Letters to the Editor

The right medicine

SIR—We read with interest the editorial of Beard [1] and the updated professorial quote: ‘The main thing that puts elderly people at risk from their medicines is their doctors’ inability to prescribe properly’.

An aspect of prescribing properly for patients admitted to hospital not addressed in the editorial is being able to accurately identify what drugs a patient was receiving prior to admission. Our usual policy is to ask the patient and/or carer to provide a list of medications or the tablet containers on admission. For some patients it may not be possible to identify an accurate list of medications in this way. Medical staff would then contact the General Practitioner’s surgery for a list.

We sought to identify whether there were discrepancies between the patient or carer provided medication list on admission and a list subsequently obtained from contact with the GP surgery. We identified 50 in-patients (all over 60 years) in our acute elderly care ward and rehabilitation wards. The medication as it was listed in the notes and on the prescription chart within the first 24 hours of the admission was recorded. The GP surgery was then contacted and a list of current medications obtained. The GP surgery receptionist provided this information from the GP notes on one occasion and from the computer record in all other cases.

We found that there was a discrepancy between the admission record (the medications we would have been giving the patient) and the GP’s computer record in 44% of subjects. Differences occurred most frequently for cardiological medications (41%; 9/22 patients). Discrepancies occurred with similar frequency in younger (42% of age 60–79; 10/24 patients) and older subjects (46% of age over 80; 12/26 patients) but were more likely for patients receiving seven or more medications (75%; 9/12 patients) compared with those receiving six or less (34%; 13/38 patients).

A difficulty interpreting the study results included uncertainty in deciding what is actually a patient’s usual medication, as the record may not have been updated with any changes occurring just prior to admission. However, the GP surgery does remain a key method of obtaining more information about a patient’s medication when uncertainty exists. The study did not attempt to address the issue of concordance, which may be different when in hospital, with a medication taken infrequently at home being taken much more often in hospital when the patient may take on a more passive role.

As a result of our study we feel it may be that a further alteration to the professorial quote is required. We would suggest ‘The main thing that puts elderly people at risk from their medicines in hospital is their doctors’ inability to prescribe the same drugs as they take at home.’

IAN C. STEELE, MAUREEN FINNEGAN
Department of Care of the Elderly, The Royal Hospitals,
Grosvenor Road, Belfast BT12 6BA, Northern Ireland


DOI: 10.1093/ageing/afh020

SARS – a geriatrician’s perspective

SIR—Amongst the many measures that have been introduced to isolate patients with Severe Acute Respiratory Syndrome (SARS) during the height of the SARS outbreak, a number have deeply impacted the practice of geriatric medicine within acute hospitals in Singapore [1–3]. The adoption of strict infection control measures (N95 mask, goggles, gown and gloves for all patient contact) has meant that patients did not get to see the faces of their health-care providers. This inevitably led to a degeneration of the sacrosanct patient–doctor relationship. Similarly, concerns about possible patient–to-patient transmission resulted in the curtailment of group activities intended to ease the older patients back to normal societal routines and that were once a constant feature of geriatric care, e.g. group therapy sessions. The introduction of restrictions on hospital visitations, while important in limiting the risk of community spread of SARS, also impeded the multi-disciplinary interaction with patients’ caregivers that has been a cornerstone of geriatric intervention.

Early local experience led to the discovery that older patients could present atypically (one patient had concurrent pulmonary oedema that masked her symptoms; another did not have the typical pattern of fever and transmitted SARS to her nurse and visitors at her nursing home; a third patient with concomitant urosepsis had late chest x-ray changes and was not initially diagnosed to have SARS, with the resultant development of a large cluster of patients in another hospital). The recent resurgence of SARS in Toronto that has been linked to a 96-year-old man initially diagnosed to have pneumonia [4] further highlights the difficulty of diagnosing SARS in older persons and lends weight to the fact that a persistently heightened state of vigilance is required when dealing with older patients.

Singapore was removed from the WHO list of countries with local transmission of SARS on 31 May 2003 [5]. Since then, the precautionary measures that are listed above have been lifted progressively [6]. While this is a psychological victory of sorts, the ease with which a new case can be imported in our highly mobile society and the risk of atypical presentations in older patients means that the landscape of aged care in Singapore (and all other countries that are similarly at risk) will need to be redefined in time to come.

Y. Y. SITOH
Department of Geriatric Medicine, Tan Tock Seng Hospital,
11 Jalan Tan Tock Seng, Singapore 308433
Email: Sympc@pacific.net.sg
Prescribing indicators

SIR—The multi-centre audit on prescribing indicators by G. M. Batty et al. [1], in which we were pleased to participate, has highlighted sub-optimal prescribing in elderly medical in-patients. We have since completed three audit cycles and have presented the findings across the hospital to most potential prescribers. The information on appropriate prescribing has also been added to the senior house officer induction pack in our department.

By repeating the audits and disseminating the prescribing indicators to medical staff, we have partially succeeded in improving the outcome. There has been significant improvement with figures approaching 90% in the documentation of allergies, avoidance of paracetamol toxicity, long-acting oral hypoglycaemic, appropriate use of aspirin or clopidogrel in angina and aspirin or warfarin in atrial fibrillation. Other indicators have largely remained unchanged.

In our experience junior medical staff has the greatest influence on the prescribing indicators. Through regular re-audits and by involving pharmacists and nurses, we were able to achieve higher standards of quality of prescribing. However, rapid turnover of junior medical staff prevented us from improving the results further.

Batty et al. recommends developing further prescribing indicators. In our repeat audits, we audited prescribing of prognostically important medications. These included Angiotensin Converting Enzyme inhibitors, beta-blockers, spironolactone and a combination of hydralazine and nitrate in the management of heart failure. Other indicators were medications for osteoporosis prophylaxis, cyclo-oxygenase II inhibitors and proton pump inhibitors with nonsteroidal anti-inflammatory drugs.

Our experience suggests that an ongoing programme of prescribing audits may prove to be an effective measure in improving prescribing in elderly in-patients.

References


DOI: 10.1093/ageing/afh005

Frailty is the main predictor of falls in elderly patients undergoing rehabilitation training

SIR—We read with interest the article by Vassallo and colleagues, recently published in Age and Ageing [1]. The authors found that elderly fallers can be predicted by easily identifiable characteristics, such as confusion, history of previous falls and unsafe gait. We want to contribute with personal data to this topic, suggesting that frailty is the main determinant of falls among elderly patients undergoing rehabilitation training.

From 1 January 2001 to 30 April 2003, a total number of 649 patients were admitted to our 25-bed Rehabilitation Unit. Of these, 271 (41.8%) were admitted because of a recent orthopedic intervention (lower limb fractures, elective hip or knee replacement, shoulder replacement), 32 (4.9%) because of recent cerebrovascular attacks (stroke, TIA lasting less than 6 months), 195 (30.1%) because of chronic neurological-related gait disorders (Parkinson disease or parkinsonisms), 77 (11.9%) because of arthritis-related gait disorders and 74 (11.3%) for cardiac or pulmonary rehabilitation. Forty-six patients (7.1%) fell once or more during their hospital stay. The table shows that, in comparison with the other patients, fallers were more impaired in functional status 1 month before admission and had a lower functional recovery in gait and balance (Tinetti score) at discharge, although they remained in hospital on average 5 days more than non fallers.

When we tested the effect of these variables on predicting falls in a logistic stepwise regression model, we found that only functional status 1 month before admission (Barthel Index ≤ 80/100; B = 0.90, 95% CI = 1.0–6.0, Odds Ratio = 2.5, P = 0.04) significantly and independently predicted falls in our population.

Because the functional status preceding the event that leads to hospital admission reflects the pre-morbid health conditions of the patient, a low Barthel Index score one month before admission could be considered a marker of frailty. Therefore, the assessment of functional status before admission could be helpfully used to recognise frail patients at risk of falls during hospital stay.