Letters to the Editor

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 75 s 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 improves efficiency and reduces mortality 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 appraisals. 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


doi: 10.1093/ageing/afu078
Published electronically 22 June 2014

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.