



ROL DEL KINESIOLOGO EN RESIDENCIAS DEL ADULTO MAYOR

KLGO CARLOS FUENZALIDA
KLGA LORETO ROJAS



Objetivos de la Presentación

- Recomendación de kinesiólogo en reglamento de ELEAM (establecimientos de larga estadía del adulto mayor).
- Definición ELEAM
- Definición kinesiólogo
- Revisión del rol del kinesiólogo en la literatura vs nuestra realidad
- Fundamentos de la recomendación internacional de evaluación geriátrica integral desde el punto de vista kinésico
- Nuestros roles y realidad
- Conclusión

Reglamento De Establecimientos de Larga Estadía para Adultos Mayores

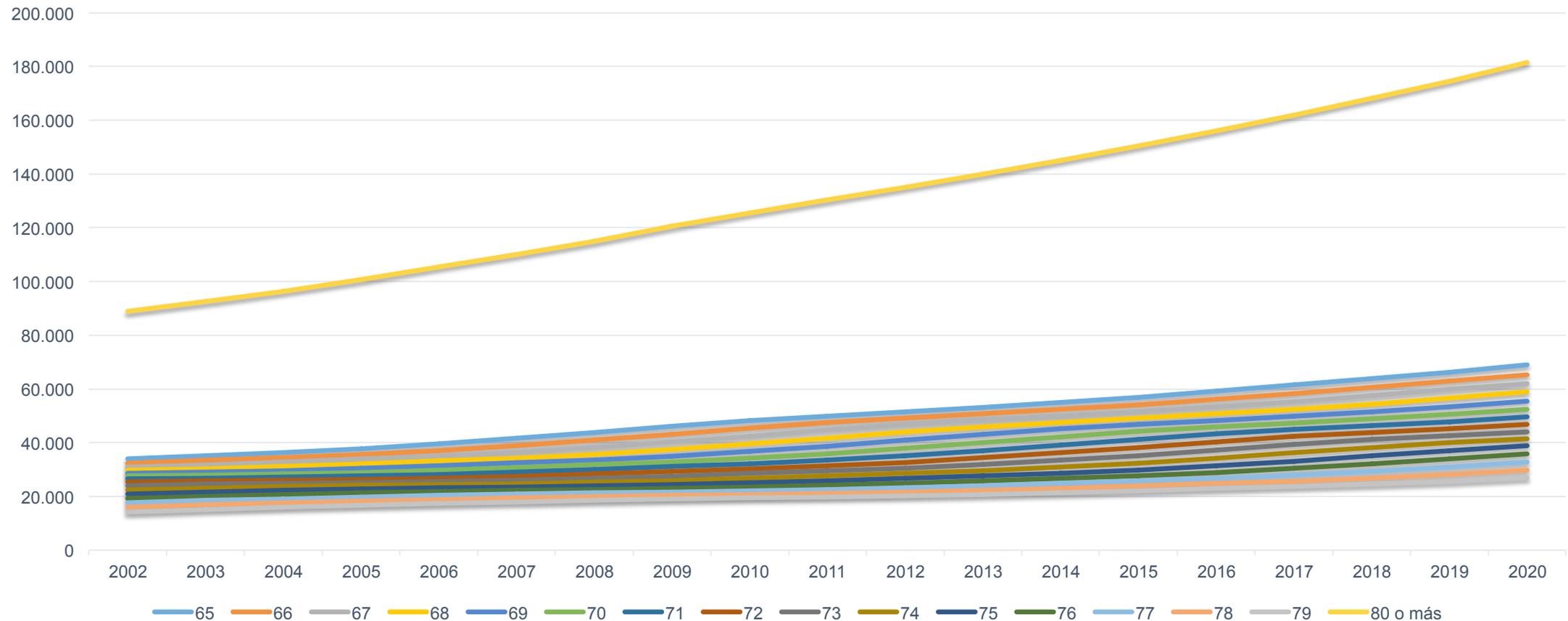
- **DECRETO N° 14 DE 2010**
- **Publicado en el Diario Oficial de 05.08.2010**
- **Artículo 14.-** Es recomendable que estos establecimientos cuenten, además, con servicios de:
 - enfermera, para la gestión de los cuidados,
 - nutricionista para la confección de minutas y dietas,
 - **kinesiólogo,**
 - terapeuta ocupacional o profesor de educación física con formación gerontológica para la rehabilitación y mantenimiento de las funciones biopsicosociales de los residentes,
 - asistente social para el desarrollo de estrategias de intervención socio comunitaria y articulación con las redes locales de servicios

Definición de ELEAM

- **Artículo 2°.-**

- Establecimiento de larga estadía para adultos mayores, o ELEAM, es aquel en que residen personas de 60 años o más que, por motivos biológicos, psicológicos o sociales, requieren de un medio ambiente protegido y cuidados diferenciados que allí reciben. Dichos cuidados tienen por objeto la prevención y mantención de su salud, la mantención y estimulación de su funcionalidad y el reforzamiento de sus capacidades remanentes.

Actualización de Población 2002-2012 y Proyecciones 2013-2020 en la RM. Instituto Nacional De Estadística Chile.



Definición de Kinesiólogo

- Es un profesional de la salud que diagnostica y trata individuos de todas las edades desde recién nacidos hasta adultos mayores que tienen problemas médicos u otras condiciones relacionadas con la salud que limitan sus habilidades para moverse y realizar funciones en su vida diaria.
- Desarrolla un plan con técnicas de tratamiento para promover la capacidad para moverse, disminuir el dolor, restaurar la función y prevenir la discapacidad

¿Qué es la Kinesiología ?

- Es una disciplina que se encarga de buscar la mejoría de distintas patologías a través del movimiento, con el propósito de acortar el periodo de recuperación y alcanzar el máximo de las capacidades funcionales de cada persona



Role of Physical Therapists In Physical Activity Programs in Nursing Homes: A Survey

Helen Deborah Skeist, *Journal of the American Geriatrics Society*

[Volume 28, Issue 3](#), pages 124–129, March 1980

- El principal rol es consulta e instrucción.
- El tiempo principal se consume en tratamiento.
- Los programas incluyen deambulación, entrenamiento de la marcha, ejercicios en cama, ejercicios en grupo.

Physical rehabilitation for older people in long-term care (Review)

Crocker T, Forster A, Young J, Brown L, Ozer S, Smith J, Green J, Hardy J, Burns E, Glidewell
The Cochrane Library
2013, Issue 2

- 67 trial, n 6300
- Al final de la intervención índice de Barthel score 6 puntos IC 95% (2-11)
- Rivermead Mobility Index (0 a 15) fue de 0.7 puntos IC 95% (0.04 a 1.3)
- Efecto benéfico en la fuerza, flexibilidad, balance, posiblemente ánimo.
- No aumenta el riesgo de mortalidad risk ratio 0.95, IC 95% (0.8 a 1.13)

Evaluación Geriátrica Integral

UPTODATE, [Katherine T Ward, MD](#), Literature review current through: Jun 2015. | This topic last updated: Feb 02, 2015

- Es un diagnóstico y tratamiento integral que identifica condiciones médicas, psicosociales y funcionales en un persona adulta frágil, con el propósito de desarrollar un plan coordinado para maximizar la salud con la edad.

Principales Componentes

CAPACIDAD FUNCIONAL

RIESGO DE CAIDAS

CONGNICION

POLIFARMACIA

CAMBIOS DE PESO

INCONTINENCIA URINARIA

FUNCION SEXUAL

VISION Y AUDICION

SALUD BUCAL

VIDA COTIDIANA

SOPORTE SOCIAL

PREOCUPACIONES

FINANCIERAS

OBJETIVOS DE LOS
CUIDADOS

ESPIRITUALIDAD

PREFERENCIAS EN
CUIDADOS AVANZADOS

Evaluando la Capacidad Funcional

- DEFINICION

- Habilidad para desarrollar actividades necesarias o recreativas en la vida diaria.

Barthel Index

Activity	Score
Feeding	
0 = Unable	
5 = Needs help cutting, spreading butter, etc, or requires modified diet	
10 = Independent	
Bathing	
0 = Dependent	
5 = Independent (or in shower)	
Grooming	
0 = Needs to help with personal care	
5 = Independent face/hair/teeth/shaving (implements provided)	
Dressing	
0 = Dependent	
5 = Needs help but can do about half unaided	
10 = Independent (including buttons, zips, laces, etc)	
Bowels	
0 = Incontinent (or needs to be given enemas)	
5 = Occasional accident	
10 = Continent	
Bladder	
0 = Incontinent, or catheterized and unable to manage alone	
5 = Occasional accident	
10 = Continent	
Toilet use	
0 = Dependent	
5 = Needs some help, but can do something alone	
10 = Independent (on and off, dressing, wiping)	
Transfers (bed to chair and back)	
0 = Unable, no sitting balance	
5 = Major help (one or two people, physical), can sit	
10 = Minor help (verbal or physical)	
15 = Independent	
Mobility (on level surfaces)	
0 = Immobile or <50 yards	
5 = Wheelchair independent, including corners, >50 yards	
10 = Walks with help of one person (verbal or physical) >50 yards	
15 = Independent (but may use any aid; for example, stick) >50 yards	
Stairs	
0 = Unable	
5 = Needs help (verbal, physical, carrying aid)	
10 = Independent	
Total (0-100):	

The Barthel ADL Index: Guidelines

- The index should be used as a record of what a patient does, not as a record of what a patient could do
- The main aim is to establish degree of independence from any help, physical or verbal, however minor and for whatever reason
- The need for supervision renders the patient not independent
- Patient performance should be established using the best available evidence provided by the patient, family, friends and caregivers; direct observation and common sense are also important, but direct testing is not needed
- Usually the patient's performance over the preceding 24 to 48 hours is important, but occasionally longer periods will be relevant
- Middle categories imply that the patient supplies over 50 percent of the effort
- Use of aids to be independent is allowed

References:

1. Mahoney FI, Barthel D. Functional evaluation: The Barthel Index. *Maryland State Medical Journal* 1965; 14:56. Used with permission.
2. Loewen SC, Anderson BA. Predictors of stroke outcome using objective measurement scales. *Stroke* 1990; 21:78.
3. Gresham GE, Phillips TF, Labi ML. ADL status in stroke: Relative merits of three standard indexes. *Arch Phys Med Rehabil* 1980; 61:355.
4. Collin C, Wade DT, Davies S, Horne V. The Barthel ADL Index: A reliability study. *Int Disability Study* 1988; 10:61.

Katz index of independence in activities of daily living

Activities	Independence	Dependence
Points (1 or 0)	Points (1) NO supervision, direction, or personal assistance	Points (0) WITH supervision, direction, personal assistance or total care
Bathing POINTS: _____	(1 point) Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity.	(0 points) Needs help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing.
Dressing POINTS: _____	(1 point) Gets clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.	(0 points) Needs help with dressing self or needs to be completely dressed.
Toileting POINTS: _____	(1 point) Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.	(0 points) Needs help transferring to the toilet, cleaning self or uses bedpan or commode.
Transferring POINTS: _____	(1 point) Moves in and out of bed or chair unassisted. Mechanical transferring aides are acceptable.	(0 points) Needs help in moving from bed to chair or requires a complete transfer.
Continence POINTS: _____	(1 point) Exercises complete self control over urination and defecation.	(0 points) Is partially or totally incontinent of bowel or bladder.
Feeding POINTS: _____	(1 point) Gets food from plate into mouth without help. Preparation of food may be done by another person.	(0 points) Needs partial or total help with feeding or requires parenteral feeding.
Total points: _____		

6 points: high (patient independent).

0 points: low (patient very dependent).

Reproduced with permission from: Katz S, Down TD, Cash HR, Grotz RC. Progress in the development of the index of ADL. Gerontologist 1970, 10:20. Copyright © 1970 Oxford University Press.

The Lawton instrumental activities of daily living scale

Activities	Points	Activities	Points
Ability to use telephone		Laundry	
1. Operates telephone on own initiative; looks up and dials numbers	1	1. Does personal laundry completely	1
2. Dials a few well-known numbers	1	2. Launders small items, rinses socks, stockings, etc.	1
3. Answers telephone, but does not dial	1	3. All laundry must be done by others	0
4. Does not use telephone at all	0	Mode of transportation	
Shopping		1. Travels independently on public transportation or drives own car	1
1. Takes care of all shopping needs independently	1	2. Arranges own travel via taxi, but does not otherwise use public transportation	1
2. Shops independently for small purchases	0	3. Travels on public transportation when assisted or accompanied by another	1
3. Needs to be accompanied on any shopping trip	0	4. Travel limited to taxi or automobile with assistance of another	0
4. Completely unable to shop	0	5. Does not travel at all	0
Food preparation		Responsibility for own medications	
1. Plans, prepares, and serves adequate meals independently	1	1. Is responsible for taking medication in correct dosages at correct time	1
2. Prepares adequate meals if supplied with ingredients	0	2. Takes responsibility if medication is prepared in advance in separate dosages	0
3. Heats and serves prepared meals or prepares meals but does not maintain adequate diet	0	3. Is not capable of dispensing own medication	0
4. Needs to have meals prepared and served	0	Ability to handle finances	
Housekeeping		1. Manages financial matters independently (budgets, writes checks, pays rent and bills, goes to bank); collects and keeps track of income	1
1. Maintains house alone with occasion assistance (heavy work)	1	2. Manages day-to-day purchases, but needs help with banking, major purchases, etc.	1
2. Performs light daily tasks such as dishwashing, bed making	1	3. Incapable of handling money	0
3. Performs light daily tasks, but cannot maintain acceptable level of cleanliness	1		
4. Needs help with all home maintenance tasks	1		
5. Does not participate in any housekeeping tasks	0		

Scoring: For each category, circle the item description that most closely resembles the client's highest functional level (either 0 or 1).

A summary score ranges from 0 (dependent, requires significant assistance to live in the community) to 8 (independent, no assistance required to maintain self in community).

Reproduced with permission from: Lawton MP, Brody EM. *Assessment of older people: Self-maintaining and instrumental activities of daily living.* *Gerontologist* 1969, 9:179. Copyright © 1969 Oxford University Press.

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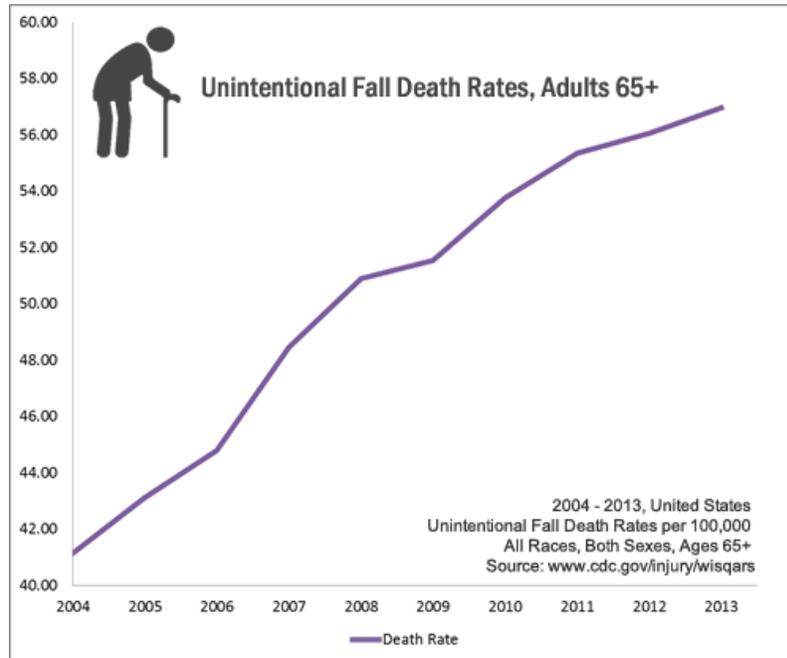
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Evaluando el Riesgo de Caídas



- **1 de cada 3** adultos >65 años que se cayeron en el año le dirán al profesional de la salud acerca de esto.

- **20 a 30%** tendrán una injuria de moderada a severa.

- Algunos que se caen desarrollarán **temor**, limitando sus actividades de la vida diaria, pérdida de la condición física y esto **aumentará su riesgo de caídas.**

Evaluación

- Escala de Berg
- Test de Tinetti
- Test de alcance
- Apoyo unipodal
- Test Time and Go
- Get up and Go
- Etc.

The "Get up and go" test for gait assessment in elderly patients

The "Get up and go" test for gait assessment in elderly patients ^[1]	
Have the patient sit in a straight-backed high-seat chair	
Instructions for patient:	
Get up (without use of armrests, if possible)	
Stand still momentarily	
Walk forward 10 ft (3 m)	
Turn around and walk back to chair	
Turn and be seated	
Factors to note:	
Sitting balance	
Transfers from sitting to standing	
Pace and stability of walking	
Ability to turn without staggering	
Modified qualitative scoring ^[2]	
1) No fall risk	Well-coordinated movements, without walking aid
2) Low fall risk	Controlled but adjusted movements
3) Some fall risk	Uncoordinated movements
4) High fall risk	Supervision necessary
5) Very high fall risk	Physical support of stand by physical support necessary
Timed test (record time from initial rising to re-seating) ^[3]	
Age (years)	Mean time (seconds)
60 to 69	8.1 (7.1 to 9.0)
70 to 79	9.2 (8.2 to 10.2)
80 to 99	11.3 (10.0 to 12.7)

Sources:

1. Reproduced with permission from: Fleming KC, Evand JM, Weber DC, Chutka DS. Practical Functional Assessment of Elderly Persons: A Primary-Care Approach [Symposium on Geriatrics-Part III]. Mayo Clinic Proceedings 1995; 70:890. Copyright © 1995 Mayo Foundation.
2. From: Nordin E, Lindelöf N, Rosendahl E. Prognostic validity of the Timed Up-and-Go test, a modified Get-Up-and-Go test, staff's global judgement and fall history in evaluating fall risk in residential care facilities. Age Ageing 2008; 37:442. By permission of the British Geriatrics Society. Copyright © 2013 Oxford University Press.
3. Data from: Bohannon RW. Reference Values for the Timed Upand Go Test: A Descriptive Meta-Analysis. J Geriatr Phys Ther 2006; 29:64.

What works to prevent falls in older adults dwelling in long term care facilities and hospitals? An umbrella review of meta-analyses of randomized controlled trials

B. Stubbs et al. / Maturitas 81 (2015) 335–342

Summary of included studies.

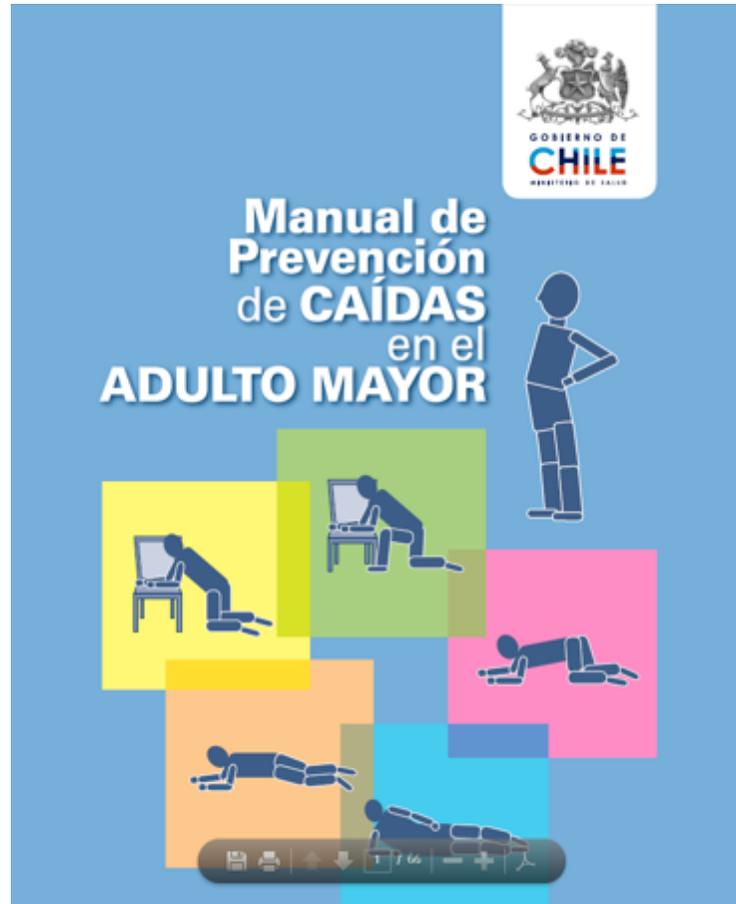
Author (Ref)	Country	Intervention and control	RCTs included (n = participants)	Participants details and setting	Define a fall?	Main results (95% CI)	Heterogeneity	Adverse events	AMSTAR	Conclusion	
Gou et al. (2013) [20]	Tai	Exercise v control	10 (n = 1262)	Older adults without cognitive impairment Mean age 64.5 to 89.0. LTCF	No	OR 0.79 (0.64–0.98)	NR	NR	4	Exercise reduces falls in older adults in LTCF. Pooled effect become non-significant when exclude 2x tai chi results from analysis. Nutritional supplements and vitamin D have no significant effect on falls.	
		Non tai chi exercise	8 (n = 917)			OR 0.84 (0.63–1.11)					
		Nutritional supplement v control	6 (n = 4934)			OR 0.93 (0.77–1.13)					
		Vitamin D v control	4 (n = 4609)			OR 0.98 (0.79–1.22)					
Choi and Hector (2012) [21]	US	Multifactorial interventions	3 (n = 1291)	Mean age 79.2 years LTCF	No	RR 0.45 (0.38–0.53)	Q = 62.7, p < 0001	NR	8	Multifactorial interventions reduce falls in LTCF.	
Cameron et al. (2012) [4]	AUS	Exercise care facilities:	8 (n = 1844)	Care facilities 84 years & 77% women Hospitals 79 years 58% women	No	RaR 1.03 (0.81–1.31)	I ² = 70%	NR	10	LT care facilities: exercise does not reduce falls as a single intervention (including when separated into high and intermediate care). Medication chart review does not reduce falls. Vitamin D supplementation does significantly reduce falls. Multifactorial interventions only reduce falls in intermediate care but not high level care settings.	
		High level care	4 (n = 625)			RaR 1.29 (0.93–1.79)					I ² = 64%
		Intermediate care	4 (n = 1219)			RaR 0.80 (0.57–1.13)					I ² = 60%
		Combination exercises	4 (n = 561)			RaR 1.24 (0.84–1.83)					I ² = 73%
		Medication review care facilities	4 (n = 4857)			RR 1.00 (0.91–1.10)					I ² = 47%
		Vitamin D care facilities	5 (n = 4603)			RaR 0.63 (0.46–0.86)					I ² = 72%
Multifactorial interventions care facilities:	7 (n = 2876)	RaR 0.78 (0.59–1.04)	I ² = 84%								

What works to prevent falls in older adults dwelling in long term care facilities and hospitals? An umbrella review of meta-analyses of randomized controlled trials

B. Stubbs et al. / Maturitas 81 (2015) 335–342

Murad et al. (2011) [25]	US	Vitamin D	10 (n=?, overall sample)	76 years, 78% female LTCF.	No	OR 0.87 (0.71–1.07)	NR	NR	8	Vitamin D does not reduce falls in people in institutions.
Silva et al. (2013) [26]	Aus	Exercise pooled analysis	14 (n= 1292) (9 RCTs combined exercise and 5 RCTs single)	68% female, 83.9 years LTCF	No	RR 0.77 (0.64–0.92)	$I^2 = 72.1\%$	NR	5	Exercise is effective in reducing falls in LTCF. It is most effective when combinations of exercises are used.
		Combined exercise interventions	9 (n= 885)			RR 0.71 (0.55–0.90)	$I^2 = 72.0\%$			
		Single exercise interventions	5 (n= 498)			RR 0.86 (0.65–1.14)				
Santesso et al. (2014) [27]	Can	Hip protectors	16 (n= 11,275) Unclear how many RCTs were LTCF? 14	65+ years LTCF	No	RaR 1.02 (0.90–1.16)	$I^2 = 92\%$	5% experience skin irritation	7	Hip protectors have no significant effect on falls in LTCF.
Bolland et al. (2014) [28]	NZ	Vitamin D with (N=1) or without calcium (N=5)	6 (n= 2013)	Mean age 83 to 89 years in RCTs, 73–100% females in RCTs	No	RR 0.96 (0.88–1.05)	NR	NR	6	Vitamin D has no significant effect on falls in a traditional meta-analysis approach.
		Vitamin D no calcium	5 (n= 1430)	LTCF		RR 0.92 (0.82–1.02)	NR			

Realidad Chilena



Clasificación Internacional de Funcionamiento, Discapacidad y Salud

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International Classification of Functioning, Disability and Health (ICF)

The International Classification of Functioning, Disability and Health, known more commonly as ICF, is a classification of health and health-related domains. As the functioning and disability of an individual occurs in a context, ICF also includes a list of environmental factors.

ICF is the WHO framework for measuring health and disability at both individual and population levels. ICF was officially endorsed by all 191 WHO Member States in the Fifty-fourth World Health Assembly on 22 May 2001 (resolution WHA 54.21) as the international standard to describe and measure health and disability.



[more . . .](#)

Evaluación Kinésica en Hogar Beit Israel



EVALUACION DE KINESIOLOGIA

FECHA 4/12/14

FECHA INGRESO: 20/07/07 FECHA INGRESO: 2/12/14 PESO: 99 ALTURA: 170
 DMC

ANTECEDENTES MORBIDOS Trastorno personalidad, hígado graso, Síndrome degenerativo frontal subcortical de probable origen vascular incipiente, depresión bipolar, Gota, QDs deterioro cognitivo, multicausal, DM, ICC, cardiopatía HTA, **dislipidemia**.

Inestable, ánimo exaltado, deterioro cognitivo importante,

1-RANGO ARTICULAR Y FUERZA

		RANGO ACTIVO		RANGO PASIVO		FUERZA	
		derecho	izquierdo	derecho	izquierdo	derecho	izquierdo
HOMBRO	Flexión	N	N	N	N	M5	M5
	Extensión	N	N	N	N	M5	M5
	Abducción	N	N	N	N	M5	M5
	Aducción	N	N	N	N	M5	M5
	Rot ext.	N	N	N	N	M5	M5
Rot int.	N	N	N	N	M5	M5	
CODO	Extensión	N	N	N	N	M5	M5
	Flexión	N	N	N	N	M5	M5
MUNECA	Extensión	N	N	N	N	M5	M5
	Flexión	N	N	N	N	M5	M5
	Pronación	N	N	N	N	M5	M5
	Supinación	N	N	N	N	M5	M5
	Radicalización	N	N	N	N	M5	M5
Capitalización	N	N	N	N	M5	M5	
CADERA	Flexión	N	N	N	N	M4	M4
	Extensión	N	N	N	N	M4	M4
	Abducción	N	N	N	N	M4	M4
	Extensión	N	N	N	N	M4	M4
RODILLA	Extensión	N	N	N	N	M4	M4
	Flexión	N	N	N	N	M4	M4
Tobillo	Flexión plan	N	N	N	N	M4	M4
	Flexión dorsal	N	N	N	N	M4	M4
	Inversión	N	N	N	N	M4	M4

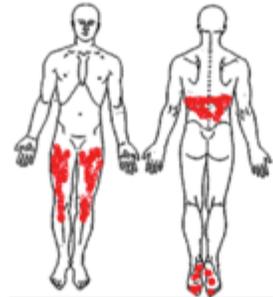
	Eversión	N	N	N	N	M4	M4
FUERZA PREHENSION		Derecha 28,6	DS-CV	Izquierda 24,2	DS-CV		

*N DENTRO DE PARAMETROS NORMALES

2-MOVILIDAD DE COLUMA: Distancia en cm de dedo medio a suelo

- A- Flexión anterior en bipedo 23 cm
- B- Lateralización derecha 47 cm
- C- Lateralización izquierda 51 cm

3-EVALUACION DOLOR: Marque con una X la región que siente dolor



ESCALA VISUAL ANALOGA DE DOLOR (0 AL 10) Refiere dolor en región lumbar, muslos cara anterior y planta de pies.

4-RIESGO DE CAIDAS TEST TIME UP AND GO:

Tiempo: 6 seg

Mayor a 13.5 seg, riesgo de caídas

5-TEST CAMINATA 6 MIN

	BASAL	POST TEST
FC	90	98
FR	21	32
SpO2	96%	97%
PA	130/70	140/80
ESCALA DE BORG(FATIGA)	0	7
DISTANCIA		200
VALOR PREDICTIVO DISTANCIA		490

6- EVALUACION POSTURAL (POSTURE SCREEN SOFTWARE)

Normal

Your Posture from Front

Your Posture Viewed from the Front

Head is shifted 1.24cm right. Head is tilted 4.9° right.

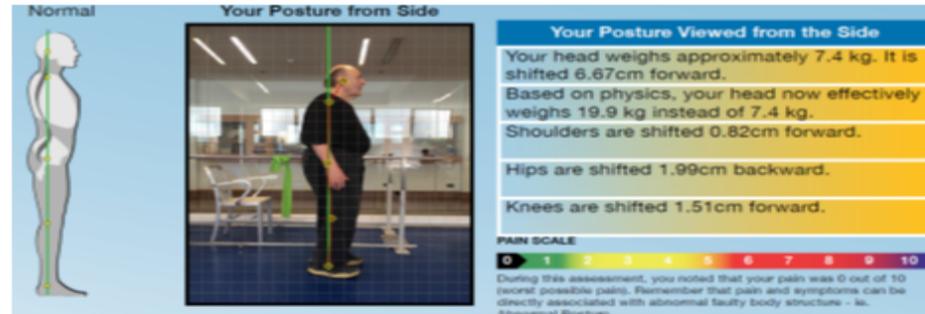
Shoulders are shifted 2.15cm right. Shoulders are tilted 1.5° right.

Ribs cage is shifted 1.70cm left.

Hips are shifted 2.27cm left. Hips are not tilted.

Any measurable deviation from normal posture causes weakening of the spine as well as increased stress on the nervous system which can adversely affect overall health.

Evaluación Kinésica en Hogar Beit Israel



7-EVALUACION RESPIRATORIA

FR 21 FC 90 SpO2 96%

NO refiere antecedentes mórbidos respiratorios, Cifosis, Ex pulmonar: MP presente, SRA, tos eficaz seca a la estimulación.

8-CONCLUSION:

Paciente vigil con trastorno de personalidad, diabético, HTA, ~~dislipidemia~~ dependiente parcial de las AVD, sedentario, obeso, asiste con asistente personal.

Rango articular dentro de parámetros normales, fuerza de presión un 69% del valor predictivo.

Sin riesgo de caídas medico por test Time and GO, sin embargo el riesgo no se excluye

Presente un dolor en región lumbar sin limitación a la movilidad, dolor en la cara plantar de pies y cara anterior de muslos bilateral.

Presenta una desviación a D de troco en el plano frontal y una cifosis en el plano sagital con entepulsion de cabeza y abdomen protruido.

El test de 6 minutos en un 40% del valor predictivo para distancia con buena respuesta en los signos vitales.

La evaluación respiratoria clínica está dentro de parámetros normales

Marcha sin asistencia con aumento de la base de sustentación.

Objetivos:

Aumentar la condición aeróbica

Aumentar fuerza

Mantener el rango articular

Fisioterapia para dolores crónicos

Plan de TTO:

Ejercicios 3 veces por semana más gimnasia grupal en talleres.

Kinesiólogo Carlos Fuenzalida V

Kinesioterapia Respiratoria

- Especialistas en tratar pacientes con enfermedades respiratorias que posean un marco teórico en fisiología respiratoria y muscular, imageneología, con una subespecialización y/o experiencia en ventilación mecánica no invasiva , aerosol terapia, oxigenoterapia, y rehabilitación pulmonar.



Kinesioterapia Respiratoria

[J.Gerontol Nurs](#). 2015 Feb;41(2):26-31. doi: 10.3928/00989134-20140807-99. Epub 2014 Aug 19.

Risk of aspiration in care home residents and associated factors.

[van der Maarel-Wierink CD](#), [van der Putten GJ](#), [De Visschere LM](#), [Bronkhorst EM](#), [de Baat C](#), [Schols JM](#).

Abstract

Pneumonia is a prevalent cause of death in care home residents. Dysphagia is a significant risk factor of aspiration pneumonia. The purpose of the current study was to screen for risk of aspiration in care home residents in the Netherlands and assess potential risk factors of aspiration. Five experienced speech-language therapists assessed 203 care home residents (115 primarily physically disabled, 88 primarily cognitively impaired) 60 and older in the first week after admission to a care home. In 43 (21.2%) residents, speech-language therapists assessed risk of aspiration and found no significant difference between physically disabled (26.1%) and cognitively impaired (14.8%) residents. After multivariate logistic regression analysis the final prediction model for risk of aspiration showed Parkinson's disease as a significant factor (odds ratio = 5.11; 95% confidence interval [1.49, 17.52]). The authors therefore conclude that risk of aspiration is a relevant care problem among Dutch care home residents and requires further assessment.

[Geriatr Gerontol Int](#). 2015 May 8. doi: 10.1111/ggi.12506. [Epub ahead of print]

Predictive factors for oral intake after aspiration pneumonia in older adults.

[Momosaki R](#)^{1,2}, [Yasunaga H](#)², [Matsui H](#)², [Horiguchi H](#)³, [Fushimi K](#)⁴, [Abo M](#)¹.

Author information

Abstract

AIM: The purpose of the present study was to clarify the predictive factors for achieving oral intake after aspiration pneumonia in elderly patients.

METHODS: This retrospective observational study used data from the Japanese Diagnosis Procedure Combination inpatient database. We identified patients who were admitted to acute-care hospitals with aspiration pneumonia. The outcome was time to achieve total oral intake. We carried out Cox regression analysis to identify predictors for the early initiation of total oral intake.

RESULTS: Of 66 611 elderly patients with aspiration pneumonia, 59% achieved total oral intake within 30 days. Cox regression analysis showed that early initiation of total oral intake was associated with female sex and higher Barthel Index. Delayed initiation of total oral intake was associated with underweight, higher scores of pneumonia severity and comorbidities.

CONCLUSION: We clarified prognostic factors for total oral intake in elderly aspiration pneumonia patients. Our findings will be helpful in nutritional care planning for elderly aspiration pneumonia patients. *Geriatr Gerontol Int* 2015; ●● ●●●●.



Kinesioterapia Respiratoria



[Swiss Dent J.](#) 2015;125(4):417-26.

Oral health and dental care of elderly adults dependent on care.

[Baumgartner W¹](#), [Schimmel M](#), [Müller E](#).

Author information

Abstract

The increase in life expectancy in Switzerland is posing new challenges, as more and more people are becoming dependent on care, both at home and in long-term care facilities. The dental profession must deal with patients retaining their own teeth until later in life with an increased incidence and severity of caries and periodontal diseases. The association between general and oral health is becoming important, particularly in older people with medical conditions. Aspiration pneumonia can develop as a result of pathogenic bacteria descending from the oral cavity to the bronchoalveolar system, which presents a frequent, potentially life-threatening danger. By adapting care and treatment concepts, the masticatory ability can be preserved or restored, which in turn helps preventing malnutrition. Other aims include preventing infections as well as maintaining subjective well-being and an attractive dental appearance. Care standards should be defined for the provision of oral-health related dentistry for the vulnerable population of the care-dependent adults. These should be implemented by an interdisciplinary care team composed of nursing personnel, long-term care facility managers, Spitex staff, physicians, dentists as well as dental assistants and hygienists.

Kinesioterapia Respiratoria

[Cochrane Database Syst Rev. 2015 Feb 23;2:CD003793. doi: 10.1002/14651858.CD003793.pub3.](#)

Pulmonary rehabilitation for chronic obstructive pulmonary disease.

[McCarthy B¹](#), [Casey D](#), [Devane D](#), [Murphy K](#), [Murphy E](#), [Lacasse Y](#).

Author information

Abstract

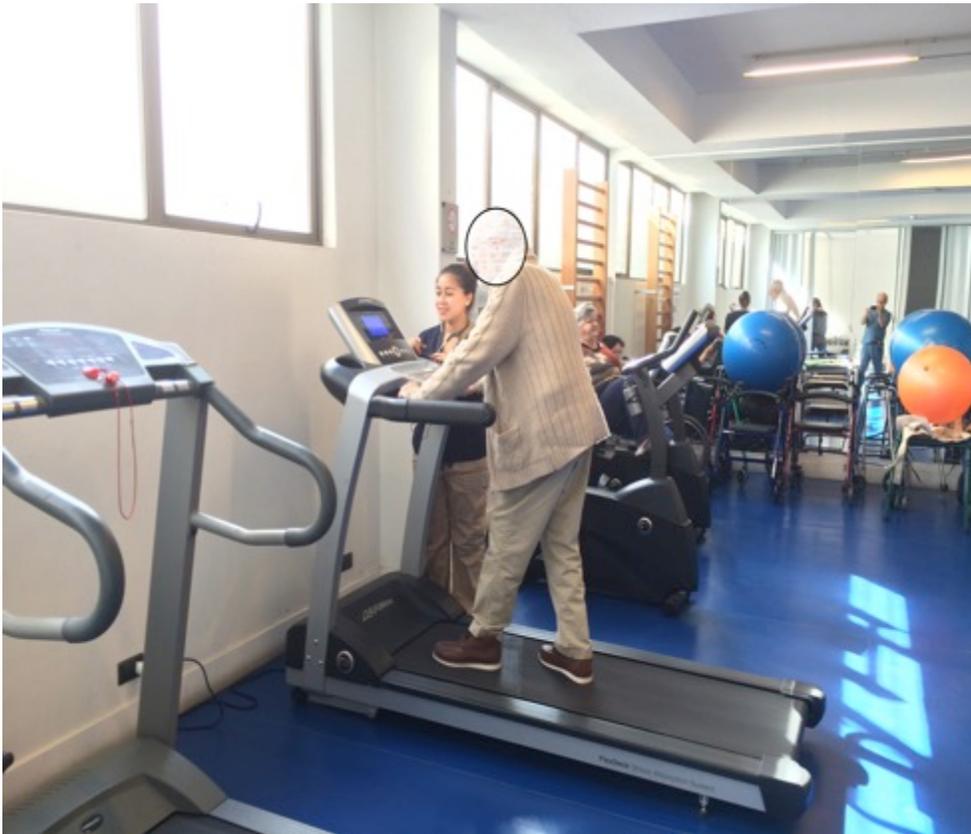
BACKGROUND: Widespread application of pulmonary rehabilitation (also known as respiratory rehabilitation) in chronic obstructive pulmonary disease (COPD) should be preceded by demonstrable improvements in function (health-related quality of life, functional and maximal exercise capacity) attributable to the programmes. This review updates the review reported in 2006.

OBJECTIVES: To compare the effects of pulmonary rehabilitation versus usual care on health-related quality of life and functional and maximal exercise capacity in persons with COPD.

SEARCH METHODS: We identified additional randomised controlled trials (RCTs) from the Cochrane Airways Group Specialised Register. Searches were current as of March 2014.



Entrenamiento Aeróbico en Treadmill



- **REHABILITACION EN EPOC** ([Thorax](#). 2015 Mar;70(3):213-8. doi: 10.1136/thoraxjnl-2014-206440. Epub 2015 Jan 5.
- Sarcopenia in COPD: prevalence, clinical correlates and response to pulmonary rehabilitation)
- **REHABILITACION CARDIOVASCULAR** ([Cardiology](#). 2015;131(3): 177-85. Epub 2015 May 8.
- Cardiac Rehabilitation after an Acute Coronary Syndrome: The Impact in Elderly Patients).
- **REHABILITACION POST AVE** ([PM R](#). 2015 Jul 8. pii: S1934-1482(15)00753-4. doi: 10.1016/j.pmrj.2015.06.444. [Epub ahead of print]
- Walking training and functioning among elderly individuals with stroke: results of a prospective cohort study)
- **REHABILITACION ARTROSIS** ([Am J Phys Med Rehabil](#). 2015 Mar 12. [Epub ahead of print]
- Intensive Gait Training for Older Adults with Symptomatic Knee Osteoarthritis)

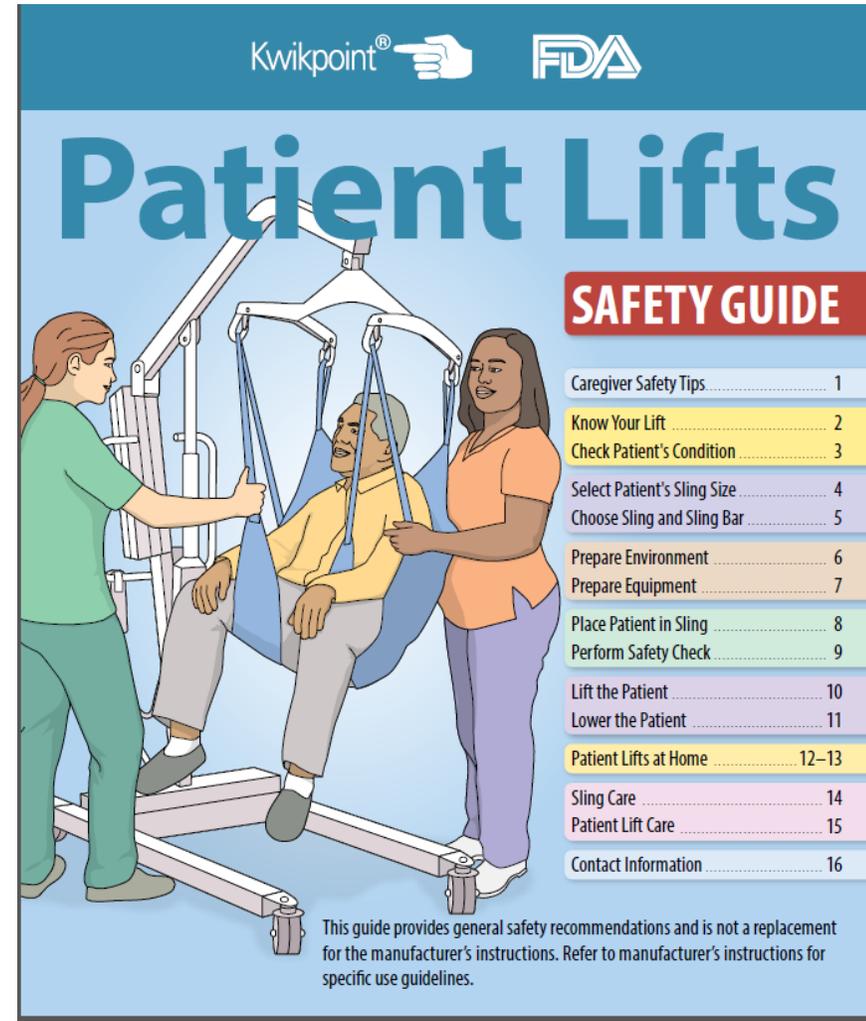
Prevención

- TECNICAS CORRECTAS PARA TRANSFERENCIA DE PACIENTES.

Una buena técnica no asegura la ausencia de lesiones



- LEVANTADORES DE PACIENTES



Ventajas

- Reduce el riesgo de lesiones a las cuidadoras y residentes.
- Peso corporal residente
 - > PC residente > dificultad de transferencia
- Asistente
 - > edad de la asistente > uso de fuerza lo que malogra la técnica de transferencia
- Residente
 - > edad > riesgo de postración > necesidad de asistencia en transferencia

Precauciones

- Se debe educar al personal en el correcto uso de este y realizar mantenimiento al equipo

Usos

Actividades rutinaria de traslados, caídas, gimnasio.



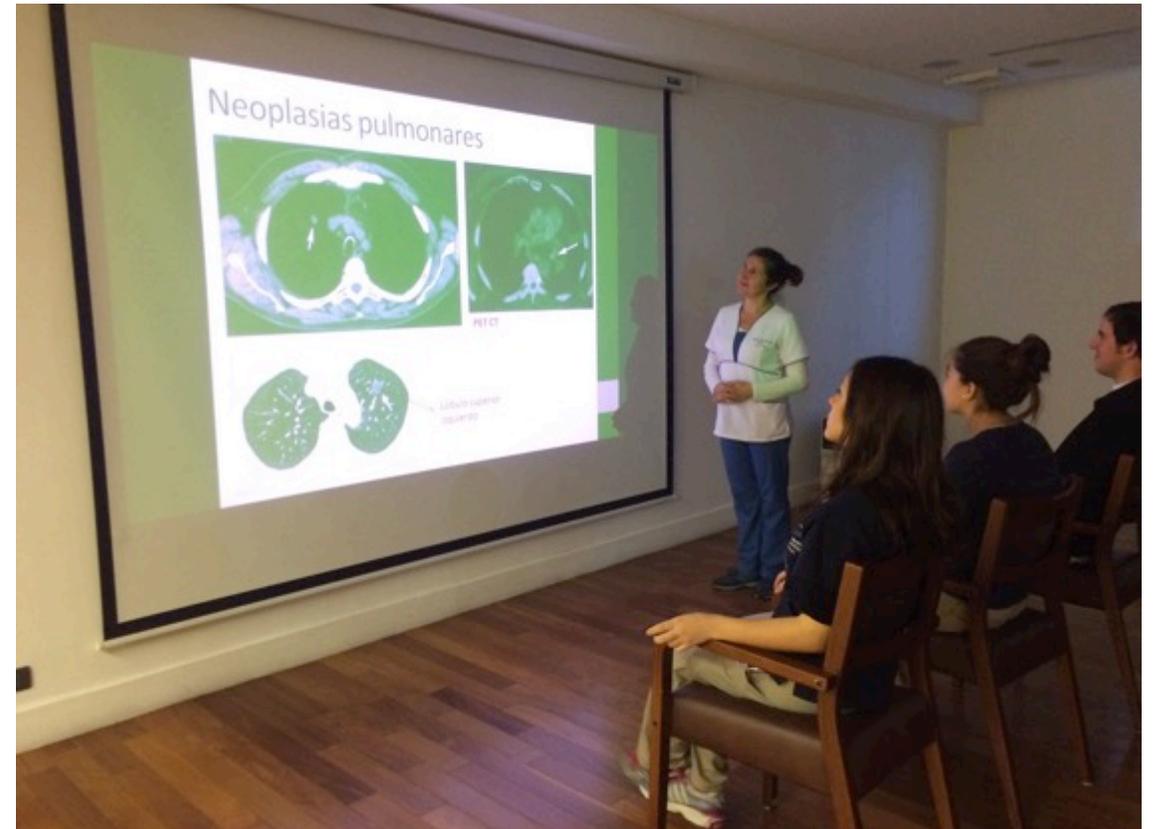
Educación y Extensión

- Charlas educativas a nuestro personal y residentes
- Talleres: - Gimnasia Médica
 - Control Motor
 - Video Gimnasia
 - Stretching
 - Otros



Docencia

- Tutores clínicos de Internado integral geriátrico .
 - Universidad de los Andes.
 - Universidad de Desarrollo.



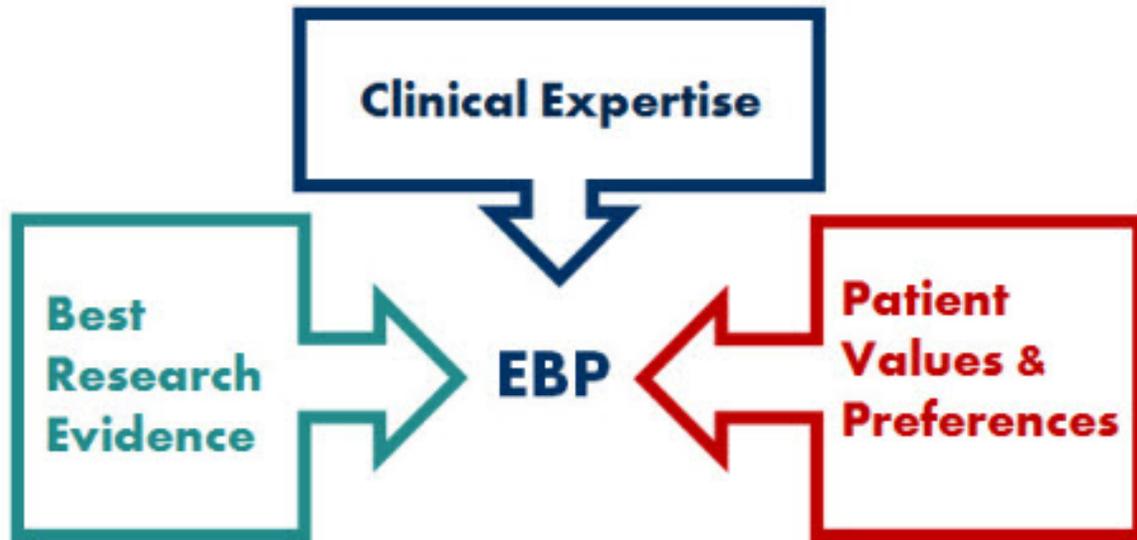
Caminata del Adulto Mayor



Más allá de lo clínico ...



Práctica Basada en Evidencia



Aplicación de la mejor evidencia científica encontrada para la emisión de una recomendación clínica en conjunto con la experiencia y raciocinio clínico y las preferencias o situaciones individuales de los pacientes.

Conclusiones

- Los roles son dinámicos y no estáticos
- Siempre estar abiertos a nuevas tecnologías
- Ser innovadores
- Registrar, objetivar la evaluación y evolución.
- Acercarse a la **PRACTICA BASADA EN LA EVIDENCIA**

GRACIAS