Timely care for frail older people: the next battleground

SIR—I read with interest the article by Silvester et al. [1] describing improvements in access to older peoples specialty beds using implementation and improvement science over a 2-year period. The paper is significant in its timing and its rigour. If Comprehensive Geriatric Assessment (CGA) improves outcomes for frail older adults with a number needed to treat of 33 to have one more patient alive and in their own homes at 12 months, it is incumbent on specialist older peoples services to ensure that every frail elderly patient has access to CGA. From the evidence base this largely means access to a CGA bed [2]. It also follows that in the current financial strictures that creating additional hospital beds or even hospitals at the rate that the expected demographic would suggest is not possible or even, as the authors point out, desirable. Whatever the reality regarding the demographic shift in older people numbers and rates of admission to hospital [3] many sectors are currently experiencing unprecedented pressures [4] and generally demand outstrips supply. These simple facts require us to emulate the improvement methodology to provide improved access to specialty beds within our current financial framework. The evidence from randomised controlled trials and meta-analysis cannot yet indicate the optimal timing for access to a CGA bed. Arguably, it does not need to. Improvements in outcome are plausible from early CGA, access to a specialist review and the avoidance of adverse consequences from non-specialist care. The risks of in hospital functional decline, falls, delirium and hospital acquired infection are not insignificant for an elderly patient. In addition, we found moving from a ‘post-take’ to an ‘on-take’ review of patients, with their carers involved, led to greater patient satisfaction and reduced complaints [5]. The reduction in mortality seen by the authors does not appear to be clarified as to whether it applies to all over 75s or simply to the geriatric medicine wards. If as suggested it applies to the geriatric medicine wards there is a significant risk, as the authors point out, that this change represents a shift in case mix. This could result from taking patients earlier in their journey, potentially taking less frail or acute patients because of increased capacity. Additionally, reducing length of stay while measuring in hospital (as opposed to 28 day) mortality will inevitably lead to some reductions which could be artefactual. It would be important if this reduction was real and other studies and methodologies will hopefully in time confirm these findings. Irrespective it is clear that it is possible to improve care, reduce costs, reduce unnecessary hospital stays and delays without the need for additional investment. We need to standardise improvement science in healthcare if we are to make gains on the implementation of our existing evidence base. This needs to be core to our clinical management methods and adequate for peer reviewed appraisal. We know enough of the evidence base to be held accountable for the services we provide. Hopefully, this will be the start of many more evidence-based management strategies.

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Conflicts of interest

None declared.

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References


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Calculating cognitive decline in delirium

SIR—We congratulate MacLullich et al. [1] on a careful review of the pathogenesis, diagnosis and management of delirium. We endorse three important conclusions in their article: (i) using the phenotype or umbrella term delirium is preferable to calling delirium in liver failure hepatic encephalopathy or delirium in uraemia uremic encephalopathy.

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Diseases responsible for delirium fall on a different axis than the delirium phenotype; (ii) there have been no ‘large scale improvements in clinical care’ of delirium; (iii) ‘high quality delirium care is complex and time-consuming’. In July 2012, we commenced a prospective randomised controlled study called Central Coast Australia Delirium Intervention Study (CADIS, Clinical Trials.Gov NCT01650896). CADIS compares CAM+ and CAM− subjects as well as subjects positive and negative by a new diagnostic criteria I devised for rapid high amplitude critical cognitive decline, as defined by a 25% decline in attention and another cognitive domains such as word-list recall at 5 min and executive function over 24 h. Most geriatricians, neurologists and general physicians in our area spend <5 min deciding if delirium is present and then an additional 5–10 min assessing acute and chronic disease. In contrast, we spend at least 30 min to establish the acuity of change of attention, five word-list memory at 5 min and executive function through interviews with the patient, family, informants and gathering past reports from geriatricians and other health professionals. When no prior cognitive tests are available we impute these from informant rating of instrumental activities of daily living. For example, a person capable to driving in a city of 4 million residents to new destinations without a navigator or GPS is more likely to have high cognitive function than a person capable to driving 10 km to the grocery store. Likewise a person who gave up cooking due to poor executive function is likely to have worse cognitive function than a person who can cook gourmet meals for several guests. We also impute scores based on 560 memory clinic patients. From the prior or imputed cognitive scores, we subtract current scores leading to a percentage acute change in attention and other cognitive domains. We then assess diseases and drugs. The 101 CADIS patients demonstrated several new findings: (i) the mean delay between symptom onset and admission was 1.4 days; (ii) for daily attention tests, 5-digit span forward improved to baseline in a mean of 1.3 days, whereas 6-digit span improved in a mean of 5.7 days; (iii) Delirium index, a 7-question instrument for monitoring delirium [2–3] improved to baseline in a mean of 5.8 days. We recommend transparent step-by-step logic in diagnosis of delirium [4]. High speed of onset and rapid reversibility in 75% of patients are key features.

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Conflicts of interest

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References


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