end-of-life care and 85% achieved this preference. Two per cent of patients identified that they wanted to be admitted to secondary care and no preference was identified in the remainder. During the course of their illness, 55 patients (16%) changed their expressed preference. Further information concerning patients who were admitted for end-of-life care and did not achieve their expressed preferences is outlined in Table 1. Seven per cent of deaths were from patients referred for non-malignant disease; 15 out of 23 of these achieved their preferences for end-of-life care.

Discussion

The proportion of patients achieving their preferences for home and inpatient hospice with this community service compares favourably with those results reported nationally and in other studies.[1,2] Despite the often unpredictable time course[5] for patients with non malignant disease the majority of these patients were able to achieve their preferences for end-of-life care.

Review of information collected upon a patient's death enabled the service to present basic information to their commissioners for discussion. The breakdown of information by primary care team and cause of admission enabled the service to consider targets for future areas of education and activity to facilitate more individuals achieving their preferences for end-of-life care. The number of patients who die at home could potentially be increased if the events which triggered acute admissions are considered as starting points to change health professional behaviour and target social care.

Achieving preferences for end-of-life care are not events which occur in isolation in the community. It involves the primary care team, out of hour's service, local palliative care service and communication with secondary care specialists. Success is a reflection of healthy community services, and not a marker of quality for community teams.

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Table 1. Triggers for admission in the patients admitted for end of life care who did not achieve their expressed preferences. Number of events in brackets.

Location patient was admitted	Trigger for admission
Hospital	New complaint identified by GP (hospice staff consulted in two of these admissions) (18)
	Exacerbation of existing symptoms (10)
	Fall (2)
	Complication of home chemotherapy (1)
	Unknown (4)
	Blocked catheter, loss of nasogastric tube, blocked stent (3)
Nursing home	Increased social support needed (5)
Inpatient hospice	Uncontrolled symptoms (vomiting, haemorrhage) (4)
	Perceived lack of social care and support (including lack of sitters) (14)

Clothing maketh the man

Rehabilitation can be defined as 'the reduction of functional deficits without necessarily reversing the underlying biology of the disease'.[1] Although often perceived as 'basic', effective rehabilitation of older patients is a complex and individualised process that requires consideration of many factors including medical illnesses, psychosocial status, environment and possibly clothing.[2]

For most, dressing is a daily routine that, as well as affording warmth and protection, reflects independence, personality and status. Modified and adapted clothing (eg specialist footwear) may assist in the rehabilitation of specific physical disabilities, but what of the role of everyday clothing in the 'average' older inpatient?

Despite clothing's obvious contribution to 'normality', venture onto any adult ward and chances are that a majority of patients will be attired in pyjamas or gowns. This is more likely to be the case the older the patient. What is the effect of this on older patients? How can we 'buck the trend', thus allowing patients to become individuals with hopes, aspirations and goals?

Current practice is that most people are changed into a hospital gown on arrival in secondary care, a powerful reminder to all that the individual is now a patient. Seemingly a minor point, this 'small' step is the first of many that may lead to the loss of normal functioning and independence. Although possibly acceptable in those who are acutely unwell, failure to actively challenge or reverse this process can be significantly detrimental to the process of rehabilitation, and at worst be considered as a form of neglect or abuse.[3] Negative publicity aside, increasing recognition of the needs of frail elderly patients led to the development and publication of the National Service Framework for older people.[4] Standard 2.8 of the NSF suggests that enhanced person-centred care should allow patients to wear their own clothes if they choose.

Little formal evidence exists looking at the area of day clothing in people in hospital, with searches of PUBMED, Medline and EMBASE yielding virtually no papers or research looking at the benefits of day clothing in healthcare settings. Factors that probably contribute towards patients not being dressed appropriately may include perceived acute illness, lack of suitable clothing, limited staffing to support dressing and, in confused patients, a belief that night attire will prevent patients absconding from ward areas. The last of these reasons is not supported by evidence from literature reviews.[5] There is a belief that patients who abscond are easier to identify if they are wearing certain clothing.

Searches of relevant databases (eg CINAHL) illustrate that nursing and other non-medical specialties fair no better concerning research, and evidence in this area is limited. One recent study of psychiatric inpatients did, however, highlight a disparity between beliefs of nurses and patients, particularly when the latter were being detained under the Mental Health Act.[6] The same research did, however, highlight the importance of day clothing in patients' quest for 'normality'.

Effective care of older people is often complex and challenging, but frequently comes down to addressing 'straightforward' issues in an attempt to maximise patients' functional abilities. Above and beyond medicine, all who care for older patients (regardless of clinical specialty) have a role in promoting dignity, independence and choice for patients. In a time of high-tech solutions, simple improvements in overall clinical care can be overlooked. Wearing day clothes is not supported by trials or meta-analyses, and yet this does not devalue the process, and allows patients to become people once more. Patients are people and clothes maketh the man or woman.

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Can the multidisciplinary input of an asthma nurse specialist and respiratory physician improve the discharge management of acute asthma admissions?

Suboptimal discharge management of asthmatic patients increases risk of early re-hospitalisation,[1,2] creating potentially avoidable burden for patients and medical services. British Thoracic Society (BTS) guidelines propose optimal management standards.[3] A 2007 audit in our hospital against those guidelines found poor discharge related asthma management. Consequently, in January 2008 an asthma nurse specialist (ANS) was introduced in parallel with respiratory physician (RP)-led management of acute respiratory admissions.

Aims

Firstly we evaluated the impact of introducing both ANS and RP on discharge management, length of in-patient stay and re-hospitalisation rates within 28 days. Secondly we examined whether review by an ANS made a difference to the above parameters.

Methods

Using case notes, data was collected for asthmatic patients discharged in the first

Table 1. Discharge related outcome measures compared between 2007 and 2009.

	2007 (N = 43)	2009 (N = 45)	P value (2009 ν 2007)
Stable 24 hours prior to discharge	51%	89%	0.01
Nebulised bronchodilators stopped 24 hours prior to discharge	42%	70%	0.03
Peak flow rate recorded > 75 %	35%	53%	0.09
Smoking advice given	25%	71%	0.01
Peak flow meter given	5%	4 %	NS
Peak flow diary given	2%	4 %	NS
Asthma action plan given	0%	0%	-
Community follow-up within two days	19%	18%	NS
Specialist outpatient review with four weeks	44%	69%	0.02
Re-hospitalisation within 28 days	14%	13%	NS

P value calculated using Z-test; NS = not significant.