Case management of frail - elderly stroke survivors

Health & Medicine, Healthcare

The process of case management (CM) is an essential component of quality healthcare. The Case Management Society of America defines case management as follows: " Case management is a collaborative process which assesses, plans, implements, coordinates, monitors and evaluates options and services to meet an individuals health needs through communication and available resources to promote quality cost-effective outcomes." (Case Management Society of America, 1995, p. 8) " Case management is an intervention strategy used by health care providers and systems to advocate for clients, coordinate healthcare delivery, and facilitate outcomes of both cost and quality." (Huber, 2006). Zander best describes the process of case management as " the nursing process applied at a systems level" (Zander, 2002, p. 58). The CM process, which is often referred to as clinical resource management is addressed in the CMSA's Standards of Practice for Case Management (2002). This provides a guideline for case management and consists of assessment, planning, facilitation, and advocacy; all of which are core functions of the clinical case manager. This case management plan is focused towards frail, elderly clients who have suffered a stroke and will be returning home upon release from their hospitalization, having care provided to them primarily by a family member. You often hear the word acute when physicians refer to a stroke, this implies that the stroke is a short-term condition when in actuality; the implications of a stroke are long term and become chronic (Young, 2001). When a stroke is treated as just an acute condition, the clinical outcomes are not as great as if an evidence based model similar to that of a rehabilitation unit is implemented upon returning home from the initial admission (BMJ 1997). The

fastest growing segment of our population is the frail elderly, aged 85 and older (Hobbs 2001). As Clinical Nurse Leaders, it is imperative that we embrace the needs of this rising population and develop plans of care to best suite their ever growing needs; ones that address their quality of life. Stroke survivors have residual neurological impairments, which require long-term support and care. " Stroke is the leading cause of long-term disability in the US with over one million Americans currently living with serious functional limitations. According to the National Institutes of Health, of individuals with stroke over the age of 65, approximately 50 percent will have persistent hemi paresis, 30% cannot walk without assistance, 19% have aphasia, 35% have depressive symptoms, and 26% require institutional care" (Brashers, 2007). Anxiety, depression and poor physical health are common effects among family caregivers of stroke survivors. There is also an association between the stroke survivor's level of disability and emotional state and the emotional distress of their caregivers (Bugge, 1999). The American Heart Association (2005) identified family cooperation as an indicator for successful rehabilitation after a stroke. However, many family members take on the responsibilities of care giving in addition to their routine activities and work schedules. Primary caregivers who work must rely on other family members to assist with care giving responsibilities. The amount of care provided by a single caregiver can be reduced if responsibilities are shared; sharing the responsibilities requires that family members collaborate and communicate. Studies have shown that family relationships deteriorate after a member survives a stroke (Anderson, Linto, & Stewart-Wynne, 1995; King et al., 2002), and ineffective family functioning (families not communicating and

problem solving well) has been associated with negative psychological outcomes for caregivers (Clark et al., 2004; Evans, Bishop, & Ousley, 1992). Model The Carondelet St. Mary's Community Nursing Network (Arizona) Model is a hospital to community approach, across –the- continuum of care, and is the model best suited to address the needs of the patient population and their families of frail elderly stroke survivors who choose to return home for rehabilitation Assessment In the assessment phase, the nurse will begin by assessing the needs of the patient; he/she will then work to develop the most appropriate plan of care specific to that particular patient and his/her needs. CMSA states in the Standards of Practice for Case Management (2002) that this assessment needs to cover health behaviors, cultural influences, beliefs / values systems and must include identification of potential barriers, negotiating realistic goals with the patient, and searching for alternatives when compromise cant be made. The U. S. Department of Health and Human Services recommends that a standardized Assessment Instrument should be used to facilitate the evaluation of the patient's actual performance of activities. Planning / Facilitation The planning and facilitation phases should be considered and approached as a collaborative measure where the patient, family, decision makers, medical / nursing staff and community resources are all considered. The nurse will begin to devise a care plan that is very individualized and focuses on evidence- based practices supported by solid research. In the plan of care, specific treatments will be identified as well as the sequence, intensity, and duration of each treatment. The initial plan may not be a success so it is imperative that fall back plans be in place in order to accommodate any sudden or unexpected

breached in the original care plan. It is important for the case manager to streamline the care by maintaining and encouraging open communication between the patient, their family and other services that may be, or that are anticipated to be provided for this patient. The case manager has the role similar to that of a social worker in that they will assist the patients and family in locating available community or private resources focused at helping to reduce the caregivers burden and provide quality of life for the patient. This is done by an individual assessment of the client and their family; taking into consideration the needs of both with the primary interest to that of the client. Below you will find a list of appropriate local community organizations and interventions that may be beneficial for the needs of this client population. With the goal of meeting the clients immediate needs having been taken into consideration. These interventions will be discussed with the client and their family to choose the ones that they think will best suit their immediate as well as long term needs. I have selected a wide continuum of care options with broad services to ease the care- giver role strain as well as to meet the main priority of meeting the needs of the client. 1. JABA – Geriatric Day Care. Provides temporary care during the day, which can alleviate caregiver role strain as well as provide an opportunity for socialization for the client. 2. Meals –On- Wheels- This community service provides free nutritious meals for clients and can accommodate the dietary needs of a client with aphasia upon request. 3. Senior Citizens Center – The Club House of the Blue Ridge. Provides temporary care during the day, which can alleviate caregiver role strain as well as provide an opportunity for socialization for the client. 4. Visiting nurse / Home health care – Provides

medical services and therapy agreed upon between the agency and Medicare or private insurance. 5. Home Health Aide / Assistant- Provides medical services and assistance as agreed upon between the agency and Medicare or private insurance. 6. Chore service – The caregiver may benefit from hiring an errand runner if they have the financial resources available to them. 7. Stroke survivor / caregiver's support group – A support group for both the client and their caregiver can provide them with an outlet to discuss challenges, fears, achievements, etc. Some helpful products for stroke management can be purchased from hospitals, pharmacies, medical equipment supply stores and catalogues. Some areas in the home and supplies to be considered include: Bathroom equipment and accessories - Grab bars, handrails, raised toilet seat, tub bench seat, hydraulic tub lift, tub mat, hand-held shower, portable commode and continence management products. Mobility devices such as chairlift, elevator access, wheelchair, walker, cane. Eating utensils- Specially designed utensils to provide for greater independence. The expected outcomes in a plan of care may vary slightly from client to client based on their clinical diagnoses (secondary included) as well as the effects of the stroke, which contribute to their limitations. Fewer Hospitalizations, improved self-care skills and ability as well as an overall enhanced quality of life are all measurable outcomes. For each intervention and expected outcome, there must be a measurement tool in place to monitor the success or failure of each. This will help the case manager adjust the plan of care to meet the client's needs. Goal setting is one way to measure the progress. 3-Week Plan of Care While the rehabilitation phase for clients whom have experienced a stroke will vary

based on the level of severity and type of stroke, below is an example of what a possible 3 -week plan of care may look like. Home Week 1: Assessment Phase Nursing Assessment/ Physical status assessment: The nurse will perform a mini mental exam, assess cognitive and perceptual function, swallowing, nutritional risk factors, communication, pain, and mobility. The level of assistance needed will be determined. A screening for depression will also be initiated. The CM will identify the primary care giver and assess family involvement. The family's educational needs, goals and expectations will be discussed. The CM will identify the immediate physical, emotional and social needs of the client. Community resources to assist in meeting those needs will be established. Multi-disciplinary interventions needed (ex: PT, OT, Speech) will be identified and the consults requested. Bladder / Bowel (B&B) retraining will begin. The clients home will receive a safety assessment in relation to fall prevention. The CM will suggest assistive devices for client that will help them become more independent. Expected Outcomes It is expected that there will be an optimal feeding method in place tailored to the client's specific needs. Continence/incontinence routines will be established, and the client will participate in self-care. Evaluation for Expected Outcomes Daily weights will be evaluated for variations in weight, either increase or decrease. If input and output are being documented for a specific client then those records will be reviewed to determine if the output is matching input and to ensure that hydration is met. The types of food and consistency will be evaluated. Skin condition will be assessed to ensure that there is no breakdown or irritation. Home Week 2: Rehabilitation Phase Nursing Assessment / Physical status assessment: The CM will review the

rehabilitation plan with family and client. During the second week, the client will set short-term goals. An example of that might be that the client will ambulate with assistance. A support system for therapy goals (family and client) will be provided. The caregivers coping ability (burden) will be assessed. A review will be done to ensure compliance with feeding method, diet type and texture of foods. Safety needs and B&B training concerns will be addressed. The CM may alter the nursing treatment plan and will take into consideration the family and client input. A complete revised Nursing Care Plan will be established and a progress note will be done to document the previous week and the plan for the following week. Expected outcomes It is expected that the client's participation in activity's of daily living are increasing. It is expected that earlier short- term goals are now being reached. Evaluation for Expected Outcomes Standardized assessment tools can be used to re-evaluate the client and can then be compared to earlier results from the initial assessment. Home Week 3: Rehabilitation Phase Nursing Assessment / Physical status assessment: The CM will identify educational needs, review current therapy goals, set long-term goals with family/ client such as reducing the required services if independence is being achieved or discussing alternate rehabilitation options if the current arrangements aren't meeting their expectations. An assessment of the B&B training will also be done. The CM may alter the nursing treatment plan and will take into consideration the family and client input. A complete revised Nursing Care Plan will be established and a progress note will be done to document the previous week and the plan for the following week. Expected outcomes Identify patient goals that have been met. The patient and family

will express the desire to continue with at home rehabilitation. The client will maintain pre-stroke weight or weight loss if it were determined that weight was a risk factor for the stroke. It is expected that cognitive orientation and concentration intact. Activity tolerance is expected to have increased by week 3. Evaluation for Expected Outcomes No evidence of mal nutrition in the client. Standardized assessment tools can be used to re-evaluate the client and can then be compared to earlier results from the previous assessment. Continuous evaluation can determine trends and identify problem areas. To evaluate cognitive orientation, the client will be asked to identify person, place and time. Concentration is evaluated by the client's ability to focus on a specific task appropriately. Participation in daily activities can demonstrate an increased activity tolerance. Advocacy Advocacy is intended to protect the best interests of the patient. This ensures patient autonomy is supported and that their needs are met in a timely manner. A form of advocacy would be assisting the client in gaining access to interventions that would be beneficial to them and their rehabilitation progress / goals. Proactive advocacy can assist the survivor to reach their previous level of functioning. The case manager will essentially go to all measures to ensure that this is met. Sustainability Cost analysis is a factor in sustainability. As a case manager, you must be prepared to show, through accurate and complete documentation, the need for continued services based off of desirable outcomes, and quality, cost-effective care. Home rehabilitation is cost effective for insurance providers and Medicare because it reduces future hospitalizations, as well as Skilled Nursing Facility costs. Variances, or deviations from the expected should be expected and

closely monitored for. The most common major categories are (1) patient/family variances, (2) practitioners variances, (3) institutional or system variances, and (4) community variances (Cohen & Cesta, 1997; Powell, 2000). In addition, there should also be consistent evidence that interdisciplinary clinical pathways maximize the outcomes for both the client and their family caregiver. Summary Rehabilitation after a stroke is a challenge for the client and their family. This challenge increases with the decision to have the client return home rather than to a rehabilitation center. It is imperative that the primary care giver of the client has a support system in place. In order to maximize the success of the case management plan, the approach taken should be one of multi-disciplinary care plan and tailored to the needs of the client. The goal of the case manager is to provide guidelines and resources in caring for the stroke survivor with impairments, activity limitations, and participatory restrictions and to assist the client in reaching optimal physical, mental and social functional levels through a diverse partnership with the interdisciplinary staff. References Anderson, C. S., Linto, J., & Stewart-Wynne, E. G. (1995). A population-based assessment of the impact and burden of care giving for long-term stroke survivors. Stroke, 26, 843-849. American Heart Association. (2005). Heart disease and stroke statistics--2005 update. Retrieved November 2, 2007, from www. americanheart. org/downloadable/heart/11053909 18119HDSStats2005Update. pdf. Baker CM. Miller I. Sitterding M. Hajewski CJ. Acute stroke patients comparing outcomes with and without case management. [Comparative Study. Journal Article] Nursing Case Management. 3(5): 196-203, 1998 Sep-Oct. Brashers T. Stroke class lecture

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