A fractured approach to care home residents

SIR—We would like to comment on the recent paper educating nursing home staff on fracture prevention: a cluster randomised trial [1]. Ceredigion Local health Board (with assistance from our osteoporosis service) participated in this National Osteoporosis Service led initiative up to June 2005. Our experiences were as follows.

There was a significant problem with staff turnover meaning that there were both starters and leavers during the project. There appears to have been a high staff turnover which is likely to lead to incomplete training from such a short initiative. Only 232 of 358 clients in 16 local care homes were assessed (65%), local participation was at the tail end of the initiative and the 3-month follow-up was poorly achieved—only 23 of the 232 assessed clients (10%) were followed up. Very often the bisphosphonate therapy will be given by the night staff—a shift that is notoriously difficult to include in educational activities that are usually nine to five based. The statement that specialist input can lead to an increase in prescribing which is not associated with a significant effect on rate of falls and fracture is interesting. Our own local experience has shown that when we first assessed clients of care homes, some 88% of those prescribed a bisphosphonate were taking it in the incorrect fashion (usually with breakfast, unpublished data); similarly there was a perception from some carers that the calcium and vitamin D supplements were to be used as an antacid and were therefore given on a PRN basis. It is therefore not simply the prescription of these drugs that achieves the fracture reduction—as is often the case when translating research results into clinical practice we do the beginning (patient identification) and end (prescribing intervention) bits well but do not perform the middle part (ensuring concordance) so thoroughly, a point that has been recognised as being related to poor fracture risk reduction outcomes [2, 3]. The landmark, published data relating to fracture risk reduction through the use of calcium and vitamin D supplements relate to interventions lasting 18 months and upwards [4]; the 1-year time scale of this initiative may have been too short to demonstrate effect in this regard.

We believe that it is an implicit responsibility for secondary care expertise in this area to be cascaded through to primary and social care in order to maximise the potential benefits of the proven interventions and to reduce unnecessary prescribing where possible. This can only be achieved by a long-term commitment to joint care across the primary, secondary and social care boundaries. Our own approach has been to include carers (all shifts), administrative staff, community pharmacy staff (e.g. rethinking the dosette box for bisphosphonates), patients and families in educational sessions held in their own setting.

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Falls in the elderly—the need for more access to chiropody

SIR—Following various researches focusing on prevention of falls and injuries among older people in community and emergency care settings, we would like to highlight a topic often taken very lightly but is in fact a serious problem in the elderly population.

I would like to highlight the case of a patient who presented with recurrent falls. We initially investigated her with regard to syncopal events, musculoskeletal problems and neurological deficit. However, we found all to be in order for her age. Further to this, with the useful input from our rehabilitation physiotherapists, we identified that it was in fact her long, unkempt toenails that hindered her from walking properly!