Flankerend geriatrisch beleid : het functioneren van geriatrische patienten tijdens ziekenhuisopname

Summary

Nowadays the ageing of society and its consequences for health care are widely discussed. Most of the time little attention is paid to the difference between elderly patients and geriatric patients. Sometimes they even are considered to be identical. This is an important misunderstanding because the number of elderly patients by far exceeds the number of geriatric patients. Further more the need for care, the diagnostic and therapeutic possibilities and the general level of functional activities is not comparable.
When the specific needs of (psycho)geriatric patients are used to determine the amount of care the whole elderly population demands the outcome will be completely unreliable. This happens for instance in many publications about geriatric care. The subject is the geriatric patient but facts and figures are dealing with care for the elderly.
The fact that no good definition of a geriatric patient is available is at least in part an explanation for this confusion. Nevertheless in practical health care practitioners seem to have selection criteria for refering a patient to an ordinary health care service or an institution with a geriatric label.
In the Academic Hospital of Maastricht from 1987 a specific geriatric consultation team is functioning. This team is working with the principles of the so-called Supportive Geriatric Care. Besides conventional medical care selected patients are given additional treatment for specific geriatric needs. The whole program is focussed on functional impairments related to multiple pathology, polyfarmacy, self-care problems, psychosocial difficulties, mobility disorders, communication problems, the need for chronic care, urinary and faecal incontinence and behavioural disturbances. The team consists of an internist, a consulting psychiatrist, a specialist in rehabilitation, physical therapists, social workers and activity therapists. They work close together with all other persons involved like medical specialists and nurses. In general the geriatric treatment schedule is based upon five objectives: reactivation, resocialisation, intensive guidance of medication, functional improvement and continuïty of care after discharge from the hospital.
In this thesis a report is given about the findings in the group of geriatric patients that were treated according to the principles of Supportive Geriatric Care during their stay in the hospital. The study was performed within a period of 27 months. Finally 1122 admissions were included.

The introductory chapter is dealing with the problem of the definition of a geriatric patient and the field of clinical geriatric medicine. Also a summary is given of the objectives of the study:

- a more precise idea about the difference between normal elderly patients and geriatric patients
- a description of the medical and functional features of the geriatric patients at the moment of admission
- analysis of the development in functional capacity of the geriatric patients during their stay in hospital
- to find out what are the consequences of geriatric problems in relation to the risk of death
- to determine wether specific geriatric scales can be used for planning the care after discharge.

Chapter 1 gives a brief overview on ageing problems. After discussing the demographics and its general consequences further attention is given to health care for the elderly in general, the impact of complexity of diseases and the necessity of differentiated care of geriatric patients.
It is concluded that there are at least three types of elderly patients

- patients with simple, mostly acute intercurrent diseases
- patients with more complex, mostly chronic medical problems that can be managed in such a way that a stabilized situation can be achieved for a longer period of time
- patients in an unstable physical psychological and social condition due to multiple pathology, high level of needs and various disabilities.

Thereafter a history of international geriatric care is given with specific attention to the literature on the outcome of geriatric hospitals. With respect to the situation in the Netherlands the author gives his own ideas about the advantages and disadvantages of separate geriatric clinics. In addition some details are given about the consequences of actual health policies in the Netherlands in relation to geriatric patient care.

Chapter 2 describes more in detail the treatment philosophy and the main points of Supportive Geriatric Care. A description is given of the organisation and accruel of patients. After this the items reactivation, resocialisation, demedication, functional re-orientation and continuity of care are discussed. Reactivation deals with all the activities focussed on ADL-disabilities, mobility disorders and incontinence problems. Resocialisation means all action to optimalize the psychosocial functioning of the geriatric patients, whether or not there are any cognitive disorders. Demedication comprizes all activities to reduce the amount of medical prescriptions as much as possible. Functional re-orientation is dealing with the consequences of a shortened life

expectancy and changes in the cure/care ratio as well as with the importance of early decissionmaking about the limits of medical care.
Finally, continuïty of care is the heading for all the activities related to the transmural character of geriatric medicine.

Chapter 3 starts with a description of the background and actual accruel of the study-population. The clinical outreach of Supportive Geriatric Care is such that at least 50% of all geriatric patients in the referal area are included in the study.
The close connection between clinical geriatric medicine and internal medicine is discussed.
Again special emphasis is given to the importance of distinction between normal elderly and geriatric patients. The aim of the study and the working-hypotheses are further discussed. This is linked to the operational effects of Supportive Geriatric Care. Thereafter a description is given of the way the research-items were registrated.

Chapter 4 gives the results of the study about the difference between normal elderly patients and geriatric patients. It is concluded that geriatric patients are more dependent on care by others and are more frequently re-admitted to the hospital. Besides physical problems they also have more frequently psychological or social problems that are responsible for their admission to the hospital. Because of their situation they are more frequently in need of consulting physicians like neurologists, psychiatrists, urologists and rehabilitation-specialists. Their average stay in hospital is twice as long compared to normal elderly patients and they die four times more often. Significant differences exist with respect to ADL-activities, mobility and incontinence problems, all in favour of the normal elderly patient. Discharge-direction is also significantly different. The amount of geriatric patients that need treatment in a chronic care hospital. a nursing home or a home for the elderly is by far higher.
These differences are proof of the existence of geriatric patients as a specific type and are the motivation for specific treatment and further research.

In chapter 5 data are presented concerning the situation of the geriatric patiënts at the moment of admission. Nearly all the patients that were included have problems with ADL-activity, mobility and/or urinary incontinence. On base of the list of diagnoses and problems 28 diseases are identified from which at least 5% of the patients are suffering. They are all together responsible for 60% of total morbidity. The correlation between these diseases is low. Cluster analysis according to Jaccard reveals five problems, characteristic for the study population: two-third of all patients have at least one of these problems: the so called geriatric complex. These five problems are cognitive disorders, caregiving problems, acute urinary incontinence, acute

immobilisation and the dementiasyndrome. The presence of one or more of these problems is strongly related to funcional impairment. Attention for these problems is a central theme in geriatric care.

Chapter 6 is dealing with the change in functional impairment during stay in hospital. Significant improvement is found at all levels between admission and discharge. There is no influence of age or gender. The separate effects of the most frequent diseases are small. The geriatric complex on the contrary has a strong negative effect on the outcome of patient-care. This is confirmed by regression and discriminant analysis. The influence of the geriatric complex is also important for the need of longterm care after discharge.

Chapter 7 gives the data of the patients who died in hospital. Age, gender, length of stay in hospital and specific disease are not discriminating. Like expected from earlier findings functional impairments are of more importance. Especially the patients who have a low level of self care, who are bedridden or who have a urinary catheter have more chance to die. Nevertheless it is not possible on the basis of logistic regression anlysis to predict with enough sensitivity and specificity the outcome in individual patients. Surprisingly the occurence of parts of the geriatric complex has an inverse relation to risk of death.
It is concluded that geriatric problems are more easy denominated when lifethreatening situations are less present.

Chapter 8 describes two different geriatric assesment scales, the Beoordelingsschaal voor Oudere Patiënten (BOP) and the Gedragsobservatieschaal voor Intramurale Psychogeriatrie (GIP). These scales are relatively complex and detailed.
With the BOP-scale the influence of cognitive disorders appears stronger linked to the need for care than suggested before. As an instrument to decide for the best treatment modality after discharge the GIP scale did not prove very usefull. In general it can be concluded that both scales according to the study results provide a kind of information that cannot apropriatedly be used in the acute-care hospital.