



## EDITORIAL

### Older people in hospital: The benefits of doing the right thing and the consequences of not choosing to do the right thing

### Mayores en el hospital: beneficios de hacer lo correcto y consecuencias de no elegir hacer lo correcto

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Ageing is a global phenomenon.<sup>1</sup> Older people are living longer with chronic conditions, many of them supported to live in the community rather than institutions. Healthcare systems worldwide are recognising that acute hospitals are seeing a rise in admissions from the older (over 65) population.<sup>2</sup> This group is the single most at risk of repeated hospital admissions, admission to residential care or death. The stakes are high for the acutely ill older adult.

Elderly people are vulnerable to the effects of illness and the impact of the care environment. Delirium for instance, is well known to be triggered or perpetuated by inappropriate approaches to management,<sup>3</sup> noisy, busy or disorientating environments. Admission to hospital alone may be a trigger for some.<sup>4</sup> Delirium is associated with prolonged hospital stays, longer-term cognitive decline<sup>4,5</sup> and an increased mortality rate.<sup>4,6</sup>

In addition the elderly receive more drugs per capita than younger people with prescriptions increasing with age.<sup>7,8</sup> They are also at most risk of drug related side effects,<sup>8</sup> and these risks are compounded by higher risks of drug interactions.<sup>8,9</sup>

The management of immobility and the risks of bed rest are well documented<sup>10</sup> and include DVT (Deep Venous Thrombosis), increased falls, constipation, confusion and depression amongst others. The elderly are most at risk from these complications and this can lead to mobility problems that prolong hospital admission or lead to higher rates of admission to residential care.<sup>11</sup> In fact older people can functionally decline whilst in and despite acute care.<sup>12</sup>

Many elderly people do not present with typical problems. They may present with a break down in social circumstances, falls, functional decline or cognitive change as a consequence of illness or other insult. Geriatricians have long argued that these vulnerable individuals require a different therapeutic approach.<sup>13</sup> This method of care requires a wider multidisciplinary group to assess patients across multiple overlapping or interrelated domains such as medical, functional, cognitive, psychological and social domains. This process is dynamic rather than a single assessment and is very much

connected with a treatment or rehabilitation plan that might tackle problems on multiple domains. The assessment and the therapeutic plans are interrelated and therefore, although this therapeutic process is often called Comprehensive Geriatric Assessment or CGA it would be a mistake to assume that the process of care ends with the identification of problems.

Acute hospital care must take a different approach in relation to the older adult. Fortunately there is a growing evidence base for different hospital based approaches to the frailer older adult. This emerging evidence base has grown over a number of years to encompass most of the hospital pathway. Classifying different forms of CGA is fraught with difficulty. In simple terms it is possible to classify care into “hyper acute” or even “direct” (in or near the emergency department), “acute” and “post acute”. Reviews of “hyper acute” care now sometimes being classed as “interface” geriatrics<sup>14</sup> or acute admission avoidance either prior to the emergency department or beginning in the emergency department<sup>15,16</sup> demonstrate that whilst further evidence is required, benefits in comparison to usual care may be real. Similarly reviews of acute care<sup>17,18</sup> have shown evidence of reduced functional decline with a higher chance of living at home at follow up (avoiding death or admission to residential care). Similarly post acute care<sup>18,19</sup> in medical and orthopaedic patients can result in lower mortality, improved functional outcomes, lower admissions to residential care and an improved odds of being alive and at home at follow up.

Evidence pooled from 10,315 participants across 22 trials in six countries demonstrates that for every 20 patients treated in a geriatric ward as compared to a general medical ward, one less patient would be either dead or admitted to residential care at up to 12 months after admission.<sup>18</sup> The effect is even more pronounced at up to six months where the number needed to treat can be as low as 13.<sup>18</sup> Other benefits of admission to CGA wards include a reduction in death or deterioration, and improvement in cognition.<sup>18</sup>

Crucially these results could not be replicated with specialist peripatetic teams in general medical ward environments.<sup>18</sup>

What seems to be consistent to these interventions is that care must be delivered in discrete specialty beds, by a multidisciplinary team trained in the assessment and rehabilitation of the

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frail elderly. The use of standardised assessment tools and multi-disciplinary meetings seems to prove a necessary component and critically the impact of specialist medical leadership and experienced ward nursing staff can prove crucial to delivering high quality care.

The evidence base is consistent and strong despite its limitations.<sup>18</sup> Implementing CGA into practice becomes the international focus along with researching the outstanding questions. Not delivering the correct form of hospital care for the elderly comes at a cost. Most significantly there is a human cost for patients, some of whom may be unnecessarily disabled, cognitively impaired, dependent or inappropriately admitted to residential care.

There is a potential cost for the healthcare organisations in increased lengths of stay that frequently accompany patients who are more dependent or await nursing home care. There is also a significant societal cost required to support additional dependent patients requiring homecare or nursing home placements. This (potentially unnecessary) cost must justify the reorganisation of acute care. Reassuringly, even without societal costs being considered evidence based care appears to be cost effective or possibly less costly than the alternative.<sup>18</sup>

Care for the frail elderly is not simply *a* priority, it is *the* priority for medical care for the beginning of the 21st century. There is much we do not yet know in the care of the frail elderly but in the light of what we do know however, we cannot afford to deliver inadequately resourced, poorly organised or unaccountable care for the frail elderly. The costs for all of us are simply too high.

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