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Nursing intervention for older patients who are discharged home from Emergency Department

Submission date
14/01/2010

Recruitment status
No longer recruiting

Registration date
17/02/2010

Overall study status
Completed

Last Edited
17/02/2010

Condition category
Other

[ ] Prospectively registered
[ ] Protocol
[ ] Statistical analysis plan
[ ] Results
[ ] Individual participant data
[ ] Record updated in last year

Plain English summary of protocol
Not provided at time of registration

Contact information

Type(s)
Scientific

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Additional identifiers

Study information

Scientific Title
Nursing intervention for older patients who are discharged home from Emergency Department: A randomised controlled trial

Study objectives
The overall aim of the study is to investigate a model for structured nursing assessment and intervention for geriatric patients in the Emergency Department and the following months. The objectives are:

1. To examine the effect of identification of geriatric patients (>70 years) at risk of functional decline and readmission.
2. To examine the effect of nursing assessment and intervention given before discharge from Emergency Department and one and six months after.

Ethics approval required
Old ethics approval format

Ethics approval(s)
1. The Ethical Board of The Capital Region of Denmark approved on the 12th of December 2007 (ref: H-D-2007-0110)
2. The Danish Data Protection Agency approved on the 6th of November 2008 (ref: 2008-41-2768)

Study design
Randomised controlled parallel group trial

Primary study design
Interventional

Study type(s)
Other

Health condition(s) or problem(s) studied
Geriatric patients; functional decline

Interventions
Geriatric patients admitted to the Emergency Department are detected using ISAR 1 screening tool. After randomisation and at discharge and one and six months after the geriatric intervention nurse does the experimental intervention that consists of a brief, standardised geriatric nursing assessment using a ten point checklist of physical, mental, medical, and social problems. The focus is on unresolved problems, new or pre-existing, that required medical intervention, new or different home care or other services, or comprehensive geriatric assessment. After this a discharge plan/plan is worked out with relevant referrals to the outpatient clinic, community care, primary physician or arrangements with next-of-kin. Patients in the control group received the usual Emergency Department services and consultations. They are not referred to the intervention nurse.

Intervention Type
Other

Phase
Not Applicable

Primary outcome(s)
1. Readmission to Emergency Department within one and six months, data collected from the Hospitals administrative database.
2. Admission to nursing home within one and six months, data collected from the Hospitals administrative database.
3. Death within one or six months, data collected from the Hospital administrative database.

Key secondary outcome(s))
1. Physical functional status at baseline, one, and six months, measured by
1.1. Chairstand test, total number of rise from a chair in 30 seconds (Jones CJ, Rikli RE, Beam WC, 1999)
1.2.Handgrip-strength using a Jamar dynamometer (Bohannon RW, Schaubert KL 2005)
1.3. Avlunds Mobility-Tiredness Scale that counts activities managed without fatigue (Avlund K, Kreiner S, Schultz-Larsen K 1996).
2. Cognitive functional status at baseline, one, and six months, measured by mini-mental status examination that consists of 11 questions, maximum score (best performance)=30 (Folstein MF, Folstein SE, McHugh PR 1975).
3. Mental functional status at baseline, one, and six months, measured by Geriatric Depression Scale (0-1=not depressed,2- 5=risk of depression)(Bull 1988)
4. Health related quality of life at baseline, one, and six months, measured by 12-itim short-form Health Survey (SF 12) (Ware J Jr, Kosinski M, Keller SD 1996).
5. Amount of patients unresolved problems, data collected from intervention nurse records.
6. Amount of help at home from the community, data collected from the community health center utilisation database.

Completion date
01/08/2011

Eligibility

Key inclusion criteria
1. Patients 70 years and older scoring more than 2 points (out of 6) when screened with Identification of Seniors at Risk 1 (ISAR 1) screening tool (McCusker 1998)
2. Discharged home from Medical Emergency Department and residents of Amager, Copenhagen
3. Able to decide on informed consent
4. Able to communicate in Danish

Participant type(s)
Patient

Healthy volunteers allowed
No

Age group
Senior

Sex
All

Key exclusion criteria
1. Patients admitted to Medical Emergency Department from nursing home
2. Patients already included who are readmitted
3. Spouses to already included patients
4. Patients who do not wish to participate

Date of first enrolment
16/02/2009

Date of final enrolment
01/08/2011

Locations

Countries of recruitment
Denmark

Study participating centre
University Hospital of Amager
Copenhagen
Denmark
2300

Sponsor information

Organisation
University Hospital of Amager (Denmark)

ROR
https://ror.org/02g2pz956

Funder(s)

Funder type
Hospital/treatment centre

Funder Name
Amager Hospital (Denmark)

Funder Name
Danish Nurses Organization (Denmark)

Funder Name
The Lundbeck Foundation (Denmark)

Funder Name
The Tryg Foundation (Denmark) (ref: J.nr. 1072-09)

Funder Name
University of Southern Denmark, Institute of Clinical Research (Denmark) - Research Unit of Nursing

Results and Publications

Individual participant data (IPD) sharing plan

IPD sharing plan summary
Not provided at time of registration