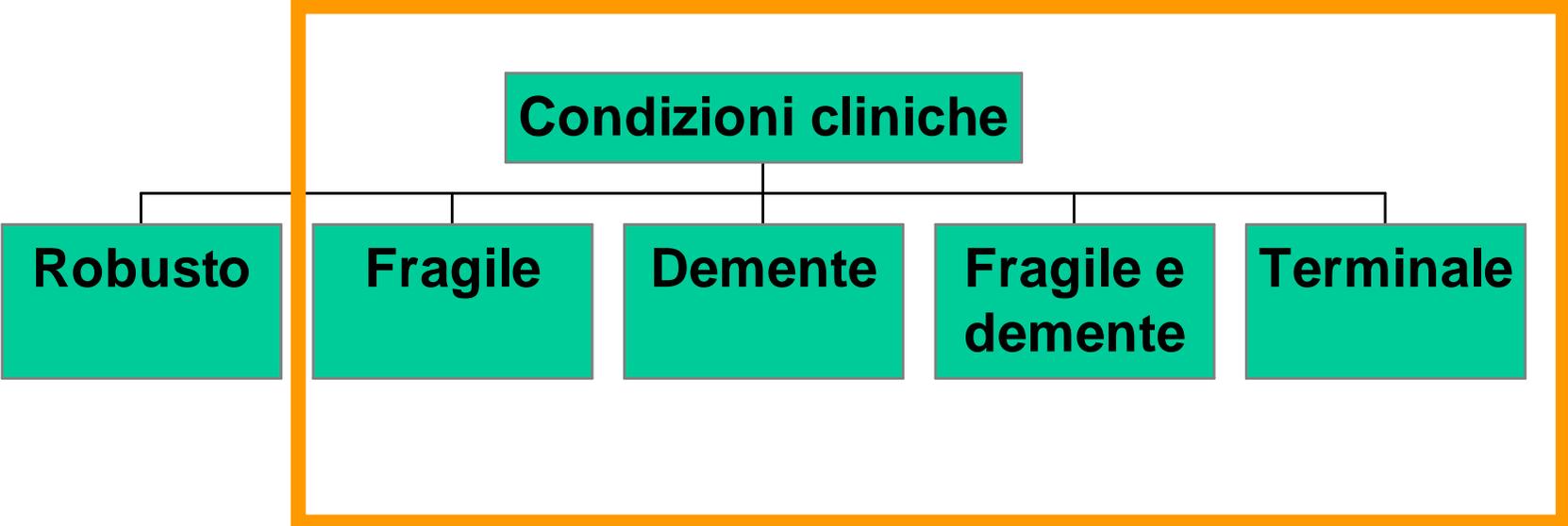




**Journal club – Aggiornamenti in Geriatria  
23 Marzo 2018**

# **Le motivazioni di medici e Infermieri per lavorare in RSA**

**Corrado Carabellese  
Fondazione Casa di Dio Onlus - Brescia**



**“L’anziano con decadimento cognitivo oltre il domicilio: il ruolo delle Residenze Sanitarie Assistenziali”**

**Physician Evaluation and Management of Nursing Home Residents.**

**(J. Ouslander and D. Osterweil Ann. Inter. Med. 1994)**

**“Physician evaluation of nursing home residents at admission and regularly thereafter is an important part of caring for this rapidly increasing segment of society.”**

**“The diverse goals of nursing home care, the heterogeneity of nursing home residents, ..... care complex and challenging.”**

**La metodologia della cura  
assistenziale e definizione:**

**Piano Individuale (PI)**

**Piano di Assistenza Individuale (PAI)**

## “L’anziano con decadimento cognitivo oltre il domicilio: il ruolo delle Residenze Sanitarie Assistenziali”

### Physician Evaluation and Management of Nursing Home Residents.

(J. Ouslander and D. Osterweil Ann. Inter. Med. 1994)

“When evaluating and caring for home residents, physicians must address many issue besides treatment of multiple chronic diseases and **concerns of family members.**”

“The physician schould be integrated with an **interdisciplinary team** composed of nurses, rehabilitation therapists, social workers, and others.”

## “L’anziano con decadimento cognitivo oltre il domicilio: il ruolo delle Residenze Sanitarie Assistenziali”

### Physician Evaluation and Management of Nursing Home Residents.

(J. Ouslander and D. Osterweil Ann. Inter. Med. 1994)

The general goals of nursing care are:

- 1) to provide a safe and **supportive environment** for chronically ill and dependent person,
- 2) to **maximize individual autonomy, functional capabilities, and quality of life,**
- 3) to **stabilize** and delay, if possibile, the progression of chronic illnesses,
- 4) to **prevent subacute and acute illnesses** and recognize and **manage** them rapidly when they do occur.

# **“L’anziano con decadimento cognitivo oltre il domicilio: il ruolo delle Residenze Sanitarie Assistenziali”**

Physician Evaluation and Management of Nursing Home Residents.  
(J. Ouslander and D. Osterweil Ann. Inter. Med. 1994)

**Valutazione multidimensionale all’ingresso Prima visita:**

**Revisione completa della documentazione clinica.**

**Inquadramento dei problemi clinici e funzionali pregressi ed attivi.**

**Rilevazione di eventuali problemi trattabili.**

**Valutazione severità e comorbilità delle malattie.**

**Rilevazione di rischi e/o problemi come: cadute, contenzioni, decubiti, disfagia, disidratazione, stato nutrizionale e cavo orale, incontinenza, problemi comportamentali, ecc.**

**Iatrogenesi e rivalutazione terapeutica**

**Dolore**

**Vista e udito**

**Elettrocardiogramma**

**Indagini di laboratorio: esami ematici di routine (no, se recenti)**

**Valutazione di ulteriori indagini diagnostiche**

**Valutazione consulenza specialistiche**

# Patient Safety in Geriatrics: A Call for action.

D. Tsilimingras et al J Gerontology 2003

Central to geriatrics is the management of a variety of medical conditions “Geriatric syndromes”, which includes falls, delirium, pressure ulcers, and underfeeding.

These geriatric syndromes tend to developed when the compensatory ability of elederly people is compromised by accumulated effect of impairments in multiple domains.

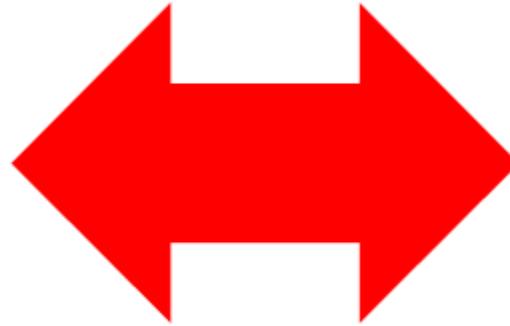
The geriatric syndromes are associated with increased mortality.

The literature has shown that these geriatric syndromes in many cases can be prevented from occurring.

## Le cure continuative nelle RSA Lombarde

<b>Responsabilità del Medico</b> Inquadramento diagnostico-funzionale Classificazione fragilità ospite (SOSIA)	Percorsi Diagnostici- Terapeutici- Assistenziali	PAI
<b>Responsabilità operatori sanitari</b> Pianificazione/Esecuzione PAI Collaborazione alla definizione PAI Organiz. e Coord. Operatori di supporto	Percorsi Diagnostici- Terapeutici- Assistenziali	PAI
<b>Responsabilità Operatori di Supporto</b> Funzioni Assegnate art. 4 del 5428/01	Percorsi Diagnostici- Terapeutici- Assistenziali	PAI

RSA  
Luogo di  
cura



RSA  
Luogo da  
abitare



**SALUTE**

**BENESSERE**



**GESTIONE DEL RISCHIO**

# Sindromi geriatriche: questo sconosciuto

## Geriatric Syndromes: Clinical, Research, and Policy Implications of a Core Geriatric Concept

Sharon K. Inouye, MD, MPH,<sup>\*†</sup> Stephanie Studenski, MD,<sup>‡§</sup> Mary E. Tinetti, MD,<sup>||</sup> and George A. Kuchel, MD<sup>¶</sup>

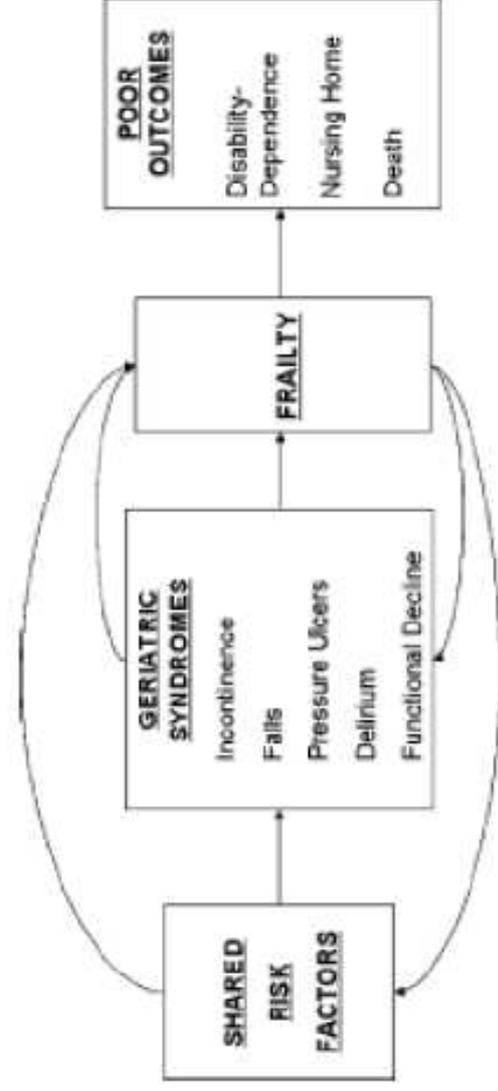


Figure 2. A unifying conceptual model demonstrates that shared risk factors may lead to geriatric syndromes, which may in turn lead to frailty, with feedback mechanisms enhancing the presence of shared risk factors and geriatric syndromes. Such self-sustaining pathways may result in poor outcomes involving disability dependence, nursing home placement, and ultimately death, thus holding important implications for elucidating pathophysiological mechanisms and designing effective intervention strategies.

# Nutrizione:

[Curr Opin Clin Nutr Metab Care](#). 2015 Jan;18(1):17-23

## Malnutrition in the nursing home.

[Bell CL](#)<sup>1</sup>, [Lee AS](#), [Tamura BK](#).

Malnutrition in the nursing home is increasingly recognized as a major international research priority, given the expanding geriatric populations, serious consequences, and challenges conducting research in nursing homes. **RECENT FINDINGS: Across the recent studies, approximately 20% of nursing home residents had some form of malnutrition. However, malnutrition definitions were variable and prevalence ranged from 1.5 to 66.5%.**

[J Nutr Gerontol Geriatr](#). 2015;34(1):1-21..

## Malnutrition and Dysphagia in long-term care: a systematic review.

[Namasivayam AM](#)<sup>1</sup>, [Steele CM](#).

Determining the co-occurrence of malnutrition and dysphagia is important to understand the extent to which swallowing impairment contributes to poor food intake in long-term care (LTC). **The reported frequency of participants in LTC with dysphagia ranges from 7% to 40%, while the percentage of those who were malnourished ranges from 12% to 54%.** Due to discrepancies used to describe and measure these conditions, it is difficult to determine the exact prevalence of either condition separately, or in combination. Consequently, the impact of dysphagia on malnutrition must be considered and studied using valid definitions and measures.

[J Am Med Dir Assoc.](#) 2015 Jun 1;16(6):527

**Both intravenous and subcutaneous infusion can be done in nursing homes.**

[Zorowitz RA](#)<sup>1</sup>.

[J Am Med Dir Assoc.](#) 2015 Mar;16(3):175-6

**Dehydration is difficult to detect and prevent in nursing homes.**

[Lima Ribeiro SM](#)<sup>1</sup>, [Morley JE](#)<sup>2</sup>.

[Int J Prosthodont.](#) 2015 Mar-Apr;28(2):198-200. doi: 10.11607/ijp.4016.

**Prosthetic rehabilitation of edentulism prevents malnutrition in nursing home residents.**

[Andreas Zenthöfer A](#), [Rammelsberg P](#), [Cabrera T](#), [Hassel A](#).

To investigate the association between prosthetic rehabilitation and malnutrition in institutionalized elders, 255 nursing home residents were recruited for this study and underwent a comprehensive dental examination. Participants with BMI < 20 kg/mc were categorized as malnourished (n = 33), whereas all others were categorized as adequately nourished (n = 222). **The number of teeth present and the prevalence of prosthetic rehabilitation were significantly lower in malnourished participants (P < .05). Malnutrition risk was 4.6 times higher for participants who were edentulous and did not wear dentures.** Adequate replacement of teeth is important to prevent malnutrition in institutionalized older people.



JAMDA

Journal homepage: [www.jamda.com](http://www.jamda.com)



### Original Study

## Basis for Sarcopenia Screening With the SARC-CalF in Nursing Homes

Felicita Urzi MD<sup>a</sup>, Boštjan Simunič PhD<sup>b</sup>, Elena Buzan PhD<sup>a,\*</sup>

<sup>a</sup>Faculty of Mathematics, Natural Sciences and Information Technologies, University of Primorska, Glagoljaška, Koper, Slovenia

<sup>b</sup>Science and Research Center Koper, Institute for Kinesiology Research, Garbaldijeva, Koper, Slovenia

**Background:** Sarcopenia is a major health problem of the older population. The European Working Group on Sarcopenia in Older People (EWGSOP) developed diagnostic criteria for diagnosis of sarcopenia that require assessing muscle mass and strength or physical performance. Recently, however, a rapid screening method SARC-CalF was developed.

**Objective:** The aim of the present study was to validate the SARC-CalF test using EWGSOP sarcopenia diagnostic criteria in a sample of nursing home residents.

**Conclusions:** SARC-CalF could be a useful screening test for sarcopenia in nursing home residents. The incorporation of the test as a basis for sarcopenia screening will provide additional value to current nursing home preventive measures.

**Appendix Table 1**

**SARC-Calf: A Simple Questionnaire to Rapidly Diagnose Sarcopenia With Calf Circumference Measurements—Original Version**

Components	Questions	Scoring
Strength	How much difficulty do you have in lifting and carrying 10 pounds?	None = 0 Some = 1 A lot or unable = 2
Assistance in walking	How much difficulty do you have walking across a room?	None = 0 Some = 1 A lot, use aids, or unable = 2
Rise from a chair	How much difficulty do you have transferring from a chair or bed?	None = 0 Some = 1 A lot or unable without help = 2
Climb stairs	How much difficulty do you have climbing a flight of 10 stairs?	None = 0 Some = 1 A lot or unable = 2
Falls	How many times have you fallen in the past year?	None = 0 1-3 falls = 1 4 or more falls = 2
Calf circumference	Measure the patient's exposed right calf circumference with the legs relaxed and feet 20 cm apart from each other	Females >33 cm = 0 ≤33 cm = 10 Males >34 cm = 0 ≤34 cm = 10

Sum (0–20 points).

0–10: no suggestive signs of sarcopenia at the time (consider periodical re-evaluation).

11–20: suggestive of sarcopenia (proceed with further diagnostic examinations).

# INFEZIONI

[Geriatr Nurs.](#) 2015 Jun 9. pii: S0197-4572(15)

**Perceived barriers to infection prevention and control for nursing home certified nursing assistants: A qualitative study.**

[Travers J](#)<sup>1</sup>, [Herzig CT](#)<sup>2</sup>, [Pogorzelska-Maziarz M](#)<sup>3</sup>, [Carter E](#)<sup>4</sup>, [Cohen CC](#)<sup>5</sup>, [Semeraro PK](#)<sup>5</sup>, [Bjarnadottir RI](#)<sup>5</sup>, [Stone PW](#)<sup>5</sup>.

**Healthcare-associated infections, while preventable, result in increased morbidity and mortality in nursing home (NH) residents.** Frontline personnel, such as certified nursing assistants (CNAs), are crucial to successful implementation of infection prevention and control (IPC) practices. The purpose of this study was to explore barriers to implementing and maintaining IPC practices for NH CNAs as well as to describe strategies used to overcome these barriers.

**Five key themes emerged as perceived barriers to effective IPC for CNAs: 1) language/culture; 2) knowledge/training; 3) per-diem/part-time staff; 4) workload; and 5) accountability.**

Strategies used to overcome these barriers included: translating in-services, hands on training, on-the-spot training for per-diem/part-time staff, increased staffing ratios, and inclusion/empowerment of CNAs. **Understanding IPC barriers and strategies to overcome these barriers may better enable NHs to achieve infection reduction goals.**

[Infect Control Hosp Epidemiol.](#) 2015 Apr 29:1-6. [Epub ahead of print]

**Multidrug-Resistant Gram-Negative Bacteria: Inter- and Intradissemiation Among Nursing Homes of Residents With Advanced Dementia.**

[D'Agata EM](#)<sup>1</sup>, [Habtemariam D](#)<sup>2</sup>, [Mitchell S](#)<sup>2</sup>.

OBJECTIVE To quantify the extent of inter and intra nursing home transmission of multidrug-resistant gram-negative bacteria (MDRGN) among residents with advanced dementia and characterize MDRGN colonization among these residents.  
CONCLUSIONS **MDRGN are spread both within and between nursing homes among residents with advanced dementia. Infection control interventions should begin to target this high-risk group of nursing home residents.**



JAMDA

journal homepage: [www.jamda.com](http://www.jamda.com)



Brief Report

## The Nursing Home Pneumonia Risk Index: A Simple, Valid MDS-Based Method of Identifying 6-Month Risk for Pneumonia and Mortality



Philip D. Sloane MD, MPH <sup>a,b,\*</sup>, Sheryl Zimmerman PhD <sup>a,c</sup>, Kimberly Ward BA <sup>a</sup>,  
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**Table 1**  
**The Nursing Home Pneumonia Risk Index**

Resident Characteristic	Minimum Data Set (MDS) 3.0 Item	Points
Male gender	A0800	+1
Age ≥85 y	A0900	+1
Diagnosis: Alzheimer disease/dementia	I14200 or I14800	+1
Chronic lung disease	I6200	+1
Chronic renal disease	K0100C	+1
Requires extensive or total assistance in eating	G0110H	+1
Noted to have coughing or choking during meals	K0100C	+1
Behavior interferes with care	E0500B or E0800	+1
Dental problems	L0200 (not B or Z)	+1
No teeth	L0200B	-1
On a sedative or antipsychotic medication	N0400 A, B, or D	+1

**The Nursing Home Pneumonia Risk Index: A Simple, Valid MDS-Based Method of Identifying 6-Month Risk for Pneumonia and Mortality.**

Pneumonia is the leading infectious cause of hospitalization and death for nursing home (NH) residents; however, diagnosis is often delayed because classic signs of infection are not present. **We sought to identify NH residents at high risk for pneumonia, to identify persons to target for more intensive surveillance and preventive measures..**

NH Pneumonia Risk Index scores ranged from -1 to 6, with a mean of 2.1, a median of 2, and a mode of 2. For the outcome of pneumonia, a 1-point increase in the index was associated with a risk odds ratio of 1.26 (P = .038) or a hazard ratio of 1.24 (P = .037); using it as a dichotomous variable ( $\leq 2$  vs  $\geq 3$ ), the corresponding figures were a risk odds ratio of 1.78 (P = .045) and a hazard ratio of 1.82 (P = .025). For the outcome of mortality, a 1-point increase in the NH Pneumonia Risk Index was associated with a risk odds ratio of 1.58 (P = .002) and a hazard ratio of 1.45 (P = .013); **using the index as a dichotomous variable, the corresponding figures were a risk odds ratio of 3.71 (P < .001) and a hazard ratio of 3.29 (P = .001).** The NH Pneumonia Risk Index can be used by NH staff to identify residents for whom to apply especially intensive preventive measures and surveillance. Because of its strong association with mortality, the index may also be valuable in care planning and discussion of advance directives.

# DOLORE

[J Am Geriatr Soc.](#) 2015 Apr;63(4):642-3.

**Pain management in American nursing homes – a long way to go.**

[Hallenbeck J](#)<sup>1</sup>.

[Ned Tijdschr Geneeskd.](#) 2015;159:A7833.

**[Treatment of spasticity in nursing homes: botulinum toxin type A as part of therapy].**

[Article in Dutch]

[Wolswijk AH](#)<sup>1</sup>, [Dirkx AE](#).

## **Complications of spasticity can severely limit daily activities and care-**

**giving.** For those who treat or provide care to patients with spasticity in nursing homes, it is important to recognise complaints in order to prevent serious complications such as care-related pain, contractures and pressure sores. Both patients received botulinum toxin injections

in the affected muscles, combined with an appropriate splint. **These efforts substantially reduced care-related pain and improved social behaviour and care options.** If spasticity prohibits treatment or care, consultation of a rehabilitation physician at an early stage is indicated.

# Physician Intervention for Medication Reduction in a Nursing Home: The Polypharmacy Outcomes Project

Bruce K. Tamura, MD, Christina L. Bell, MD, Karen Lubimir, MD, Wendy N. Iwasaki, PharmD, Laura A. Ziegler, MD, and Kamal H. Masaki, MD

**Objective:** To examine the effects of a medication review project by geriatricians and geriatric medicine fellows on polypharmacy in a teaching nursing home.

**Design:** Quality improvement intervention study

**Setting:** Long-term care facility in Honolulu, HI

**Participants:** Seventy-four patients with the Minimum Data Set quality indicator criteria of polypharmacy (9 or more medications).

**Intervention:** Geriatric medicine fellows and faculty reviewed each patient's medication list, consulted the updated Beers Criteria and Epocrates online drug-drug interaction program, and recommended medication changes to the patients' primary care physicians.

**Measurements:** Descriptive statistics, including means, standard deviations, and sums of variables were obtained for the number of medications in the following categories: total number, scheduled, pro

re nata, high risk, contraindicated, with potential drug-drug interactions, and with no indication.

**Results:** Of 160 patients residing in a nursing home, 74 were on 9 or more medications. After the intervention, the mean number of medications per patient in the following categories decreased significantly: total number (16.64 to 15.54,  $P < .001$ ), scheduled (11.3 to 10.99,  $P < .001$ ), pro re nata (5.33 to 4.56,  $P < .001$ ), high risk (0.94 to 0.73,  $P < .001$ ), contraindicated (0.29 to 0.13,  $P = .004$ ), with potential drug-drug interactions (6.1 to 4.83,  $P < .001$ ), and with no indication (3.34 to 3.29,  $P = .045$ ).

**Conclusion:** Polypharmacy in long-term care is prevalent and can lead to increased adverse effects and potentially inappropriate prescriptions. This study demonstrates an effective geriatrician-led intervention that both reduced polypharmacy and provided core competency training for geriatric medicine fellows. (*J Am Med Dir Assoc* 2011; 12: 326–330)

**Keywords:** Polypharmacy; long-term care; nursing home

[Ugeskr Laeger](#). 2015 Mar 16;177(12).

**[Teminal care in a nursing home].**

[Andersen JH<sup>1</sup>](#), [Hansen J](#), [Rosholm JU](#).

This article focuses on patients with limited life expectancy who no longer benefit from preventive medication but not yet qualify for palliative care - a time frame often referred to as End-of-Life (EOL). The purpose of this article is to identify and assess international guidelines for prescribing in EOL. No relevant clinical trials were available, but we found advice mainly based on logic assumptions and thoughts. Optimal prescribing for EOL patients remains mostly unexplored. Our study revealed two pivotal questions: How do we identify EOL patients, and what specific drugs should be removed?

[J Am Med Dir Assoc](#). 2015 May 1;16(5):434-5.

**Hospice in the nursing homes: perspectives of a medical director.**

[Raider M<sup>1</sup>](#).

# Instabilità clinica e gli eventi acuti



Società Italiana di  
Gerontologia e  
Geriatra

G GERONTOL 2009;57:23-32

ARTICOLO ORIGINALE  
ORIGINAL ARTICLE

# La complessità e l'instabilità clinica nell'anziano istituzionalizzato

## Clinical complexity and clinical instability among the nursing home residents

S. LOPEZ, A. SIBILANO, M.G. STEFANONI, G. GAZZARDI, R. BALCONI, A. GUAITA\*

Unità Organizzativa Complessa Vigilanza e Controllo, ASL della Provincia di Milano 1; \* Fondazione Golgi Cenci, Abbiategrasso (MI)

## I criteri di Halm

temperatura corporea  $> 37,8$  gradi;  
frequenza cardiaca  $> 100$ /minuto;  
frequenza respiratoria  $> 24$ /minuto;  
saturazione di ossigeno:  $SO_2 < 90\%$  ;  
incapacità ad alimentarsi in modo autonomo;  
delirium;  
dolore.

Fig. 1. Distribuzione percentuale degli ospiti stabili e instabili ai criteri di Halm.

		Controllo		Tot. 450 (100%)
		Stabili	Instabili	
Coorte di 450 anziani		249 (55,33%)	201 (44,67%)	Tot. 450 (100%)
Ingresso RSA	Stabili	285 (63,33%)	69 (15,33%)	
	Instabili	165 (36,67%)	132 (29,33%)	
Tot. 450 (100%)		Soggetti con periodi di instabilità: 234 (52%)		

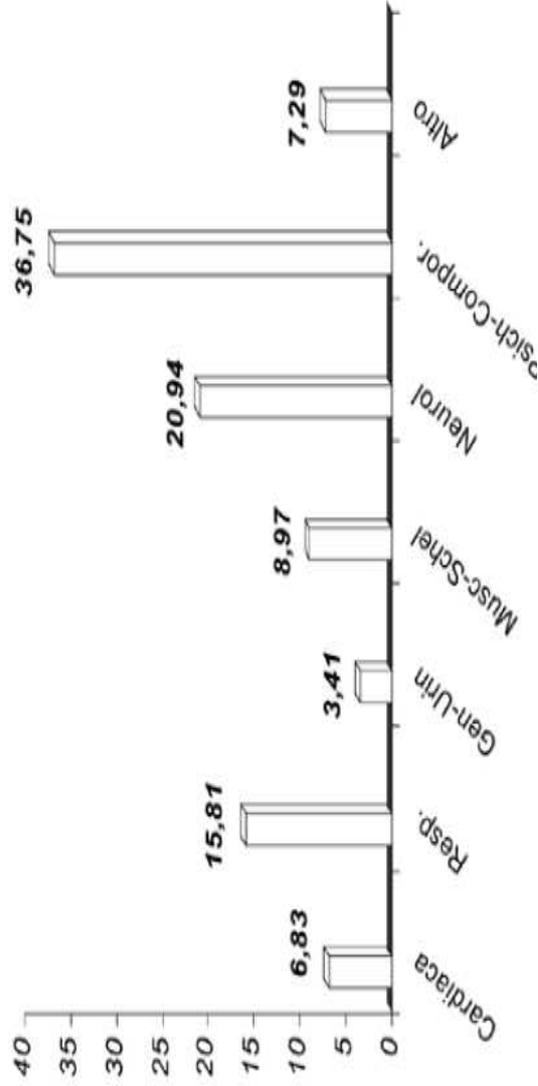
Fig. 2. Frequenza (%) compresenza criteri di Halm.



Tab. VI. Distribuzione percentuale dei criteri clinici di Halm negli ospiti instabili.

Criteri di Halm	Frequenza criteri di Halm nei 165 anziani instabili all'ingresso in RSA	Frequenza criteri di Halm nei 201 anziani instabili al momento del controllo
Temperatura corporea	25%	23,4%
Frequenza cardiaca	9,7%	8,4%
Frequenza respiratoria	14%	13%
Saturazione O <sub>2</sub>	9,7%	15,4%
Alimentazione non autonoma	76%	83%

**Fig. 3.** Frequenza raggruppamenti diagnostici (CIRS) in quadri di instabilità clinica nei 234 ospiti.



**Tab. VII.** Frequenza del monitoraggio medico-infermieristico negli ospiti instabili ai secondo i criteri di Halm.

Scala Instabilità Clinica (valutata con riscontro documentale del livello di assistenza Med.-Inf. erogata)	Instabili secondo i criteri di Halm al momento dell'ingresso n. soggetti (%)	Instabili secondo i criteri di Halm al momento del controllo n. soggetti (%)
1 - Stabili	1 (0,6%)	4 (2%)
2 - Moderatamente stabili	7 (4,2%)	18 (9%)
3 - Moderatamente instabili	34 (20,6%)	46 (22,9%)
4 - Instabili	48 (29%)	61 (30,3%)
5 - Altamente instabili	68 (41,2%)	49 (24,3%)
6 - In fase di acuzie	7 (4,2%)	23 (11,4%)
N. soggetti valutati	Tot. 165	Tot. 201

**Tab. VIII.** Frequenza del monitoraggio medico-infermieristico negli ospiti stabili ai criteri di Halm.

Scala Instabilità Clinica (valutata con riscontro documentale del livello di assistenza Med-Inf. erogata)	Stabili secondo i criteri di Halm al momento dell'ingresso n. soggetti (%)	Stabili secondo i criteri di Halm al momento del controllo n. soggetti (%)
1 - Stabili	0 (0%)	2 (6%)
2 - Moderatamente stabili	37 (53,62%)	18 (54,54%)
3 - Moderatamente instabili	14 (20,28%)	7 (21,21%)
4 - Instabili	13 (18,84%)	5 (15,15%)
5 - Altamente instabili	5 (7,24%)	1 (3%)
6 - In fase di acuzie	0 (0%)	0 (0%)
N. soggetti valutati	Tot. 69	Tot. 33

## Gli eventi Clinici Avversi (ACEs)

In 12 mesi si sono verificati 932 ACEs coinvolgendo 195 (83,3%) ospiti dei 234 instabili.

Gli ACEs che hanno richiesto l'invio in PS senza ricovero 39 (14,5%).

Gli ACEs che hanno richiesto l'invio in PS con ricovero 56 (23,9%).

Fig. 4. Frequenza patologie causa di accessi in P.S., non seguiti da ricovero.

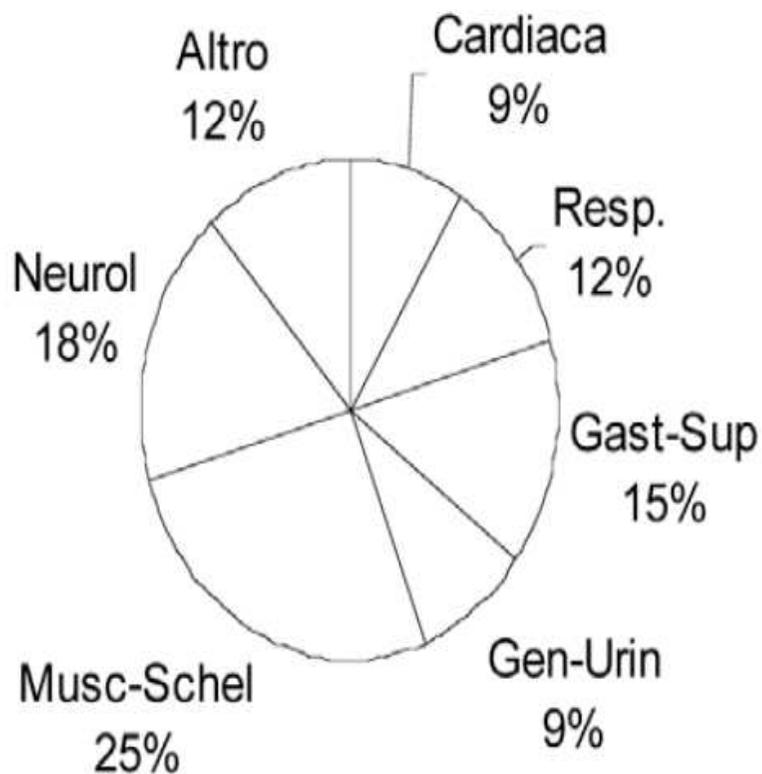
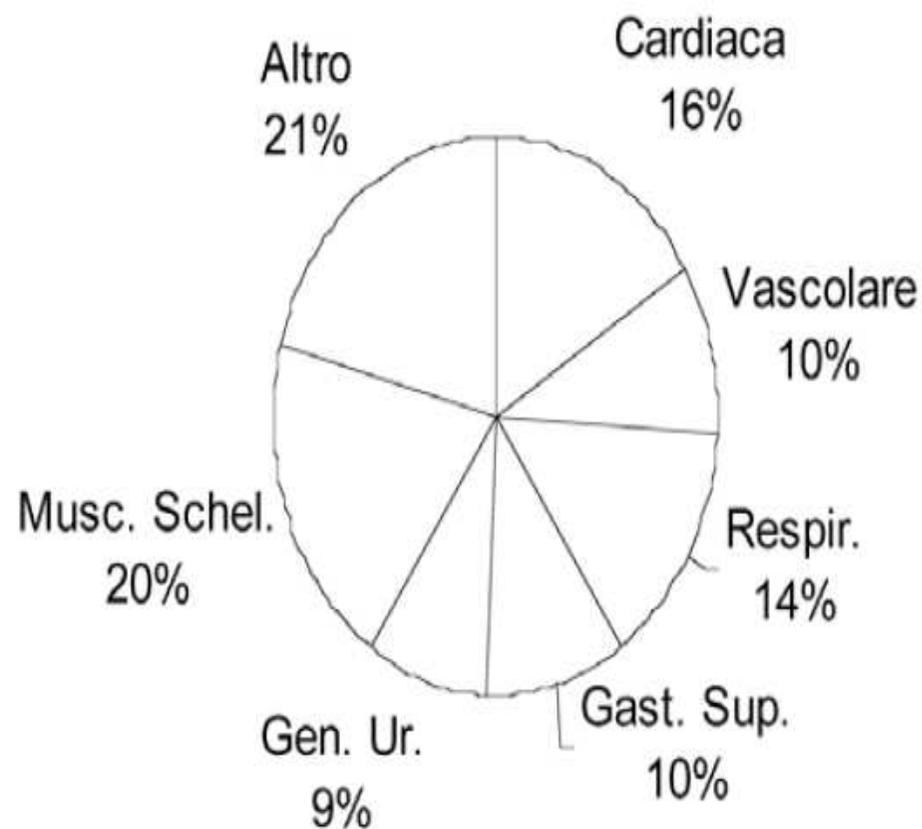


Fig. 5. Frequenza delle patologie causa di ricoveri ospedalieri.



[Behav Med.](#) 2006 Summer;32(2):64-70.

**To hospitalize or not to hospitalize? That is the question: an analysis of decision making in the nursing home.**

[Cohen-Mansfield J](#), [Lipson S](#).

The authors examined the processes and factors that influence physicians' decision-making processes as regarding hospitalization of nursing home residents. In a large nonprofit nursing home, 6 full-time male physicians and 1 female nurse practitioner completed questionnaires that described the medical decision-making process for 52 nursing home residents for whom hospitalization was considered. The questionnaire covered the following topics: medical event description, the decision-making process, considerations in making treatment decisions, and the role of advance directives. Hospitalized residents had fewer treatments considered and fewer treatments chosen than those who were not hospitalized. Residents with fractures were the most commonly hospitalized residents, whereas residents in frailer conditions, with breathing problems, and for whom the physician considered quality of life to be most important were less likely to be hospitalized. The results of this study clarify the complexity of factors affecting the decision-making process and suggest a methodology that may assist in discerning those factors in the future.

# Motivazioni della scelta

J Am Med Dir Assoc. 2016 Mar 1;17(3):188-92. doi: 10.1016/j.jamda.2015.12.016. Epub 2016 Jan 21.

**Frailty: An Emerging Public Health Priority.**

Cesari M., Vellas B.

The absolute and relative increases in the number of older persons are evident worldwide, from the most developed countries to the lowest-income regions. Multimorbidity and need for social support increase with age. Age-related conditions and, in particular, disabilities are a significant burden for the person, his or her family, and public health care systems. To guarantee the sustainability of public health systems and improve the quality of care provided, it is becoming urgent to act to prevent and delay the disabling cascade. Current evidence shows that too large a proportion of community-dwelling older people present risk factors for

major health-related events and unmet clinical needs. **In this scenario, the "frailty**

**syndrome" is a condition of special interest. Frailty is a status of**

**extreme vulnerability to endogenous and exogenous stressors**

**exposing the individual to a higher risk of negative health-related**

**outcomes.** Frailty may represent a transition phase between successful aging and disability, and a condition to target for restoring robustness in the individual at risk. Given its syndromic nature, targeting frailty requires a comprehensive approach. The identification of frailty as a target for implementing preventive interventions against age-related conditions is pivotal. Every effort should be made by health care authorities to maximize efforts in this field, balancing priorities, needs, and resources. Raising awareness about frailty and age-related conditions in the population is important for effective prevention, and should lead to the promotion of lifelong healthy behaviors and lifestyle.

Eur J Intern Med.2016 Jun;31:11-4. doi: 10.1016/j.ejim.2016.03.005. Epub 2016 Mar 18.

**The geriatric management of frailty as paradigm of "The end of the disease era".**

Cesari M., Bernabei R.

**Abstract**

The sustainability of healthcare systems worldwide is threatened by the absolute and relative increase in the number of older persons. The traditional models of care (largely based on a disease-centered approach) are inadequate for a clinical world dominated by older individuals with multiple (chronic) comorbidities and mutually interacting syndromes. There is the need to shift the center of the medical intervention from the disease to the biological age of the individual. Thus, multiple medical specialties have started looking with some interest at concepts of geriatric medicine in order to better face the increased complexity (due to age-related conditions) of their average patient. In this scenario, special interest has been given to frailty, a condition characterized by the reduction of the individual's homeostatic reserves and increased vulnerability to stressors. Frailty may indeed represent the fulcrum to lever for reshaping the healthcare systems in order to make them more responsive to new clinical needs. **However, the dissemination of the frailty concept across medical specialties requires a parallel and careful consideration around the currently undervalued role of geriatricians in our daily practice.**

**Come si può pensare che il Medico di Famiglia abbia tutte queste competenze in RSA e Territorio?**

# The Importance of Physician Presence in Nursing Homes for Residents with Dementia and Pneumonia

Margaret R. Helton, MD, Lauren W. Cohen, MA, Sheryl Zimmerman, PhD, and Jenny T. van der Steen, PhD

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**Objective:** To study whether physician presence in the nursing home is related to clinical decision making, certainty, and honoring care preferences for patients with dementia and pneumonia.

**Design:** Cross-sectional survey of physicians.

**Setting:** Nursing homes in the United States and the Netherlands.

**Participants:** Twenty-four US and 38 Dutch physicians who provide care for nursing home patients.

**Measurements:** Physicians reported their presence in the nursing home, diagnostic and treatment decisions for patients with dementia who had pneumonia, certainty about the diagnosis and patient and family preferences, and the extent to which they honored these preferences. These variables were examined in reference to physician presence in the nursing home.

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**Results:** Physicians with higher nursing home presence were less likely to order a chest x-ray and to hospitalize patients with dementia and pneumonia, although this difference was not significant when adjusted for country. They also were more likely to be certain of family preferences, a difference that held even when adjusted for the strong confounder of country.

**Conclusion:** Physician presence in the nursing home relates to some treatment decisions for patients with dementia and pneumonia. Policies that affect physician presence may change health care practices and related costs. Future studies should more closely examine how physicians use their time so as to better understand the importance of presence and what the US health care system might learn from the Dutch system. (*J Am Med Dir Assoc* 2011; 12: 68–73)

**Keywords:** *Nursing homes; physicians; decision-making; hospitalization; pneumonia*

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[R I Med J \(2013\)](#). 2015 Mar 3;98(3):20-2.

### **The Roles and Functions of Medical Directors in Nursing Homes.**

[Nanda A](#)<sup>1</sup>.

The medical director is an important member of the healthcare team in a nursing home, and is responsible for overall coordination of care and for implementation of policies related to care of the residents in a nursing home. The residents in nursing homes are frail, medically complex, and have multiple disabilities. **The medical director has an important leadership role in assisting nursing home administration in providing quality care that is consistent with current standards of care.** This article provides an overview of roles and functions of the medical director, and suggests ways the medical director can be instrumental in achieving excellent care in today's nursing facilities.

[J Am Med Dir Assoc](#). 2015 Apr 7.

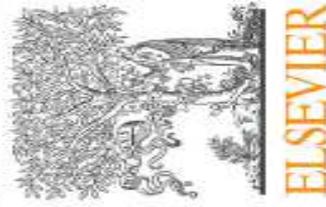
### **Physicians in Nursing Homes: Effectiveness of Physician Accountability and Communication.**

[Lima JC](#)<sup>1</sup>, [Intrator O](#)<sup>2</sup>, [Wetle T](#)<sup>3</sup>.

**OBJECTIVES:** The objective of this study was to develop a measure of the perceptions of nursing home (NH) directors of nursing (DONs) on the adequacy of physician care and to examine its variation as well as its construct validity.

**RESULTS:** The established EPAC score is the first measure to capture specific components of the adequacy of physician care in NHs. EPAC exhibited good construct validity: more effective practices were correlated with greater physician involvement in discussions of do-not-resuscitate orders, the frequency with which the medical director checked on the medical care delivered by the attending physician, the tightness of the NH's control of its physician resources, and the DON's perception of whether or not avoidable hospitalizations and emergency room visits could be reduced with greater physician attention to resident needs.

**CONCLUSION: As increased attention is given to the quality of care provided to vulnerable elders, effective measures of processes of care are essential.** The EPAC measure provides an important new metric that can be used in these efforts. The goal is that future studies could use EPAC and its individual domains to shed light on the manner through which physician presence is related to resident outcomes in the NH setting.



Editorial

## The Dutch Move Beyond the Concept of Nursing Home Physician Specialists

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**Table 1****The Critical Professional Situations for the Training Program of ECP**

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Critical Professional Situation (CPS)	
1.	The patient/elderly patient and polypharmacy
2.	The patient/elderly patient with abdominal symptoms
3.	The patient/elderly patient with weight loss
4.	The patient/elderly patient with skin disease/skin problems
5.	The patient/elderly patient with a wound
6.	The patient/elderly patient with (chronic) pain
7.	The patient/elderly patient with incontinence (urine and/or feces)
8.	The patient/elderly patient who has fallen
9.	The patient/elderly patient with breathlessness
10.	The confused patient/elderly patient
11.	The patient/elderly patient with reduced level of consciousness
12.	The patient/elderly patient with loss of neurologic function
13.	The patient/elderly patient with fever
14.	The patient/elderly patient in the terminal phase
15.	The patient/elderly patient with problematic behavior
16.	The family/representative experienced as problematic
17.	The patient/elderly patient with memory problems
18.	The patient/elderly patient with depression
19.	The patient/elderly patient with anxiety
20.	The overworked informal carer
21.	The patient/elderly patient with problems of loneliness
22.	The distrustful/suspicious patient/elderly patient
23.	The patient/elderly patient with an addiction
24.	Rehabilitation of the patient/elderly patient with a neurologic condition
25.	The patient/elderly patient in rehabilitation after an orthopedic operation
26.	The patient/elderly patient in a diminished general condition
27.	The patient/elderly patient who no longer wishes to live
28.	Active participation in a quality committee

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**Table 2**  
**The Professional Activities in the Training Program of ECP**

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1. Carrying out a geriatric assessment
  2. Drawing up and implementing a treatment plan
  3. Practicing emergency elderly care medicine
  4. Advance care planning
  5. Evaluating the ability to give informed consent
  6. Dealing with compulsory treatment and use of restraints
  7. Communicating with the patient/support system
  8. Collaborating with other care professionals
  9. Leading and collaborating in multidisciplinary teams
  10. Working with management
  11. Efficiently and effectively organizing personal care practice
  12. Participating in integrated care/treatment as an elderly care physician
  13. Participating in and contributing to quality monitoring of care and treatment
  14. Contributing to the further development of elderly care and elderly care medicine
  15. Functioning as an ambassador for the profession and for the elderly in society
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## PROSPETTIVE PER IL FUTURO DELLE RSA

[J Am Med Dir Assoc.](#) 2015 May 23. pii: S1525-8610(15)00253-4.

### **Effect of a Novel Interdisciplinary Teaching Program in the Care-continuum on Medical Student Knowledge and Self-Efficacy.**

[Lathia A](#)<sup>1</sup>, [Rothberg M](#)<sup>2</sup>, [Heflin M](#)<sup>3</sup>, [Nottingham K](#)<sup>2</sup>, [Messinger-Rapport B](#)<sup>4</sup>.

**OBJECTIVES:** Medical students report that they receive inadequate training in different levels of care, including care transitions to and from post-acute (PA) and long-term care (LTC). The authors implemented the Medical Students as Teachers in Extended Care (MedTEC) program as an educational innovation at the Cleveland Clinic to address training in the care-continuum, as well as the new medical student and physician competencies in PA/LTC.

**SETTING:** The program occurs in a community facility that includes subacute/skilled nursing, assisted living, and nursing home care.

**RESULTS:** Between October 2011 and December 2013, approximately 100 students participated in 20 sessions of MedTEC. All students reported improved self-efficacy and attitudes regarding care of older adults and care transition management. Mean percentage correct on the knowledge test increased significantly from 59.8% to 71.2% ( $P = .004$ ) for the MedTEC participants but not for the comparison group students (63.1%-58.3%,  $P = .47$ ). There was no significant difference in mean percentage correct on the post-program knowledge test between MedTEC medical students and hospitalists (71.0% versus 70.3%,  $P = .86$ ). Students led 8 in-service sessions for facility staff on various topics relating to the care of older adults in PA/LTC.

**CONCLUSION: The MedTEC program appears to be a successful innovation in medical student education on levels of care.** It could serve as a model for building competency of health professionals on managing care transitions and determining appropriate levels of care for older adults.



## Editorial

### Concrete Steps Toward Academic Medicine in Long Term Care

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Over the past 5 years, many articles have been published about the role of nursing home (NH) physician specialists in the quality of medical care in long term care settings.<sup>1–12</sup> Recently, Katz and Pfeil<sup>7</sup> argued in the *Journal* that there is a necessity to increase the credibility of NH physicians. One of the initiatives of the board of directors of the American Medical Directors Association (AMDA) was to develop a core set of competencies for physicians working in NHs. Katz and

#### NH Physician Specialist

Working in NHs makes unique demands on (1) problem-oriented working methods; (2) medical knowledge of chronic diseases and the presentation of illness in frail elderly; (3) communication skills, multidisciplinary cooperation, and organization; and (4) the competency to deal with complex medical-ethical dilemmas. Against this

#### Teaching

One of the strengths of the close collaboration between the university and NHs is that parts of the curriculum of medical school take place in NHs. The Radboud University Nijmegen Medical Centre, for instance, offers students a year 1 nursing attachment and a year 5 mandatory internship, both in NHs.<sup>18,19</sup> Our own research revealed that NHs and hospitals were found to be equally suitable for the enhancement of students' early professional development.<sup>20</sup> Students

qualità

# Feasibility of Quality Indicators for the Management of Geriatric Syndromes in Nursing Home Residents

Debra Saliba, MD, MPH, David Solomon, MD, Laurence Rubenstein, MD, MPH, Roy Young, MD, John Schelle, PhD, Carol Roth, RN, MPH, and Neil Wenger, MD, MPH

**Purpose:** The assessment and management of dementia, falls and mobility disorders, malnutrition, end-of-life issues, pressure ulcers, and urinary incontinence have been identified as important quality improvement targets for vulnerable elders residing in nursing homes. This study aimed to identify valid and feasible measures of specific care processes associated with improved outcomes for these conditions.

**Methods:** Nine experts in nursing home (NH) care participated in a modified Delphi process to evaluate potential quality indicators (QIs) for care in NHs. Panelists met and discussed potential indicators before completing confidential ballots rating validity (process associated with improved outcomes), feasibility of measurement (with charts or interviews), feasibility of implementation (given staffing resources in average community NHs), and importance (expected benefit and prevalence in NHs). The NH panel's median votes were used to identify a final set of QIs that were subsequently reviewed by a clinical oversight committee.

**Results:** Sixty-eight geriatric syndrome QIs were identified as valid and important in NH populations. Panelists assessed 12 (18%) of these QIs as having questionable feasibility to implement in average community nursing homes trying to provide quality care. Nine (13%) would not be included in systems assessing quality of care for persons with advanced dementia or poor prognosis.

**Conclusions:** Steps of care critical to the assessment and management of geriatric syndromes in NHs were identified. Feasibility is an important issue for a significant number of these, indicating that much remains to be done to design systems that efficiently and reliably implement these care processes. (*J Am Med Dir Assoc* 2004; 5: 310-319)

**Keywords:** Nursing home; quality; dementia; falls; mobility; malnutrition; end-of-life care; pressure ulcers; urinary incontinence

**RESEARCH ARTICLE**

**Open Access**

# The Resident Assessment Instrument-Minimum Data Set 2.0 quality indicators: a systematic review

Alison M Hutchinson\*<sup>1</sup>, Doris L Milke<sup>2</sup>, Suzanne Maisey<sup>3</sup>, Cynthia Johnson<sup>4</sup>, Janet E Squires<sup>5</sup>, Gary Teare<sup>6</sup> and Carole A Estabrooks<sup>5</sup>

Typically, data collected from residents in a facility is aggregated to produce indicators of the quality of care provided at an individual and at facility level.

Some indicators, such as *bedfast residents*, are computed according to their prevalence (i.e., number of existing occurrences), while others, such as *new fractures*, are calculated according to their incidence (i.e., number of new occurrences).

The indicators "are not absolute measures of quality but are markers of potentially poor (or good) care practices and resident outcomes" [[5] p. 603]. Furthermore, addressing quality of care using the QIs requires that the indicators are valid and reliable [6].

# Geriatrics territoriale

## La geriatria Territoriale:

Questo scenario ha imposto, ed impone sempre con maggior forza, la necessità di ripensare l'impianto organizzativo del Servizio Sanitario Nazionale, ed in particolare del sistema delle cure primarie, non più focalizzato sull'ambito ospedaliero, a cui rimane ascritta la sola mission di fronteggiare le acuzie, ma piuttosto sbilanciato sulla centralità dell'assistenza territoriale.

### **Il geriatra territoriale:**

- Utilizzo degli strumenti di valutazione multidimensionale
- capacità di lavorare con altri professionisti, non sempre e non solamente afferenti all'universo sanitario propriamente detto.

Il contesto assistenziale (fragilità) in cui si muove il geriatra territoriale è sospeso tra bisogni sanitari e sociali. Un contesto, quindi, dove non è possibile frazionare l'unicità della persona scomponendola in sottocategorie di bisogni da fronteggiare separatamente.



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Editorial

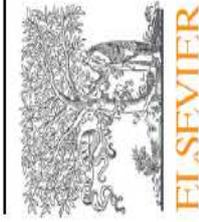
## Has the Time Come for Salaried Nursing Home Physicians?

Paul R. Katz MD, CMD<sup>a,\*</sup>, Kenneth Scott MD<sup>b</sup>, Jurgis Karuza PhD<sup>a</sup>

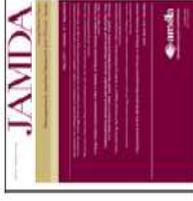
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Health care reforms will need to increasingly focus on the drivers of physician performance that go beyond reimbursement and that include lifestyle and overall job satisfaction. If the hospitalist movement is any guide to the future,<sup>13</sup> moving toward a salaried model bodes well for NHs in terms of physician recruitment and retention. If the perception of the NH physician as the “occasional visitor” is to evolve to one of “committed employee,” NH owners and administrators must be convinced of the physician’s inherent value to the bottom line—that being cost and quality.



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## Editorial

## Incentivizing Nursing Home Quality and Physician Performance

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Nursing homes (NHs) are under increasing pressure to accurately gauge and improve the quality of care they provide to their residents. Higher patient acuity, demand from consumers and policy-makers, and media reports of inadequate care are providing the impetus for change. In response to these pressures, researchers are devising more appropriate indicators of quality,<sup>1</sup> states are creating innovative financial models to reward the delivery of higher quality care, and the American Medical Directors Association (AMDA) is developing strategies to better gauge the performance of NH physicians and medical directors.

A recent study<sup>29</sup> was able to link a measure of NH medical staff organization to some of the federally mandated NH quality indicators.<sup>28</sup> These measures included restraint use, pneumococcal vaccination rates, and the prevalence of pain, pressure ulcers, and catheter use. Other potential indicators that possibly could help define individual NH physician performances include the appropriate use of antipsychotics, avoidable re-hospitalization rates, and patient-centered transitional care outcomes. Ongoing research and the work of the AMDA's Competency Workgroup will be very helpful in further defining NH physician performance indicators.

The NH industry is moving toward more accurate and comprehensive measurement of its services so that valid strategies for rewarding higher quality can be implemented. The performance of NH physicians impacts quality but accurate measurement remains elusive.