Collaborative Care of the Patient with Obesity

A SHC Inter-disciplinary Panel

Learning Objectives

- Identify high risk patients with obesity
- Investigate assessment tools used by respective disciplines for patients with obesity
- Consult appropriate interdisciplinary teams
- Collaborate with those teams to develop an IPOC
- Review gaps in meeting the needs of patients with obesity

Case study

- 59 year old female, married
- Lives at home with spouse, primary caregiver
- Admitted with increasing shortness of breath, acute exacerbation of CHF
- Past medical history: severe morbid obesity (BMI 48), chronic BLE nonhealing ulcers, DM, HTN, CHF, COPD, A Fib, diabetic foot ulcer, Hyperlipidemia
- ProBNP 1612, WBC 18.9, BUN 68, Cr 2.2, Albumin 2.8, glucose 177
- Braden scale on admit 15

Assessment

- Assess co-morbidities caused or exacerbated by obesity
- Determine patient's level of understanding re: obesity
- Educate patients/family
- Identify resources available as both an in and outpatient

Plan of Care/ Goal Setting

- Engage the patient in their care
- Consult members of the inter disciplinary team
- Initiate the IPOC
- Obtain educational material and outpatient resources from Cheryl Holsworth, Bariatric Nurse Specialist as needed

Nursing Interventions

- Enter weight into Electronic Medical Record.
- Provide equipment that is appropriate for size
- Identify that equipment using AliMed ® capacity stickers
- Apply principles of SPM to avoid injury to staff and/or patients

Gap and Opportunities

- Assist staff to recognize their own biases
- Provide education re: obesity as a disease
- Develop a highly reliable system that identifies this population upon admission
- Provide bariatric equipment immediately

Nursing Guidelines of Care
Bariatric Patient Addendum

1. Nutritional/Metabolic Status
2. Functional Status
3. Integument
4. Pulmonary
5. Cardiovascular
6. Gastrointestinal
7. Psychosocial
8. Documentation

Nutrition Consult Triggers

- Malnutrition
- Enteral Nutrition (EN)/ Total Parenteral Nutrition (TPN)
- Skin Injuries and Pressure Ulcers
- Length of stay
- NPO + 5 days
- Poor PO intake
- Unintentional weight loss prior to admission
- Failure to thrive
- Diet texture modification

Nutrition Assessment

- Nutrition needs based on BMI: Estimated kcal, protein and fluid needs are based on Adjusted Body Weight.
- High protein requirements, increasing in the critically ill or skin injuries
- Fluids: General fluid guidelines
- Critically Ill Obese: High protein hypocaloric feed is recommended
- Physical nutrition examination

Plan of Care/ Goal Setting

- Assess for and focus on biomarkers of metabolic syndrome, and evaluation of comorbidities
- Provide special attention and consideration to patients who have had surgical bariatric surgery
- Clinical Nutrition Goal: to maintain protein and micronutrient stores and metabolic control without under/overfeeding the patient.

Interventions

- Provide diet restrictions consistent with co-morbidities. May need additional protein supplements to meet higher needs.
- Mediterranean or anti-inflammatory diet may help modulate obesity-induced inflammation.
- Early feeding using an EN formula low in calorie and high in protein

Evaluation

- Monitoring nutrition related labs
- Intake/tolerance to nutrition therapy
- Weight trends
- I&O
- Overall nutrition progress
- Discharge Education – weight management and comorbidities

Collaboration

- MD
- RN
- Nutrition hostess
- Diet Tech
- Case manager
- Pharmacy

Physical Therapy Consult Triggers

- Higher risk population of mobility issues:
  - Admitted for a flair up in comorbilities
    - Diabetes, CHF, cardiac issues, wounds, respiratory issues

  - Determine prior level of function
- Unlikely to need PT during hospital admission:
  - Admitted for bariatric surgery and independent coming into hospital

Mobility Assessment

PT Evaluation

- Subjective assessment
  - How patient was mobilizing at home, how frequently, and what they are using for help.
  - Patients are the experts on how to move their mass
- PT evaluation assesses patient's mobility and safety throughout evaluation.
  - Start with rolling in bed, and sitting up at the edge of the bed
- Progress patient based on improvement and safety.
  - Usually have assist of 2 persons, but we are dependent on available equipment.

PT Plan of Care/ Goal Setting

Determining PT Goals:

- Ask patient their mobility goals
- Determine if goals are realistic
  - Depends upon patient's prior level of function and current status
- Set short term (weekly) PT goals based on:
  - Prior level of function
  - Patient's long term goals

Collaboration

- Nursing: Collaborate on how to move the patients
    - Identify what is safe for the nurse vs. what is safe to do with PT
        - Lift Team
        - Bariatric commode vs. toilet
        - STOP/ Communication sign accuracy
- Social Work / Case Management:
    - Determine if the patient is safe to go home
    - Communicate any barriers or social issues early
- Occupational Therapy:
- Co-treat if able to work on functional goals with both disciplines
- PT focuses on mobility; OT focuses on ADLs

Gaps and Opportunities

Mobilizing these patients currently increases the risk for injury to patients, therapists, and other staff members.

Equipment gaps:

- Standing lifts not wide enough
- Improving beds
- Sit to stand aids not rated above 400 pounds and not wide enough

Occupational Therapy Consult Triggers

- A physician's order is required for inpatients
- "OT Evaluation and Treatment" order is generated to determine if the patient is able to manage basic self care/activities of daily living (ADLs) and be safe to discharge from the hospital
- Basic self care/ ADL assessment includes:
  - Feeding
  - Grooming and hygiene
  - Upper body and lower body dressing
  - Upper body and lower body bathing
  - Toileting
  - Toileting transfers and functional transfers
- Considerations:
  - Medical history
  - Current deficits
  - Functional skills
  - Prior level of function
  - Home situation/ available resources
  - Potential to improve

Assessment

- Chart Review
- Patient interview
- Interdisciplinary staff interview (usually primary RN)
- Information from family and friends
- Patient demonstrates ADLs/ functional skills

Plan of Care/ Goal Setting

- OT plan of care discussed with the patient and interdisciplinary team
- Patient Goal setting:
  - focuses on functional skills
  - patient centered
  - includes family expectations and priorities
  - realistic and measurable
- OT Goal: Improvement of ADL/functional mobility skills, independence and safety prior to hospital discharge

Interventions

Therapy precautions:

- If BMI > 35 assist of a second person when working with patient out of bed or transferring for ADLS
- Coordinate with PT or Nursing
- Modification of activities
- Adaptive equipment
- Bariatric Equipment
- Frequency and duration of sessions

Collaboration

- Regular communication and coordination
  - Primary RN (before and after OT)
  - PT
  - Other interdisciplinary teams members as needed
- Face to face, telephone, written communication
- Collaboration issues
  - scheduling
  - treatment precautions
  - medical updates
  - psychosocial
  - discharge planning

Gaps and Challenges

- Missed OT sessions
  - fatigue
  - scheduling conflicts
  - wound care
  - patient refusal
- Coordination of care
- Scheduling of PT sessions
- Availability of second person to assist
- Family and/or social support

Consult Triggers

- All pressure ulcers or wounds that may be related to pressure
- Moisture/incontinence related skin breakdown
- Ostomies (old and new)
- Severe skin tears
- Evaluation for management of urinary/fecal incontinence
- Evaluation for specialty mattresses and beds.

Assessment

- Braden scale, tool for predicting risk for pressure injuries
- Head to toe skin assessment
    - behind neck (under straps if intubated, O2 tubing)
    - back
    - underarms/ breasts
    - under abdomen or pannus (lift and look)
    - upper and lower thighs
    - buttocks, sacrum, perianal skin
    - calves, ankles, heels

Case Study Assessment

- Moisture- Associated Skin Damage (MASD) – under breasts, pannus and groins
- Pressure Injury – sacrum, bilateral heels
- Cellulitis/ chronic non-healing ulcer – bilateral lower extremities
- Abscess/ Diabetic Foot Ulcer (DFU) – right great toe
- Friction – left posterior thigh

Picture of wounds

Interventions

Treatments and prevention:

- barrier ointment
- heel protectors
- adhesive silicone foam
- keep clean and dry
- antimicrobial fabric, wash, gauze
- bariatric bed with trapeze
- allow sufficient turning, turn and reposition q2h and prn
- Lift rather than drag using SPM equipment (total lift/friction reducing devices)
- keep head of bed lower than 30 degrees if not contraindicated

Collaboration

- Nutrition consult
- Physical Therapy consult

Consult Trigger

- Obstructive Sleep Apnea (OSA) screening for patients with a BMI> 30
- Screening is performed by a Respiratory Therapist or a Registered Polysomnography Technician

Assessment: Patient Interview

- OSA screening tool called the “STOP-BANG” is used (it does not diagnose OSA but is a reliable indicator of risk)
- Patient responses determine a score
- A high score indicates a high risk for OSA

When risk of OSA is identified

- Collaborate with nursing to determine if patient is symptomatic
- Request a referral for Home Sleep Study
- The Patient Empowerment OSA RCP visits the patient as needed
- OSA symptoms team members closely monitor the patient and obtain an order for a CPAP unit for them to use while in the hospital

Gaps and Opportunities

- Different processes between entities
- Bariatric emergency intubation equipment availability
- Staffing inconsistencies for screening and interventions

Consult Triggers

- Mental health issues
- Life altering illness/ injury
- Family dynamic concerns
- Discharge Planning needs

Psychosocial Assessment

- Reason for referral
- Identifying data
- Current situation
- Relevant significant history
- Interview data/ mental status

Transition Planning

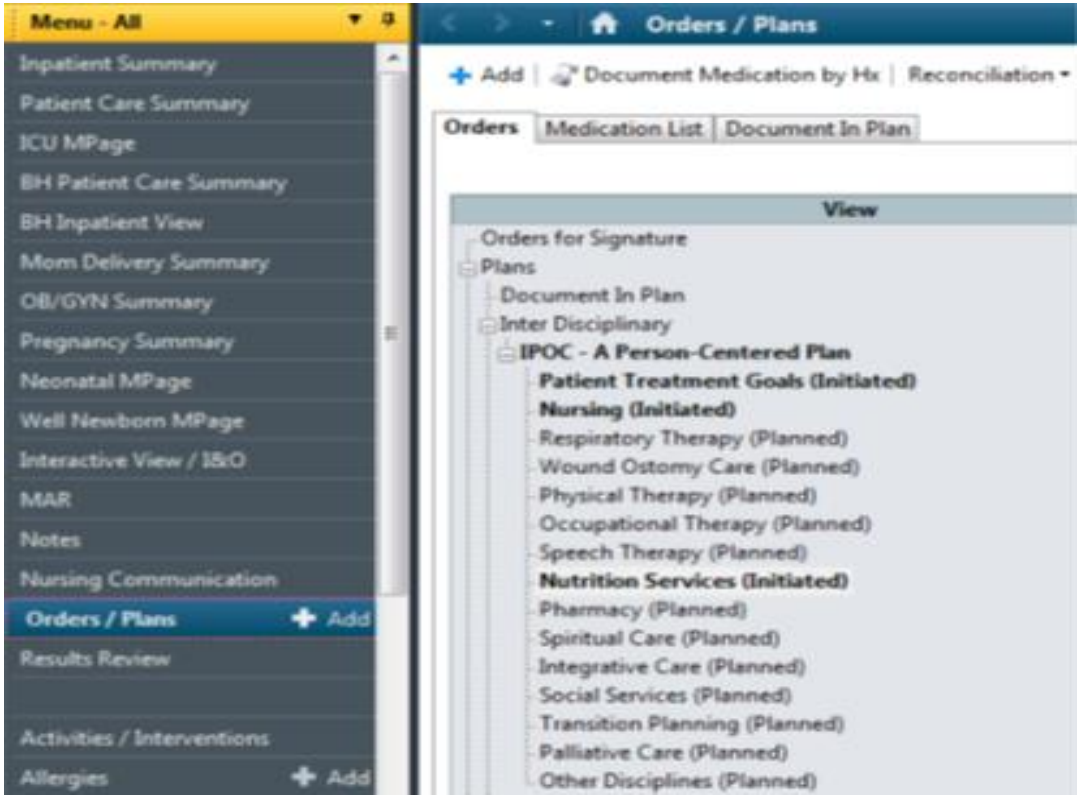
Demographics

- Home environment
- Transition needs
- Barriers to discharge identified
- Discharge options

Plan of Care/ Interventions

- Counseling for mental health issues
- Counseling for life altering illness/ injury
- Advocating for the patients
- Explaining elements of the patients hospital care and care transition options.
- Working with and preparing the patient/family/significant others for a safe discharge
- Assisting with and optimizing healthcare insurance benefits
- Coordinating care transition needs such as DME and post acute service

Inter-disciplinary Plan of Care



In Conclusion

- Increased understanding of obesity as a chronic disease
- Increased understanding of weight bias and the effect it has on obese patients
- Improved understanding of each disciplines role in providing care to patients with obesity
- Gaps, challenges, and opportunities have been identified to improve services provided
- Evolution of a system-wide task force/ committee focused on reviewing best practices and process improvements

Collaborative Care of the Patient with Obesity Panel

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Questions or comments