Letters to the Editor

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homes, some 88% of those prescribed a bisphosphonate were taking it in the incorrect fashion (usually with breakfast, unpublished data); similarly there was a perception from some carers that the calcium and vitamin D supplements were to be used as an antacid and were therefore given on a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 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.

PHIL JONES1*, DEBBIE STONE2
1Consultant Physician, Hywel Dda NHS Trust, Bronglais Hospital, Caradoc Road, Aberystwyth SY23 1ER, UK
Email: phil.jones@carmarthen.wales.nhs.uk
2Osteoporosis Specialist Nurse, Hywel Dda NHS Trust, Bronglais Hospital, Caradoc Road, Aberystwyth SY23 1ER, UK
*To whom correspondence should be addressed


doi: 10.1093/ageing/afn222
Published electronically 21 November 2008

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!
Letters to the Editor

Indeed, in the elderly, it is very difficult if not impossible to maintain feet and toenail hygiene. There are several reasons, including simple mechanical difficulty resulting from arthritic hips or lack of strength, as well as neglect due to dementia. Solving this problem in hospital currently is more difficult than it appears.

Nurses are allowed to cut fingernails untrained, but not allowed to cut toenails. In order to cut toenails they must undergo a special training course, and a few nurses have actually undergone training. In addition to this, elderly toenails are very tough and difficult to cut and so require a special tool which inevitably a minority in the wards (including geriatric) and so even if nurses are trained appropriately their expertise would be futile.

At present, the only service on offer for hospital inpatients or out-patients which is capable of remedying the problem of long toenails is the Chiropody Department. However, chiropody is only available for diabetic patients or those at increased risk of infection. There is no chiropody service for non-diabetics.

As highlighted in this case, long toenails frequently contribute significantly to fall in the elderly people and are also an important but overlooked cause for falls. Greater and more universal access to chiropody services would have significant benefit for all elderly patients and help to avoid a large number of hospital admissions.

SHIVA DINDYAL1,*, NEEL BHUVA2, PRAKASH KUMARASWAMY2, HIRO KHOSHNAW4

1Vascular and Endovascular Research Clinical Fellow and Accident and Emergency Clinical Fellow, Barts and the Royal London Vascular and Endovascular Academic Surgical Unit, London, UK
Email: doctordindyal@hotmail.com
2PRHO in Acute Medicine, Charing Cross Hospital, London, UK
3SHO in General Surgery, Royal Cornwall Hospital, Treliske, UK
4Care of the Elderly Consultant, The Royal Surrey County Hospital, Guildford, UK
*To whom correspondence should be addressed

doi: 10.1093/ageing/afn243
Published electronically 11 November 2008

Jed Rowe—We lost one of our own

SIR—I am writing to express my deep sense of loss on hearing of the death of Jed Rowe. I am in the privileged position of having worked with Jed. I was a specialist registrar under him in 2000, and then joined the team at South Birmingham PCT and University Hospitals Birmingham, as a consultant, in 2003. I did of course know him much earlier than that—it is impossible not to have known him as both a medical student in Birmingham and an aspiring geriatrician. There was a palpable ‘buzz’ of excitement in the lecture theatre when we knew Jed was coming to talk to us. He would lumber in to the room, clothes and hair awry, whip out a pile of floppy discs (later replaced by the memory stick perpetually worn around his neck), and deliver a performance laced with humour, passion and compassion. It was never on what the lecture schedule said it would be, but that did not matter. We laughed with him, cried with him, felt the ferocity of his beliefs, respected him and loved him. It is no accident that the West Midlands produces so many geriatricians. I was extremely fortunate (everybody wanted to work with him) to spend 15 months as a specialist registrar under his tutorage. When you trained with Jed, you knew that you were in the presence of someone extraordinary. Watching him work was like watching magic. He had an intuitive way of getting straight to the problem; he provided care that was both evidence-based and innovative, all of it delivered with both a fierce seriousness and a dry sense of humour. I once watched him cry with the wife of a patient who was dying. I will never forget it, he put his arms around her and they both sobbed. He had real empathy for people, patients and relatives, and they loved him for it. The staff both respected and adored him; anybody would have done anything for Jed. He could quote virtually every reference for any paper, with the capacity to remember anything that he had read. We had some posters together at the BGS. Watching him do research and publish was to watch a genius at work. He was cutting edge, an ‘out of the box’ thinker and a trailblazer. His contribution to geriatric medicine is mammoth and cannot be overestimated. There is a whole new generation of geriatricians as a result of him; I have watched countless young doctors arrive as physicians and leave as geriatricians as a result of 6 months working with Jed. He was one of the most popular people at BGS conferences; to him it was like a get together of old friends. There was always a ripple of excitement when his hand shot up in questions—we all knew we going to hear a ‘Jed-ism’, something either brilliant or hilarious, or both, delivered with colourful language, passion and no ‘airs and graces’.

As a consultant colleague he was the best. He helped me through the transition from specialist registrar to consultant, sitting and chatting whilst watching the ducks in the garden at his beloved Moseley Hall Hospital. He fought tirelessly for older people and the department and would do anything for his colleagues and the hospital. It is a cruel irony that one of our greatest, pioneering, geriatricians will not reach old age himself. We should feel tremendously proud that he was a member of our specialty. We are privileged to have known both the man and the doctor, and we should grieve our loss but also celebrate his life. After all, that’s what Jed would have wanted us to do.

PAULA J. NENN (NEE TURNBULL)
Medical Research Director, Optimal Health and Prevention