

Community Geriatric Nursing Integrated Interprofessional Collaboration in Community-Based Geriatric Care



ILO5 - Work collaboratively with healthcare professionals, families, and community resources to deliver integrated and effective geriatric care

Objectives

At the end of this lecture, students should be able to

1. Identify team members of the multidisciplinary team who provide community-based geriatric care.
2. Identify the role of nurses who provide geriatric care in community settings.
3. Identify effective strategies to collaborate with families and caregivers in community-based geriatric care.
4. To discuss strategies for integrated geriatric care in the community.

Multidisciplinary Team Members in Community-Based Geriatric Care

- Nurses
- Doctors (GPs, geriatricians)
- Physiotherapists
- Occupational therapists
- Social workers
- Community health workers
- Volunteers & NGOs





Roles of Nurses in Community-Based Geriatric Care

- Health assessment & screening
- Medication management
- Health education for family and caregivers
- Chronic disease management
- Home visits and follow-up
- Counseling and emotional support
- Coordination with the multidisciplinary team
- Refer people with specialized needs for further management

Effective Collaboration Strategies with Families

- Active listening and empathy
- Including families in care planning
- Providing caregiver education and training
- Encouraging shared decision-making
- Regular communication and feedback
- Empowering families to manage daily care

Strategies for Integrated Care

- Case management approach
- Use of electronic health records
- Interdisciplinary meetings
- Community outreach programs
- Partnership with local organizations
- Continuity of care between hospital and community

Case Management Approach

- Assign a **case manager (often a nurse or social worker)** to coordinate care.
- Ensures continuity of care across hospital, community, and home.
- Example: A nurse case manager tracks medication adherence, schedules follow-ups, and coordinates care with other therapists

Interdisciplinary Team Meetings

- Regular meetings with doctors, nurses, physiotherapists, occupational therapists, social workers, and family members.
- Facilitates **shared decision-making** and avoids duplication of services.
- Example: Team meeting to plan home safety modifications for an older adult with recurrent falls.

Shared Care Plans

- Develop a **personalized care plan** that is accessible to all providers and caregivers.
- Includes medical, nursing, social, and rehabilitative needs.
- Example: Care plan for an elderly diabetic with vision loss includes medication schedule, home diet plan, and family responsibilities.

Continuity of Care after Hospital Discharge

- Establish **hospital-to-home transition programs** to reduce readmissions.
- Follow-up visits, home health nursing, and rehabilitation support are arranged before discharge.
- Example: A patient discharged after hip replacement receives scheduled home physiotherapy and nurse visits.

Community Outreach and Home Visits

- Mobile health clinics, community health workers, and home nursing visits to reach isolated or homebound elders.
- Helps in early detection of complications.
- Example: Monthly nurse home visits to check blood pressure and medication adherence in elderly hypertensives.

Use of Technology & Digital Health

- Telemedicine for specialist consultations.
- Electronic Health Records (EHRs) for information sharing among providers.
- Example: A caregiver uses a mobile app to update blood sugar readings which are shared with the community nurse.

Partnerships with Local Organizations

- Collaboration with NGOs, religious groups, senior citizen clubs, and community volunteers.
- Provides **social support, nutrition programs, and caregiver respite.**
- Example: NGO providing home-delivered meals to undernourished elders.



Family & Caregiver Empowerment

- Education, training, and psychosocial support for caregivers.
- Encourages families to actively participate in care.
- Example: Training a spouse in safe lifting techniques to prevent back injury while caring for a bedridden older adult.

Health Promotion & Preventive Care

- Focus on vaccination, fall prevention, nutrition, exercise programs, and mental health promotion.
- Example: Community-based exercise classes for older adults to improve mobility and reduce fall risk.

Case Scenario 1

Background:

- Mrs. Neela, a 75-year-old widow, lives with her daughter in a semi-urban community. She has **osteoporosis, hypertension, diabetes, and mild cognitive impairment**. She had two recent falls at home while walking to the toilet at night. Her daughter reports difficulty reminding her to take medications correctly, and she often forgets whether she has already eaten.
- **Challenges Identified:**
 - High **fall risk** due to osteoporosis and mild cognitive impairment.
 - Poor **medication adherence** due to forgetfulness.
 - Risk of **fractures and hospitalization** if not managed.
 - Burden on daughter (primary caregiver).

How can the nurse coordinate the MDT and empower the daughter to prevent future falls?

Case Scenario 2

Background:

Mr. Perera, 75 years old, lives with his wife in a rural community. He has **osteoporosis, hypertension, diabetes, and mild cognitive impairment**. Recently discharged after a hip fracture, he is bedridden for long periods. His wife, also elderly, struggles with providing physical care and is worried about his long-term needs.

• **Challenges Identified:**

- Recent **fracture with reduced mobility** → high risk of complications (pressure ulcers, infections).
- Needs **rehabilitation** but lives far from the hospital.
- Wife experiencing **caregiver strain**.
- Risk of poor diabetes and BP control due to immobility and irregular diet.

What integrated community resources can be mobilized to support both Mr. Perera and his wife in managing health and caregiver burden?