Editoriale

A NEW METHODOLOGY IN NURSING HOME: THE INTEGRATED INDIVIDUALIZED CARE PLAN

W. Verrusio, A. Renzi, A. Evangelista, F. Cecchetti, F. Ionta, M. Coi

RSA "Casa di riposo ebraica di Roma", Via Portuense, Rome

Abstract

We propose a new work strategy in nursing homes, also known as "residenze sanitarie assistenziali – RSA" in in the Italian health care system. Currently the Italian legislation provides individualized rehabilitation plans for patients living in RSA (called "piano di assistenza individualizzato, PAI"). We propose a new methodology based on the integrated view of different services offered to the patient. We believe that it is essential to treat the elderly assisted in RSA not only as individuals but also as a part of a community that shares similar issues.

Keywords: Elderly, nursing home, frailty, rehabilitation

The Italian legislation provides the application of an individualized care plan ("piano di assistenza individualizzato-PAI") for elderly living in nursing homes, which in the Italian health care system are known as *residenze sanitarie assistenziali* (RSA). These care facilities are intended for non-autonomous elderly in need for social and/or clinical assistance. Priority is given to group activities with special focus on each individual's rehabilitation.

However, we note several limitations to this approach:

- Patient's individual care can transform in individually the work of rehabilitation staff, reducing integration between the work of nursery operators and the failure in achieving common therapeutic strategies;
- Excessively individualized assistance may determine the worsening of risk of isolation in elderly

- The risk to lose group dynamics that can facilitate socialization among individuals and mutual help in functional and/or cognitive-psychological recovery.

We propose a new assistance method based on the integration of services offered to the patient. The new implementing instruments proposed are two:

1. multidisciplinary performance status form (MPSF);
2. "cluster analysis" of patients.

The aim is to propose an approach that consider not only the individual characteristics of the patient, but also the specificities of the group of patients that show common risk factors in order to provide a shared therapeutic plan. The present model originates from the experience gained in the RSA "Casa di Riposo Ebraica di Roma", a nursing home in which 20 patients are assisted (average age= 88 years; 3 Males).

The MPSF is an interdisciplinary datasheet that is filled in by the operators involved in assistance and rehabilitation (Fig. 1). This instrument allows us to make a monthly monitoring of the health condition of patients and the results achieved by the rehabilitative interventions established in the PAI.

In the MPSF each operator will indicate the monthly target of provided treatments and the outcome achieved at the end of the month. Furthermore, the MPSF provides information on two specific variables that can negatively affect the frail elderly patient's state of health:

1) pain;

2) body weight.

The datasheet includes a timetable in which the operator will mark the days he worked with the patient.

The application of the MPSF in the nursing home offers several advantages:

- facilitating the exchange of relevant information about patient's health con-

dition, so improving the teamwork that is necessary for proper implementation of the PAI;

- monthly monitoring of the results of the rehabilitation program;
- control the level of compliance for the patient after the treatment.

Although current legislation emphasizes on the need of tailoring the rehabilitation treatment to the patient, it is also true that often the elderly cared in these facilities can be easily divided into groups of patients that share the same (or similar) risk factors or frailty characteristics. The division into different groups of intervention (that in our model are defined "Task Force") allows to standardize the treatment of patients which shows homogeneous individual characteristics, and to have the rehabilitative treatment, in terms of duration and frequency of sessions, based on the specific needs of each group of patients. This approach implies a more careful rationalization of the resources according to the needs.

Fig. 1 - *The Multidisciplinary Performance Status Form. [A: timeline in which each operator indicates the sessions conducted; B: monthly changes in the body weight in Kg; C: Numerical rating scale and visual analogue scale for the pain assessment; D: graphic indicator of the outcome achieved related to the target fixed (the symbol ">" shows a positive outcome, the symbol "="shows no changes; the symbol "<" shows a negative outcome); E: graphic indicator of the compliance of the patient to the treatment provided (increased or decreased)].*
For download: http://www.crer-rsaebraica.org/progetti-e-collaborazioni/

E.g. in our nursing home, regarding the Physiotherapy rehabilitation we identified three task forces named:

1. *immobilisation syndrome task force*: patients bedridden or with a high risk of bedridden;
2. *risk of falling task force*: patients with a high risk of falling;
3. *maintenance task force*: patients with a walking deficit with a level that goes from mild to moderate.

As regard the Occupational Therapy, we have identified three task forces named:

1. *Cognitive task force*: patients with a cognitive deficit with a level that goes from moderate to severe;
2. *Psychic-Immaturity task force*: patients who suffer of mental delay;
3. *Activity of Daily Living task force*: patients who undergoing a specific treatment for the maintenance and/or the recovery of the autonomy in the performance of some activities of daily living.

Once patients have been divided into different therapeutic groups, our model contemplates a differentiation based on the frequency of treatments and the applied rehabilitative method. For example in our experience the task force called "fall risk" follows a rehabilitation protocol focused on reducing the risk of falling that includes the use of an exoskeleton for to improve balance (1, 2). Instead, in the "psychic immaturity" task force, the type of intervention aims to improve patients' social skills and adapting to the rules of the community life, through classes focused on the upgrading of the skills of these subjects.

We aim to apply this model also to Psychological rehabilitation, aiming to positive results in: a) promoting the socialization process among patients, b) increasing self-esteem and confidence, c) promoting positive surrounding reality.

Thus, the community life of these patients should lead to the creation of care plans that enhance the sociability and promote rehabilitation programs that are shared between patients with homogeneous features. It is also relevant for the assessment and monitoring of the patient health status to adopt a new instrument towards a multidisciplinary rehabilitative intervention. This model represents an effort to improve the quality of offered treatments to the elderly through an integrated view of the rehabilitation plan that implies active participation of all the operators of the nursing home.

Acknowledgement

References

1. Verrusio W., Cecchetti F. et al. Fall prevention and mood in the elderly using an exoskeleton Human Body Posturizer. Case report. Italian Journal of Geriatrics and Gerontology 2015;3(2):39-42.
2. Verrusio W, Cacciafesta M, Marigliano V, et al. Fall prevention in the young old using an exoskeleton human body posturizer: a randomized controlled trial. Aging Clin Exp Res. 2016.

Corrispondenza
W. Verrusio
Via Portuense 214-216, 00149 Rome