like to support this article based on our experience in admission to Intermediate Care (referrals from emergency department [ED] or directly from the community by a coordinated multidisciplinary team managed by a geriatrician) in a comparable facility situated in the same geographic area.

Because of the high use of ED by vulnerable older patients and associated risks of adverse events\textsuperscript{2–4} of ED admission in this population, in our country several groups have been developing intermediate care hospital research for subacute older patients, as an alternative to acute hospitalization, suggested by Catalan Health Department programs.\textsuperscript{5,6} Our unit has focused on avoiding conventional hospitalization and reducing ED use, managing acute phase of reactivated chronic diseases in old patients in need of specific low-intensity geriatric management, not focused on rehabilitation. From 2009 December to 2012 July, 201 patients were admitted to our ICU. Main characteristics of the sample were comparable to the work of Colprim et al\textsuperscript{1}: age 84.2 (10.2) years; Barthel Index 40 (35.9); cognitive impairment in 55%; referrals from ED in 87%; and directly from the community in 13%. Main admission acute conditions were respiratory infection (57%), heart failure (18%), urinary infection (10%), and other (15%). Length of stay in our unit was 10.4 (5.6) days. Readmission rate for the same failure (18%), urinary infection (10%), and other (15%). Length of stay within 30 days following discharge was 5.5%. The rate of health care resources use within 30 days of discharge was 7.8%. Main data were consistent with the standards established by expert consensus of local health department for such units.\textsuperscript{7}

In our experience, we agree with the authors that ICUs seem an opportunity as an alternative to conventional hospitalization of selected older patients with reactivated chronic disease. This resource could potentially avoid a negative effect of conventional hospitalization and provide care focused on needs of vulnerable patients.

References


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information about each person to light. All staff members in nursing homes likely need ongoing assistance, reminders, and encouragement to keep the true intent of the RAI process in focus — using the information to provide individualized care.

Moving forward, studies need to be developed to observe and report what is currently happening in facilities nationwide. Are people using MDS 3.0 information to provide individualized care? A solid foundation has been prepared by Dr. Saliba and colleagues with their work on MDS 3.0. Now we need to be aware of what that "elephant" is doing in our long term care facilities. We need to be encouraging and helping staff interview the residents as outlined in MDS 3.0 and help them design individualized care processes. Operationalized as intended, the revised MDS can help improve care practices in our nation's nursing homes.

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Marco 360

To the Editor:
There was nothing unexpected about his decline over the last 3 years of his life. Arthritis had worn him down so that the only comfortable place for him was in a swimming pool, where despite immobility on land, he could swim for a mile with his mask, fins, and snorkel. He loved the water. He loved anything related to the water especially if it had salt in it. I loved hearing about his days of scuba diving: discovering ship wrecks with his diving buddies in the New York Bight in the early 1960s; spear fishing off of the jetties in the Rockaways; the picture of the 19-pound lobster that he bagged; and of course, the first to get to Grand Cayman, Bonaire, and the British Virgin Islands when people first just started doing those sorts of trips to those kind of places.

When he finally could no longer get himself into a pool, the rest of the story unfolded like a well-worn map. We take care of these patients. Immobility gradually and predictably worsened and then there was the fateful day of stupidity. Bringing the garbage to the curb, he was not quite able to juggle the pail and his walker simultaneously. The hip fracture, he swore, occurred on the second bounce. Only he really cared about such details his whole life. Only he could be so sarcastic when the situation was so grave.

He was hospitalized for the repair of the hip; then sent to the rehabilitation hospital where he was deemed a “failure”; then to the skilled nursing facility where he was treated with respect and encouragement; then home without a plan because he said that “he didn’t need one”; then back to the skilled unit because he really did need a plan; then home with somewhat of a plan; then finally back to the skilled nursing facility where he could be assisted appropriately without killing his wife of 59 years along with himself.

We educate ourselves about palliative care in the skilled nursing facility and most of the time our facilities get it right, but sometimes they do not. If Marco did not want to participate in therapy it was not because he was being noncompliant, it was because he felt very poorly. If Marco was yelling in the dining room, it was because the nursing assistant did not realize that Henry had his favorite table and could not speak to fend for himself. If Marco did not want to take a medication, it was not because he was being difficult but because he did not want to pee all over himself. If Marco got angry with the nurse doing the wound care for him, it was probably because she was not listening to him on behalf of his own comfort: “There’s a patient attached to the other of that wound, ya know!,” he would admonish. He would tell me that the staff would wake him to take his vital signs; when that happened, he would point out that he is dying and explained in great detail, why they should not bother with such things. I spent a great deal of time with the staff trying to coach them about his point of view, but Marco did most of the real education.

The last 6 weeks of his life were easy to predict. It started with that palliative care conversation that you have with patients about empowerment. When he said that he had no choices, I made it clear to him that indeed he did. If he did not want to take his medications, no one would force him; if he did not want to use his breathing machine (CPAP) at night that would be his decision; if he did not want to eat or to have wound care any longer, he just needed to say so. With the silence that followed that dialogue, the unmistakable clockwork of gears were set in motion.

See the last 6 weeks of life for Marco started the day they took away his scooter, his only means of freedom. It was the final insult to his independence. When I was notified of the removal, I assumed that he had hurt another resident at the facility [he had not], that he had injured an employee [only very minor but not the reason for confiscation], or that he injured himself severely [injury yes; severe no]. No, the nurse reassured me, it was none of those things. He had simply fallen asleep at the wheel; and as he slumbered, his hand pushed the control for the scooter slightly forward and a little to the left: she said that he was doing 360s in front of the nursing station with his eyes fully wide shut.

I wish that I had that video of Marco doing 360s. It would have been a wonderful memory of my father and he would have been able to laugh hysterically from heaven with me every time I played it back.

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