ASSOCIAZIONE ITALIANA
PSICOGERIATRIA
Sezione Regionale Campana

Azienda Ospedaliera Universitaria Federico II
Integrata con il Servizio Sanitario Regionale

Il punto di vista del Geriatra dell'Azienda Ospedaliera Universitaria

Vincenzo Canonico

Unità di Valutazione Alzheimer
Cattedra di Geriatria
Università "Federico II" Napoli

Tipologia di pazienti ricoverati in Unità Operativa di Geriatria di AOU

Pazienti anziani con malattia acuta o riacutizzata con compromissione dello stato generale, con prognosi variabile spesso seria, severa o infausta per quanto riguarda lo stato funzionale e/o la vita

Un Paziente svantaggiato in partenza

alto rischio di

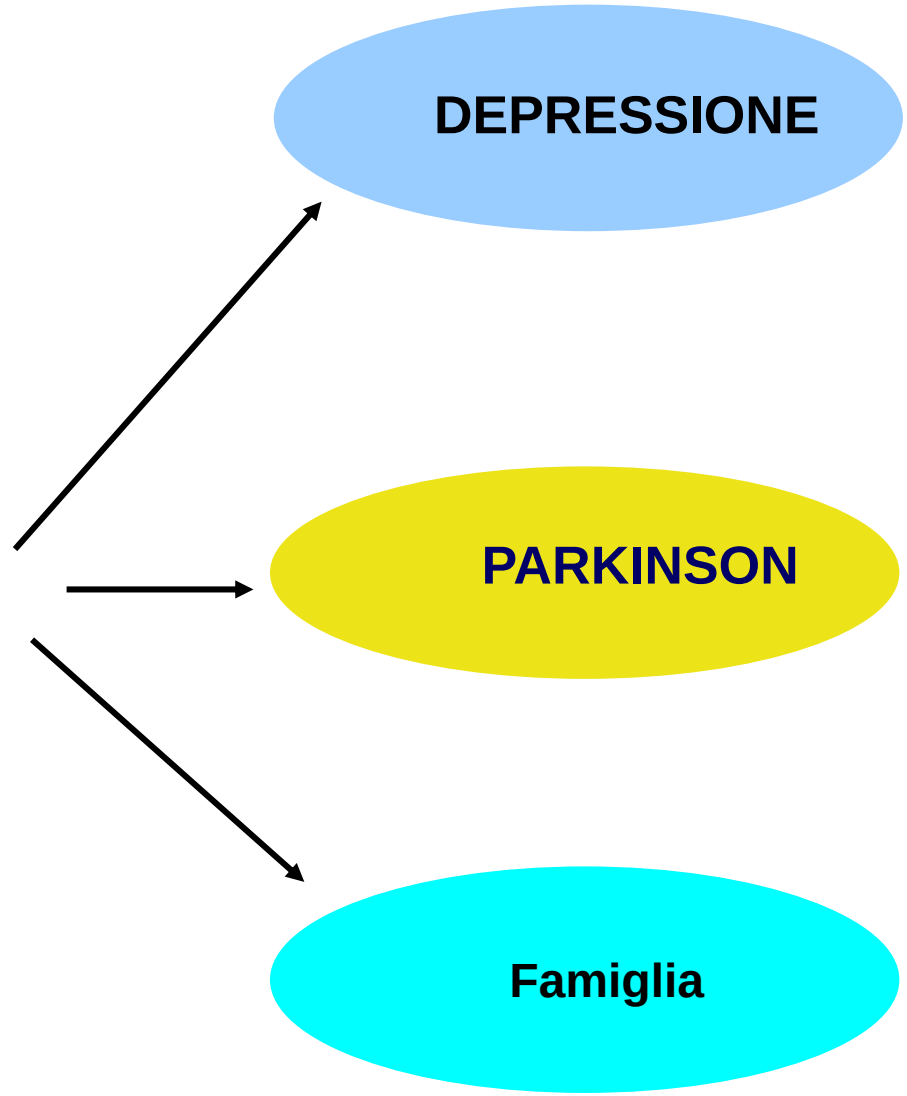
- cadute
- malattie acute
- ospedalizzazione
- disabilità
- non autosufficienza
- istituzionalizzazione
- morte

SCOMPENSO A CASCATA

PAZIENTE CON DEMENZA IN UO DI GERIATRIA

- **Età > 75 aa**
- **Deficit sensoriali**
- **Comorbilità**
- **Disturbi psichiatrici**
- **Politerapia**
- **Incontinenza**
- **Cadute**
- **Problemi nutrizionali**
- **Osteoporosi**
- **Anemia**
- **Sarcopenia**
- **Instabilità clinica**
- **Patologia a cascata**
- **Non autosufficienza**

DEMENZA (BPSD)



Stato premorboso

Robusto | **Intermedio** | **Disabile Lieve** | **Disabile Grave** | **Dipendente**

Comorbilità

Spettanza di vita

Scompenso cardiaco

OUTCOME

Vita *(Longevous care)*

Percorso diagnostico terapeutico completo invasivo 1 (tecnologia +++)

Funzione *(Ameliorative care)*

Percorso diagnostico terapeutico semi-invasivo 2 (tecnologia ++)

Comfort *(Palliative care)*

Percorso diagnostico terapeutico non invasivo 3 (tecnologia +)

Not just specific diseases: systematic review of the association of geriatric syndromes with hospitalization or nursing home admission

Wang SY, Shamliyan TA, Talley KM, Ramakrishnan R, Kane RL.

Arch Gerontol Geriatr. 2013 Jul-Aug

Abstract

To examine the association between geriatric syndromes with hospitalization or nursing home admission, we reviewed studies that examined hospitalization and nursing home admission in community-dwelling older adults with multiple morbidities, cognitive impairment, frailty, disability, sarcopenia, malnutrition, impaired homeostasis, and chronic inflammation. Studies published in English language were identified through MEDLINE (1990 through April 2010), Cochrane databases, the Centers for Disease Control and Prevention website and manual searches of reference lists from relevant publications. The study had to include general (non-disease specific) populations of adults aged 65 years or older. Using a standardized protocol, two investigators independently abstracted information on participant characteristics and adjusted measures of the association. Studies that controlled for the presence of specific diseases were further identified and analyzed. When the syndrome examined was similar from different studies, we computed the pooled risk estimates using a random-effects model. We assessed the strength of evidence following the recommended guidelines. We identified 47 eligible articles from 6 countries. ***Multiple morbidity, frailty, and disabilities were associated with hospitalization and nursing home admission (moderate evidence).*** *Cognitive impairment was associated with hospitalization (low evidence) and nursing home admission (moderate evidence). Among these studies, 20 articles controlled for specific diseases. Limited evidence suggested that these geriatric syndromes are associated with hospitalization and institutionalization after controlling for the presence of specific diseases.* ***We conclude that geriatric syndromes are associated with risk of hospitalization or nursing home admission. Efforts to prevent hospitalization or nursing home admission should target strategies to prevent and manage these syndromes.***

Risk factors for hospital admissions associated with adverse drug events

Kongkaew C, Hann M, Mandal J, Williams SD, Metcalfe D, Noyce PR, Ashcroft DM

Pharmacotheray 2013, 33; 827-37

Abstract

STUDY OBJECTIVE:

To identify predictors of hospital admissions associated with adverse drug events (ADEs) and to determine the preventability of ADEs in patients admitted to two hospitals.

SETTING:

Medical admission units at two British National Health Service hospitals in the United Kingdom.

PATIENTS:

3904 adults age 16 years or older who were admitted to the two hospitals between June 2006 and November 2007.

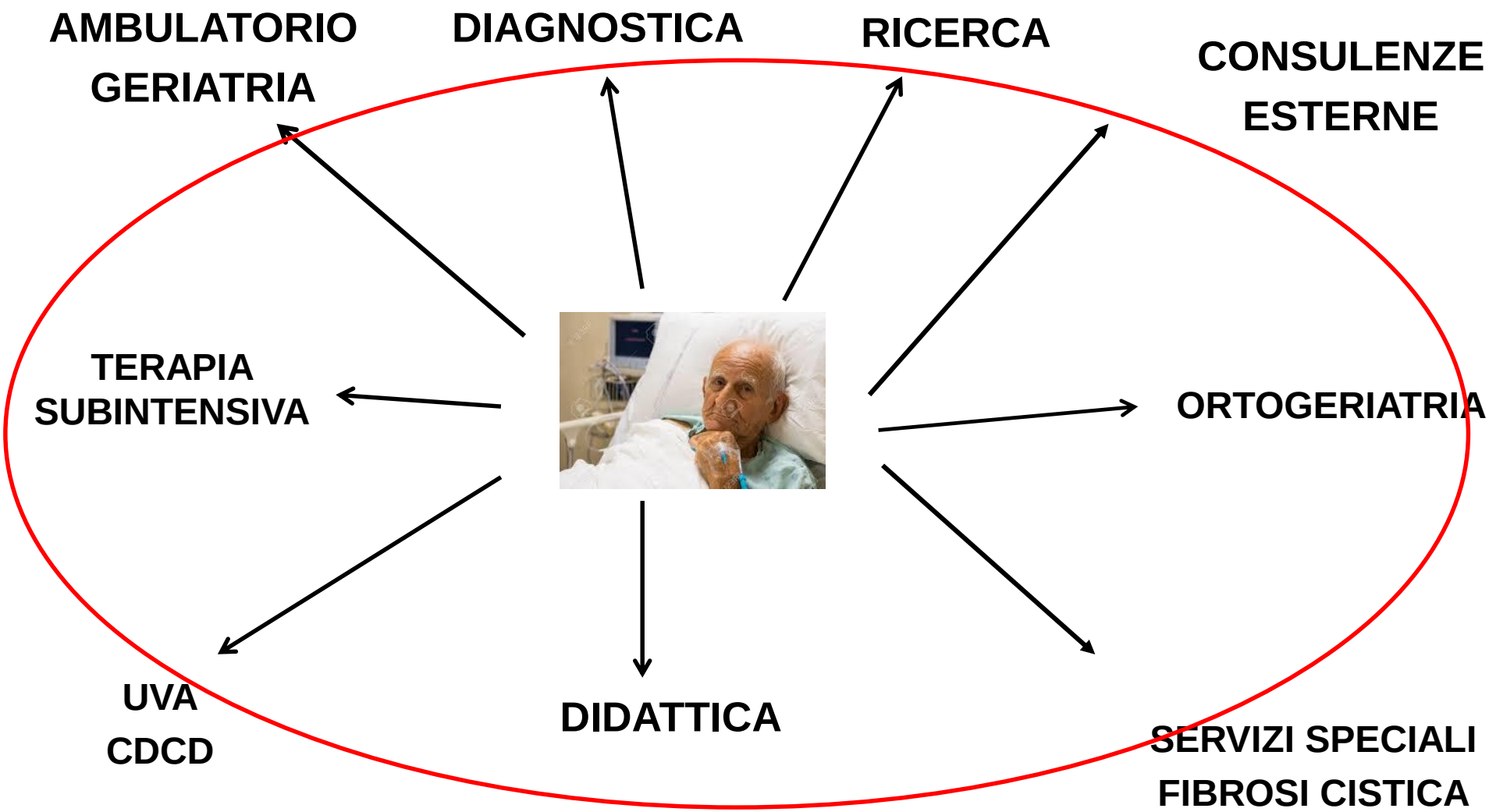
MEASUREMENTS AND MAIN RESULTS:

Clinical pharmacists identified hospital admissions associated with drug-related problems by using medical record review, supplemented by patient interview for those identified as having an ADE. The contribution of ADEs to hospital admission and the causality, severity, and preventability of the events were independently assessed by a multidisciplinary clinical team. Multivariate logistic regression was used to identify predictors of hospital admissions associated with ADEs, and a maximum-likelihood multinomial model was used to examine predictors of the preventability of ADEs. Of the 3904 patients included in the analysis, 439 (11.2%) were judged by the review panel to have experienced ADEs. Of these, 209 patients (47.6%) experienced preventable ADEs. Four independent variables were found to have significant relationships with ADE admissions and preventability of ADEs: patient age, length of time since starting new drug, total number of prescription drugs, and hospital site. Drug classes most commonly associated with preventable ADEs were antiplatelet drugs, anticoagulants, diuretics (loop and thiazide diuretics), angiotensin-converting enzyme inhibitors, and antiepileptic drugs.

CONCLUSION:

Adverse drug events are an important cause of hospital admission. Better systems for health care practitioners to identify patients at high risk of preventable hospital admissions associated with ADEs (e.g., age > 65 years old, receiving more than five drugs, and starting new high-risk drugs) should be implemented in order to minimize the risks to patients and the burden on the health care system.

SERVIZI PRESENTI IN UO DI GERIATRIA



COSA E' NECESSARIO IN UO DI GERIATRIA

- preparazione culturale di fondo e specifica dei Geriatri e dell'équipe
- ambiente e personale costantemente orientati al counseling positivo su pazienti e familiari
- particolare attenzione a: ispezione del paziente, monitoraggio e rilevazione dei parametri vitali: valutazione ed interpretazione di temperatura corporea, alvo, diuresi e continenza, pressione arteriosa, polso, peso, nutrizione, ritmo sonno/veglia, motricità, cognitività, con trasmissione delle informazioni al personale di turni successivi
- osservazione e supporto all'assunzione di farmaci, di liquidi e di cibo
- cultura della Riattivazione (sistema orientato alla mobilizzazione precoce)
- organizzazione per dimissioni protette (presa in carico globale del caso e piani per la continuità delle cure)

Unica Cartella Clinica durante tutto il percorso diagnostico-terapeutico

La Cartella clinica integrata accompagnerà il paziente in tutte le fasi del ricovero anche in diverse Unità Operative della stessa Azienda Ospedaliera; rappresenta uno dei presupposti della continuità e della personalizzazione dell'assistenza. Tale strumento deve essere costruito in modo da essere fruibile da tutti gli operatori coinvolti nel processo assistenziale e deve fornire l'informazione necessaria esclusivamente a chi è deputato a farne uso. Contiene tutte le informazioni anagrafiche e socio-sanitarie utili nonché i dati del ricovero e favorisce la visione immediata degli interventi di tutte le figure coinvolte (medici, infermieri, consulenti) evitando al medico di riscrivere la stessa terapia e, di conseguenza, facendo diminuire il rischio di possibili errori di trascrizione.

Il Coinvolgimento del Paziente e della Famiglia

The New England Journal of Medicine

Post-Hospital Syndrome — An Acquired, Transient Condition of Generalized Risk

Harlan M. Krumholz, M.D.

Nearly one fifth patients discharged from a hospital have an acute medical problem within the subsequent 30 days that necessitates another hospitalization. These recently discharged patients have heightened risks of myriad conditions, many of which appear to have little in common with the initial diagnosis.

How might the post-hospital syndrome emerge? Hospitalized patients are not only enduring an acute illness, which can markedly perturb physiological systems, but are experiencing substantial stress. During hospitalization, patients are commonly deprived of sleep, experience disruption of normal circadian rhythms, are nourished poorly, have pain and discomfort, confront a baffling array of mentally challenging situations, receive medications that can alter cognition and physical function, and become deconditioned by bed rest or inactivity.

CRITICITA' NELL'INTEGRAZIONE OSPEDALE-TERRITORIO

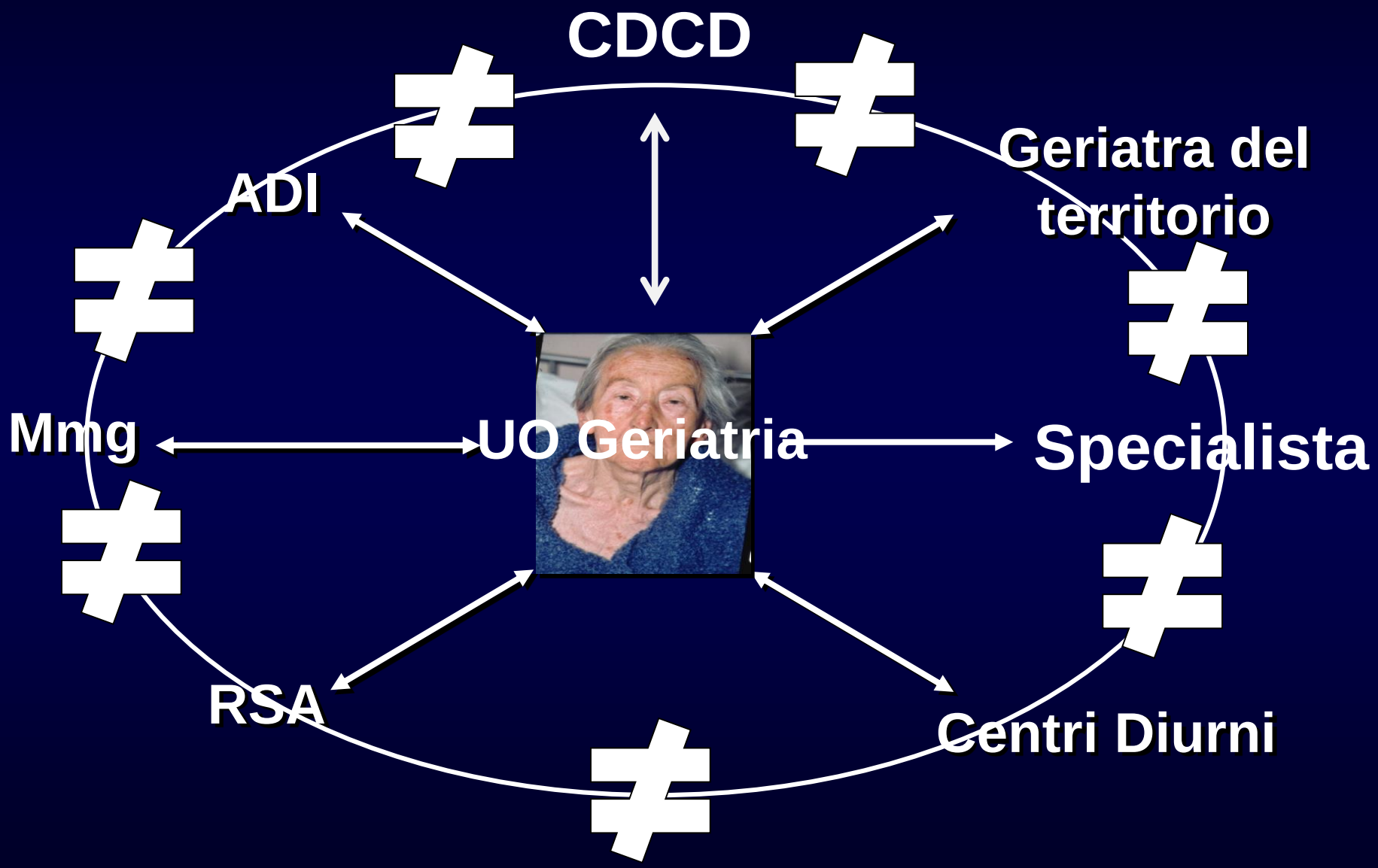
Per le UO di Geriatria:

- Numero inferiore alle necessità
- Degenza prolungata per problemi organizzativi
- Nessun coinvolgimento del Geriatra Territoriale o del MMg durante la degenza o alla dimissione
- Assenza dimissione protetta
- Foglio di dimissione con informazioni limitate
- Cartella clinica a volte poco chiara consegnata in ritardo
- Alti costi

Per la Geriatria Territoriale:

- Territori di competenza spesso ampi
- Scarso filtro per limitare i ricoveri
- Tempi lunghi per le prestazioni
- Limitate possibilità di eseguire indagini diagnostiche
- Assenza di "canale preferenziale" per ricoveri

Un Sistema chiuso



Un sistema aperto