of informal care, but also the ability of the informal caregiver to cope with this burden. In addition, it is an easy-to-use instrument, as it is a single question combined with intuitive interpretation. Given the current and previous findings, this instrument seems promising for use in research setting. For future research, it would be worthwhile to consider more subpopulations of informal caregivers and to assess other aspects of this instrument’s psychometric properties. If current findings are confirmed, Perseverance time could additionally be a useful screening instrument in clinical practice, for example for early detection of crises and timely intervention.

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Iatrogenic Nosocomial Disability Diagnosis and Prevention

To the Editor:

The traditional model of hospitalized care has changed dramatically over the past century, from addressing acute self-limited pathologies toward addressing much more complex patient profiles that are characterized by frailty, disability, multimorbidity, and polypharmacy in older and chronic patients. These changes have marked the appearance of geriatric syndromes that modify patient life trajectories. Despite these changes in patient profiles, the hospital model remains stuck in the previous century model in such a way that hospitalization can perfectly manage acute diseases, such as pneumonia or cardiac failure, although it can also contribute to several risks that are clearly avoidable.

Hospitalization is a sentinel event and a leading cause of long-term disability, defined as disability that lasts for more than 6 months and the incidence of new disability associated with hospitalization ranges from 5% to 60%.5,6 Loss of function in activities of daily living (ADL) tasks following hospitalization increases the risk for institutionalization, regardless of predmission ADL impairment.5,6 One of the first studies to address this issue was the Hospital Outcomes Project for the Elderly (HOPE),7 and it showed that at discharge, 31% of the patients had lost the ability to perform at least 1 ADL and that 40% were no longer able to carry out 3 or more ADLs. At 3 months, 19% of the surviving patients had a decline in ADLs, and 40% had a decline in Instrumental ADLs. Additionally, the development of new disabilities during hospitalization is associated with higher mortality,8 health care utilization,9 and cognitive impairment, depressive symptoms, or quality of life.10 This deficiency in the clinical outcomes arises from the acute diseases themselves but is also related to patient management during the hospital stay, despite great sensitivity to this issue.11,12

It is in this context that several devastating concepts appear, such as iatrogenic and nosocomial disability. Iatrogenic adverse events are usually defined as any unintended injury, harm, or complication that results more from health care management rather than the underlying disease process.13 The National Conference on Health has defined iatrogenic conditions as “any adverse condition of medical origin in the broad sense, taking into account the state of the art at a given time, and which in no way implies error, fault or negligence.” Disability refers to a “limitation of function (usually of activities of daily living) or restriction of activities” (World Health Organization ICF 2001).14 A multidisciplinary working group of health professionals addressed these issues previously in 2011, and the task force defined iatrogenic disability as functional decline that results from 1 or several iatrogenic adverse events occurring during hospitalization, involving 3 components that interact and have a cumulative effect: (1) the patient’s preexisting frailty, (2) the severity of the disorder that led to the patient’s admission, and (3) the hospital structure and the process of care.15 However, since the introduction of this term, a search in PubMed for related articles found very few articles.16

The concept of iatrogenic adverse events in a hospital is mostly linked to nosocomial infections or other procedures, but it has not been linked to the notion of disability, although the prevalence of disability can be even worse for short- and long-term outcomes. Many older patients admitted to hospital are forced to bed and
Poor health, disability, and dependency are not inevitable consequences of aging. Ideally, evidence-based cognitive and functional interventions should be a routine aspect of comprehensive geriatric interventions. Physical activity as an intervention is one of the most important components in improving the functional capacity of hospitalized patients. Simple measures, such as increasing the time spent walking, have the potential to significantly decrease the incidence of chronic disease. In the issue of nosocomial disability, it is essential to develop a multicomponent exercise program based on the current evidence, which should include aspects of strength, power, and balance. Multicomponent exercise programs, and particularly those including strength training, are the most effective interventions to delay disability and other adverse events. Indeed, it has been recently reported that multicomponent exercise training, including explosive resistance training, improved neuromuscular function and functional outcomes in frail nonagenarians after long-term physical restraint, as well as in frail patients with several chronic diseases. Furthermore, physical exercise administration is relatively free of potential unwanted side effects caused by common medications that are prescribed in this type of patient. Several previous consensuses have established various concepts, such as posthospital syndrome, but we must focus our attention on the whole period, not just the recovery period (secondary prevention). We should mainly focus on the period in which a primary prevention intervention can have a greater impact because the hospitalization period affects patients at high risk of iatrogenic nosocomial disability. Adding the term “nosocomial” not only allows the inclusion of the hospitalization period but also the integration and unification of the concept of iatrogenic disability when discussing research in this area. Furthermore, iatrogenic disability can occur at home, in nursing homes, and in rehabilitation units, so linking the term nosocomial to hospital-acquired iatrogenic disability focuses attention on the hospital period and the proper characteristics of this type of disability. Although other definitions have previously been used, a search with those terms related to iatrogenic disability or posthospital discharge syndrome returns very few related articles. We consider it vital to relaunch the definition of the comprehensive concept of iatrogenic nosocomial disability to target this vulnerable population and address preventable hospital-acquired syndromes.

What does it matter if we offer the best hospital treatment or the best technology if the disability resulting from this treatment or technology leads to an overwhelming hospitalization-acquired long-term disability?

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