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Geriatric Interdisciplinary Team Training

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Case Study: Geriatric Interdisciplinary Team Training

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The authors are members of the Planning Group Committee for the Geriatric Interdisciplinary Team Training (GITT) Project. GITT is a project of the Virginia Geriatric Education Center (VGEC), in partnership with Sentara Health System and Eastern Virginia Medical School in Norfolk, Bon Secours-Richmond Health System and Medical College of Virginia Hospitals of Virginia Common-wealth University. GITT is being funded (1997-2000) by a grant from the Department of Health and Human Services. The authors represent MCVH/VCU's Schools of Medicine (Internal Medicine, Division of Geriatrics, and Physical Medicine and Rehabilitation), Social Work, Nursing, and Pharmacy, and the VGEC, Department of Gerontology in the School of Allied Health Professions. Other Schools involved in GITT include Dentistry, Education, and the College of Humanities and Sciences. Other Depart-ments include Occupational Therapy, Physical Therapy and Rehabilitation Counseling in the School of Allied Health Professions. The objectives of the grant are three-fold: (1) to provide education to health care professionals in the areas of gerontology/geriatrics and interdisciplinary team training, (2) to create a graduate-level video-based geriatric inter-disciplinary team course for current graduate students and health care professionals, and (3) to establish new clinical placement sites for VCU students in interdisciplinary team settings.

Case Study Educational Objectives

1. To demonstrate the importance of training health care professionals in inter-disciplinary teamwork and geriatric health issues.

2. To increase one's knowledge of the roles and responsibilities of the various disciplines involved in interdisciplinary teamwork.

Case Study

Introduction

The planning committee designed a training exercise titled, "Name that Discipline!" This exercise involved the presentation of a case study and summaries of different disciplines' clinical responses to it. The exercise was intended to demonstrate that, although health disciplines have distinctive roles and responsibilities in treating older adult patients, there is enough overlap between disciplines to make delineation difficult. The other salient issue is that team effectiveness is greatly diminished if members of various disciplines lack a clear understanding of the roles and contributions of their colleagues. The challenge for the planning committee was to write each clinical response to the case in such a way that the role of that discipline was clear but, at the same time, the overlap with the responsibilities of the other disciplines on the team was recognized.

Method

GITT trainers presented the case study to participants who consisted mainly of those whose primary

discipline was social work or nursing. Following the case presentation, the partic-ipants were asked to listen to eight clinical responses, each of which was read by a GITT planning group member or health care professional assisting in the training. The participants were asked to write down which discipline they thought had made the clinical response. Upon completion of the training session, the participant answer sheets were gathered to deter-mine how accurately each of the eight responses was ascribed to the appropriate discipline.

The Case

A 70-year old female was admitted through the ER of your community hospital at 4pm for an acute change in mental status. Evaluation in the ER revealed normal electrolytes, mildly impaired renal function, mild anemia, and evidence of a urinary tract infection by urinalysis. As best you can tell from the ER note, the physician (who is no longer available until the morning) also obtained an EKG (evidence of an old inferior wall myocardial infarction, but no acute changes), a chest X-ray, and a blood gas (normal). She was seen by Psychiatry, who spoke briefly with the family (who have now left and apparently do not have a working phone), who reported several weeks of declining function and behavior that they labeled as "depression." The consulting Psychiatrist felt a medical work up was indicated prior to considering psycho-tropic medications, but agreed to follow the patient in the hospital.

You interview and examine the patient, and note the following: She is a short, moderately obese female who is lying comfortably on the bed. She appears lethargic and "puffy" (including eyes, neck, hands, feet). She is arousable for 1-2 minutes at a time when questioned. She is oriented to name, "hospital", and "January 1999." Some of her responses include:

"I have been feeling tired, real tired for a long time. I just can't get up out of bed in the morning. Sometimes, I even fall asleep while I'm on the toilet. Lately, I've been wetting myself at night because I don't wake up. I've gotten so weak I can't even walk to the bathroom myself."

"Are you the man from Medicare? Who is paying you for this? You're such a nice man, can you call my daughter and tell her to come get me? Why are you asking me all of these questions? Do I know you? Dr. Scaggs is my doctor, but he's retired now. I've had an opportunity to meet the new doctor, but I can never get a ride there. He's one of those new doctors from the medical college. You're a nice doctor."

"No, I haven't had a problem with my heart, just pressure and sugar. The doctor had me on some water pills, but I only take them when I need them. My feet and hands just 'swol' up overnight. No, I'm not short of breath and my chest doesn't hurt. It will if you keep pressing on it like that! That stethoscope is cold!"

"I'm worried about my hair, it keeps falling out. It's probably my mother-in-law. She's 90 years old and lives with us. I take care of her because she isn't in the best of health and can't live alone. She's a lot of work."

"I've been eating well. My joints hurt sometimes, especially when it rains: you know "Arthur" comes to visit me then. I've been sleeping too much lately, no energy. I feel a little worried about my bills, but I'm not sad or depressed like my children say. Suicide is against God's words. Besides, I've got to take care of my 'granbabies.'"

"I take a little pink pill, a blue one, two yellow ones, and those two big white ones, and my sugar diabetes shots. My niece checks my sugar. I used to take a pill for my neck, hemorrhoids or something, but I ran out of that around Christmas. My niece is a nurse and she's been watching my pressure and sugar. She gives me the fluid pills when I keep water on. They haven't worked as well lately."

"I don't drink or smoke. I barely eat anything, just breakfast, lunch, and dinner, but I keep gaining weight. My rings don't even fit anymore. My daughter told me to stop eating them ham biscuits, but it's my only treat. Besides, my brother, who lives with us, just loves my cookin' and he sure hates to eat alone. I only use a little salt, a little lard, and a little pepper."

Her physical exam is significant for the following: BP: 110/70; P: 64 Regular; R: 20; T: 101.4 orally; mild diffuse hair loss without scalp abnormalities; neck fullness, no tenderness JVD; thyroid is enlarged and nodular; no meningismus; rare rales-rhonchi at lung bases bilaterally; normal cardiac exam, regular, no murmur; non-tender abdomen with no mass and active bowel sounds; 2+ pitting edema in both legs; 50% help (moderate assistance) for bed mobility, transfers, and gait with a walker (new for patient); cognitive dysfunction as demonstrated in history with no focal neurological deficits.

What assessments do you make of this challenging patient?

The following are the eight clinical responses that training participants had to attribute to different disciplines. See how well you do. The answers appear later, along with the percentages of correct attributions from the participants.

Response 1: The individual has had a new onset of functional decline related to an at least partially treatable acute illness. She was able to function independently at a household level several weeks prior to her admission, and there does not appear to be any irreversible motoric deficits. Therefore, she should be expected to return to her premorbid condition with appropriate rehabilitation interventions. Factors that need to be more clearly elucidated in order to support this prediction are: social support systems (both informal and formal), premorbid cognitive functioning, and ability to participate in and tolerate therapy.

Response 2: For more information, I would ask the following questions: (1) What were you able to do before you started feeling so tired? Were you able to dress and bathe yourself? Cook and clean? Laundry? Shopping? Money management? Hobbies? (2) Do you use any adaptive equipment to complete daily tasks? Reacher? Tub bench? Bedside commode? (3) Which joints hurt you from your arthritis? (4) How has your decline in health affected your strength and ability to move your arms and upper body? (5) Are you comfortable lying in your bed and sitting in a chair? Do you have any bedsores?

Based on the information provided, I would write up the following treatment plan: (1) positioning 2^{o} edema, (2) prescription for edema, (3) ADL retraining, ILS retraining, (4) functional transferring (toilet and bath), and (5) modality prescription for arthritis.

Response 3: Her function and behavior had been declining for several weeks. The patient appears to have several chronic medical problems including hypertension, diabetes, arthritis, and edema. She also has a urinary tract infection. She reports taking four prescription pills daily (a pink one, a blue one, two yellow ones, and two white ones), a daily insulin injection, and a diuretic when needed. Her compliance with these medications and her use of over the counter medications is unknown. Her niece monitors glucose in her urine, her blood pressure, and gives her the diuretic when she seems to need it. A conversation with her niece would be helpful to identify all of the medications she is taking and whether she takes them as prescribed, particularly since the patient has not been seeing a doctor regularly recently. Each of her medications needs to be evaluated to determine whether it is effective, necessary, and has minimal side effects.

Response 4: Obviously, there are biological issues that need to be addressed immediately with this patient. I would wonder about her diabetes and how well that is controlled, and would assume that she may have hypothyroidism, given the symptoms described. Parallel to the physiological issues, there are a number of psychosocial needs that require addressing. Her support system appears to be somewhat limited in that her family is not present, has no working telephone, and does not have transportation available to get to her physician. She is responsible for the care of her 90-year old mother-in-law who is reportedly "a lot of work," and she also cares for her grand-children. Physically she is too tired to care for herself, much less her family members, and with the appropriate diagnosis and intervention, hopefully, some of her strength can be restored. For the time being, however, she needs the appropriate supports to get her to that point and that would be my major concern right now.

Response 5: First of all, she has some confusion. I will need to provide an environment in which she will be safe. I will see if I can place her in a room close to the nurses' station. I will have to move some other patients around, but I need to monitor her closely. I am concerned about her cardiac functioning. I will weigh her everyday, and put this in my care plan for others to follow. I will monitor her intake and output. Her diagnosis of impaired renal function and her questionable cardiac history are sources of concern. I wonder if the physician prescribed a renal diet? Although her electrolytes are normal, I think she would benefit from this. I would assist her with her care. If she is too weak to use the bathroom, a bedside commode will be better. Research indicates that patients expend more energy using a bedpan than bedside commode (this information influences my decision).

Response 6: This patient has demonstrated a marked decline in functional mobility from her prior level. If a walker is new to the patient, she must have been an independent ambulator prior to this episode. The patient would require further gait training with this assistive device or a trial of devices to see which is appropriate for her use in regards to safety and her home situation. After this, the appropriate equipment would need to be ordered and fitted to the patient. The patient would also require bed mobility and transfer training, as she now requires moderate assistance and, again, it

appears that the patient was previously indepen-dent. It also means that the patient would not be able to perform ADLs independently at this time.

Response 7: I would like to obtain the following: patient's height, current weight, usual body weight, current lab values - more specifically: albumin/ prealbumin, sodium, potassium, chloride, carbon dioxide, Blood Urea Nitrogen, Creatinine, Glucose, Calcium, Ion Calcium, Phosphates, Magnesium, Triglycerides, and Cholesterol. I would like to be able to com-plete a 24-hour dietary recall with the patient, since the patient states she has been eating well and then states that she barely eats anything. How much is the niece involved in her care? Is the niece aware of the impor-tance of nutrition? A complete list of meds and amounts should be taken daily. And how much of weight gain is excessive fluid?

Response 8: There are some immediate acute problems. Primarily, she has a fever, probably from a UTI. There is also evidence for delirium, which could be attributed to the UTI but might have other causes. I'd like to know something about her glucose reading and the status of her diabetes. Obviously, it is important to know the names and doses of her medications as soon as possible. There is a strong suggestion of hypo-thyroidism as a factor for both her delirium and her recent functional decline. The issue of depression can't be adequately evaluated until the delirium is resolved and hypothyroid state, if present, is treated. The anemia needs to be further explored. It is not really explained by the apparent diagnosis. There are significant concerns about the caregiving environment, given her apparent non-compliance and the delay in seeking attention/medications.

Results

The disciplines that produced the eight clinical responses follow. Training participants ascribed the responses correctly 62.5% of the time. Accuracy for each clinical response is also given.

Response 1: Physiatry	0% correct
Response 2: Occupational Therapy	64% correct
Response3: Pharmacy	24% correct
Response 4: Social Work	84% correct
Response 5: Nursing	92% correct
Response 6: Physical Therapy	88% correct
Response 7: Nutrition	96% correct
Response 8: Physician	52% correct

Background

Interdisciplinary Teamwork

Interdisciplinary teamwork is not a new concept. Throughout the history of teaming, various terms have been introduced to identify the different types of teams (e.g., multidisciplinary, interdisciplinary, trans-disciplinary) found within healthcare (Tsukuda, 1998). Each of these types of teams has distinct characteristics which influence the care provided to the patients being served. Rather than differentiating between the terms, Tsukuda (1998) chooses to use Brill's definition of teamwork, which

contains components that are crucial for an effective team. Brill (1976, as cited in Tsukuda, 1998) describes teamwork as work conducted by a group of individuals, each of which has a specific area of expertise; members of the group make individual decisions, with a common goal, and meet, in order to share and combine knowledge to form plans which influence future decisions. This definition describes the common goal that each team member shares without placing primary responsibility on any one individual.

Interdisciplinary Team Training with Older Adults

Geriatric Interdisciplinary Team Training is designed to increase knowledge of the needs of the older adult population. As is well known, older adults frequently have multiple health conditions that require treatment from a variety of health care specialists. These specialists often prescribe their own regimen for the older adult. Although providing specific treatment for specific impairments is beneficial to the individual seeking services, treatments may overlap and/or medically conflict when these specialists do not consult with one another. Difficulty arises when these team members work independently instead of acting as a cohesive whole. This, in turn, can cause further medical complications. Without inter-disciplinary teamwork, lapses and health hazards may arise which can result in significant harm to the older adult.

Because of the heterogeneity of the older population, diverse social, biological, and psycho-logical histories must be clearly explored and considered when treating older persons, and a highly individualized approach must be utilized (Pfeiffer, 1998). This individualized approach requires multiple health care participants, each with his or her own specialization.

Three major points can be deduced from this case. First, when Geriatric Interdisciplinary Team Training is conducted, it demonstrates the complexity of older adults. Second, Geriatric Interdisciplinary Team Training highlights the unique perspective of each discipline and what each discipline adds to the assessment of older individuals. Third, Interdisciplinary Teamwork requires a clear understanding of what other disciplines do. In summary, Geriatric Inter-disciplinary Team Training stresses the importance and necessity of bringing multiple disciplines together in order to provide the best and most effective healthcare for the older population.

Study Questions

1. What does each discipline add to this case in terms of assessment?

2. Why is it important to recognize what each discipline would do in this case?

3. Why is it important to use an interdisciplinary team approach when working with older adults?

References

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