focusing on interdisciplinary cooperation in the future. Interviews with more respondents and with medical doctors would have strengthened our study.

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Cardiac Care Bridge: study protocol of nurse-coordinated transitional care in older cardiac patients

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Background: After a hospital admission for heart disease, older patients are at high risk for adverse health outcomes such as readmission and death. Geriatric conditions as dizziness, malnutrition, impairments in activities of daily living and cognition increase this risk. The current treatment in older cardiac patients is mainly focused on disease management with attention for cardiovascular risk management and cardiac rehabilitation (CR). However, these patients are less likely to receive CR due to e.g. multimorbidity or transport difficulties. In this single disease management approach, inadequate attention is paid to wider healthcare needs and this may lead to insufficient medical care.
In the Cardiac Care Bridge (CCB) program we aim to examine the effectiveness of a nurse-coordinated transitional intervention including case management, cardiovascular risk management and home-based rehabilitation for high-risk cardiac patients of >70 years on reducing readmissions and mortality within six months after discharge.
Materials/Methods: A double-blind multi-centre randomized clinical trial will be performed from May 1st 2016. Patients admitted to the departments of cardiology or cardiothoracic surgery of >70 years at high risk of functional loss are eligible to participate. 500 Patients will be included. In the intervention case management, disease management and home-based CR are combined in three phases: In the clinical phase, patients receive a comprehensive geriatric assessment and to develop an integrated care plan. This is leading during all phases of the intervention. The transitional phase starts before discharge. A coordinating community care nurse (CCN) visits the patient to receive an in-person handover from the disease manager. After discharge, the post-clinical phase starts including CR. The CCN performs multiple home visits within three months to continue care based on the integrated care plan and works in close collaboration with the physiotherapist and disease manager.
We hypothesize a 12.5% absolute reduction in readmission and mortality at six months after hospital admission. Secondary endpoints in this study are ADL- / iADL-functioning, self-management skills and abilities, lifestyle adherence, health-related quality of life, symptom burden, cardiovascular status, healthcare utilization and caregiver burden.
Conclusion: This study aims to contribute to evidence based health care services in older high-risk cardiac patients. Changes in health care systems and the growing aging population result in a prolonged period of independency with increased needs for home care services. In contrast to patients who receive single disease management, we expect that by combining case- and disease-management these patients might have a significantly better outcome.

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The occurrence and perceived influence of nurses on patient problems across nursing settings

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Background: In order to enhance the nursing profession and its scientific foundation, nurses need to demonstrate how they contribute to quality of care and good outcomes in their patients. This requires systematic, standardized data collection about patient problems, nursing interventions and patient outcomes. However, currently little is known about which patient problems nurses encounter in daily practice, how they help their patients in dealing with these problems, and with which result. As a first step towards systematic and standardized data collection, the objective of this study is to identify which patient problems are most frequently encountered by nurses, and how much influence nurses report to have on these problems.
Materials and method: Data were collected through an online questionnaire. Descriptive statistics were used for the data analysis.
Results: A total of 440 nurses, active in various health care settings, completed the questionnaire. The majority of patient problems fall into the following categories: mental functions, self-care, functions of the cardiovascular, haematological, immunological and respiratory systems, sensory functions and pain and mobility. Nurses report having the most influence on patient problems in respect of self-care, mobility, functions of the skin and related structures, functions of the digestive, metabolic and endocrine systems and general tasks and demands. In general, nurses report having little influence on problems related to mental functions, even though such problems are relatively common.
Conclusion: This study identifies the most common patient problems in daily nursing practice. The extent to which nurses feel they contribute to the prevention or minimization of patient problems was also determined. It has provided a valuable insight into the daily nursing practice. The patient problems identified in this study can serve as a foundation to establish a standardized core set of patient problems. A standardized core set of patient problems is necessary to collect uniform data, in order to facilitate research into the actual influence of nurses on quality of care and the health and quality of life of their patients.

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Concordance between nurse-perceived quality of care and publicly reported by quality indicators

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Background: Nurse-sensitive indicators are commonly used to measure and benchmark the quality of nursing care. In the Netherlands, the Health Care Inspectorate requires hospitals to publicly report various quality indicators, among which nurse-sensitive indicators. In the literature however, there is a debate about the accuracy of these kinds of indicators as measures of quality.
Aim: To assess the convergent validity of nurse-sensitive indicators by comparing them with a subjective measure of quality, namely nurse-perceived quality of care.
Materials and methods: Nurse-perceived quality ratings were obtained from staff nurses working in six non-university teaching hospitals in the Netherlands. These hospitals were pilot-testing hospitals for the Dutch Essentials of Magnetism II, a survey that measures nurses' perception of quality of care and job satisfaction, as well as their opinion about the work environment. Additionally, for each of the six hospitals a composite performance score was calculated, based on averaging the percentage scores of the mandatory nurse-sensitive screening indicators, including delirium, malnutrition, and pain assessments. Spearman's correlation was used to analyze the degree of correspondence between the quality measures.
Results: Nurse-perceived quality of care differed significantly between the hospitals, also after adjusting for nursing experience, educational level, and regularity of shifts (N = 2338 nurses). The composite screening performance scores ranged from 63% to 93% across the six hospitals. The hospitals with high-levels of nurse-perceived quality were also high-performing hospitals according to nurse-sensitive screening indicators. A strong correlation was found between the two quality measures (r S = .943, P = .005).
Conclusion: Our findings showed that there is a significant positive association between objectively measured nurse-sensitive screening indicators and subjectively measured perception of quality. Moreover, the two indicators of quality of nursing care provide corresponding quality rankings. This implies that improving factors that are associated with nurses' perception of what they believe to be quality of care may also lead to better screening processes. Although convergent validity seems to be established, we emphasize that different

kinds of quality measures could be used to complement each other, because various stakeholders may assign different values to the quality of nursing care.

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Essential elements of the nursing practice environment and the relation with quality of care

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Background: In recent years, hospital length of stay has reduced and the number of inpatient beds has decreased, resulting in an increase of care intensity for inpatients. Also, the patient population is aging and older patients frequently have multi-morbidity. At the same time, nurse staffing levels and educational levels in hospitals do not match this increase in care intensity, resulting in a strain on quality of care and patient safety. A possible answer to the existing concerns may be the creation of a productive and healthy practice environment, as this impacts the quality of care.
Aims: (i) to define how the practice work environment is best measured by valid and reliable measures and (ii) to assess elements of the nursing practice environment that are related to quality of care and that require improvement.
Material and methods: A two phased cross-sectional, correlational study design was used. In the first phase, we determined construct validity using hypotheses testing, relating the Dutch Practice Environment Scale of the Nursing Work Index (PES-NWI) to the Dutch Essentials of Magnetism II (D-EoM II). We formulated fifteen hypotheses prior to data-analysis. Data were collected from qualified nurses ($N = 259$) between March and April 2012 on nine randomly selected hospital units. In the second phase, the essentials of magnetism were used to define elements of the nursing practice environment. Correlation between the essentials of magnetism and perceived quality of care was determined in a sample of $N = 1113$.
Results: Response rate was 47% ($n = 121$). Total scores of both instruments are strongly correlated ($r = .88$). Twelve out of fifteen hypotheses (80%) were confirmed and three were rejected. Correlation between the essentials of magnetism and quality of care were all significant and varied from $r = .17$ (nurse-physician relationships) to $r = .52$ (adequacy of staffing).
Conclusion: The D-EOM II has satisfactory construct validity for measuring the nursing practice environment in hospitals and can be used by nurses, managers, health policy makers, hospitals and even governments to assess nursing practice environments and to identify processes and relationships that are in need of improvement to safeguard quality of care for all patients, including older patients.

A-P-289

Building consensus on an integrated care pathway in geriatric rehabilitation: a Delphi study

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Background: Older people who go through the whole trajectory of hospital admission, admission to a geriatric rehabilitation facility and home discharge, face various challenges regarding continuity and coordination of care. To tackle these challenges, an integrated care pathway was developed and implemented in the south of the Netherlands, focusing on improved communication and collaboration between organizations. Because our final goal is to implement this care pathway on a nationwide level, we used a Delphi study to reach consensus on the content of the care pathway among national experts in geriatric rehabilitation.
Materials and Methods: Dutch elderly care physicians ($n = 82$) specialized in geriatric rehabilitation were invited to participate in this two-round Delphi study. In round 1 they received a questionnaire with 65 statements, representing the integrated care pathway. These statements involved the process of care in the hospital, in the geriatric rehabilitation facility and in primary care and the communication and transfers between settings. Participants were asked to indicate their level of agreement on the statements on a Likert scale from 1 to 5. An Inter Quartile Range (IQR) of =1 was used to indicate agreement. To reach a higher level of consensus, the statements that did not reach agreement were presented to the participants in round 2.
Results: 37 (45%) elderly care physicians participated in the first round and 29 in the second round. After round 2, consensus was gained on 60 statements (92%). Participants agreed with 54 statements and disagreed with 6 statements. The content of the statements will be discussed at the conference.
Conclusion: These results imply that there is broad consensus on the content of the integrated care pathway and that it has the potential to be disseminated and implemented on a wider level. Future research is necessary to determine how the five elements that did not reach consensus could be adjusted to reach broader consensus.

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The challenges of involving people with dementia and their caregivers in decision-making

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Background: People with dementia and their caregivers must make many decisions. Shared decision-making is the preferred way of involving people in these decisions. However, decision-making in the context of dementia is complex. It involves multiple participants with different capacities and interests: people with dementia, their informal caregivers, and professionals. Our study aimed to describe the challenges of shared decision-making in dementia care networks.
Methods: A multiperspective qualitative study using face-to-face interviews with 113 respondents in 23 care networks consisting of 23 people with dementia, 44 of their informal caregivers, and 46 of their professional caregivers. The interview guide addressed the decision topics, the decision-making participants, and their contributions to the decision-making. We used content analysis to delineate categories and themes.
Results: The three themes that emerged describe the challenges of shared decision-making for dementia care networks: 1) adapting to a situation of diminishing independence, which includes shifting roles in the decision-making; 2) tensions in network interactions, which result from different perspectives and interests and which require reaching agreement about what constitutes a problem in the situation; and 3) timing decisions well.
Conclusion: The challenges in dementia care networks have implications for a model of shared decision-making in dementia care networks. Such a model requires flexibility regarding changing capabilities to preserve the autonomy of the person with dementia as long as possible. It requires working towards a shared view about what constitutes a problem in the situation. It also requires adjusting the decision-making pace to that of the care network members.

A-P-303

The older patient in the emergency department; special care needed?

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Introduction and aim: The number of older people in the Belgian population is expected to increase over the upcoming years, resulting in a growing number of hospitalizations. According to the National Institute for Statistics, in 2050, 50% of the hospitalized patients will be older than 65 and one out of three patients over 75 years. The aim of this study is determine the nurses' perception if older patients require special care.
Method: A multicenter cross-sectional research surveyed emergency care nurses and reference nurses in geriatric care working in the emergency department of nine Antwerp hospitals. This study focused on their image of being old, how they provide care and whether they considered older patients needing specific care during their stay in the emergency department.
Results: 99 emergency nurses (response rate 43%) and 9 referent nurses in geriatric care (response rate 100%) participated. Most emergency nurses (81%) indicated age, mostly over

