



EDITORIAL

Benefits of specialized specialized care in a specific frailty unit ☆



Beneficios de la atención especializada en una unidad de fragilidad

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Fragility is an age-associated syndrome characterised by a lower functional reserve, leading to greater vulnerability to situations of stress, such as illness and hospitalisation.¹ The relationship between fragility and the need for institutionalisation of patients with greater functional and cognitive impairment during their hospital stay is a well known fact. Apart from this impairment, fragile hospitalized patients have longer hospital stays, a higher rate of readmission and higher intrahospital mortality than those patients who do not suffer from fragility criteria.^{2,3}

These poor results are mainly due to the actual pathology derived from a hospital stay. Among other factors, illness leads to a drop in physical activity, and an increased risk of delirium and malnutrition. However, we should take into account that the hospital environment and its organisation contribute to the loss of the patient's independence, promoting inactivity, forced dependence for basic activities and delirium.^{4–6} Other elements which form part of treatment, such as peripherally inserted central catheters, urinary catheters and polymedication have also been identified as risk factors for increasing dependence.⁴

From all of the above-mentioned factors, it is important to highlight inactivity, for its magnitude in the hospital environment and its relevance in increasing adverse events in elderly patients. Brown et al. analysed the activity of a group of patients over 65 years of age during hospitalisation, obtaining surprising results: the patients stayed in bed for 20 of the 24h in the day and the mean time dedicated to ambulation was only 43 min a day.⁷

At present there is sufficient evidence to endorse that physical exercise is an essential basis relied upon to improve the outcome on elderly patient discharge and particularly in fragile elderly people.^{8,9} Recently a Spanish team assessed the effect of a physical exercise programme in hospitalized elderly patients in the Geriatric Service. They concluded that training based on exercises of moderate intensity resistance, balance and ambulation was able to reverse the functional impairment associated with hospital stay (measured as a loss of score on the Barthel scale and the Short Physical Performance Battery).⁹

On the strength of this data, we decided to adapt a hospital unit in our centre to the requirements of the elderly with fragility criteria, so as to reduce functional impairment on discharge. To do so, we stopped using a traditional model of care focused on the illness and started to use a model which attaches higher importance to the patient and how they are able to function, where nurses and nursing auxiliary staff were of particular relevance.

The central measurement upon which care is based in this unit is physical activity. The patients are moved from bed to chair early on, once initial clinical stability has been

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established and they are constantly encouraged to walk. To do this, technical aids are available (walkers, portable oxygen therapy...), as well as physical aid from staff and instructions to family members to get them moving. Furthermore, self-care is encouraged, incentivising the patient to carry out the basic activities they would do at home, including bathing and daily hygiene. As a complement to the increase in physical activity, the patients go to occupational therapy, which mainly consists of cognitive stimulation. Finally, in order to prevent delirium and encourage appropriate rest at night, medication administration times, measuring vital signs and analytical extractions are completed during daylight hours, adapted to meal times.

With regard to medical attention, standard management of the pathology leading to admission is executed, with special attention paid to geriatric syndromes such as malnutrition or delirium and stepping up the care of details such as early removal of devices (urinary catheters, serum therapy and administration routes).

With these measures that almost exclusively entail organisational and cultural changes to staff, we obtained satisfactory results. The patients in the unit had a lower mean stay and lower mortality than those with similar characteristics who were staying in a standard ward of internal medicine and geriatrics in our hospital. Regarding functionality, the number of patients who were unable to walk when discharged decreased by almost 20% and the loss of urinary continence dropped by 6%.

It would be interesting if this cultural change in the staff and as a consequence in the hospital care model could be extended and adapted to the different hospital units, such as intensive care, where the prevalence of fragile patients is 30%.¹⁰

Fostering and encouraging measures that prevent the functional impairment associated with hospital stay and especially in the fragile elderly patient due to their increased vulnerability but also in every patient cared for in our centres should become a priority for all health professionals. In doing so, we will contribute to improving the patients' quality of life and reduce emotional and financial costs so important to society.

Conflict of interests

The authors have no conflict of interests to declare.

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