Clinical & Scientific letters

Letters not directly related to articles published in *Clinical Medicine* and presenting unpublished original data should be submitted for publication in this section. Clinical and scientific letters should not exceed 500 words and may include one table and up to five references.

Experience of a consultant-led service to improve the safety of insertion of chest drains

In response to the National Patient Safety Agency alert on the safety of insertion of intercostal chest drains (ICDs) in 2008, a pilot of a consultant respiratory physician-led service was run to offer advice, training and supervision for ICD insertion during normal working hours in a district general hospital (Milton Keynes) providing acute medical services to a population of over 264,000 over a five-month period starting on 17 November 2008. The issue of inadequate supervision was addressed by:

- trying to reduce unnecessary out-of-hours insertion of chest drains through making casualty and emergency medicine on-call doctors ask themselves the question 'Does it need to be done as an emergency or can it wait?'
- providing direct supervision to chest drains inserted during normal working hours either by a consultant or by a registrar well-experienced in the procedure and personally signed off as competent by the consultant.

Direct teaching and reminders through computer screen savers were used. Every chest drain inserted out of hours for any indication was reported to one of the three respiratory consultants and all out-of-hours procedures were reviewed by them. Virtually all patients with ICDs were transferred to one of the two respiratory wards (except one patient with a traumatic haemothorax who was transferred directly from the acute medical unit to the care of thoracic surgery at a different hospital).

Over the five-month period, 52 unique patients had undergone ICD insertions. Out of these 18 (34.62%) had pneumothorax and 34 (65.38%) had pleural effusions. Twenty-five (48.07%) of the ICD insertions were performed in respiratory wards, 10 on the medical admission ward (19.23%), and nine (17.30%) in the accident and emergency (A&E) department. Data on exact geographical location within the hospital where ICDs were inserted were not available in eight cases (15.4%) but they did all take place out of hours and were either in the A&E department or the medical admissions ward. Out of the 34 patients with pleural effusions, 31 (91.17%) had radiological imaging to confirm the diagnosis prior to ICD insertion. Three of the 34 patients (8.82%) who had ICD without prior radiological imaging were done in suspected empyema in the emergency admission department. Two ICD insertions performed for symptomatic pneumothorax were complicated by infection of the pleural space with *Staphylococcus aureus*. No other major complications occurred in the remaining 50 patients. Initial ICD was displaced in eight patients needing further ICD insertions (15.38%).

This experience demonstrates that a consultant-led ICD insertion service is feasible in an acute hospital and that it improves patient safety. It can reduce unnecessary out-of-hours insertion of chest drains by less experienced trainees and can improve their training by more senior support. Appropriate job planning is needed to systematically include pleural procedure sessions for respiratory consultants to provide the necessary support to hospital-wide ICD insertions in order to improve the quality and the safety of the procedure.

RAHUL MUKHERJEE
Consultant physician
Department of Respiratory Medicine and Physiology
Birmingham Heartlands Hospital

AJIKUMAR KAVIDASAN
Consultant physician
Department of Respiratory Medicine
Milton Keynes Hospital

MILAN BHATTACHARYA
Consultant physician
Department of Respiratory Medicine
Milton Keynes Hospital

How effective are acute geriatric wards at admitting geriatric patients?

The role of the acute geriatric unit is to ensure prompt access to comprehensive geriatric care for which there is an evidence base.[1] Systems to ensure that appropriate patients are admitted vary from using age as a proxy for appropriateness to selecting patients using specific characteristics suggesting need for geriatric care.[2,3] To assess the effectiveness of access to geriatric care of appropriate patients, an analysis was made of how many hospital bed days in general medicine and geriatric medicine were used by acutely admitted patients with an International Statistical Classification of Diseases (ICD-10) code that would unambiguously signify the need for geriatric care, R54 'Senility'. The use of this code varies from hospital to hospital. In some, it is attached to all complex elderly patients to show their nature and attract extra funding if appropriate to the tariff. In others, it is used sparely when there is no obvious diagnosis. However it is used, it is extremely unlikely that a patient with this coding would not have needs appropriately met by a geriatric service.

Hospital episode statistics (HES) were obtained from Northgate Information Solutions Limited, which is responsible, on behalf of the NHS, for this data. Data were obtained for code R54 episodes in general medicine and geriatric medicine wards throughout England. The available data were for the number of patient admissions in any one year to the particular departments and the average length of stay. Hospital bed days were calculated by multiplying the number of episodes by average length of stay. The data available were for episodes not spells, that is to say that

Table 1. Hospital bed days occupied by patients with diagnosis R54 'senility' in general (internal) medicine (GIM) and geriatric (GER) wards by year and age. Percentages show proportion of time these patients occupied geriatric beds.

Age	65–74		75–84		85+	
Year	GIM	GER (%)	GIM	GER	GIM	GER
2003/4	12,520	5,103 (29)	63,740	59,015 (48)	67,473	71,652 (63)
2004/5	10,035	7,595 (43)	68,134	53,592 (44)	64,828	64,512 (50)
2005/6	12,359	6,440 (34)	67,680	54,538 (45)	74,271	70,265 (49)
2006/7	10,127	5,624 (36)	58,608	54,327(48)	70,722	69,195 (49)

patients during one admission (or spell) may have been admitted under general medicine and transferred to geriatric medicine, and so counted as two episodes.

Table 1 shows that patients aged 65 and over with a diagnosis R54 'senility' spent the majority of their time on general medicine wards. In three out of the four years, even patients aged 85 and over with this diagnosis were for at least half of the time looked after on general wards. One wonders what their clinical management in those wards involved. Over the period studied, it was common practice for acute hospital patients to be admitted under general medicine for one or two days and then transferred to an appropriate specialty ward. The bed day data show that patients spent much longer on general medicine wards than would be accounted for by such a model of care. Virtually every acute hospital in England has an acute geriatric ward. Systems need to be improved to allow accessibility of acute geriatric care for appropriate patients. This may involve more beds and staff or more efficient use of current beds and staff including transfer of wards from general medicine to geriatric medicine.[4]

KALMAN KAFETZ
Consultant geriatrician, London

References

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