding and confidence in self management
- Improved symptom management
- Increased patient confidence
- Improved access to care
- Continuity of care **BUT unlikely to reduce resource or arresting the progressive decline of the patient condition**

NURSE LED CASE MANAGEMENT

GOODMAN C, DRENNAN V, DAVIES S, ET AL. 2010. NURSES AS CASE MANAGERS IN PRIMARY CARE: THE CONTRIBUTION TO CHRONIC DISEASE MANAGEMENT. SOUTHAMPTON,NIHR SDO REPORT NO: 08/1605/122

DRENNAN, V., GOODMAN, C., MANTHORPE, J., DAVIES, S., SCOTT, C., GAGE, H., & ILIFFE, S. (2011). ESTABLISHING NEW NURSING ROLES: A CASE STUDY OF THE ENGLISH COMMUNITY MATRON INITIATIVE.

JOURNAL OF CLINICAL NURSING, *20*(19-20), 2948-2957.

AMBIVALENCE

- *I see my role as mainly ensuring that patients gets the care they need whether it be from the district nursing team, specialists, adult services or other services such as charities, palliative care services…A lot of what I do is overseeing the care of patients, I liaise a lot with GPs, sometimes I feel like it's more of an advocacy role than* ***pure nursing***

- *Community matron*

CONTRIBUTION OF THE COMMUNITY NURSE FROM A PATIENT PERSPECTIVE

I don't' know exactly how she has done it, but since we first met her ***a lot more seems to have happened*** *and we seem to be getting* ***more support*** *from all kinds of people. I think the nurse* ***seems to be helping my wife too****, and that makes me feel quite happy."*

PATIENT DEFINITIONS OF GOOD NURSE CASE MANAGEMENT AND DESIRABLE OUTCOMES

- Clinical expert, intermediary and source of support and resources (including time)
- Access to services, quality and continuity of care
- Patient outcomes: ↑ confidence , ↑ self management **life easier**, addressing their priorities

HOW EXPERIENCED USERS OF HEALTH AND SOCIAL CARE SERVICES EVALUATED NURSE CASE MANAGERS

- Comparison with other professionals and services
- Comparison with other nursing disciplines
- How well their story was known

  "shared personal and clinical history between two individuals "

NURSE TO NURSE REFERRALS

- *You get to feel like an animal or something, you know, knock, knock, come in, blow into this, needle into here, thank you very much and bam they're (staff nurses) gone. ..*

WORKING AS A CASE MANAGER WITHIN THE HEALTH CARE ORGANISATION

- Had to negotiate and establish case manager role and contribution within the organisation
- Constant change and service redesign
- Increasing patient case load → referrals to other nursing services and involvement of other less qualified staff
- Role drift : case manager becoming clinical mentor/manager and innovator within the organisation

IMPACT OF NURSE CASE MANAGEMENT

- Expensive **BUT** many older people were in the last year of life : highest use of health and social care service is in the last year of life irrespective of age
- Works for a patient population that have complex health and social care needs who do not fit existing provision
- We do not know how many nurse case managers we need in the nursing workforce
- Very difficult to sustain within the existing infrastructure

REVIEW OF PROCESS OF CARE AND ITS EFFECTIVENESS WHEN NURSING IS ONE OF MANY DISCIPLINES

- How different **components and processes** of interprofessional working for older people living at home with complex needs had an impact on outcomes

- Identify the models of working that provide the strongest evidence base for practice with community dwelling older people

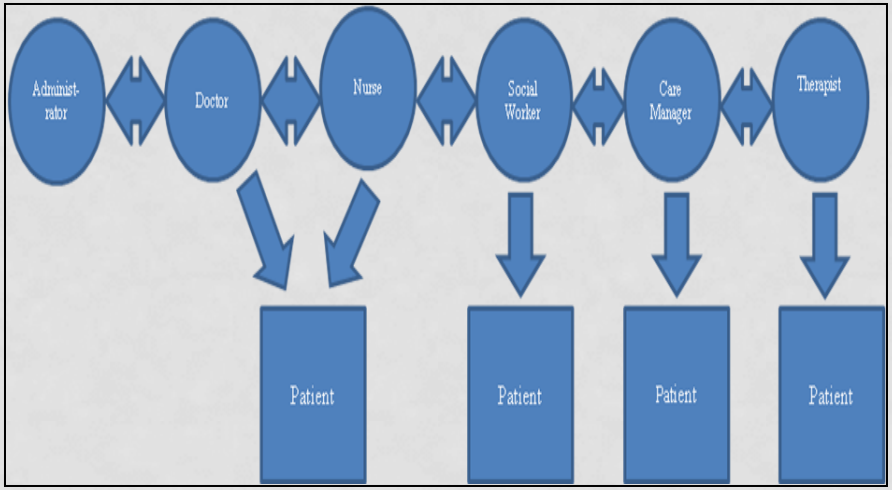
  Trivedi, D., Goodman, C., Gage, H., et al (2013), The effectiveness of inter-professional working for older people living in the community: a systematic review. *Health & Social Care in the Community,* 21: 113–128. doi: 10.1111/j.1365-2524.2012.01067.x

- Do different models of working have a different impact over time?
- What was the experience of different models of care from a patient perspective?
- Are certain attributes or mechanisms more significant than others?
- Is frailty a useful clinical measure?

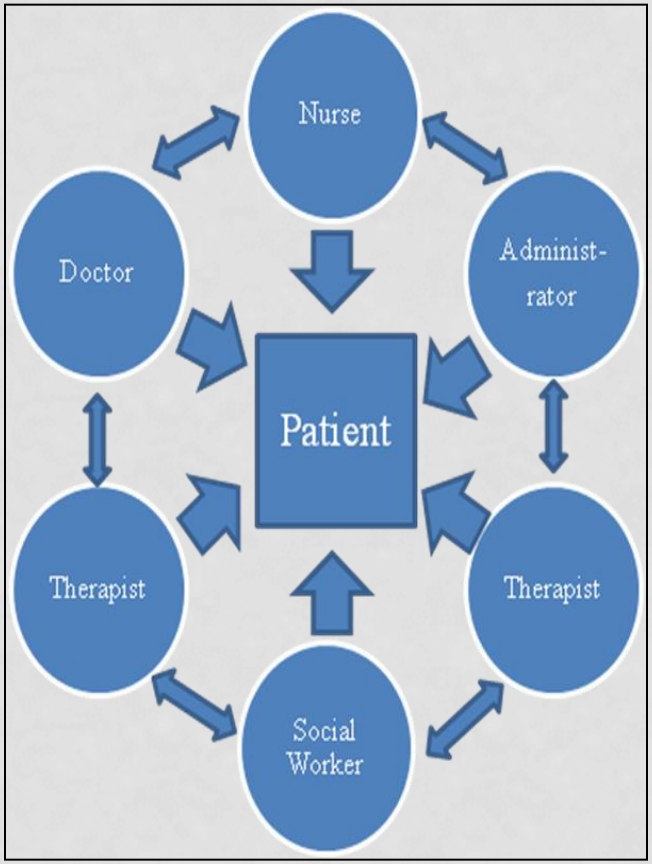
- Goodman, Drennan et al 2012 Topic: A study of the effectiveness of inter professional working for community dwelling older people (TOPIC) NIHR www.netscc.ac.uk/hsdr/projdetails.php?ref=08-1819-216

WHAT MODEL IS EFFECTIVE FROM THE PATIENT PERSPECTIVE?

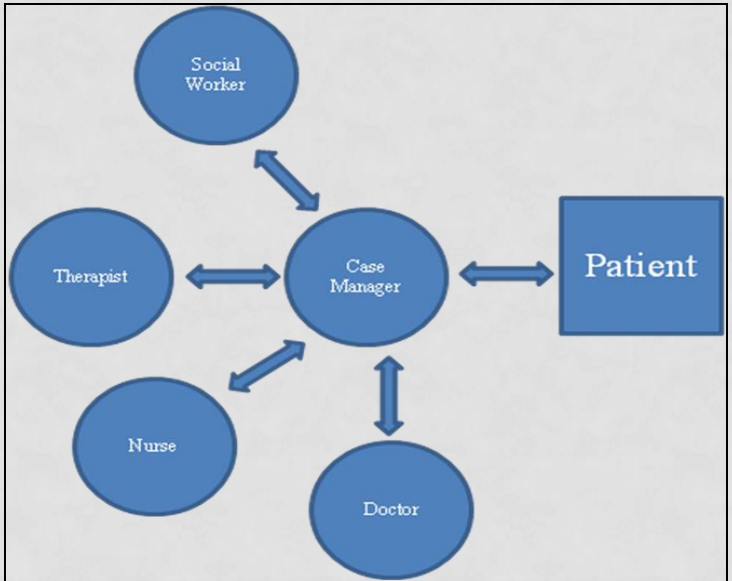
Integrated team model



Collaborative model



Case management model



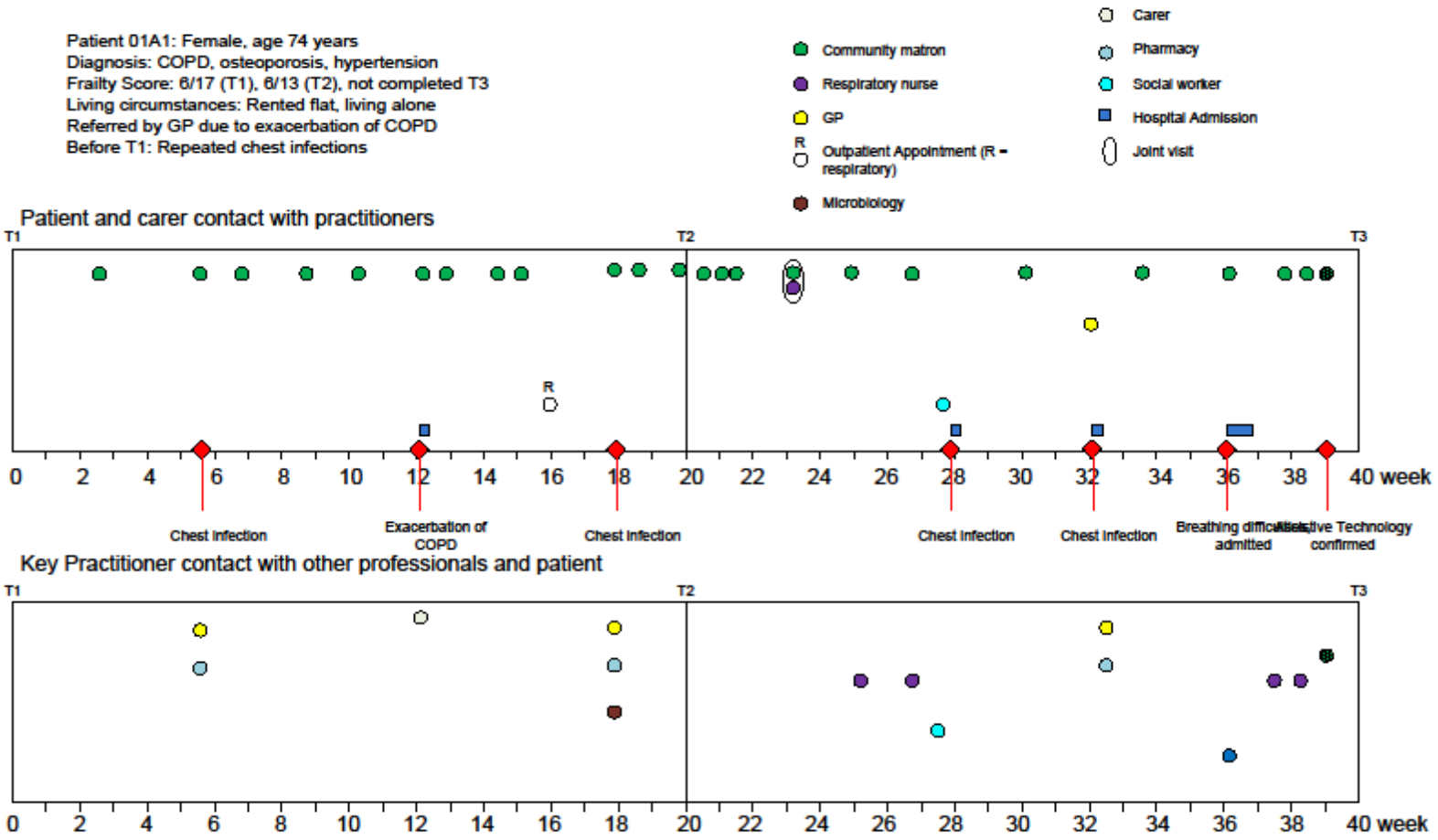
TOPIC

PHASE TWO

- Prospective case studies in 6 different sites looking from the patient perspective
- 3 different models of inter professionals working
- Tracking the care older people and their carers receive over nine months

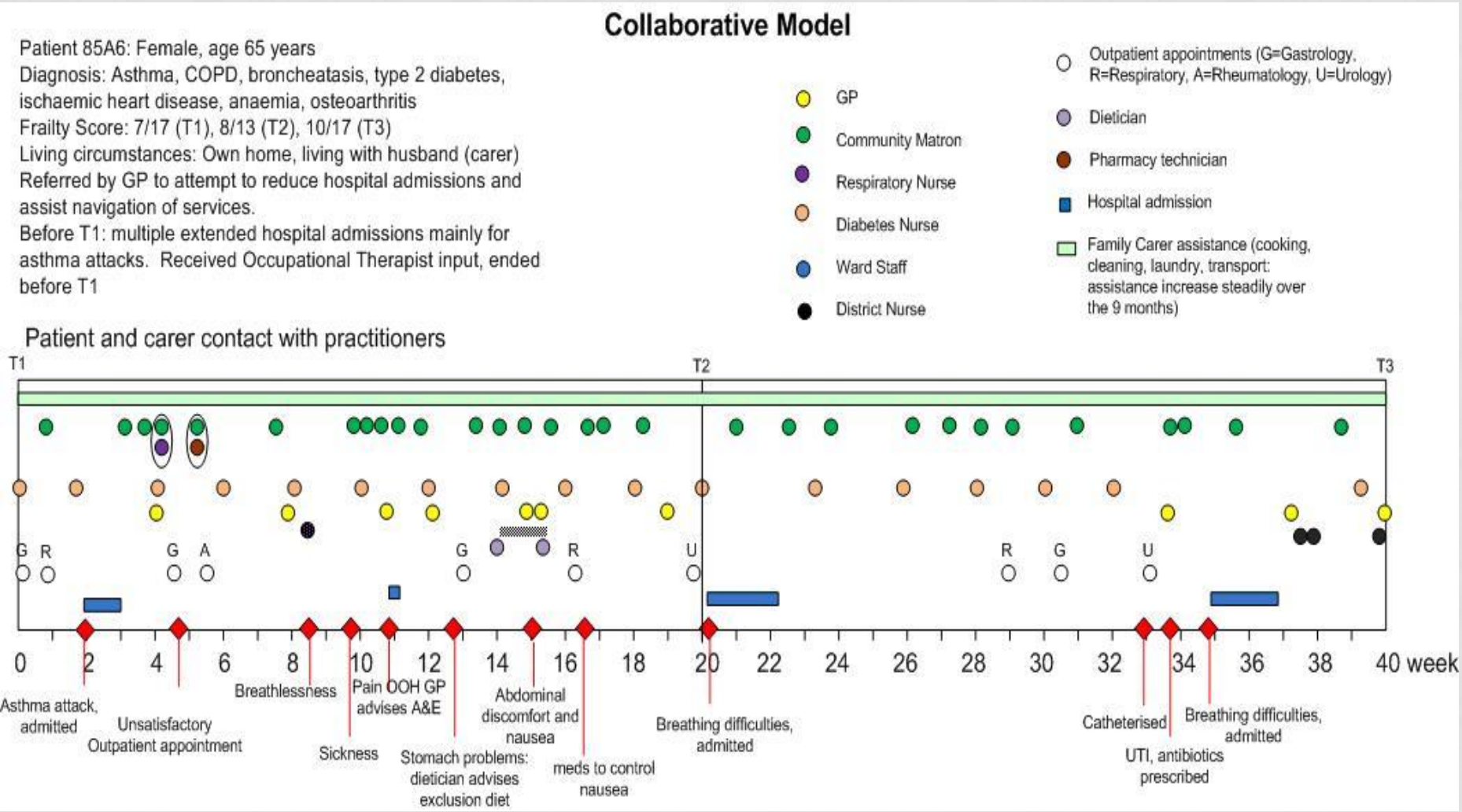
Case Management Model

Patient 01A1: Female, age 74 years
Diagnosis: COPD, osteoporosis, hypertension
Frailty Score: 6/17 (T1), 6/13 (T2), not completed T3
Living circumstances: Rented flat, living alone
Referred by GP due to exacerbation of COPD
Before T1: Repeated chest infections



Collaborative Model

Patient 85A6: Female, age 65 years
Diagnosis: Asthma, COPD, broncheatasis, type 2 diabetes, ischaemic heart disease, anaemia, osteoarthritis
Frailty Score: 7/17 (T1), 8/13 (T2), 10/17 (T3)
Living circumstances: Own home, living with husband (carer)
Referred by GP to attempt to reduce hospital admissions and assist navigation of services.
Before T1: multiple extended hospital admissions mainly for asthma attacks. Received Occupational Therapist input, ended before T1



KEY ATTRIBUTES FOR OLDER PEOPLE WITH COMPLEX, MULTIPLE AND ONGOING NEEDS

- Continuity
  - Information
  - Relational
  - Management
- Co-production
- Horizontal integration
- Identified key/care worker: usually a nurse

FOR NURSING TO MAKE A DIFFERENCE…….

- Needs:
  - **A mandate** to fulfil a role that is recognised and valued by others providing or commissioning services
  - **A viable working relationship** with a multidisciplinary team, including doctors
  - Advanced clinical skills and clarity of purpose
  - Protected time for ongoing patient contact and involvement

IN SUMMARY

- Patient and carers experience of health often characterised by cumulative complexity
- Nursing support for older people in community a consequence of multiple agendas
- Patients can define the kind of nursing care that makes a difference to their lives
- In the community, nursing is always a collaborative activity **BUT** not always co-operative
- One model will not fit all but key attributes valued by patients
- Without a mandate very difficult to sustain nurse led care
- The impact of nurse to nurse working on patient outcomes in community settings needs further investigation

Thank you!

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- **NIHR SDO Project: 08/1819/216 "TOPIC"**:A study of the effectiveness of inter professional working for community dwelling older people Vari Drennan St Georges Medical School and Kingston university Steve Iliffe UCL, Jill Manthorpe KCL, Heather Gage University of Surrey, Fiona Scheibl, Mel Handley ,Daksha Trivedi, Leon Poltawski, Avril Nash UH, Dhrushita Shah St Georges and Kingston Univeristy,

- Disclaimer: The views and opinions expressed in this presentation are those of the author, and do not necessarily reflect those of the funding body, the National Health Service or the Department of Health.