

## EDITORIALS

# Unnecessary ward moves

### Bad for patients: bad for healthcare systems

NHS hospital services face increasing pressure on bed availability as hospital bed numbers contract and emergency admissions rise. Cold weather and norovirus outbreaks add to the strain on a system with no slack. One consequence of this pressure is the ‘boarding’ of patients out of their own base specialty ward to other wards to accommodate influxes of new patients. A recent survey of members by the Royal College of Physicians of Edinburgh suggests that boarding no longer occurs simply during ‘winter pressures’ but is a year-round occurrence [1]. The perception that boarded patients receive poorer quality of care is evident from a separate small survey of medical staff in which 92% of doctors would refuse to have a relative of theirs boarded out [2]. In a welcome joint initiative, the Royal College and the Scottish Government have agreed to review the number and specialty type of beds for acute care, ensure that there are sufficient medical consultants and nurses and encourage daily consultant patient reviews.

The majority of patients being boarded is frail, elderly and cognitively impaired because most patients admitted acutely to hospital have these characteristics, and because such patients are likely to stay in hospital long enough to fall victim to boarding. The sole justification for moving an older patient from one hospital ward setting to another is if that move will be to their overall clinical benefit. Yet we know that changes of environment are a risk factor for both falls and delirium in older, frail patients; problems that are associated with risk of serious injury and increased death rates [3]. Boarding patients off dedicated Medicine for the Elderly units also deprives them of receiving the evidence-based standard of care—Comprehensive Geriatric Assessment (CGA)—a method of care which reduces future hospital admissions and the requirement for future institutional care. Systematic reviews show resoundingly that successful CGA delivery needs to take place in a dedicated Medicine for the Elderly unit with a dedicated multi-disciplinary team [4]. All other models of peripatetic care by Medicine for the Elderly teams to older patients on non-specialist wards do not improve outcomes for older people—in fact the outcomes are identical to those which a team of non-specialist physicians would achieve.

Boarding is sometimes viewed as a necessary evil—at least compared with the alternative of having no bed in which to admit patients from the overflowing acute admissions unit. Yet at a systems level, boarding appears to be a false economy—every ward move increases the length of stay [5, 6], thus exacerbating the very problem that boarding

attempts to circumvent. Worse still, frequent moves around a hospital are likely to increase the risk of infection transmission, a factor Trusts have been advised to incorporate into bed management policies [7].

At a time when the health service faces unprecedented financial challenges, cost neutral solutions to bed pressures appear elusive. Reducing reliance on the acute hospital sector should not be achieved at the expense of quality of care, and admission avoidance schemes are proliferating despite limited evidence of their effectiveness [8]. Evidence is still lacking that the care of older patients outwith acute hospitals is as safe and as effective as hospital care, notwithstanding any possible gains in value for money. Given their multimorbidity and the complexity of presentation, older people have a greater requirement for access to diagnostic investigations, a point which has depressingly eluded some key policy-makers [9].

How then to cut this Gordian knot? Firstly, older people require access to acute hospital care and the rapid diagnostics available in hospital—admission avoidance risks prejudicing good care and proper assessment of older people. Secondly, both health and social care systems need to reconfigure to allow older people to exit hospital much more rapidly than at present. Thirdly, we urgently need high quality evidence on which system alterations facilitate rapid discharge and care outside hospital without compromising the health, function and quality of life of frail older people. And finally, while we await the evidence we need to guide safe alternatives to the current system, sufficient beds and specialist staff must be available to care for older people in hospital, without the risks associated with ward moves. This is going to cost money in the short term. As with all significant risks in healthcare, healthcare organisations need to fully and honestly inform older patients and their families about the risks associated with such moves. As the NHS begins a painful process of rehabilitation following publication of the Francis Report, perhaps greater ‘candour, openness and transparency’ about unnecessary ward moves would be a good place to start [10].

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### Key points

- Boarding of older patients in hospital is increasingly common.
  - Changes of environment increase the risk of falls and delirium.
  - The adverse associations of unnecessary ward moves should be shared with patients and families.
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# Multidose drug dispensing and optimising drug use in older people

Medications for older people are increasingly dispensed in dose administration aids (DAAs). This includes automated or multidose drug dispensing (MDD)—machine-dispensed disposable sachets in which medications are packaged according to the intended time of administration. MDD is already common in Northern Europe, while blister packs, dosettes and other forms of DAAs are widely used elsewhere. In this issue, Kwint *et al.* report that community-dwelling recipients of MDD in the Netherlands have better medication adherence but poorer medication knowledge compared with age- and sex-matched recipients of manual medication dispensing [1].

This research has both clinical and policy implications. Provision of DAAs is now mandated in specific settings in countries including Australia, Denmark and the Netherlands. These settings include when nurses or aged-care workers administer medications to patients considered at high risk of adverse events, including those with cognitive and functional impairment. The rapid uptake of DAAs is largely based on assumptions of enhanced safety, improved medication adherence, reduced cost and time efficiency. However, published evidence to support these assumptions remains limited and inconsistent [2, 3].

Previous research on MDD highlights both advantages and areas for improvement. Norwegian data suggest that implementation of MDD is associated with fewer

discrepancies in medication histories and improved inter-professional communication compared with manual medication dispensing [4, 5]. Conversely, large cross-sectional studies conducted using Swedish healthcare registers reveal that recipients of MDD are more likely to be prescribed potentially inappropriate medications, such as anticholinergics and long-acting benzodiazepines [6, 7]. A Danish study reported that recipients of MDD were less likely than those receiving manually dispensed medications to request a review of their medication regimen [3]. This may result in inappropriate or suboptimal prescribing being perpetuated, or medications being continued beyond their intended duration. MDD has been associated with fewer medication regimen changes in the 6 months following hospital discharge than manual dispensing [8]. Furthermore, packing quality and accuracy should not be assumed. An audit of sachets supplied to Australian aged-care facilities identified incidents (discrepancy between medication chart and sachet contents, unsuitable repackaging, damaged medications, or inappropriately altered medications) in 14.5% of sachets [9]. In Sweden, patients who used one MDD system had a 5.9-fold higher risk of medication errors (defined as discrepancies in the medication reconciliation process) than those who did not use this medication dispensing system [10].

As in the present study, most research on MDD and potentially inappropriate medication use has been cross-