RAI-LTCF die neue, integrierte Lösung von interRAI

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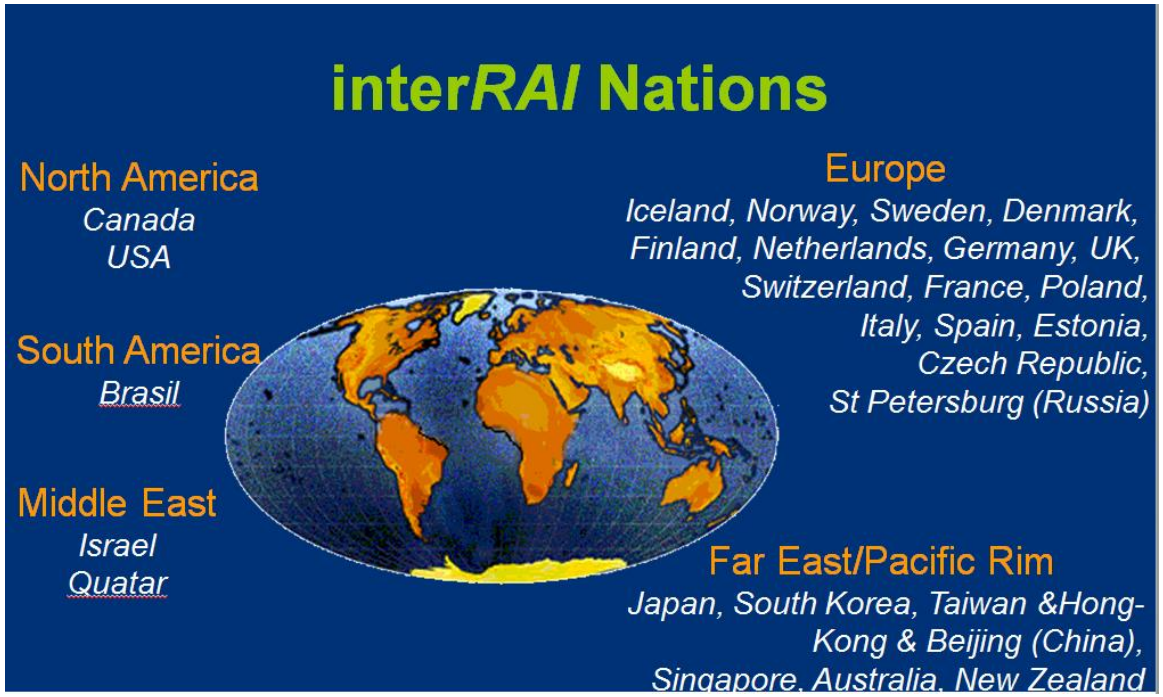
Outline

- Disclosure
- interRAI world
- What did nurses think, in Finland
- What was improved
- Summary
- Conclusions

A summer party in the Kustaankartano long-term care facility, Helsinki, in 2016

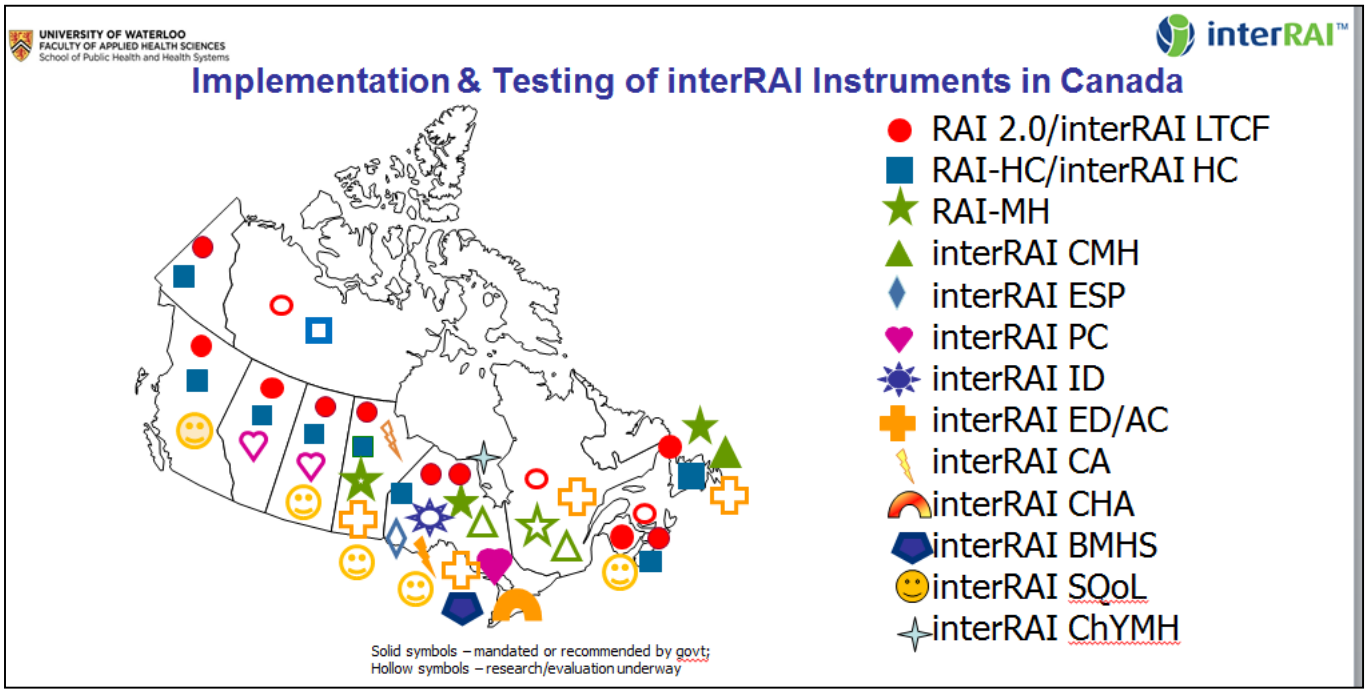


INTERRAI WORLD

interRAI world (1)

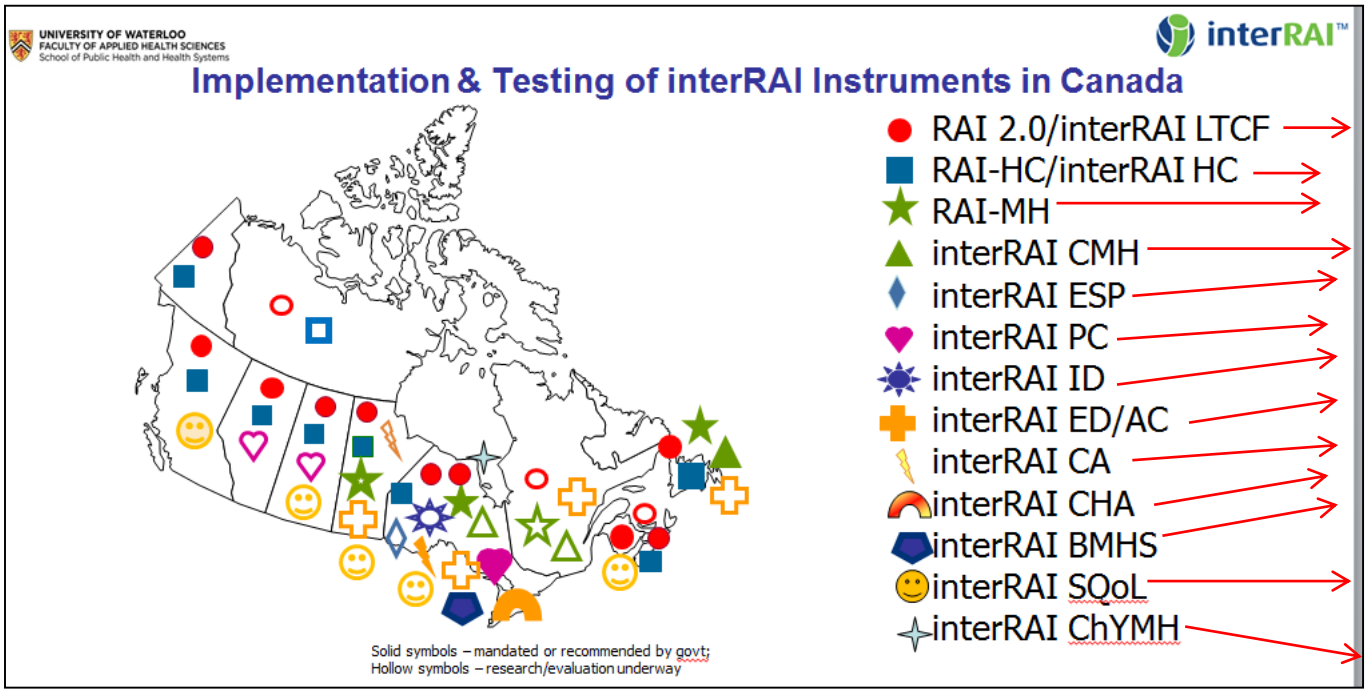
- interRAI is a collaborative **network of researchers in over thirty countries** committed to **improving care** for persons who are disabled or medically complex. Our consortium strives to promote evidence-informed clinical practice and policy decision making
  - You can find this statement of our organization, and more information: http://www.interrai.org/organization/
- interRAI, as an organization, has existed since (end of 80's) 1990. It started from long-term care facilities (LTCF's) -> home-care -> psychiatric care -> intellectual disabilities –> acute care -> children's instruments
- In the pipe:
- -> Suite for self assessed quality of life
- -> Informal care giver instrument
- -> Self assessments

interRAI world (example Canada)



- **9,000 clinicians in 1,900 organizations** use interRAI assessments
- **645,180 new** in-person assessments annually
- **> 2 million** Canadians assessed in-person by end of 2015
- **> 9 million** in-person assessments by end of 2015
- **Appr 1 milloin in LTCFs**

interRAI world (example Canada)



Long-term care facility
Home care
Mental health (hospital
Community mental health
Emergency/Psychiatric
Palliative care
Intellectual disabilities
Emergency acute care
Contact assessment
Community Health
Brief Mental Health screener

Self assessed quality of Life

Child and young instruments

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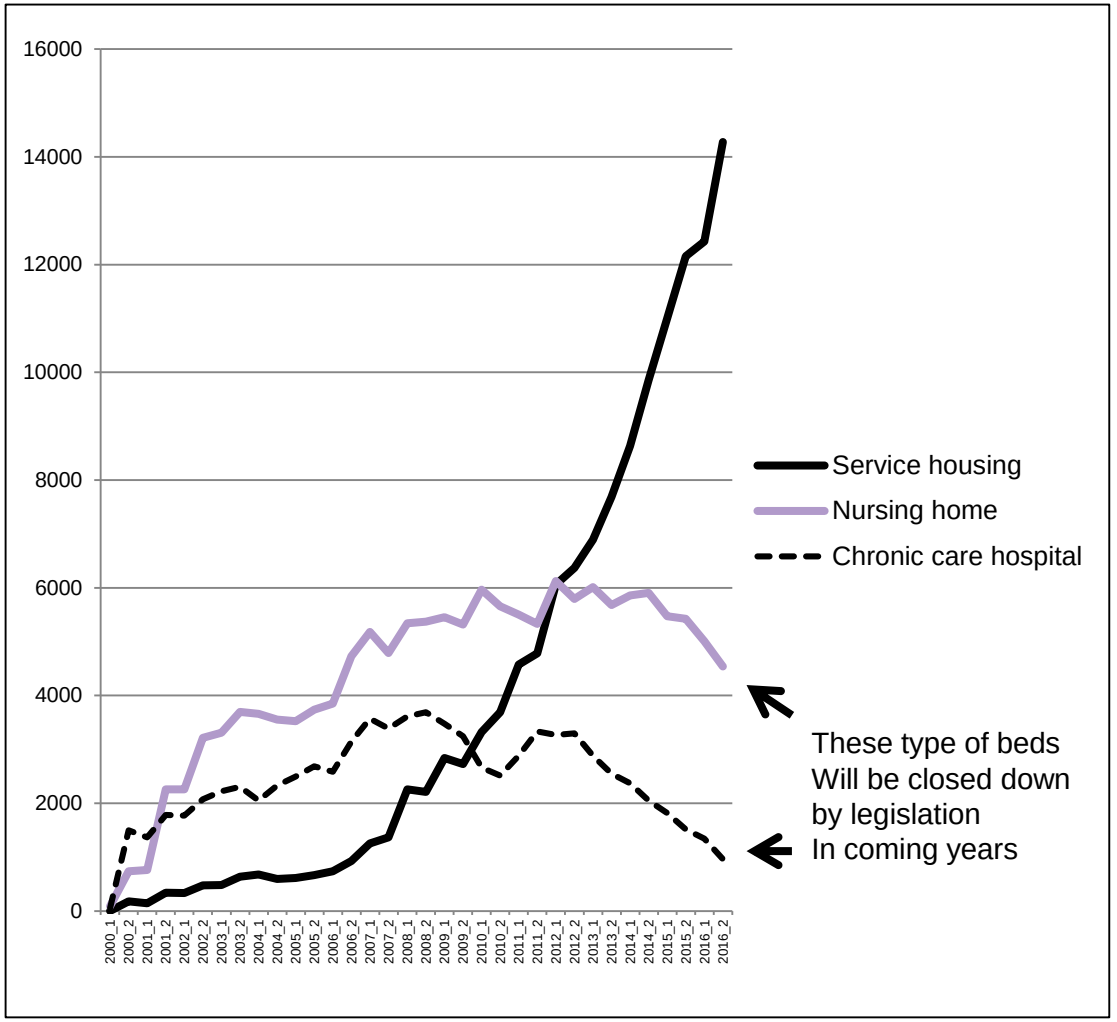
interRAI world (example Finland)

- **Voluntary use of MDS-2.0** since the year 2000
- In 2000, annually were 2000 individuals assessed, in the long term care facilities (LTCFs)
- Today 25 000 individuals are annually assessed in the LTCFs and 22 000 individuals in home care
- Assessment are always performed by **own personnel**
- Institute for Health and welfare provides benchmarking x2 annually
- Finnish national policy is to **cut down long-term care facility beds.**



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WHAT WAS IMPROVED WHEN UPDATING THE MDS 2.0

Lessons learned from the SHELTER study, in Finland

SHELTER-study

- the Services and Health for Elderly in Long TERm care (SHELTER) study.
- Funded by EU 2009-2011
- Finland: nursing homes from 3 municipalities different parts of the country
- **Only those LTCFs participated that had used MDS 2.0 earlier, appr 800 interRAI-LTCF assessments were collected during 12 months**

LTCF Nurses view afterwards

- **Easy to learn** how to switch from MDS 2.0 to interRAI LTCF
- The only part that took some effort was ADL. However, it was easy to use once you learned it
- Best improvements from the care planning point of view, according to nurses, are marked in red in the following slides

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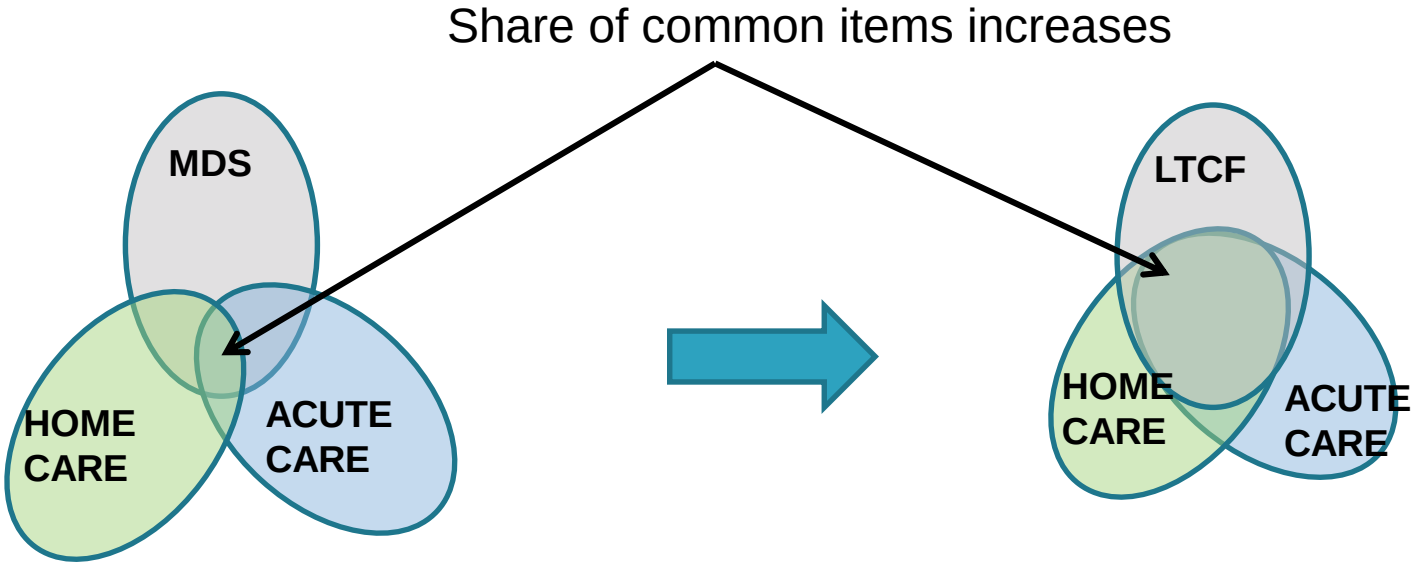
Improved parts

- Time period for observation changed **from 7 to 3 days**
- **InterRAI still asks** ”what really happened” instead of ”how well could this person perform if…”
- In the assessment form
  - All the ”almost identical” questions through the different settings **were made exactly identical** to ensure **identical scales** through the whole service structure
  - Necessary **new data based on new research results / way of thinking** was included
  - Questions with minor importance **were removed**
  - Way of thinking ADLs was **slightly** changed
  - Questions were reorganized in a little bit different order

Improved integration



- Improved integration allows exactly identical scales in LTCFs, home care, and in acute care (Note: time window)
- New residents: previous interRAI assessments from home care can be used in care planning
- In LTCFs information can be utilized from Acute care and Emergency care

What was improved (1)

Section A. Identification Information

Section B. Intake and Initial History

Section C. Cognition

Section D. Communication and Vision

Section E. Mood and Behavior

Section F. Psychosocial Well-Being

Section G. Functional Status

Section H. Continence

Section I. Disease Diagnoses

Section J. Health Conditions

Section K. Oral and Nutritional Status

Section L. Skin Condition

Section M. Activity Pursuit

Section N. Medications

Section O. Treatments and Procedures

Section P. Responsibility and Directives

Section Q. Discharge Potential

Section R. Discharge

Section S. Assessment Information

- Section A B R S are country specific and **do not change** unless you need to change them due to your own or Cantons reasons

What was improved (2)

Section A. Identification Information

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Section S. Assessment Information

Section C

- Improvement for care planning
- Small but necessary terminological changes
- Memory
  - Short term
  - Long-term
  - Procedural
  - Situational
- Some change to identify delirium

What was improved (3)

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Section R. Discharge

Section S. Assessment Information

Section D

- No comments
- Shortened and simplified

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What was improved (4)

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Section E F

- Major improvement for care planning (particularly for setting goals for care)
- Section E ADDED
  - Self reported mood
  - inappropriate public sexual behavior or public disrobing
- Section F ADDED
  - sense of involvement
  - strengths as
    - positive outlook
    - Good family relationships
    - Finds meaning in life

What was improved (5)

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Section G

- Major improvement for care planning (particularly for setting goals for care). May take more time than before
- Reserve time to learn to assess ADLs correctly
- MINOR changes in questions
- MAJOR revision in coding. The revised version considers ”independent” as fully independent (exeptions removed)
- ADDED locomotion/walking:
  - Timed 4 meter walking
  - Distance walked
  - Distance wheeled
- ADDED activity level

What was improved (6)

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Section Q. Discharge Potential

Section R. Discharge

Section S. Assessment Information

Section H I

- Section H No major changes
  - should add an item: no incontinence during daytime
- Section I no comments
  - the boxes reorganized, some diagnoses removed
  - activity of diagnoses to be coded
    1. Not present
    2. Primary diagnosis / diagnoses for current stay
    3. Diagnosis present, receiving active treatment
    4. Diagnosis present, monitored but no active treatment

What was improved (7)

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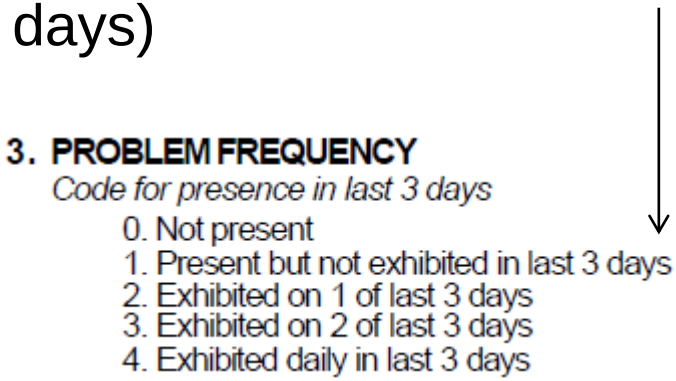
Section J

- Major improvement for care planning to relieve suffering
- Updated list for symptoms
- Updated coding to master also those frequently occurring problems that are not presented during the observation time (in 3 last days)



What was improved (8)

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Section S. Assessment Information

Section K L M

- No comments
- Section K
  - Issues basically as before – some simplified changes in the structures of the questions
- Section L
  - Simplified, Mainly as before
- Section M
  - Mainly as before

What was improved (9)

Section A. Identification Information

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Section R. Discharge

Section S. Assessment Information

Section N O

- Section N The Finnish nurses wished to get rid of the medication list once and for all
  - includes officially some simplifications.
  - However, filling section N will be reduced in the future -> Major reduction for nursing burden
- Section O
  - Prevention is an improvement for care planning purposes

What was improved (10)

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Section P. Responsibility and Directives

Section Q. Discharge Potential

Section R. Discharge

Section S. Assessment Information

Section P Q

- No comments
- Section P
  - Simplified, country specific
- Section Q
  - No basical changes

Summary

- RAI-experienced nurses from 3 municipalities , in Finland, considered interRAI-LTCF easy to learn, easy to use.
- They concluded that the interRAI-LTCF contains major improvements compared to MDS for:
  - Rehabilitation of the resident
  - Advance care planning of the resident
  - Quality of life of the resident
  - Quality of care planned and delivered by nurses
  - Comparisons of the quality of care between different settings (benchmarking)

Conclusions

Our task is to deliver best possible care

Let us go for it!