The thrust of government policy since the launch of the National Service Framework for Older People 2001 has been focused around the promotion of independence and a shift in health provision from secondary to primary care. This supports the expectation that mental health for older people should be community based [1]. Choice about where care is received and care closer to home are the mantra of the modernised NHS. Choice about from whom and where we receive such care is no longer an aspiration but an expectation amongst society and especially by its ageing population.

The extension of choice is a welcome development and provides people with greater opportunity to make decisions about their lives and well-being; for those with dementia and their families it has the potential to provide further challenges about balancing risk and safety with the empowerment of individuals to live a full life. Currently across the UK it is estimated that the total number of people with dementia is 775,000. It is estimated that by 2010 there will be 870,000 people with dementia in the UK and by 2050 the numbers will have risen to 1.8 million [2].

The investment and development of assistive technologies are seen globally as an important contribution to delivering high-quality care in the 21st century. The scope and range of such technologies have the potential to improve the safety and well-being of many dementia sufferers and enable them to live more safely in their own homes.

One of these technologies is the electronic tagging system. This provides a global positioning system, which can track individuals who wander. Such a system supports the provision of a safe and empowering approach, which allows individuals with dementia freedom to wander, thus enhancing quality of life for sufferers and enabling carers to be reassured by an ability to track movements. However, concern has been expressed that ‘an individual wearing a device is as likely to be injured near their home as one who walks some distance; using a tag may increase risk by reducing the attention of a carer’ [3]. Vigilant observation and appropriate response are as important as the device itself. It also raises the issue of risk, and the ethical and moral questioning for individuals who may lack capacity to consent, being harnessed to such a system.

The debate about the impact that tagging has on individuals and practice has divided opinion, with emerging camps suggesting that electronic tagging has been promoted as a ‘novel system, which improves clinical safety and reduces carer stress’ [4]. Others suggest that it is a process which further divides a group of often stigmatised and marginalised individuals, likening them to children, criminals, animals and a subhuman existence [5].

How does the use of tagging devices impact clinical practice? Is tagging a care enhancer or poor substitute affording suboptimal care? There is a potential to reduce staffing ratios through reliance on technology [6]. It is suggested that tagging provides an alternative to locked doors, potential for less serious accidents and incidents, and a useful alternative to drug therapy [7]. However, it cannot be a substitute for the human dimension of care giving. The perception of many professionals is that behaviour which sits outside perceived societal and care practice norms is a problem and can cause much anxiety to both the professional and carer. It is not often seen as a symptom of an underlying cause. It is the cause of perceived ‘challenging’ behaviour such as a tendency to wander, not its impact on care giving, that needs attention. It therefore raises the issue that electronic tagging is a control and restraint, which masks the need for expert clinical care and infringes human rights. Understanding the meaning and developing a person-centred approach is fundamental to meeting individual need [8]. Consideration of the impact of tagging on the human rights of the individual along with the issue of dignity and consent are acknowledged in relation to surveillance, privacy and respect of the individual’s wishes [9].

The introduction of the Mental Capacity Act 2005 will further challenge clinicians and carers in making informed decisions in the best interest of patients who lack capacity. The best interests of patients must be at the heart of all decision making. This is not just ‘what the person would have wanted themselves’ but an objective test, considering all relevant factors’ [10]. The Act also takes into account the issue of capacity in relation to research. There is reassurance in a legal framework, which will challenge the perception of the professional being in the dominant role with the potential to interpret the situation to meet organisational agendas rather than the best interests of the patient whom they serve at the centre of that decision.

What is clear is that the issue of tagging is far from a simple solution to the management of wandering and has immense implications for professionals, carers and executive accountability for the management of risk and human rights. What is seen as a device of safety and reassurance is equally balanced by the view of a system which restricts, restrains and infringes on a basic need for us all as individuals to access the world in which we live.

Restraint or enabling device-tagging systems will continue to form part of the new technology era. The increasing investment in design and development of assistive technology has to be seen as a progressive, logical and welcome contribution to improving care for people with dementia.
and allows us to provide solutions for an ever challenging and increasing demand on our health system. However, it should enhance and support care and not become a poor substitute for expert assessment, the identification of complex care needs and management strategies that protect the dignity of, choice for and empowerment of patients.

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References

Classifying older patients in hospital

The paper by Campbell et al. in this issue makes an important contribution to the development of a clinical case-mix measure suitable to capture the key attributes of acutely admitted older hospital patients [1]. It builds on a substantial process of preparation which included preliminary studies [2] and a systematic review [3], which generated seven variables which the European collaborative group have now tested as predictors of clinical outcomes in 1,626 patients across eight centres in six countries.

The seven predictor variables were age, gender, living alone, ‘geriatric giants’, functional ability (ADL) by the Barthel Index, cognition and a broad diagnostic category (ICD-10 heading). Data collection involved case-note review, interview of a health professional treating the patient and a brief patient interview on day 3 of the hospital admission. The outcomes were in-hospital mortality, institutionalisation (including continued hospitalisation at 90 days), or return to usual residence within 90 days (home), along with hospital length of stay (LOS).

Physical function, cognition, age, gender and living arrangement were each associated with one or more of these outcomes. The authors report their intention to use these findings to create a case-mix tool and investigate its feasibility and reliability in clinical practice.

As the authors point out, such a tool might be considered useful for several purposes relevant to the challenges faced by health services for older people, although the suitability of the predictor variables and clinical outcomes may differ accordingly. These purposes include comparing clinical effectiveness, targeting specialist services and prediction of resource use.

Acute medical services that serve older people vary widely in their context and operation. Hospital admission policies and the availability of service alternatives to hospital care vary considerably between and within countries. In many countries, acute hospital episodes may be linked to spells of nursing home, intermediate or domiciliary-based post-acute care and rehabilitation. It is highly likely that there will be wide variation in case-mix between individual services and therefore comparisons of performance should be between systems or complete pathways of care.

Among older patients, particularly the very old, the important outcomes of care following acute illness or injury include mortality, ADL recovery, returning home and the costs of care, both during the acute episode and thereafter.

In most countries with ageing populations and developed health services, there is pressure to reduce hospital admissions and LOS. Where this is done by bringing direct financial pressure on the healthcare provider, by a ‘Payment by Results’ policy such as in the publicly funded UK National Health Service (NHS) or by private insurance companies in the USA and elsewhere, failure adequately to recognise and to fund the more complex care needed by the frail older person with extensive co-morbidity could result in ageism and poorer standards. Lower cost, lesser skilled and less effective care programmes may be