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Development and implementation of responsible discharge care protocol for hospitalized elderly with chronic diseases and in need of special nutritional support

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Abstract

Introduction: Elderly with chronic non-communicable diseases (NCD's) are often hospitalized with fragility and malnutrition and Nutrition Therapy (NT) may be needed. Objective: To report an experience of development and implementation of a care protocol for hospitalized elderly with NCDs complications and need of NT, and to organize protocol activities in accordance with responsible discharge and continued care planning. Methodology: Experience report of a transition and continued care protocol development and implementation for hospitalized elderly patients with NCDs, malnutrition, and need of NT, between August, 2011 and January, 2012. Results: Participation of elderly and their families/caregivers was central in designing the protocol. The responsible discharge and the communication in health, through home visits, were systematized on transition and continued care planning. Discussion: The systematized protocol allowed health care continuity across settings through communication strategies. The high prevalence of malnutrition in hospital settings suggests that nutritional surveillance, appropriate and early NT planning and monitoring of nutritional status in primary care are flawed. When indicated, nutritional support established in hospital settings must be continued in patient's home and NT must be ensured in primary care. Conclusion: Care protocol development and implementation, with transition and continued care planning and responsible discharge, supported health communication to continuity of NT at home.

Key words: Chronic Disease. Aged. Patient Discharge. Health Communication. Nutrition Therapy. Nutricional Surveillance.

Introduction

Currently, chronic non-communicable diseases (NCDs), considered to be one of the greatest public health problems, are the leading causes of mortality worldwide, especially in developing countries, among the low-income population and the elderly. 72% of deaths in Brazil in 2007 were due to NCD complications, and it is estimated that it will account for 66% of deaths in 2015. Circulatory system diseases, cancer, type 2*diabetes mellitus* and chronic respiratory diseases are reported as the causes of deaths.[1-3]

Demographic transition and nutritional transition may partially explain the model of health transition. Population aging increases prevalence and incidence of NCDs, but its main causes are modifiable risk factors such as poor diet and increasing prevalence of overweight and obesity.[2,4,5]

The current dietary pattern consists of high intake of saturated fats, sodium and refined sugar. Foods rich in fiber, vitamins and minerals, considered to be beneficial to health, are ingested in small amounts. Maintaining a healthy diet can help prevent and treat NCDs.[3,6,7]

Nutrition is, thus, one of the conditioning and determining factors of good health. According to the Brazilian Federal Constitution (FC) and the Organic Health Law (OHL), which regulates the Unified Health System (SUS), health is a fundamental human right, and the State shall, in conjunction with the individual himself, family, society and private companies, provide the conditions for its full realization. Thus, the Human Right to Adequate Food (HRAF) is also guaranteed in the CF and it considers the Food and Nutrition Safety (SAN) as a means to achieve it. FNS is the assurance of regular, permanent and unrestricted access to safe food in safe and suitable quantity and quality, without compromising access to other essential needs, based on health promoting food practices that respect cultural diversity and that are environmentally, culturally, economically and socially sustainable. The government should adopt policies and actions that are necessary to promote and ensure FNS.[8-11]

The OHL determines the achievement of actions for prevention of diseases and injuries and promotion and restoration of health. In this respect, it is also necessary to make early diagnosis, and start appropriate treatment immediately in order to prevent or delay harmful health consequences.[12]

NCDs and their complications require continuous and intensive assistance at all points of health care, especially for the elderly, because they are mpre fragile, vulnerable and dependent.[4,5,13]

One of the principles of the SUS is comprehensive care. This is defined as"*continuous and coordinated set of actions and preventive and curative services, provided individually and collectively, required for each case, at all complexity levels of systems [our translation]* ". Comprehensiveness includes health care and rehabilitation, pivotally carried between the points of health care and multidisciplinary integration[9,14,15] thus requiring development of health care protocols.[16,17]

Because patients with NCDs often have health complications, they may require hospitalization at times when they are frequently malnourished already. Malnutrition is one of the most common diseases in hospitals. Classical studies estimate that about 50% of hospitalized individuals have some degree of malnutrition. Severe malnutrition[18,19] is manifested by approximately 12% of patients.[18-20] The elderly often have compromised nutritional status, stemming mainly from the underlying disease, whether neoplastic or not, decreased oral intake, reduced digestive capacity, obstruction of the gastrointestinal tract, preexisting chronic diseases, infection and inflammation and socioeconomic factors.[21,22]

NCD complications and malnutrition can determine the need for nutrition therapy (NT) during hospitalization, especially for elderly patients.[23-25] NT is a set of therapeutic procedures applied as nutritional intervention for maintenance or recovery of nutritional status. NT procedures are parenteral, enteral and oral, performed at the different health care units.[26-28]

There are frequent cases in which patients must continue NT after hospital discharge for extended periods of time. The articulation of different professional practices and units of the health care network favors the engagement of patients and families in home NT, and it can be structured based on health care protocols.[29]

The care protocol provides integration flows of units of the Health Care Network (HCN), depending on the needs of the elderly. In this sense, the structure of specialized health care in the HCN logic must be integrated with other health care units and be effective in cases of greater severity. Primary care, as a point of user return after discharge from specialist care, should be able to provide continued health care,[13,16] especially the treatment of diseases and rehabilitation at home.[2]

Health care units in the HCN are on a single horizontal plane and form a progressive and complementary health care network that must ensure continued care and promote the integration of different services.[2] The role of primary care is to meet the priorities set locally, while specialized services, hospitals, rehabilitation centers, among others, are designed to meet health care demands in an immediate and timely manner while using

highly technological devices. Despite the apparent distinct objectives, the common goal is to provide comprehensive health care to people.[30,31]

In order to meet the principle of comprehensiveness, there must be coordination and continuous communication among health care units so that user demands can be met.[30] The reference and counter-reference system and of SUS is important so that its principles are indeed effective and can strengthen health care provision.[32,33] Safe intermediation between hospital discharge and return to the household is performed by different types of care by health staff, and home visits are particularly important.[34-36]

Home visits are part of home care and refer to a type of intervention that can be promoted by hospitals. In this type of care, hospital staff contact usersregularly in order to collect and/or supply information. Educational activities, training of families and caregivers and the articulation of the HCN with other sectors of health care are performed for this purpose.[37,38] Therefore, communication among health care units, in the logic of the HCN, should be effective.

Communication among health care units aims to facilitate user access to the service, to offer basic conditions of health care, infrastructure and skilled human resources.[33]The continued process of health education of elderly patients and caregivers about procedures prescribed and taught at the hospital and the adaptation of such procedures to the lifestyle of the elderly and caregivers are to be performed by primary care, and they may be favored with home visits.[39]

To ensure comprehensive health care and HRAF and consolidate the principles of SUS, the modes of organization of health care are undergoing transformations in order to improve the articulation of multidisciplinary practices and different areas of health care and the adoption of more efficient ways of using scarce resources.[29]

The creation of protocols for health care provision is important to increase the efficiency of treatments for NCDs and their complications. The protocol, as described herein, standardizes and defines continued care in order to ensure comprehensive care for the elderly with NCDs, during hospitalization, discharge and return to the household.

The protocols should include multidisciplinary and intersectoral actions, and encourage health communication through procedures such as home visits, which aim at counter-reference, continued care and comprehensive care.[2] The most vulnerable population groups, such as the elderly, should be a priority in the implementation of actions from the protocol.

The objective of this study is to report the experience of designing and implementing a multidisciplinary care protocol for elderly patients hospitalized due to NCD and in need of NT, and organize the activities from the protocol in line with responsible discharge planning and continued care planning.

Methodology

This study reports the experience of developing and implementing a multidisciplinary protocol for treating NCDs in hospitalized elderly patients with NCD complications and in need of NT in a highly-complex university hospital located in Curitiba, Paraná, southern Brazil. Continued care in this protocol calls for careful implementation of the model of health care to elderly patients with Chronic Diseases at the micropolicy level, so as to serve as a model for actions within the macropolicy.[2]

Responsible hospital discharge is based on the transfer of care and is accomplished through guidance to the elderly and their families/caregivers regarding the continuity of treatment, reinforcing patients' autonomy and encouraging self-care procedures. Continued care should be performed at all health care units, through reference and counter-reference, and home visits are one of the instruments to do so.

The protocol was developed by residents, preceptors and mentors of the Multidisciplinary Residency Program in Hospital Care, particularly in the area of Adult and Elderly Health Care (AEHC), in partnership and collaboration with the Committee on Institutional Humanization, from August, 2011 to January, 2012. The team of professionals involved in the years 2010 and 2011 included a physiotherapist, a dietitian and an occupational therapist; in 2011, a psychologist joined the team.

Results

according to the perception of the multidisciplinary team of hospital care during routine care, elderly patients admitted to that hospital had multiple comorbidities and a higher number of NCD complications. Besides, their nutritional status was often compromised. As a result, they usually remained in hospital for long periods of time and were exposed to multiple procedures (diagnostic tests, NT, drug polytherapy and others). It is suggested that hospitalization, therefore, made the elderly even more fragile.

The established Continued Care for the Elderly is based on the identification of risks and comprehensiveness of care at different stages of health care. After the risk is identified, priority is placed on reducing the impacts of NCDs in the functional status of the elderly. Therefore, the association between health care units and effective care should be recommended.[40]

In hospitals, Continued Care for the Elderly provides Therapeutic Project, which results from discussions by the multidisciplinary team. The objective is to assess or reassess health conditions and, if necessary, reset the lines for therapeutic intervention of professionals involved in care provision.

The Therapeutic Project is part of the Responsible Discharge Protocol, which is a tool used to organize continued care, establishing flowcharts, procedures and guidelines during hospitalization, discharge and return to the household, by reference and counter-reference. These are administrative devices used for communication among units in the HCN, with the goal of promoting user access to services and continued care. Home visits established as the operationalization stage of the Responsible Discharge Protocol aims: referral by the reference primary care team; integration of the elderly into their social and family environment; revaluation of instructions given at discharge.

The multidisciplinary team has listed inclusion criteria for home visits based on the likelihood of risks to the integrity of the hospitalized elderly, according to the profession and area of expertise (Table 1), and prepared a flowchart (Figure 1) to illustrate elderly patients' eligibility and referrals established by the protocol.

Table 1. Inclusion criteria for home visits as a counter-reference strategy in care provision to elderly patients with NCDs discharged in 2011.

Profession	Inclusion criteria for home visits
Physiotherapy	Elderly with functional limitations and/or chronic degenerative disease.
Nutrition	Elderly under nutrition therapy and/or with impaired nutritional status.
Psychology	Elderly under psychological distress and/or in need of psychotherapeutic treatment.
Occupational therapy	Elderly with impaired performance in daily activities and in need of caregivers.

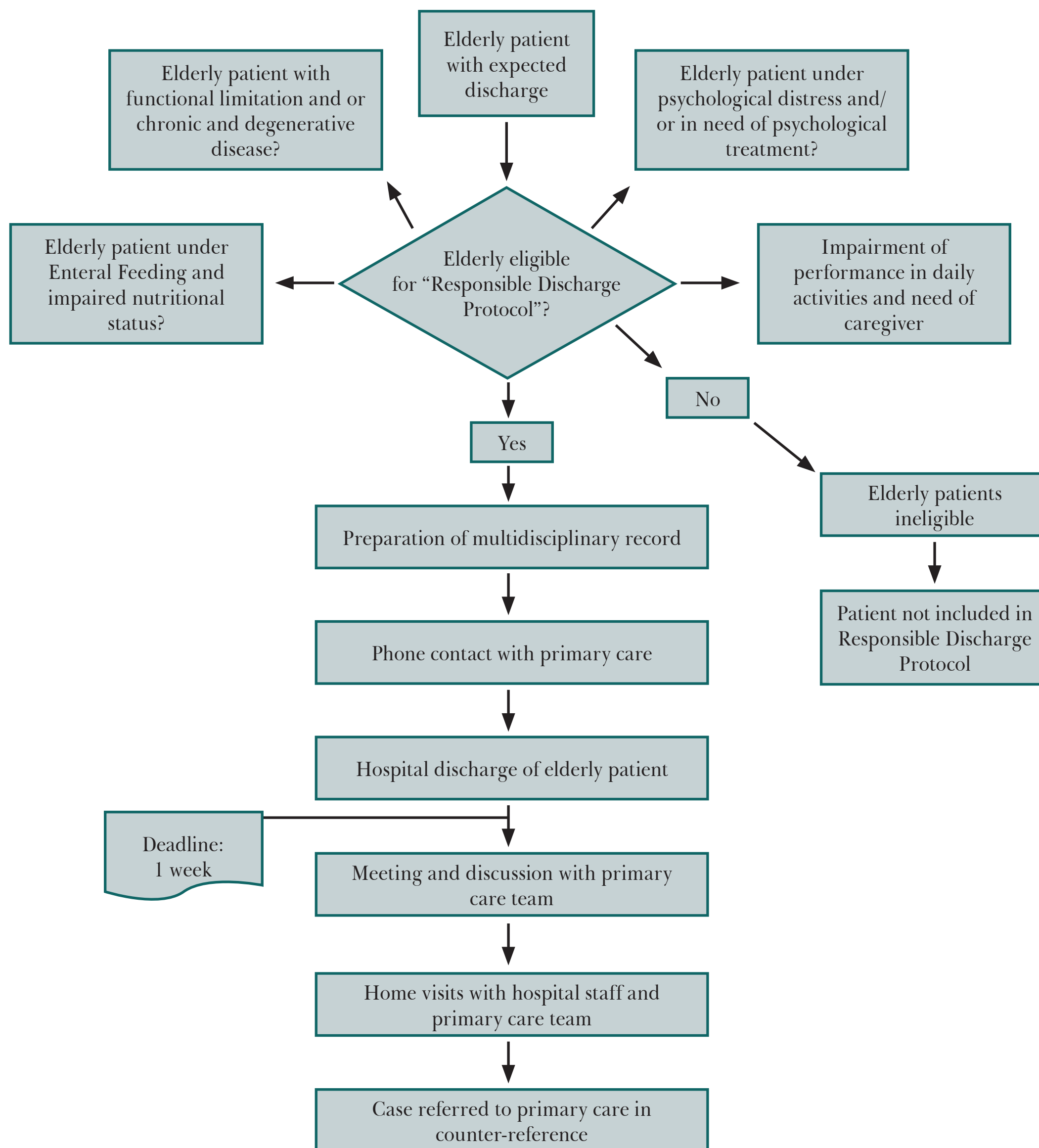

Figure 1. Flowchart of activities developed in the responsible discharge protocol in 2011.

To complement the counter-reference strategy, a document entitled "De-hospitalization Form", was prepared. It was completed in triplicate by the hospital health care team. This document consists of data relating to the patient, such as address and association with primary care, clinical history and behaviors of care team members while the elderly stayed in the hospital and future prospects for continued care after return to the household. The form was signed by the health professionals and the elderly patient or the caregiver.

One copy of de-hospitalization form was delivered to the caregiver, who was responsible for delivering it to the Sanitary Authority of the Health Care Unit (HCU) before hospital discharge, favoring the bond between people responsible for the elderly and primary care professionals. The other two copies were given to the hospital staff itself and the elderly patient, respectively.

The hospital staff were responsible for contacting the team at the reference HCU near the residence of the elderly and schedule home visits with representatives of the HCU. Visits should be made within seven days after discharge. Usually one day before the home visit, one member of hospital staff made a telephone call to the caregiver and a representative of the primary care unit to confirm the visit. The home visit was made by the hospital multidisciplinary team in conjunction with at least one professional of the primary care unit; whenever possible, a community health agent preferably joined the visit as well. These actions helped develop and implement the planning. To clarify the protocol, objectives, goals, actions, responsibilities and evaluation of the activities were prepared (Table 2).

Table 2. Plan of hospital discharge and home visits as a counter-reference strategy for elderly patients with complications of non-communicable chronic diseases, impaired nutritional status and need of nutritional therapy in 2011.

OBJECTIVES	GOALS	ACTIONS	PERSON IN CHARGE	EVALUATION
1) To promote the responsible discharge of elderly patients who met the inclusion criteria.	1) Perform responsible hospital discharge.	1.1) Preparation of hospital discharge program. 1.2) Filling of de-hospitalization form. 1.3) Delivery of form at the HCU by the caregiver. 1.4) Guidance to elderly patient and caregiver. 1.5) Telephone contact with HCU.	1.1) hospital multidisciplinary team 1.2) Caregiver	1.1) Performance of the steps of the hospital staff. 1.2) In 1 case (total of 5 cases) the caregiver did bring the de-hospitalization form to the HCU. It is assumed that they did not undertand the flow previously established.
2) Promote development of continued care.	2.1) Communication between Specialized Care and primary care team.	2.1.1) Initial notification by means of the de-hospitalization form. 2.1.2) Visit made by hospital staff to HCU. 2.1.3) Meeting between hospital staff and HCU.	2.1.1) Specialized Care Team. 2.1.2) Primary care Team.	2.1) A total of 3 visits to the HCU and 2 visits to the household. There were mistakes, e.g. a situation where the elderly patient understood that he should go the hospital, or another case, where the elderly patient died the day before the visit to the HCU and the home visit.
	2.2) Home visit	2.2.1) Home visit by hospital staff and HCU. 2.2.2) Strengthening and / or reconsideration of the discharge guidance provided by the hospital staff. 2.2.3) Identification of new demands. 2.2.4) Acceptance of demands through actions of hospital staff and / or HCU. 2.2.5) End of link between the elderly patient and the staff of Specialized Care. 2.2.6) Transfer of the case to primary care.	2.2.1) Specialized Care Team 2.2.2) Primary Care Team. 2.2.3) Elderly 2.2.4) Family members and / or caregivers.	2.2) Identification of facilitators in the acceptance of the elderly and family members within the home environment and the availability of the primary care staff to join the home visit, also in the search of strategies for developing continued care. Identification of difficulties in setting priorities, considering the complexity of cases and range of needs presented by the elderly and their families, as well as the need for more resources in the community that will address these demands in an intersectoral manner.

HCU: Health Care Unit; Primary Care: Primary Care.

The results indicate that the development and implementation of continued care involve teams from different health care areas and also the elderly person and their family/caregivers at all stages of this complex process of health care initiatives.

The hospitalized elderly included in the Responsible Hospital Discharge Protocol had impaired nutritional status. Malnutrition is a systemic organic condition. Therefore, malnourished individuals may have impairments in immunity, tolerance to exercise and daily activities with increased risk of fatigue, changes in body perception, changes in cognition and restrictions on independence and autonomy.

Malnutrition was diagnosed in complete nutritional assessment by hospital dietitians. After diagnosis, NT was initiated with the goal of maintaining or restoring the individual's nutritional status during hospitalization.

A multidisciplinary team developed interventions proposed by each professional area, focused on the specifics of the individual described in the protocol and based on eligibility criteria. Guidance for organization of routine, training for joint protection for energy conservation and joint protection in everyday activities, and training of caregivers are examples of strategies developed to foster greater opportunities for autonomy.

Counter-reference, with home visits as a tool, enabled the multidisciplinary team of Specialized Care to verify whether the guidelines provided in the hospital could be feasibly implemented at home. When unfeasible, the communication between health teams from different health care units, as well as with the elderly, family and caregivers, allowed the guidelines to be adapted the conditions of the home and the therapeutic possibilities of primary care. After discharge, primary care was responsible for maintenance, monitoring and evolution or change of NT.

Discussion

SUS is supposed to monitor morbidity and mortality in NCDs, an essential component for health surveillance.[2] The fact that the elderly were admitted to hospital with compromised nutritional status may be indicative that the risk factors for NCDs were not controlled effectively, the clinical diagnosis was late, the prescribed treatment was not carried out properly, and there were gaps in surveillance and clinical nutritional care within primary care. Furthermore, the elderly and families/caregivers were not able to identify signs and symptoms of the disease and its worsening, and of malnutrition.

The development of actions focused on comprehensive health care is a challenge in the new logic of SUS. At all the different stages of integrated health care, depersonalized and fragmented care should progressively change into a set of integrated actions and individualized treatment plans, shaping the types of continued care.[41]Within the specificity of NCDs, strengthening the health care system implies strengthening primary care, with the–articulation of units of the HCN.[42] This systematics meets the goal of satisfying needs, demands and desires of SUS users.[41]

This assumption means that regular care grounded in the reality of health care services and users are needs that pose challenges to SUS.[41] It can be said that the development of Responsible Discharge Protocol, described in this study, is an answer to one of the many challenges posed to successful continued care.

The use of the protocol, as indicated by the results, was the attempt to cover the multiple stakeholders involved in health care (elderly, family/caregiver, hospital staff and the HCU staff). The logic of dialogue between the services of the hospital and the home of the elderly, through primary care, was an effective tool in identifying the real demands of the elderly, as well as a mechanism for empowerment and accountability of the elderly and their family in their treatment.

There were limitations in primary care as regardsthe structure of some health teams, who were not yet in line with the logic of the Family Health Strategy (FHS) as well as some HCUs, which had wide coverage area, limiting the integral care to the elderly. Therefore, there are challenges to both the instrumentalization of primary care teams, the reflection of new workflows, and initiatives to creating new services, especially in HCUs, that can be appropriate for an increasing population.

Strategic planning is a mechanism that can be effective for analyzing the efficiency of resources used in producing the expected results. It is frequently used in the management of health care services and aims to study the goals of an intervention, the means and the results produced.[43] Thus, to achieve results as planned, this tool should be used for defining indicators to evaluate the results achieved when implementing continued care to elderly patients with NCDs.

The analysis of the comprehensive approach to NCDs shows that such approach includes care provision at all stages of health care in the field of macro and micropolicies. At the macropolicy level, there are regulatory actions, intersectoral articulations and organization of the service network; at the micropolicy level, provision of continued

care, involvement and accountability of caregivers, and development of user autonomy.[44] This involves, in addition to political mechanisms for regulation,[41] measures to support self-management (counseling, education and information) and the health system in multidisciplinary teams; mechanisms for developing effective decision making tools (evidence based practice) and measures of health communication (team-user and teams from different services). Therefore, the focus of this model is the production of information between services, user evaluation, optimization of treatment and follow-up between different services.[2,42]

This study identified some actions focused on macro and micropolicies. The protocol was an experience for promoting responsible discharge and developing mechanisms for continued care. By identifying the need for association between primary care teams and elderly patients with NCDs after hospital discharge, this study reflected on the possibility of ensuring continued care within the HCN. The results indicate actions that guarantee part of this goal. It is recognized that, beyond the limitations identified in linking the elderly with the responsibility for their care, other mechanisms in macro and micropolicies are needed for this purpose, such as intersectoral agreement (especially health and social care), development of care technologies that address different areas of health care, as well as new mechanisms for work processes.[41]

Therefore, health care teams that assist patients with NCDs should be informed about the harmful consequences of this condition, which may vary at different levels of disability, and even cause death. Proper treatment, then, must be stipulated in order to prevent or delay harmful consequences to health or else provide adequate care for sequelae that could no be avoided, such as the need for NT.[27,28,45]

The challenges of NT within the HCN range from the lack of enough health professionals, especially nutritionists, that are able to provide surveillance and nutritional care in NT, to the shortage of supplies and equipment for providing the therapy. All members of the multidisciplinary team should be able to check the poor nutritional status of individuals in the community and in the hospital environment, and be trained to refer these individuals to the care provision by a nutritionist for a nutritional diagnosis and the start of the NT early as possible to avoid further sequelae.

Nutritional care can foster health promotion and primary prevention of NCDs, as well as prevent secondary and tertiary disabling complications that result from these diseases. The need for specialized NT, such as the one provided by gastric tube, is

frequent when the sequelae of NCD complications prevent patients from being fed orally. Especially in more severe cases, a multidisciplinary effort is important in helping implement the physical and psychological adaptations to the new mode of feeding, handling and positioning the probe and the elderly to avoid complications such as aspiration, as well as complications that may arise from inadequate supply, such as gastrointestinal ones.

The costs of health care to NCDs and their complications are high. It is assumed that the higher life expectancy is, the greater are the expenses on health services associated with the presence of chronic diseases and their complications.[4,5,46] The types of specialized and industrialized food and nutrition also increase the expenses, and they can be costly for the family/guardian or the State.

Thus, the implementation of the protocol, with performance of counter-reference and home visits, allowed adequacy of NT according to the available resources at the primary care unit and at the household, replacing more expensive industrialized food formulas prescribed during hospitalization and explained at discharge with other types of food formulas provided by primary care or by other foods. The transition of formulas or types of feeding was supported by the teams from health care units in the zone of residence of the elderly patient, by determining the clinical and nutritional outcome after hospital discharge and by ensuring ongoing monitoring by the primary care team. The bond between the elderly and the primary care team, established through counter-reference, is one of the mechanisms that can ensure continuity of nutritional and clinical care, the right to health and HRAF.

Thus, among other factors, the lack of effectiveness of the reference and counter-reference system leads to delays in the process of de-hospitalization. In primary care, inadequate surveillance of NCDs and their complications and inadequate nutritional status lead to increased number of admissions or readmissions.[33,42,47]

The development of systematic actions for health care provision to patients with NCDs is one of the effective mechanisms in ensuring comprehensiveness. The use of protocols can be useful in the organization of the work process and the solvability of health-oriented actions. Although the protocol is limited to previously established procedures and actions, when the protocol is structured to meet the needs of people with NCDs, it can be a tool that allows the response to real demands in different clinical situations.[41]

Conclusions

The development and implementation of the Responsible Discharge Protocol by establishing continued care is a feasible mechanism for hospital discharge and counter-reference. The planning made for the protocol was able to promote the articulation of different areas of health care and comprehensive care to individuals under NT.

The HCN should be structured to prevent health problems associated with food and nutrition. Thus, initiatives to individuals in need of NT must ensure the right to health and adequate food.

The report of this experiment showed the importance of care provided by a multidisciplinary team to patients with special dietary needs. Interdisciplinary care should be performed efficiently and systematized in all areas of health care.

The challenge in using the protocol described in this study is placed on the development of objective indicators and evaluation of results as well as the systematization of other actions that may favor full care provision to patients with NCDs and in need of NT.

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