Eye care in nursing homes; collaboration from nursing home physicians' perspective

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A-P-38
Improving quality of long-term care (intramural) using a family participation roadmap
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Background: Transfer to an intramural long-term care setting often comes with a loss of identity, and therefore loss of quality of life: the person becomes a patient and loses many of the unique aspects and relations that make out his personality.

The author has been a carer for his wife with dementia for five years, of which 2.5 years intramural. Quote of Dutch Health minister Van Rijn (VWS): 'I want to achieve a quality improvement by increasing the warm involvement of family and loved ones and to improve the relationship between clients and providers'. This is exactly the aim of this Family Participation Roadmap.

Aim: The continuation of the relationship between the client and his informal network, after moving into intramural care. To entice family-carers and volunteers to more involvement. The family-caregiver/volunteer/health-care-professionals work together as a close family. Within one year deployment in hours of family-carers and volunteers should double. Within 5 years 90% of the domain well-being and 10% of the domain care should be taken over by the family-carers and volunteers.

Innovation: A five-step roadmap with mutually reinforcing innovative ideas. The five ‘steps’ each form a detailed action plan. The steps involve: 1) Entice new family-carers and their (family)network; deprofessionalizing approach and good support at moving in; 2) Entice current family care givers: a group is like a big family where the members can not choose each other. Good cooperation between carers and volunteers is essential; 3) Entice new volunteers (informal care); Location Manager will personally tell the need and necessity, more customer-oriented, less organization focused. These eyes and ears on the workplace will advise him regularly; 4) Issues for healthcare professionals: I own a profession, I take what I need; 5) Aspects for the organization: only facilitating, delegate while maintaining control, let things go.

Experience: This project proposal has already been accepted by the project ‘Dignity and Pride’ of the Dutch Ministry for Health VWS. At the congress the first results of the Roadmap will be pres

A-P-69
At least he coughs - implementation of a dysphagia screening tool in a Swiss tertiary hospital
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Background: Difficulties with swallowing is a common problem in elderly people. It is estimated that more than 45% of the people aged 75 and older suffer from dysphagia. In the daily hospital care, problems with swallowing are often overseen and the complications of it underestimated. However, undetected dysphagia can lead to dehydration, malnutrition, pneumonias and poor quality of life.

Objective: The aims of this practice development project were to enhance the nurse awareness of dysphagia in elderly people and to establish and implement a dysphagia screening tool.

Innovation: The screening tool was implemented in the entire hospital at the same time for all patients at risk for dysphagia, not only patients with stroke. The project was built up in collaboration with physiotherapists, speech therapists and occupational therapists specialized in swallowing therapies, including nutritionists as well. Nurses were trained in using the dysphagia screening tool and bedside-teaching was offered by the clinical nurse specialists. Patients detected with the risk for dysphagia were discussed by the interprofessional team and a therapy plan of care was established.

Experience: The awareness of patients at risk for dysphagia raised considerably in the six months since the implementation of the screening tool. However, it is vital to coach the nurses at the bedside, perform group screening and to offer micro-teaching at the ward level. It was quite challenging to collaborate with the therapists and mind broadening to see how they think and work. It is important to detect dysphagia, but it can’t be properly treated as an isolated symptom. We have to point out the importance of mouth hygiene and proper mouth care as well as the management of delirium.

A-P-73
Eye care in nursing homes; collaboration from nursing home physicians’ perspective
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Background/introduction: Currently, 4% of older adults reside in long-term care facilities in the Netherlands. In the Dutch adult population the highest estimated prevalence (≥40%) of visual impairment (low vision and blindness) is found in the subgroup of residents in nursing homes. More than 1500 nursing home physicians (NHPs) work in the nursing home sector, and are responsible for designing and evaluating the residents’ integrated care plans, also with regard to vision related problems.

Aim: To explore the current practice of eye care collaboration inside and outside of the nursing home from the perspective of the nursing home physician. This study is part of a larger research project concerning eye care in nursing homes.

Research questions: With whom are NHPs collaborating inside and outside of the nursing home with regard to eye care for the residents?

Materials and methods: A digital online survey was executed. In the analyses, using IBM SPSS software, the Friedman two-tailed test for k-related samples was applied to test differences in the frequencies of categories.

Results: 123 NHPs filled in the questionnaire. A significant difference was observed regarding the extent to which professional caregivers inside of the nursing home are contacted (P = 0.000). Nurses are ‘frequently’ contacted by more than 50% of the NHPs (Md = 4). The occupational therapist is contacted ‘sometimes’. More than 50% of the NHPs ‘almost never’ contact a colleague nursing home physician, or technical staff member.

The extent to which eye care professionals outside of the nursing home are contacted differed significantly (P = 0.000). Ophthalmologists and low vision specialists are contacted ‘sometimes’ by more than 50% of the NHPs. Opticians, optometrists and orthoptists are contacted (almost) never. The collaboration with eye care professionals outside of the nursing home, was not considered to be structural by 50.4% of the NHPs.

Conclusions: To raise awareness on visual problems of nursing home residents, more collaboration in eye care, inside and outside of the nursing home is needed. Inside of the nursing home, the NHP should perform a structural eye screening. Furthermore the use of a Visual Functioning Questionnaire (VFQ) such as the NEI-VFQ 25 may give the ward nurse more insight into the experienced visual functioning of the residents and stimulate them to involve other members of the care team. More attention is needed for developing structural collaboration outside of the nursing home between NHP and eye care professionals.