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Book of Abstracts

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PLATFORM PRESENTATION: TECH IN GERIATRIC MEDICINE: WEDS 10.30-10.45

2886. Scientific Presentation - Health Service Research

Video-based Patient Records for Supporting Care Delivery for Older Adults with Frailty: the Isla for Frailty Feasibility Study

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Introduction: Written documentation and verbal handovers can be ineffective at communicating the specifics of frail, older patients' complex functional abilities and support needs. Video-recordings of individual patients may help to convey a patient's condition in a more nuanced, objective way, potentially improving safety at care transitions. The Isla platform interfaces with electronic health record systems, allowing care providers to capture video-recordings during patient care. We evaluated the acceptability, feasibility, and potential effectiveness of video-based patient records (the Isla platform) for supporting the care of older frail inpatients within the acute hospital setting and at care transitions.

Method: Over a three-month pilot period, a non-randomised, mixed-methods feasibility study of video-based patient records (alongside usual care) was conducted within three elderly medicine wards of a large acute hospital in England. Patient and public involvement and engagement (PPIE) was central to study design and implementation. Participant enrolment figures; semi-structured interview data; and video capture and view metrics were examined within an embedded process evaluation, appraising intervention acceptability amongst patients, carers, and ward staff; barriers and facilitators to intervention implementation; and perceived intervention impacts.

Results: The study enrolled 57 ward staff and 29 patients (56.9%); one patient withdrew. Enrolment figures and early interview analyses indicate apparent acceptability of video-based patient records to patients and carers. Intervention barriers (e.g. patient pain), facilitators (e.g. staff-patient rapport) and potential intervention impacts (e.g. improved person-centred care, team communication) were identified. Modal use-cases for video-recordings were to document patients' transfers (n=16), mobility (n=13), and eating/drinking supports (n=3); however, view metrics suggested limited engagement with videos once captured.

Conclusion(s): Preliminary findings indicate the acceptability and feasibility of video-based patient records, although several implementation considerations warrant address. Perceived intervention impacts (e.g. improved person-centred care) were promising; although greater engagement with videos is a probable precondition to demonstrating efficacy in future research.

PLATFORM PRESENTATION: TECH IN GERIATRIC MEDICINE: WEDS 10.45-11.00

2793. Scientific Presentation - Health Service Research

Virtual Wards for People with Frailty – Evidence to Think Anew?

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Introduction: Increasing prevalence of people living with frailty is a key challenge to healthcare providers. One solution may be virtual wards (VWs). Our research sought to: examine different frailty VW models; and determine how, why and under what circumstances VWs may work effectively.

During our early research, NHS England (NHSE) started roll-out of short-term VWs intended to treat acute patients with frailty crises at home instead of hospital. We expected our work to inform NHSE policy, especially how to 'do' VWs better.

Methods: We conducted a rapid realist review of frailty VWs, searching published and grey literature for evidence on multidisciplinary VWs based in the UK, using a literature-based definition of VWs. Information on how and why VWs might 'work' was extracted and synthesised iteratively into context-mechanism-outcome configurations (CMOCs). Throughout we engaged closely with clinicians and patient/public contributors. The iterative nature of the realist review led to emerging understanding.

Results: From 28 documents, we identified two VW models: longer-term, proactive care wards admitting patients at high risk of a frailty crisis; and short-term reactive care wards for people experiencing a frailty crisis. Using evidence from both models, we generated 12 CMOCs, under three themes.

First, building blocks for effective VW operation (e.g. common standards agreements, information sharing, a multidisciplinary team planning patient care remotely). Second, how the VW delivers the frailty pathway (e.g. patient selection, assessment, proactive care). Third, Patient/Caregiver empowerment.

Mechanisms included motivating professionals (e.g. a 'team-of-teams'); buy-in; building relationships: professionals, patients and caregivers.

VWs should be set within frailty management guidance, and a whole-system approach to care is needed. For sustainability of VWs, proactive care for people at high risk of a frailty crisis should be provided.

Conclusions: This review has implications for optimal implementation and sustainability of frailty VWs, through proactive care and a whole system approach.

PLATFORM PRESENTATION: WELL-BEING/MORAL INJURY: WEDS 12.30-12.45

2747. Scientific Presentation - Education / Training

The Impact of Specialised Geriatric 5M Education on Mobilisation of Older Adult Patients in Acute Care in five Canadian Hospitals

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Background and Objectives: Research suggests that specialised education for nurses decreases frailty and improves functionality in hospitalised older adults. This study explored the impact of a specialised geriatric education program on mobilisation rates for older adult patients in acute care in 5 hospitals.

Methods: A mixed methods approach with pre- and post- intervention questionnaires (Geriatric In-hospital Nursing Care Questionnaire (Ger-INCQ) and study specific knowledge assessment) was used to explore facilitators and challenges of caring for older adults, the knowledge base and experiences of staff, and the impact of providing specialised education. Acute care nursing staff participated in a 4-hour education intervention focusing on the Geriatric 5Ms (Mind, Mobility, Medications, Multi-complexity and Matters Most) and frailty prevention. Patient level data was collected through mobility audits (I-MOVE) and observation of shift handover communication. Semi-structured interviews with staff were completed to explore the results of the questionnaires.

Results: Registered nurses, licensed practical nurses and personal care attendants (N=64, Mean age=36.9, 87% female) who participated in the specialized training did not show significant change in their assessment scores. Patient (N=99, mean age=76.2, 54.5% female) mobilisation did not differ between phases of intervention (p=0.08), nor was there any significant change in reporting mobility at shift handover. Ger-INCQ indicated neutral responsibility for falls incidents and retention of patient mobility, with interviews (n=26) revealing that patients are kept immobilised for safety and workload management.

Conclusion: Staff had positive attitudes toward caring for older adults; however, their understanding and application of geriatric principles were limited and remained unchanged. Interview participants stated their work environment limits their capacity to deliver the best practice care presented in the education sessions. These findings suggest that education alone is unlikely to influence prioritisation of mobility for frail older adults in a strained acute care setting.

PLATFORM PRESENTATION: WELL-BEING/MORAL INJURY: WEDS 12.45-13.00

2795. Scientific Presentation - Big Data

Using the Dynamics of the Frailty Index to Assess Population Health Across Different Countries

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Background: Worldwide population ageing is motivating how to measure the health of ageing populations. One approach is to compare dynamics of frailty, assessed by the cumulative-deficit frailty index, across different populations. We aim to compare the frailty distribution, mortality risk, and change in frailty over time between 18 countries.

Methods: Using data from five harmonised international surveys (HRS, SHARE, ELSA, CHARLS and MHAS) we assessed frailty with a 40-item frailty index (baseline, 2-, 4- and 6-year follow-up), along with mortality status. We constructed separate regression models for participants with the fewest baseline health deficits ("zero-state" – assessing ambient health of the population) and the rest of the population ("non-zero-state"). Using logistic and negative binomial, respectively, we assessed the odds of mortality and the rate of deficit accumulation (i.e. change in frailty index) between countries, adjusted for baseline frailty, age, and sex.

Results: Highest baseline frailty, mortality risk, and the most rapid increases in frailty were observed in Mexico, followed by China. Differences in mortality risk and deficit accumulation were similar regardless of baseline frailty. Lowest mortality risk and the slowest rates of deficit accumulation were observed in Scandinavian countries and in Switzerland. Differences between Central/Southern European countries, USA and UK varied when comparing zero-state with non-zero-state models. For example, mortality rates and deficit accumulation were relatively lower among the healthiest subset of the USA (and to a lesser extent UK) population. However, when modelling those with some degree of baseline frailty, mortality and deficit accumulation in the USA were relatively higher compared to European countries.

Conclusion: Dynamics of the frailty index can provide insights into population-level differences in health across different settings. For some, but not all, countries, findings are sensitive to the degree of frailty present at baseline, which may reflect inequalities in healthcare provision or access.

PLATFORM PRESENTATION: CLINICAL QUALITY SESSION: WEDS 14.40-14.55

2753. Clinical Quality - Patient Centredness

Prioritising Patient Experience: A Multidisciplinary, Quality Improvement Project Using Patient Feedback and Co-design.

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Introduction: There are multiple national drivers promoting person-centred healthcare. In the face of competing pressures, patient experience is often compromised.

Aim: To increase the percentage of service users in our orthogeriatric rehabilitation ward rating experience as more than 6/10 to 90% by June 2024.

Methods: A multidisciplinary project using quality improvement methodology. Patients and carers were involved throughout. Patient, staff and carer interviews shaped improvement themes and change ideas. Broad themes identified:
-Communication
-Provision, and facilitation of, ward activities
-Environment
Several, cost neutral, tests of change were studied: weekly exercise class, mobile library, 'activities trolley', music concerts, volunteer recruitment, improved signposting and coordinating weekly relative update.

Run and SPC charts were used to study impact. Measures used:
-Outcome: Patient and carer satisfaction using 10-point Likert scale (1=poor, 10=excellent) in weekly, random cohort (P-chart). Mapping themes over time.
-Process: Minutes of physiotherapy delivered/week. Number of patients participating in activity other than PT/OT (C-chart). Percentage of relatives updated by MDT/week
-Balancing: Length of Stay (LOS). Readmission within 1-month. Staff Feedback. Inpatient falls.

Results: The % of patients scoring experience >6/10 increased over the project but did not meet 'special cause' criteria. Feedback themes shifted positively.
-The median percentage of relatives receiving a weekly update increased (45% to 78%).
-Participation in activities improved, with special cause variation observed. The amount of physiotherapy delivered each week increased by 3 hours due to exercise classes.
-There was no significant change to falls, readmissions or LOS.
-Staffing, covid outbreaks and workload impacted negatively during the project.

Conclusions: -'Experience' is individually unique and cannot be improved with a unilateral approach.
-Using continuous feedback from patients and carers, we tested multiple interventions across several areas, demonstrating positive changes.
-Patient experience is challenging to measure quantitatively but should not deter improvement work in this area.

PLATFORM PRESENTATION: CLINICAL QUALITY SESSION: WEDS 14.55-15.10

2829. Clinical Quality - Clinical Effectiveness

Improving door to needle times in stroke thrombolysis through simulation-based training in a district general hospital

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Introduction/Background: Teamwork is very important in hospitals where the medical on-call team manage the stroke and thrombolysis alert calls. In addition to technical skills, human factors play a very significant role in meeting a target door-to-needle time.

Aim: To improve door-to-needle time by improving human factors (leadership, understanding and delegation of roles and confidence in participation) and technical factors (quick NIHSS and efficient documentation of vital information on radiology request forms for urgent CT head).

Method: We conducted 6 simulation-based training sessions and de-briefing sessions (role-playing and education around technical and non-technical skills) starting from November 2022. We measured the participants' responses before and after the sessions, with the help of Kirkpatrick's four level training evaluation model. We measured and compared the thrombolysis breakdown data (total of 38 consecutive patients from May 2022 to February 2023) throughout the process. We used statistical process control (SPC) charts to calculate and visually represent median values to demonstrate the changes.

Results: Thrombolysis breakdown data revealed substantial improvement post intervention (November 2022) compared to data from May-October 2022. SPC charts demonstrated significant reduction and step change in median door-to-needle time (83.7 to 52.2 minutes) and CT imaging to reporting time (36.2 min to 19.5 min).

Conclusion: A series of simulation-based training sessions and debriefing sessions for stroke thrombolysis was able to demonstrate statistically significant improvement in door-to-needle time. We will continue the simulation sessions and will assess sustainability of the interventions.

References:

1. Ajmi SC, Advani R, Fjetland L, et al Reducing door-to-needle times in stroke thrombolysis to 13 min through protocol revision and simulation training: a quality improvement project in a Norwegian stroke centre. BMJ Quality & Safety 2019;28:939-948.
2. Chalwin, R.P. and Flabouris, A. (2013), Non-technical skills training for MET. Intern Med J, 43: 962-969. https://doi.org/10.1111/imj.12172

PLATFORM PRESENTATION AND LIGHTNING ROUND: THUR 14.30-14.45

2836. Scientific Presentation - Diabetes

Age differences in efficacy of newer glucose lowering treatments for type 2 diabetes

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Background: Newer glucose-lowering agents for type 2 diabetes (sodium glucose cotransporter 2 inhibitors (SGLT2i), glucagon-like peptide-1 receptor analogues (GLP1ra) and dipeptidyl peptidase-4 inhibitors (DPP4i)) improve hyperglycaemia and SGLT2i and GLP1ra reduce the risk of major adverse cardiovascular events (MACE). It is not clear whether the efficacy of these agents varies by age.

Methods: We searched Medline and Embase, plus clinical trial registries, for randomised controlled trials of SGLT2i, GLP1ra and DPP4i, versus placebo or active comparator, in adults with type 2 diabetes. Outcomes: HbA1c and MACE. Where IPD were available, we modelled age-treatment interactions for each trial. Otherwise, we assessed age distributions along with results from aggregate trial data. IPD and aggregate findings were combined in a Bayesian network meta-analysis to assess whether the efficacy differed by age.

Results: We identified 616 eligible trials (604 reporting HbA1c, 23 reporting MACE) and obtained IPD for 75 trials (6 reporting MACE). Mean age was 59.0 (10.7) years and 64.0 (8.6) in HbA1c and MACE trials, respectively. SGLT2i reduced HbA1c by 0.5-1.0% overall compared to placebo. This reduction versus placebo was attenuated in older participants (change in HbA1c 0.25 percentage-points less for 75-year-olds compared to 45-year-olds). SGLT2i showed greater relative efficacy in MACE risk reduction among older than younger people. This finding was sensitive to the exclusion of one of the IPD MACE trials, however, in all sensitivity analyses, SGLT2i were either as efficacious or more efficacious in older participants. There was no consistent difference in efficacy by age for GLP1ra or DPP4i for HbA1c or MACE.

Conclusion: Newer glucose-lowering drugs are efficacious across age and sex groups. SGLT2i are more cardioprotective in older than younger people despite smaller HbA1c reductions. Age alone should not be a barrier to treatments with proven cardiovascular benefit providing they are well tolerated align with patient priorities.

PLATFORM PRESENTATION: LONELINESS AND SOCIAL DEPRIVATION: FRI 10.30-10.45

2783. Scientific Presentation - Psychiatry and Mental Health

Addressing Depression and Loneliness in Older Adults: Findings from the BASIL+ Randomised Control Trial

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Background: Older adults were more likely to be socially isolated during the COVID-19 pandemic, with increased risk of depression and loneliness. The Behavioural Activation in Social Isolation (BASIL+) trial investigated whether a Behavioural Activation (BA) intervention delivered remotely could mitigate depression and loneliness in at-risk older people during the COVID-19 pandemic.

Methods: We undertook a multicentre randomised controlled trial [ISRCTN63034289] of BA to mitigate depression and loneliness among older adults (65+) with multiple long-term health conditions, including low mood or depression. BA was delivered remotely (telephone or video call) with intervention participants (n=218). Control participants received usual care, with existing COVID wellbeing resources (n=217).

Results: Participants engaged with an average of 5.2 (SD 2.9) of 8 remote BA sessions. Adjusted mean difference (AMD) for depression (Patient Health Questionnaire-9, PHQ-9) at 3 months [primary outcome] was -1.65 (95% CI -2.54 to -0.75, p<0.001). There was an effect for BA on emotional loneliness at 3 months (AMD -0.37, 95% CI -0.68 to -0.06, p=0.02), but not social loneliness (AMD -0.05, 95% CI -0.33 to 0.23, p=0.72). For participants with lower severity depression symptoms (5-9 on the PHQ-9) at baseline, there was an effect AMD PHQ9 1.13 (95% CI –2.26 to 0.01, p=0.051), though this was less pronounced than for those scoring 10 or more at baseline (-2.48, 95% CI -3.81 to 1.16, p=0.0002).

Conclusion: Behavioural activation is an effective and potentially scalable intervention that can reduce symptoms of depression and emotional loneliness in at-risk groups in the short term. The findings of this trial add to the range of strategies to improve the mental health of older adults with multiple long-term conditions. These results can be helpful to policy makers beyond the pandemic in reducing the global burden of depression and addressing the health impacts of loneliness, particularly in at-risk groups.

PLATFORM PRESENTATION: LONELINESS AND SOCIAL DEPRIVATION: FRI 10.45-11.00

2772. Scientific Presentation - Other medical condition

Poor appetite predicts worse health in community dwelling older adults.

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Introduction: Poor appetite affects 15-20% of community dwelling older adults. Studies link poor appetite with frailty and sarcopenia; however, lack of longitudinal evidence exists to inform potential causality. We aimed to determine if poor appetite predicts frailty or sarcopenia-related factors in community dwelling older adults.

Methods: Secondary data analysis on adults aged >60 years recruited from, syncope, fragility fracture and comprehensive geriatric assessment clinics with 2.5 year follow up. Appetite was assessed by Simplified Nutritional Appetite Questionnaire (SNAQ); a score of <14/20 defining poor appetite. Hand grip strength (HGS) was measured using a dynamometer, low HGS was defined by European criteria (<27kg for males and <16kg for females). Frailty was measured using self-report of Fried phenotype.

Results: 86 participants, mean age of 78 years, 62% female. Sixty-two (72%) were followed up, of those 9 had died. Baseline mean SNAQ score was 15.2 (SD 8.1); 14 (16.3%) scored <14. Mean SNAQ score for the 53 participants at 2.5 year follow up was 14.9, 12 (14%) scored <14. Baseline and follow up SNAQ scores correlated moderately (Pearson's r=0.5; P=<.001). Fifteen (28%) individuals had low HGS at follow up, 12 had frailty (22%). Baseline SNAQ score <14 was associated with increased odds of frailty (OR 18.00; 95% CI 2.92-111.00) and low HGS (OR 7.76; 95% CI 1.62-37.30) after 2.5 years. The association of baseline SNAQ <14 with presence of frailty was robust to adjustment for age and comorbidities (OR 13.50; 95% CI 1.14-160.03), while association with low HGS was attenuated (OR 2.29; 95% CI 0.27-19.39).

Conclusion: Poor appetite is predictive of presence of frailty and low HGS after 2.5 years in community dwelling older adults. This suggests poor appetite as causative in the development of poor health outcomes in older people and so a key intervention target to optimise healthy ageing.

PLATFORM PRESENTATION: MOVEMENT DISORDERS: FRI 10.30-10.45

2875. Scientific Presentation - Health Service Research

The association between multiple long-term conditions, person- and disease-related factors and adverse inpatient outcomes

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Introduction: People living with multiple long-term conditions (MLTC) are more likely to experience hospital admission, which is often associated with unintended consequences. Preventing or providing alternatives to admission by predicting adverse admission-related outcomes is important. This study aims to provide an overview of the association between MLTCs and adverse outcomes following hospital admission through a systematic review of systematic reviews.

Method: We searched Medline, Embase, CINAHL, Web of Science and PsycINFO for systematic reviews assessing risk factors/predictors of functional decline (FD), nursing home admission (NHA), or changes in quality of life among adults (≥18 years) experiencing unscheduled acute hospital admission. Eligible reviews had to assess MLTC (LTC counts, indices, or individual LTCs), either alone or with other predictors. Titles/abstracts and full texts were screened in duplicate and candidate predictors were extracted.

Results: 14 systematic reviews assessed predictors of FD (n=8) or NHA (n=6). Reviews focused on studies of general inpatients/mixed presentations (n=8: 6 FD, 2 NHA); hip fracture (n=2: 1 FD, 1 NHA); stroke (n=2: 1 FD, 1 NHA) and cognitive impairment (n=1, NHA) or delirium (n=1, NHA). Assessment of MLTC was heterogenous: comorbidity indices (n=4), counts of LTC (n=2), specific LTC (n=8), and 'comorbidity' without further qualification (n=3). Higher comorbidity indices, higher counts, and a range of specific comorbidities (most notably dementia) were associated with FD and NHA. Reviews assessing MLTC alongside other predictors highlighted a broad range of sociodemographic, functional, social, and admission-related factors that were associated with FD and NHA. In general, reviews did not assess the relative importance of MLTC alongside other predictors.

Conclusion: While MLTC may predict unwanted outcomes following admission their qualification is often inconsistent and their relative importance as predictors, alongside broader factors such as social complexity, is rarely assessed in existing systematic reviews.

PLATFORM PRESENTATION: MOVEMENT DISORDERS: FRI 10.45-11.00

2862. Scientific Presentation - Neurology and Neuroscience

Multimorbidity and Subjective Cognitive Decline: Evidence from the ELSI-Brazil Study

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Introduction: Global population ageing, cognitive impairment, and chronic diseases have increased the demand for elderly healthcare. Multimorbidity (MM), defined as the coexistence of two or more chronic conditions, presents a challenge due to its higher prevalence with age. Subjective cognitive decline (SCD) refers to a perception of decreased cognitive abilities without evidence of impairment on neuropsychological tests. Understanding the relationship between these factors is essential to develop effective management strategies.

Method: This cross-sectional study analysed data from the Brazilian Longitudinal Study of Aging (ELSI-Brazil), involving 2508 participants aged 50 years and older. SCD was defined using criteria from the Subjective Cognitive Decline Initiative Working Group, while Multimorbidity was assessed based on the presence of two or more diseases from a 14-item self-reported health conditions. Robust Poisson regression model estimated adjusted prevalence ratios (PR) for the association between MM and SCD, controlling for potential confounders.

Results: The occurrence of SCD was 27.2 (95%CI: 24.6-29.9). After adjusting for confounders, there was a higher prevalence of SCD among women, in people with less education, and in rural residents. The prevalence of MM was 64.4% (95%CI: 61.1 - 67.6). The occurrence of SCD in the MM group was 31.6 (95%CI: 28.5 - 35) compared to 19.2% (15.9 - 22.9) in the no MM group (PR: 1.349, p=0,006).

Conclusion: Our study demonstrated an association between SCD and MM, which is important for developing and managing care for individuals with cognitive decline and/or multimorbidity. The results could also provide a foundation for future research exploring the causality between these variables.

PLATFORM PRESENTATION AND LIGHTNING ROUND: FRI 11.30-11.45

2768. Scientific Presentation - Other medical condition

Needs of People with Dementia in the Perioperative Environment from the Perspective of Healthcare Professionals

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Introduction: The incidence of dementia among patients in perioperative settings is on the rise, presenting significant challenges for healthcare professionals in delivering adequate and appropriate care to this patient population. In order to gain a deeper understanding of the perioperative care needs of patients with dementia, thirty healthcare professionals were interviewed. The focus was on their experiences and perspectives regarding the fulfilment of these needs. Key factors influencing perioperative care were identified and categorised into three main themes: patient-related factors, healthcare professional-related factors, and healthcare environment-related factors.

Methods: Thirty interviews were conducted with a diverse group of healthcare professionals, including anaesthetists, surgeons, nurses, and other perioperative staff. Thematic analysis was employed to process and interpret the data, identifying recurring themes and sub-themes that reflect the complexities of perioperative care for patients with dementia.

Results: The analysis revealed three primary themes: 1) Factors related to the patient with dementia: Cognitive impairment and comorbidities uniquely challenge perioperative care. The unfamiliar hospital environment often exacerbates cognitive symptoms, and adherence to postoperative protocols can be problematic. Family involvement is crucial in supporting these patients. 2) Healthcare Professional Factors: Perceptions of dementia, communication issues, pain assessment, and the need for personalised care were highlighted. Training and education deficits among healthcare professionals were evident, impacting the quality of care. 3) Institutional Factors: Organisational policies and resource allocation significantly affect the provision of dementia care. Support for healthcare professionals through ongoing education and the development of dementia-specific guidelines were identified as essential needs.

Conclusion: Effective perioperative care for patients with dementia requires addressing multifaceted challenges. Improving communication, enhancing education and training for healthcare professionals, involving family members, and ensuring institutional support are critical steps. A comprehensive, empathetic approach can lead to better outcomes and experiences for patients with dementia in the perioperative setting.

PLATFORM PRESENTATION AND LIGHTNING ROUND: FRI 11.45-12.00

2671. Scientific Presentation - Health Service Research

A Description of a Patient Navigator Program for Persons Living with Dementia in Canada

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Introduction: Receiving a dementia diagnosis can be overwhelming for persons living with dementia (PLWD) and their carers. Accessing information and home supports can be challenging. Having access to a Patient Navigation (PN) program is one way that may assist PLWD and their carers.

Methods: This study used a mixed methods design and involved the implementation of a Patient Navigation (PN) program in 6 primary care settings in New Brunswick, Canada, between July 2022-July 2023. PLWD/carers living in their own homes were eligible to enrol.

Results: There were 150 PLWD with a mean age of 76.4 (SD=9.4) years and 51.4% were male. The majority (60.7%) were living in rural communities. Most (50.7%) had been diagnosed within the past 2 years with 50.7% having seen a specialist, most commonly a geriatrician. Almost all (88.7%) had a primary care provider; however, only 25.2% were connected to the social care system, and 19.8% were connected to the home care system. The most common reasons for enrolling were gaining access to social programs and home supports and seeking dementia specific information. The average number of goals per PLWD/carer was 3.79 (SD=1.7). The average time in the program was 121.7 days (SD= 100.0) and 76.6% achieved their goals. The majority (84.0%) were somewhat to very satisfied with the PN program. Carers stated that with increased knowledge, access, and support there was a decrease in social isolation as well as improved confidence, which allowed PLWD to remain in the community longer.

Conclusions: Most PLWD/carers were connected to the health system, but the minority were connected to social and home care programs. Through connection to the PN program, carers increased their confidence; improved their knowledge; and increased their access to home supports and other care programs, allowing PLWD to remain in the community longer.

PRESIDENT ROUND

2897. Scientific Presentation - Cardiovascular

Characterisation of the local prevalence of hypertriglyceridemia in a city of North Eastern Colombia during 2020-2022.

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Introduction: There is limited data on the prevalence of hypertriglyceridemia (HTG), a recognised risk factor for cardiovascular disease, in the northeastern region of Colombia. Therefore, we aimed to characterise the local prevalence of HTG and cardiovascular disease-related variables in the subsidized regime population of a city in north-eastern Colombia during the period 2020-2022.

Methods: We conducted a retrospective review of medical records from all health centres in Bucaramanga, Santander, Colombia. The study included patients aged 60-95 years who were part of the subsidised regime and had records of cardiovascular risk variables, including the lipid profile. Mean ± standard deviation (SD) was used to describe quantitative variables. Microsoft Excel was employed for database creation, and statistical analyses were performed using the Statistical Package for the Social Sciences (SPSS, v.22.1; Chicago, IL).

Results: We included 105,461 patients, of whom 72,556 (69%) were female. The mean age was 66 years. The most common comorbidities were hypertension (82%), followed by non-insulin-requiring diabetes mellitus (28%), chronic kidney disease (24%), hypercholesterolemia (24%), insulin-requiring diabetes mellitus (8%), and COPD (8%). A total of 58,456 (55%) patients had hypertriglyceridemia, with mean triglyceride levels of 194.9 mg/dL. Mean cholesterol levels were 168.4 mg/dL, mean HDL levels were 42.7 mg/dL and mean LDL levels were 111.9 mg/dL.

Conclusions: More than half of the subsidised regime population in Bucaramanga, Santander, Colombia, were found to have hypertriglyceridemia during the period 2020-2022, along with cardiovascular disease-related variables.

PRESIDENT ROUND

2834. Scientific Presentation - Diabetes

Frailty in randomised controlled trials of glucose-lowering therapies for type 2 diabetes

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Background: The representation of frailty in type 2 diabetes trials is unclear. This study used individual patient data (IPD) from trials of newer glucose-lowering therapies to quantify frailty and assess the association between frailty and efficacy and adverse events.

Method: We analysed IPD from 34 trials of SGLT2 inhibitors, GLP1 receptor agonists and DDP4 inhibitors. Frailty was quantified using a cumulative deficit frailty index (FI). For each trial, we quantified the distribution of frailty; assessed interactions between frailty and treatment efficacy (HbA1c and major adverse cardiovascular events [MACE], pooled using random-effects network meta-analysis); and associations between frailty and withdrawal, adverse events, and hypoglycaemic episodes.

Findings: Trial participants numbered 25,208. Mean age 53·8 to 74·2 years. Using FI>0·24 to indicate frailty, median prevalence was 1·9% (IQR 0·8% to 6·1%). Prevalence was higher in trials of older people and people with renal impairment. For SGLT2i and GLP1ra, there was a small attenuation in efficacy on HbA1c with increasing frailty (0·07%-point and 0·14%-point smaller reduction, respectively, per 0·1-point increase in FI). Findings for MACE had high uncertainty (few events). A 0·1-point increase in the FI was associated with more adverse events (incidence rate ratio, IRR 1·43, 95% confidence interval 1·34 to 1·53), treatment-related adverse events (1·35, 1·22 to 1·50), serious adverse events (2·04, 1·80 to 2·30), hypoglycaemia (1·18, 1·04 to 1·34), MACE (hazard ratio 3·02, 2·49 to 3·68) and withdrawal (odds ratio 1·45, 1·30 to 1·62).

Interpretation: Frailty is associated very modest attenuation of treatment efficacy for glycaemic outcomes and with greater incidence of both adverse events and MACE. Frailty was rare in most trials. While these findings support calls to relax HbA1c-based targets in people living with frailty, they also highlight the need for inclusion of people living with frailty in trials as the absolute balance of risks and benefits remains uncertain.

PRESIDENT ROUND

2201. Scientific Presentation - Ethics and Law

Motivations for being informal carers of people living with dementia: An updated systematic review

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Background: Informal caregivers offer vital continuous, unpaid care to improve the quality of life of people with dementia and ease the demand for care services. The dyadic process of caregiving has multifaceted impacts warranting efforts to reduce caregiver burden and improve well-being, understanding motivations for adopting a caregiving role can predict experiences, perceptions, and impacts on caregivers. A systematic review conducted by Greenwood and Smith found motivators for informal caregivers. Substantial evidence documents variations in cultural perception and social values influencing caregiver experiences and motivations.

Objective and Method: The purpose of this systematic review was to update the searches by Greenwood and Smith to describe and compare the motivations of caregiving between demographics, ethnicities, and cultures. Six electronic databases were searched from August 2018 to January 2024. Titles and abstracts screened using Machine Learning approaches (ASReview). A subset of full texts was screened in duplicate. Included studies were appraised using the Mixed Methods Appraisal Tool (MMAT). Extracted data were grouped into themes. Initial database searches identified 1,530 articles and the following deduplication and screening 38 shortlisted studies were included. These were analysed as a continuation to the 26 studies from Greenwood and Smith. Cultural explanations for motivations for caregiving include familism, ethnic identity, cultural values and beliefs, obligation, and sense of fulfilment. Cultural perception and social values influence caregivers' experiences and perceptions thus affecting the family's engagement/acceptance of formal care/support.

Conclusion: Further research is warranted to inform advances in psychosocial support interventions for ethnically diverse caregivers to achieve personalised care and reduce the burden on family caregivers.

PRESIDENT ROUND

2663. Scientific Presentation - Other medical condition

Estimating the effect of frailty on long term survival following emergency laparotomy

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Introduction: Around 30,000 emergency laparotomies are performed each year across the United Kingdom. Over half are in people aged 65 years or above, with a third of this group living with frailty. The association between frailty and 90-day mortality following surgery is well documented, but longer-term mortality risk has been less extensively studied, despite clear implications for person-centred care. This study aimed to estimate the influence of frailty on longer-term mortality (> 90 days) following emergency laparotomy.

Methods: A retrospective analysis of National Emergency Laparotomy Audit (NELA) data was undertaken, including records entered between 01/12/18 and 30/11/20. Baseline patient characteristics including Clinical Frailty Scale (CFS) are routinely collected within NELA. Data are linked via NHS Digital with Office for National Statistics mortality data. A multivariate analysis was undertaken using a Cox proportional hazards model with hospital-level random effects. Potential confounders were identified via a directed acyclic graph and included in the model as covariates.

Results: 23,290 patients remained alive at 90 days post-surgery and were therefore included in the analysis. After adjusting for other covariates, increasing frailty was associated with an increased risk of longer-term mortality. Compared with CFS 1-3, adjusted HR were 1.86 (95% CI 1.68 – 2.05) for CFS 4, 2.23 (95% CI 2.03 – 2.45) for CFS 5, 3.26 (95% CI 2.99 – 3.57) for CFS 6, 4.53 (95% CI 3.97 (95% CI 5.17) for CFS 7, 5.80 (95% CI 4.44 – 7.57) for CFS 8 and 5.36 (95% CI 4.06 – 7.08) for CFS 9.

Conclusion: Older people living with frailty remain at increased risk of death beyond 90 days following emergency laparotomy. This information should be incorporated into shared decision-making, enabling patients to make informed choices about their care. Future work must explore how outcomes for this group might be improved through targeted post-operative support.

PRESIDENT ROUND

2816. Scientific Presentation - Other medical condition

Decision-making experiences with older adults following a cancer diagnosis: a systematic review.

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Introduction: Little evidence exists about decision-making with older adults diagnosed with cancer (Bridges et al 2015). However, older age is associated with changes in physical, social, and psychological health domains in ways that influence treatment decisions potentially impacting on quality and quantity of life. We sought to explore the experiences of older adults, their significant others and healthcare professionals when decisions regarding cancer treatment and support are made.

Methods: Synonyms relating to search terms Cancer, Older People, Complexity and Qualitative research were used to search the databases CINAHL, Medline, Embase and PsychINFO. The Mixed Methods Appraisal Tool (MMAT) identified strengths and limitations of the evidence allowing concurrent appraisal of qualitative, quantitative, and mixed methods studies.

Results: Searches identified 534 articles: 37 studies underwent full text screening, and 15 of these were included. The synthesis identified six themes: Preconditions in decision-making; Identifying frailty and setting goals; Maintaining independence; Information provision; Support during the decision-making process/role distribution; Trust in physicians; Preferences and choice. Most included studies reported the views of the older person, or health care professionals (predominantly physicians/oncologists/surgeons). However, there is a paucity of evidence representing the views of the older adult's significant other and a dearth of evidence exploring the efforts and contributions of all people involved in the process of decision-making.

Conclusions: Research is needed urgently to understand how and why decisions are made regarding cancer treatment and support, as well as how older adults are involved in these decisions throughout their cancer trajectory. Understanding this would assist healthcare professionals to prioritise individual's healthcare preferences with the potential to positively influence service delivery and workforce development. This review has informed the research design for The CHOICES study which aims to understand how clinicians, older individuals and their significant others make decisions following a new diagnosis of cancer.

PRESIDENT ROUND

2830. Scientific Presentation - Other medical condition

A Systematic Review of the Association Between Ethnicity and Frailty Prevalence, Incidence, Trajectories and Risks

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Background: Ethnic variations in frailty are poorly understood. This systematic review examined ethnic variations in frailty prevalence, incidence and trajectories; associations between frailty and sociodemographic/lifestyle risk-factors; and health-related outcomes of pre-frailty and frailty.

Methods: We searched four electronic databases from 2000 to April 2023 using terms for ethnicity and frailty. Inclusion criteria: observational studies assessing frailty in adults ≥18 years from community-based settings, including care homes; ethnicity defined by race, country of birth, language, ancestry, or culture. We supplemented searches with manual citation and reference list searches. Primary outcomes: prevalence, incidence, and transitions of frailty. Secondary outcomes: factors associated with frailty and health-related outcomes (e.g., falls, hospital admissions, mortality). Two reviewers independently screened all articles; conflicts were resolved by a third reviewer.

Results: We included 80 studies, representing data from 13 countries plus two multi-national samples from 15 European and 10 Asian countries, respectively. Across settings, frailty prevalence was higher in minority groups (including Black or Hispanic people in USA, South Asian or Black people in UK, Moroccan or Surinamese in the Netherlands, “non-white” groups in South America, Māori in New Zealand, and non-Han groups in China) compared to majority groups (White in most settings, or Han in studies in China). Ethnic differences appear sensitive to methods used to measure frailty. Two US-based studies found that ethnic differences were independent of sociodemographic differences. Six studies from USA or UK showed that Black and South-Asian people, respectively, had higher frailty incidence or more rapid frailty progression. There were no significant differences in mortality risk of frailty between ethnic groups.

Conclusion: Ethnic variation in frailty prevalence and dynamics persist across multiple settings, with minority groups adversely impacted. Future research should seek to explain ethnic differences in frailty measurement. Interventions targeting frailty need to take account of structural inequalities faced by minority groups.

PRESIDENT ROUND

2873. Scientific Presentation - Psychiatry and Mental Health

Post Traumatic Stress Disorder in Older Adults After Delirium: A Systematic Review

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Introduction: Post-traumatic stress disorder (PTSD) is an anxiety disorder caused by frightening or traumatic events. Delirium is a state of acute confusion associated with acute illness, surgery, and hospitalisation. Delirium is known to be associated with a risk of PTSD in patients in the Intensive Care (ICU) setting. However, there is limited information on the prevalence of delirium in older adults outside of Intensive Care. We therefore undertook a systematic review to ascertain the prevalence of PTSD in elderly patients after an episode of delirium on a general ward.

Methods: The systematic review was conducted using MEDLINE (1946-10/01/2024), Embase (1974- 10/01/2024), and PsycINFO (1806- 10/01/2024) to identify studies. Studies were eligible if they included adults aged ≥ 65 years, admitted to an acute hospital, diagnosed with delirium using a validated screening tool, (e.g. 4AT, CAM-ICU) and subsequently screened for PTSD at any point following discharge with a validated screening tool (e.g. the PTSS-14). The exclusion criteria excluded ICU cohorts and terminal illness with < 3 months life expectancy. Two researchers (SM, NM) independently reviewed all studies with any disparities resolved through a 3rd researcher (AM)

Results: After removal of duplicates, the search identified 1042 titles from which only 3 eligible studies were identified. All 3 studies were in older patients after surgical procedures (n=132 participants in total). Two of the studies reported no association between delirium and the subsequent risk of PTSD. However, the largest study (n=77) reported a significant independent association between delirium and the 3-month risk of PTSD.

Conclusion: The current body of research on the prevalence of PTSD following episodes of in-patient delirium in older adults is limited. The findings of this review highlight the need for further research. A prospective cohort study on Geriatric Medicine wards is being planned.

PRESIDENT ROUND

2845. Scientific Presentation - Big Data

Prevalence and Outcomes of Recorded Dementia: a Population-Based Study of 133,407 Older Adults using Linked Routine Data Sources

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Introduction: Recording dementia diagnoses is essential to ensure appropriate post-diagnostic support and care. We examined the prevalence of recorded dementia in different routine datasets and associations with emergency hospitalisation and mortality.

Methods: This retrospective longitudinal cohort study included all adults ≥65 years registered with a Southeast Scotland GP on 1st April 2016. Dementia diagnoses were identified in primary care, hospital discharge and community prescribing records. New diagnoses were considered from 1st April 2016 to 1st April 2020. All individuals were followed up to 23rd October 2023.

Cox proportional hazards and Fine-Gray models were used to estimate associations between recorded dementia and death and emergency hospitalisation, respectively. Diagnosis capture in other datasets was examined, accounting for mortality.

Results: On 1st April 2016, 7544/133407 (5.7%) individuals had a recorded dementia diagnosis: 1254 (16.6%) in a single dataset, including 940 (12.5%) only in primary care and 279 (3.7%) in hospital data. Between 1st April 2016 to 1st April 2020, 7359/133,407 (5.8%) had a new diagnosis: 5165 (70.2%) first recorded in primary care, 1634 (22.2%) in hospital and 560 (7.6%) in community prescribing data.

People with dementia had higher risks of death [adjusted hazard ratio (HR) 2.46 (95% Confidence Interval (CI) 2.39-2.54)] and emergency hospitalisation [adjusted subdistribution HR 1.58 (95%CI 1.56-1.60)] then those without dementia. People with diagnoses first recorded in hospital had higher mortality rates than those with community diagnoses [<30days: aHR 8.96 (95%CI 6.94-13.52); >365days: aHR 1.29 (95%CI 1.19-1.41)]. Only 562 (35.9%) of those with hospital diagnoses had recorded primary care diagnoses within a year.

Conclusions: Dementia is often recorded in single datasets, sometimes only in hospital data. Dementia is associated with adverse prognosis, with highest mortality in those with first diagnoses recorded in hospital. Findings highlight the need for better recording, dataset integration and scrutiny of hospital-based diagnostic pathways to ensure appropriate post-diagnostic support and care.

PRESIDENT ROUND

2856. Scientific Presentation - Epidemiology

Prevalence and associated factors of mental-physical multimorbidity among Brazilian elderly people (ELSI-Brazil)

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Introduction: Mental-physical multimorbidity (MP-MM) is defined by the presence of two or more morbidities, including at least one mental morbidity. Especially among the elderly it is associated with important negative outcomes like the high burden of healthcare utilisation. This study aimed to analyse the prevalence of MP-MM and associated factors among 6.929 participants of the second wave (2019-2020) of the Brazilian Longitudinal Study of Ageing (ELSI-Brazil). MP-MM was defined as the presence of two or more morbidities, including at least one mental morbidity, and was evaluated using a list of 16 physical and mental morbidities.

Method: Frequency description of variables and bivariate association were performed using Stata v.15.2 software.

Findings: The prevalence of MP-MM was 11.4% (CI95%:10.7-12.2), higher in women (69.4%), individuals between 60-69 years (60.0%), high scholarship (33.7%), with a partner (73%), living in an urban area (88.8%), without health insurance (72.9%), and in an area with primary care coverage (67.2%). A higher prevalence of hypertension (69.8%) was higher in MP-MM individuals.

Conclusion: The prevalence of MP-MM is higher and reveals gaps in the provision of healthcare, especially related to sex.

PRESIDENT ROUND

2882. Scientific Presentation - Other medical condition

Frail2Fit study: a feasibility and acceptability study of an intervention delivered by volunteers to improve frailty

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Introduction: Physical activity (PA) and replete nutritional status are key to maintaining independence and improving frailty status among frail older adults. We aimed to evaluate the feasibility and acceptability of training volunteers to deliver a remote intervention, comprising exercise, behaviour change, and nutrition support, to older people with frailty after a hospital stay.

Methods: Volunteers were trained to deliver a 3-month, multimodal intervention to frail (Clinical Frailty Status ≥5) adults ≥65 years after hospital discharge, using telephone, or online support. Feasibility was assessed by determining the number of volunteers recruited, trained, and retained; participant recruitment; and intervention adherence. Interviews were conducted with 16 older adults, 1 carer, and 5 volunteers to explore intervention acceptability. Secondary outcomes included physical function, appetite, well-being, quality of life, anxiety and depression, self-efficacy, and PA. Outcomes were measured and compared at baseline, post-intervention, and follow-up (3-months). Interviews were transcribed verbatim and analysed using thematic analysis.

Results: Five volunteers (mean age 16, 3 female) completed training, and 3 (60%) were retained at the end of the study. Twenty-seven older adults (mean age 80 years, 15 female) signed up to the intervention (10 online;13 telephone). Seventeen completed the intervention. Participants attended 75% (IQR 38-92) online sessions, and 80% (IQR 68.5-94.5) telephone support. Self-reported total PA ($p = .006$), quality of life ($p = .04$), and appetite ($p = .03$) improved significantly post-intervention, with a non-significant decrease at follow-up. The intervention was safe and acceptable to volunteers, and older adults with frailty. Key barriers were lack of social support, and exercise discomfort. The online group was a positive vicarious experience, and telephone calls provided reassurance and monitoring to socially isolated older adults.

Conclusion: Volunteers can safely deliver a remote multimodal intervention for frail older adults discharged from hospital with training and support from a health practitioner.

POSTE

2835. Scientific Presentation - Incontinence

Evaluation of Paceycuff as a Novel Treatment for Male Stress Urinary Incontinence: The First UK Experience

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Background: Prostate cancer and bladder outlet obstruction, often treated surgically, are increasing in the aging population, leading to more cases of stress urinary incontinence (SUI). While implantable continence devices are beneficial for many, a growing number of frail patients are unsuitable for surgery and rely on incontinence pads or penile clamps, which are limited to three-hour use to prevent tissue ischaemia.

We present the first UK evaluation of the new PaceyCuff penile clamp, designed for 24-hour wear while maintaining blood flow, to assess its efficacy, safety, and impact on patient quality of life.

Method: Men with urodynamically-proven SUI were identified. Baseline penile and finger peripheral oxygen saturation (SpO2), three-hour pad weight, 24-hour pad count and patient-reported outcomes (ICIQ-UI, QoL) were measured. Participants were then fitted with the PaceyCuff, and reassessed immediately, at three hours post-application and (via telephone) after two weeks.

Results: 13 men (average age 74, range 62-82) were recruited. ICIQ-UI scores decreased from 17 to 10, and QoL scores from 13 to 9. Average three-hour pad weight dropped from 94g to 10g and daily pad usage decreased from 4 to 0.9 pads. Participants reported good tolerance, with an average pain score of 1.8/10 and only 2 minor adverse effects (skin abrasion, transient pain). Penile SpO2 remained stable before, immediately after, and three hours post-use (76%, 82%, and 81% respectively).

Sub-group analysis of patients over the age of 80 (n=4) confirmed equal effectiveness. (ICIQ-UI decreased 18 to 10, QoL decreased 13 to 9, three-hour pad weight decreased 77g to 9g, daily pad usage decreased 4 to 1.5 pads, average pain 1.5/10)

Conclusions: The PaceyCuff has demonstrated both efficacy and tolerability in managing SUI in a UK cohort for the first time and offers a potential treatment option for elderly patients who are ineligible for surgical intervention.

POSTE

2678. Scientific Presentation - Neurology & Neuroscience

Small vessel disease contributions to acute delirium: A Pilot Feasibility MRI Study

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Background and aims: Delirium carries an eightfold risk of future dementia. Small vessel disease (SVD), best seen on MRI, increases delirium risk, yet delirium is understudied in MRI research. We aimed to determine MRI feasibility, tolerability, image usability, and prevalence of acute and chronic SVD lesions in acute delirium.

Methods: This case-control feasibility study performed MRI (3D T1/T2-weighted, FLAIR, Susceptibility-weighted, and Diffusion-weighted imaging (DWI) on 20 medical inpatients >65 years: 10 with delirium ≥3 weeks and 10 without delirium, matched for vascular risk, Clinical Frailty Scale (CFS), and cognitive status. We excluded acute stroke, agitation necessitating sedation, assistance of >2 staff to mobilise, and MRI contraindications. We measured scan duration, tolerability, image usability, acute infarcts on DWI, and chronic SVD features. Six months later, we recorded CFS and cognitive diagnoses.

Results: Mean age was 83.5 years (delirium 78.7 vs non-delirium 88.4); 13/20 were female; 17/20 had premorbid cognitive decline/impairment or dementia. Acquisition took mean 26.8 minutes. MRI was well-tolerated in 16/20 (7/10 in delirium arm; 9/10 in non-delirium arm). 4/20 had early scan termination but 20/20 had clinically interpretable images. We detected DWI-hyperintense lesions in 3/10 (33.3%) with delirium (2/10 small subcortical and 1/10 cortical) and in 3/10 (33.3%) without delirium (2/10 small subcortical; 1/10 cortical). Mean SVD score was 2.4 in delirium vs 3.3 without.

Conclusions: MRI is feasible, usable, and tolerable in delirium, and we detected DWI hyperintense lesions in one third of patients overall. This study indicates acute vascular contributions, including SVD, to delirium, supporting the need for larger studies.

POSTE

2776. Scientific Presentation - Neurology and Neuroscience

Leveraging Technology for Delivery of Dementia Prevention Interventions Remotely: Through the Participant's Lens

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Objectives: The objective of this study was to examine participant's experience with remote delivery during SYNERGIC@Home/SYNERGIE~Chez soi (NCT04997681), a home-based, double-blind, randomised controlled trial targeting older adults at risk for dementia. Metrics included study adherence, adverse events (AEs), participant's attitudes towards technology, and protocol deviations (PDs) due to technological difficulties.

Methods: Participants underwent 16 weeks of physical and cognitive interventions (three sessions/week) remotely administered in their homes via Zoom for HealthcareTM. Participants used a laptop, webcam, and required email and internet access. Throughout the trial, adherence, AEs, and PDs were recorded. Post- intervention, survey questions about satisfaction with technology were administered and semi-structured interviews were conducted which underwent thematic analysis.

Results: Sixty participants, mean age 68.9 and 76.7% female, were randomized to one of four intervention arms, with 52 completing the 16-week intervention. Adherence rate was 87.5% with no significant difference between treatment arms (p=0.656). There were 88 AEs reported in 42 participants. The majority (71.6%) of AEs were unrelated to the intervention, and 69.3% were classified as mild. There was one serious AE, unrelated to the intervention. Most (74.9%) participants reported overall satisfaction with technology, with Zoom being both enjoyable (81.0%) and easy to use (96%). Most enjoyed using the computer (87%), and the majority (87.0%) encountered few difficulties with connectivity. Of the 2496 intervention sessions, 14 (0.56%) were missed due to technical difficulties. Technical difficulties requiring modification to the intervention, such as an unstable internet connection, were reported on 79 occasions (3.0%). Themes from the interviews were: participants built rapport with the research assistants; felt better participating; had fun; and technology helped overcome barriers to participation.

Conclusions: Using technology to deliver dementia prevention interventions remotely was well received by participants Participation occurred safely from the comfort of their own home with few technical difficulties.

POSTE

2655. Scientific Presentation - Other medical condition

Risk factors for acute kidney injury in orthogeriatric trauma admissions: a retrospective cohort analysis

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Introduction: Guidelines on risk assessment for acute kidney injury (AKI) are generalised and may not adequately consider atypical presentations such as major trauma. Older people are largely absent in past studies of trauma-AKI, creating an evidence gap of major trauma-associated AKI risk factors in older people.

This evaluation aimed to determine whether major trauma-AKI risk factors in older people match those found in standard AKI guidelines, and whether trauma-specific factors emerged.

Method: Retrospective analysis of admissions to our Trauma Admissions Unit in people aged ≥65 years during 2014-2022 using a longstanding AKI quality improvement programme dataset. We identified factors associated with AKI using multivariable logistic regression. We included known co-morbid and acute risk factors, admission laboratory and observation values, and trauma-specific factors such as trauma body site, mechanism of injury, and injury severity score.

Results: There were 765 admissions, 12% developed AKI. Mean age 78.6±8.3years, 51% female. The most common comorbidities were diabetes (18%) and heart failure (11%).
Factors associated with AKI at the level $\alpha<0.05$ were sepsis (hazard ratio 6.2 [1.7-22.9]), heart failure (4.2 [2.3-7.7]), infection (3.4 [1.7-6.8]), CKD chronic kidney disease (2.4 [1.3-4.6]), lower limb trauma (2.4 [1.1-5.4]), and trauma as a secondary diagnosis (3.1 [1.4-7.0]). No admission laboratory or observations parameters were significantly associated with AKI, nor were other anatomical trauma sites, injury severity score, or mechanisms of injury.
AKI was associated with inpatient mortality (HR 2.2 [1.2-4.3], $p=0.016$) and length of stay >14 days (2.5 [1.2-3.9], $p<0.001$).

Conclusions: Risk factors for AKI in older trauma patients are comparable to those found in most guidelines for AKI risk assessment, with the addition of lower limb trauma and major trauma as a secondary reason for admission. These factors could be considered useful adjuncts in major trauma-AKI risk assessment tools to facilitate stratified care.

POSTE

2844. Scientific Presentation - Other medical condition

'You are as frail as your arteries' - exploring the correlation between frailty, and chronological and vascular age parameters

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Introduction: Thomas Sydenham, English physician stated, "a man is as old as his arteries". Chronological age has been noted to correlate strongly with vascular/ biological age. However, little is known about how chronological and vascular parameters of ageing, correlate with frailty. In this study, we sought to study the correlations between frailty, chronological age and parameters of vascular ageing.

Methods: Data from two studies with participants aged ≥ 60years investigating the associations between Cytomegalovirus infection and frailty indices and vascular parameters were included. Two hundred and sixty community dwelling adults were enrolled in both studies. Vascular parameters were measured by cardio-ankle vascular index (CAVI) using VaSera VS-2000® and pulse wave velocity-PWV (carotid-femoral and carotid-radial) using COMPLIOR®. Hand grip strength (HGS) and Charlson co-morbidity index (CCI) were measured for clinical frailty data. Patients were excluded if they had malignancy, were on active treatment for cancer or were unable to give consent.

Results: There were 260 study participants, (mean age ± SD; 72 ± 8years), with gender distribution M:F (50:50). Chronological age strongly correlated positively with vascular ageing parameters such as CAVI ($r=0.6$, $p<0.001$) and cf-PWV($r=0.5$, $p<0.01$). Similarly, chronological age correlated positively with CCI ($r=0.7$, $p<0.001$) and negatively with HGS ($r= - 0.3$, $p<0.001$). Vascular ageing as measured by CAVI (estimated CAVI age) correlated positively with CCI ($r=0.5$, $p<0.01$) and negatively with HGS ($r = -0.2$, $p=0.01$). Other measures of vascular ageing such as cf-PWV positively correlated with CCI ($r= 0.4$, $p<0.01$) and negatively with HGS ($r=- 0.1$, $p =0.09$).

Conclusion: Clinical frailty parameters correlate strongly with measures of vascular ageing and chronological age. Vascular ageing is a strong independent predictor of frailty.

POSTE

2444. Scientific Presentation - Psychiatry and Mental Health

Prevalence and factors associated with depression and depressive symptoms among Chinese older persons: an integrative review

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Introduction: China is the country with the largest population of older persons. Depression stands out as the most common mental health issue among older adults, a trend expected to increase as societies continue to age. With the global increase in depression and depressive symptoms among this demographic, the resulting disease burden poses a significant challenge for Chinese health and social care systems.

Method: To synthesise the empirical literature on the prevalence factors of depression and depressive symptoms in Chinese older adults, an integrative literature review was conducted informed by the guidelines of Whittemore and Knafl. The literature search encompassed EMBASE, SCOPUS, CINAHL, Web of Science, PubMed, PsycINFO, SocINDEX, China National Knowledge Infrastructure Database, and Wanfang Database. The review included 65 studies, 29 in English and 36 in Chinese.

Findings: This review summarized the prevalence of depression or depressive symptoms in Chinese older adults as 3.78% - 84.3%. According to the analysis based on the biopsychosocial theoretical framework, the associated factors involved in the included studies were: biological factors—physical health, disability, drug effects, gender; psychological factors—self-esteem, coping skills, trauma, emotions, beliefs, hobbies; social factors—family relationships, peers, family circumstances, school, residential area, social support, social structure.

Conclusion: Future research should emphasize relevant characteristics of older adults for timely identification of depressed populations and the development of interventions.

POSTE

2526. Scientific Presentation - Psychiatry and Mental Health

Web-Based Compassion Interventions for Family Caregivers' Mental Well-being

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Introduction: The ageing population has increased the demand for family caregivers, who often suffer from psychological distress, especially compassion fatigue. This systematic review and meta-analysis evaluate the effectiveness of web-based compassion interventions in improving the mental well-being of family caregivers.

Methods: MEDLINE, Embase, PsycINFO, Web of Science, Cochrane Library, and Proquest were searched from database inception until manuscript submission date. Eligible studies included family caregivers participating in web-based compassionate interventions with reported mental wellness indicators, such as self-compassion. Two independent researchers conducted a literature review, extracted data, and assessed the quality of each study using the Risk of Bias 2 tool. Random effects meta-analysis was performed to pool the data, followed by subgroup analyses, sensitivity analyses and Egger's tests.

Results: Out of 1095 studies evaluated, eight randomized controlled trials (encompassing 1978 participants) were included, with 75% exhibiting low risk of bias and high-quality evidence. Meta-analysis results indicated positive effects of web-based compassion interventions on family caregivers' self-compassion (SMD = 0.33, 95% CI 0.08 to 0.58, P = 0.009) and mindfulness (SMD = 0.46, 95% CI 0.03 to 0.90, P = 0.04). These interventions also demonstrated a positive impact on reducing stress (SMD: -0.32, 95% CI -0.59 to -0.04, P = 0.02) and anxiety (SMD: -0.28, 95% CI -0.47 to -0.09, P = 0.003). Subgroup analyses highlighted superior self-compassion outcomes for caregivers supporting individuals with mental illness and cancer compared to those caring for individuals with Alzheimer's disease. Interventions lasting ≥ 8 weeks were the most common and effective.

Conclusions: Web-based compassion interventions benefit family caregivers by enhancing self-compassion, mindfulness, and reducing anxiety and stress. More well-designed studies are suggested for future clinical applications.

POSTE

2799. Scientific Presentation - Psychiatry and Mental Health

Exploring the physiotherapy and exercise needs and preferences of nursing home residents with dementia: a qualitative study

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Introduction: Functional decline and restricted mobility are common issues among nursing home residents with dementia, resulting in frequent use of physiotherapy services. While these residents can typically articulate their therapy needs and preferences, these have not been investigated properly regarding physiotherapy and exercise, which may compromise therapy adherence. This study aims to explore the needs and preferences of nursing home residents with mild to moderate dementia in relation to physiotherapy and exercise interventions.

Methods: Semi-structured individual interviews were conducted with 15 nursing home residents diagnosed with mild to moderate dementia, who could understand and speak Dutch and were capable of providing informed consent. Thematic analysis was used to analyse interview data.

Results: From the interviews a total of 82 unique codes were identified, leading to four major themes: preferences regarding physiotherapeutic treatment, differences between physiotherapy and other exercises, preferences for unsupervised exercise, and communication and involvement preferences. Overall, residents wanted physiotherapy that included exercise and advice aimed at maintaining physical functioning and independence. Many participants indicated that a physiotherapist was not always required to supervise exercises as long as safety and quality were ensured. While residents wanted their family caregivers to stay informed about their therapy, they mostly preferred to exercise with someone other than a family caregiver.

Conclusions: Residents emphasised the importance of a physiotherapist providing information and understanding, and noted that sessions could be supervised by others if quality and safety are maintained. While residents preferred regular updates to their family, they did not want to exercise with them. A future coaching role for physiotherapists to oversee exercise interventions could enhance healthcare cost efficiency.

POSTE

2828. Scientific Presentation - Big Data

The influence of ethnicity and social disadvantage on frailty in a United Kingdom (UK) population

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Background: Frailty has both health + health economic consequences. There are however few data concerning occurrence of frailty in different ethnic groups in the United Kingdom (UK). The aim of this analysis was to determine frailty prevalence across an ethnically diverse city and to explore the influence of age/social-disadvantage/ethnicity on occurrence. We looked also at frailty related risk of severe illness in relation to COVID-19 infection.

Methods: Using data from the Greater Manchester Health Record (GMCR), we defined frailty index based on the presence/absence of up to 36 deficits scaled 0-1. We defined frailty based on those with 9 or more deficits (out of total=36) and electronic frailty index (eFi) as the total number of deficits present, divided by 36 (range 0-1).

Results: There were 534567 people aged 60+years on 1January2020 in Greater Manchester. There was noticeable variation in frailty prevalence across general practices. The majority were white (84%) with 4.7% self-describing as Asian/Asian British, and 1.3% Black/Black British. The prevalence of moderate to severe frailty (eFI>0.24) was 22.1%. Prevalence was higher in women than men (25.3% vs 18.5%) and increased with age. Compared to the prevalence of frailty in Whites (22.5%) prevalence was higher in Asian/Asian British ethnicity people (28.1%) and lower in those of Black/Black British descent (18.7%). Prevalence increased with increasing social disadvantage (p=0.002 for trend across disadvantage quintiles). Among those with a positive COVID-19 test those with frailty were more likely to require hospital admission within 28-days, with increased risk for Asian/Asian British descent (OR=1.47; 95% CI 1.34-1.61) and Black/Black British descent (OR 1.86; 95% CI 1.56-2.20) people vs Whites.

Conclusion: There is marked variation in occurrence of frailty across Greater Manchester. Frailty is more common in Asian/Asian British people than Whites and less common among Black/Black British with a gradient that relates to social disadvantage.

POSTE

2632. Scientific Presentation – Cardiovascular

Determining the feasibility of a TCD-NIRS protocol to measure cerebral haemodynamics in dementia, delirium, and depression

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Introduction: Transcranial Doppler ultrasonography (TCD) and Near-Infrared spectroscopy (NIRS) are indirect measures of neurovascular coupling (NVC). NVC is the relationship between cerebral blood flow and neuronal activity to meet the metabolic demands of the brain. No studies have integrated TCD-NIRS to investigate the feasibility of measuring NVC in those with dementia, delirium, and depression.

Methods: 32 participants (median [IQR] age 73.0 [70.0,78.5], 50% female, healthy (HC, n=10), depression (n=11), dementia (n=6), delirium (n=5)), underwent continuous cerebral blood velocity measurements in the middle (dominant MCAv) and posterior (non-dominant PCAv) cerebral arteries using TCD at rest and in response to four tasks. Heart rate (3-lead ECG), end-tidal CO (nasal capnography), blood pressure (Finometer), and prefrontal oxygenated (HbO2) and deoxygenated (HbR) haemoglobin (NIRS) were also measured. NVC was determined as absolute change in MCAv (cm/s) or concentration change for an attention task (serial subtraction), passive motor (arm movement) and passive sensory task (cotton wool), or PCAv for a visuospatial task (dot counting). We determined differences in NVC by a mixed two-way repeated measures analysis of variance, with post-hoc testing via Tukey.

Results: Resting CBv (cm/s) was significantly different between groups in MCAv (HC: 53.9 (SD=8.09), depression: 41.9 (9.31), dementia: 42.5 (13.7), delirium: 32.6 (7.48), p=0.002) and PCAv (p=0.045), after correction for age and BP (p=0.011).
TCD: initial NVC responses increased for all three groups (delirium excluded) for all tasks (20-30s), (p=0.026), but with no main effect of diagnosis.
NIRS: There was a significant difference between tasks for the HbO2 and HbR responses (p=0.046, p=0.033). Diagnosis had a significant effect on the HbR response only (p=0.034).

Conclusion: An integrated TCD-NIRS protocol was feasible in these patient groups to measure NVC, but less-so in delirium. Further work is needed to investigate NVC using integrated TCD-NIRS in larger sample sizes.


WITHDRAWN

POSTE

2808. Scientific Presentation - Epidemiology

Sociodemographic factors and comorbidities associated with mild cognitive impairment and dementia in Brazilian older adults

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Background: Cognitive impairment (CCL) and dementia are conditions typically occurring throughout the aging process, becoming major concerns in elderly healthcare. Advanced age, genetic factors, lifestyle habits, and comorbidities are risk factors that may increase the risk for both conditions. Thus, the aim of this study is to assess sociodemographic characteristics and comorbidities associated with CCL and dementia in older adults.

Methods: Cross-sectional analysis of the second wave (2019-2021) of the Brazilian Longitudinal Study of Aging (ELSI-Brazil). To assess the definition of CCL and dementia, the z-score of global cognitive function was calculated, evaluated through measurements of temporal orientation, verbal fluency, episodic, retrospective, and semantic memory domains. In addition, the IQCODE instrument and Activities of Daily Living were used to evaluate dementia. The Chi-Square test was used for the association of variables. The study was approved by the ethics committee.

Results: A total of 2951 participants were included, of whom 158 (5.4%) had CCL and 204 (6.9%) had dementia. Prevalence analyses of CCL revealed higher rates among individuals aged 65 to 74 years (6.18%), females (6.71%), divorced individuals (10.65%), rural residents (8.39%), hypertensive individuals (5.95%), non-diabetics (5.70%), and non-cardiac individuals (5.60%). Meanwhile, for dementia, prevalence was higher in individuals aged 75 or older (26.76%), females (8.50%), widowers (18.06%), rural residents (9.75%), hypertensive individuals (8.57%), diabetics (9.01%), and cardiac individuals (13.51%).

Conclusions: It was observed that long-lived elderly individuals have higher rates of dementia compared to CCL, as dementia symptoms increase with advancing age. Females and rural residents are in more vulnerable positions in society, explaining the high prevalence of both diseases. Comorbidities are significant risk factors for dementia development, with cardiovascular diseases, in particular, playing a prominent role in vascular dementia. This broad view highlights the importance of specific management and prevention approaches to preserve cognitive functions during the aging process.

POSTE

2644. Scientific Presentation - Falls, Fracture and Trauma

Falls and Physical Function in Older Patients with Benign Paroxysmal Positional Vertigo (BPPV)

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Introduction: Benign Paroxysmal Positional Vertigo (BPPV) is the most common cause of vertigo in older adults. Due to the high incidence of BPPV in older adults presenting with falls, vestibular assessment, and diagnosis of BPPV and other vestibular disorders has become a recommendation in the World Guidelines for Falls Prevention. There has been a paucity of evidence in well conducted randomised controlled trials (RCTs) to evaluate vitamin D for prevention of BPPV recurrence and its relation to falls and function.

Method: This is a Phase IIa single centre, placebo controlled, double blind RCT to evaluate vitamin D supplementation together with diet and Canalith Repositioning Procedure [Group A] or diet alone combined with CRP [Gorup B] can reduce recurrence rates of BPPV. *Post hoc* analyses were performed evaluating BPPV recurrence, falls and function.

53 participants were recruited. 14 were vitamin D replete at baseline [Group C- diet alone], the remaining 39 were randomised into Groups A and B. Group A was associated with 0.75 fewer clinical BPPV recurrences per one person year (IRD -0.75, 95% CI -1.18 to -0.32, P=0.035).

Findings: Older adults in the study who suffered a fall during the 12 month follow up had lower Activities of Daily Living scores. They also had poorer Short Physical Performance Battery scores at baseline. Participants in Group A had better 5x sit to stand time compared to Group B even accounting for underlying frailty scores. 25% of participants who fell in the 12 month follow up reported fear of falling compared to 43% in those with no falls in the 12 month follow up. Vitamin D supplementation improved physical performance in 5xchair stand test.

Conclusion: In this study population, more participants without an incident fall during follow up experience fear of falling, prompting further consideration into the complex concept that is fear of falling.

POSTE

2672. Scientific Presentation - Health Service Research

Exploring Stakeholders' Experiences Implementing a Navigation Program for People Living with Dementia and their Carers

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Introduction: Navigating dementia care is challenging, but patient navigation (PN) offers valuable support for this population. The "Navigating Dementia NB / Naviguer la démence NB" program piloted a PN program in New Brunswick, Canada, targeting people living with dementia (PLWD) and their carers. The program aimed to assist participants in navigating health and social care systems, matching their needs with available services.

Methods: Navigating Dementia NB was co-developed by researchers, patient partners, and clinicians. This pilot program embedded six PNs in primary care clinics/centres across the province between July 2022 and July 2023. Using a mixed methods approach, participant surveys and interviews were used to explore program benefits and recommendations for improvement. Focus groups were used to explore facilitators and barriers to program development and implementation.

Results: There were 150 participants (PLWD and carer dyads) enrolled in the PN program who provided informed consent. Interviews were conducted with 36 PLWD and their carers. Focus groups were conducted with nine members of the research team and five patient navigators. Program benefits included: emotional support from navigators, provision of relevant information, and facilitating connections to appropriate services. Recommendations for improvement included: the need for PLWD and their carers to have access earlier in the patient journey and the need to reassess provincial policies related to home care support. Facilitators for implementing a PN program included: providing appropriate staff training and leveraging established connections within the health and social systems. Barriers included a compressed timeline and existing systemic issues to service access.

Conclusions: The findings suggest that embedding PN for PLWD in community based primary care can be done. The program was beneficial for PWLD and their caregivers/care partners. Future plans involve partnering with government to support the implementation and evaluation of a province-wide scale-up of the PN program for this population.

POSTE

2473. Clinical Quality - Clinical Effectiveness

Improving inpatient frailty identification and its impact on Advance Care Planning

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Introduction: Clinical frailty scale (CFS) is used to generate a score ranging from 1 (very fit) to 9 (terminally ill) for people aged ≥65 years. A CFS of ≥7 correlates with a one-year mortality rate of ~50%, making it useful for identifying individuals potentially approaching last year of life. NICE recommend this patient group are offered Advance care planning (ACP). ACP is paramount to ensuring individuals receive high-quality, personalised end of life care. We aimed to investigate CFS documentation and frequency of ACP discussions following educational interventions.

Methods: We performed a retrospective analysis of all inpatients admitted to an Elderly Medicine department on a given day. Data for demographics, documented CFS score, and ACP discussions was collected. CFS scores were recalculated to assess accuracy. Following formal education sessions on CFS documentation and ACP delivered to the MDT, data was recollected. Subsequently, CFS scores were recorded within electronic "flowsheets" to ensure scores could automatically populate future clinical notes and be extracted for research purposes.

Results: The initial sample included 61 patients with 52 in the repeat sample. 36% of patients had CFS recorded in the initial sample compared to 77% in the repeat. In the initial sample, there was an 18.1% difference in documented and recalculated CFS for patients with a CFS≥7 compared to 7.7% in the repeat, showing improved identification of advanced frailty. In the initial cohort, 18% had pre-existing ACP and 16.4% had inpatient ACP discussions, compared to 21.2% in the repeat with pre-existing ACP and 15.4% having inpatient ACP discussions; demonstrating minimal difference.

Conclusions: CFS documentation improved highlighting effectiveness of education involving the whole MDT to better identify frailty within the inpatient setting. Despite this, ACP discussion rates remained low. Potential barriers include time-pressure and lack of confidence approaching ACP demonstrating a need for further awareness and training.

POSTE

2633. Clinical Quality - Clinical Effectiveness

Reducing Delays in Administration of First Dose Denosumab through Introduction of ACP Led Consent Process during Inpatient Stay

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Introduction: At Wrightington, Wigan and Leigh we admitted over 400 patients with hip fracture diagnosis in 2023. As part of orthogeriatric review, denosumab treatment would be utilised in a cohort of patients where this is appropriate, in line with NOGG guidelines. Traditional model of delivering first dose after outpatient appointment led to delays in treatment initiation and did not address the significant risk of "imminent fracture" which was recognised in the latest NOGG guidelines. The aim of this project was to reduce delays in denosumab treatment initiation by introducing consenting process during hospital stay led by orthogeriatric Advanced Clinical Practitioner.

Method: Utilising hospital electronic records, a sample of patients was selected from patients admitted in 2022 (19 patients), 2023 (19 patients) and 2024 (6 patients). Time of decision to treat with denosumab to time of first dose administered was used as the outcome measure. Alongside this, analysis of time to outpatient appointment was completed which was where the pre-intervention consent was taken. Intervention of inpatient consent being taken was implemented in September 2023.

Results: The average length of time from clinical decision being made to first dose of denosumab being administered was 187 days in 2022 sample, 76 days in 2023 sample and 27 days in 2024 sample. The governance around consent process was established and adopted by the whole orthogeriatric team. Waiting times for outpatient bone health clinic were on average 240 days in 2022, 164 days in 2023 and unknown in 2024 cohort.

Conclusion(s): Introduction of ward-based consent process for patients who are suitable for denosumab led to significant decrease in delays in time to first dose. This ensures that patients benefit from bone protection in a timely manner, as their risk of refracture is greatest in the first 6 months post index fracture.

POSTE

2645. Clinical Quality - Clinical Effectiveness

Delivering Safe Admission Avoidance via Comprehensive Geriatric Assessment under an Emergency Department Frailty Service

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Background: Older people account for >40% of acute hospital admissions. Delivering alternatives to hospital admission and community-integrated care closer to home are increasing priorities. We aimed to develop an Emergency Department (ED) Frailty MDT to provide rapid assessment, early Comprehensive Geriatric Assessment (CGA), and reduce inpatient admission rates for frail older people.

Methods: From November 2023 to April 2024, a newly formed Royal Infirmary of Edinburgh ED Frailty team delivered CGA for older adults aged ≥75 (≥65 if care home resident) with Clinical Frailty Scores ≥5 in the ED. The ED Frailty Team consists of an Emergency Medicine Consultant with an interest in Frailty, a Consultant Geriatrician, two Frailty Advanced Nurse Practitioners, an Occupational Therapy Advanced Practitioner, Occupational Therapists and a HomeFirst Social worker. We prioritised patients who were most likely to achieve same-day discharge. We built on strong integrated community pathways including Hospital @ Home, Rapid Access Day Hospital, and Discharge2Assess. We evaluated efficacy and safety using readmission and mortality rates.

Results: We reviewed 344 patients and discharged 209/344 (60.7%) of frail older patients who were awaiting medical beds. We discharged 114/209 (54.5%) with Hospital @ Home; 49/209 (23.4%) with rapid access Day Hospital; 21/209 (10%) home with GP follow-up; 18/209 (8.6%) home with no follow-up; 5/209 (2.3%) home with other community follow-up; and 2/209 (1%) home with ambulatory care. Discharged patients had a 19.4% 30-day representation rate and a 5.8% 30-day mortality rate. Admissions from ED amongst Edinburgh city residents reduced from 60% to 43% in 75-85 year olds and from 52% to 46% in the 85+ age group.

Conclusion: ED Frailty MDTs can effectively deliver CGA in an Emergency Department setting, facilitating admission avoidance and delivery of integrated care closer to home that is effective and safe.

POSTE

2656. Clinical Quality - Clinical Effectiveness

Healthcare Professionals' views on optimising pain services for older adults living with frailty: preliminary findings from the POPPY study

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Introduction: Frailty and persistent pain are both common amongst older adults (OAs) and together contribute to disability and emotional distress. The impact of pain on everyday life is potentially modifiable with appropriate pain management techniques, but current services do not always take account of the needs of frail OAs. The Pain in Older People with Frailty Study (POPPY) is a mixed-method study to develop the content and implementation strategies for services to optimise the support available for OAs living with frailty and pain. Initial objectives of the POPPY study included seeking views from healthcare professionals (HCPs) and commissioners on existing local services including their experiences of the barriers faced by OAs with frailty accessing these services, and views on how resources might be best deployed to support OAs with frailty.

Methods: In-depth qualitative interviews were conducted with HCPs from across England, based in specialist, secondary care and community services. Interviewees included commissioners, GPs, physiotherapists, occupational therapists, psychologists, nurses, doctors, and health coaches. A thematic approach to data analysis was used.

Results: Forty-two HCPs and 2 commissioners from 9 pain services and 2 generic community services were interviewed. HCPs recognised that OAs living with frailty and pain formed a distinct group, experiencing shared facilitators and barriers to engagement. Meeting the needs of this group was challenging for services. Most HCPs thought a dedicated pain service for frail OAs was impractical and disagreed with the concept of age-based pain services. HCPs thought the needs of frail OAs were most likely to be met by community-based services, staffed with appropriately skilled multi-disciplinary teams, interacting effectively with other specialist services, and delivering holistic individualised approaches.

Conclusion: Pain services need to be responsive to the specific needs of OAs with frailty and recognise the importance of adapting content and delivery of interventions to reflect this.

POSTE

2694. Clinical Quality - Clinical Effectiveness

Improving the quality of discharge summaries in the geriatric wards

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Introduction: A good discharge summary for a patient is an important clinical record that narrates and communicates clinical information about the patient's entire hospitalisation. Discharge communications between healthcare facilities play a pivotal role in the coordination of patient care. As geriatric patients' physical health is intricately woven into their social circumstances, mobility, and available care facilities, the mention of these parameters becomes quite important as it informs the community medical team of the patient's condition more comprehensively. Crafting a good summary is challenging and we noted insufficient documentation of geriatric domains.

Methods: A discharge summary QIP was run in the geriatric wards at the Royal Gwent Hospital for 5 cycles. In these 5 cycles, we introduced a poster, electronic MDT, teaching sessions, and discharge summary checklist respectively as our chosen intervention. We collected data prospectively and calculated the percentages of presenting complaints, diagnosis, comorbidities, history, examination findings, investigations, management, mobility, care needs, discharge destination, cognition, resuscitation and escalation plan, whether were documented or not in the summaries.

Results: A total of 20-30 patients' discharges were included in each cycle. Overall, there was good documentation in general medical domains (95-100%). A remarkable rise in the documentation of care needs (65%), mobility (80%), and discharge destination (50%) amongst other parameters was noted. However, there is a comparatively small improvement in cognition, resuscitation and escalation plans as some of them do not apply to all patients. The improvement is progressing as the physicians are now frequently referring to the checklist for writing the summaries.

Conclusion: These interventional measures showed the quality of discharge summaries has improved dramatically. Hence, we uploaded the discharge checklist to our health board intranet and included it in the induction booklet. We hope to include it in our yearly induction sessions to maintain the level of improvement.

POSTE

2724. Clinical Quality - Clinical Effectiveness

The Impact of Preoperative Comprehensive Geriatric Assessment on Anticholinergic Burden in Older Surgical Patients

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This service evaluation reviewed the impact of the Perioperative Care of Older People Clinic (POPS) on Anticholinergic Burden (ACB) in older surgical patients and identified areas for improvement. The study assessed 75 patients aged ≥65 years, revealing widespread anticholinergic use. Among patients on anticholinergics, 34% experienced a reduction in ACB post-POPS review. However, maintaining these changes at ≥6 months was challenging, with 50% of patients experiencing a change in their ACB score due to new prescriptions or the re-initiation of old medications. The study identified communication gaps at the POPS-primary care interface affecting de-prescribing efforts, underscoring the need for improved discharge letters, systems to flag high ACB patients, and a universal ACB tool.

Introduction: The UK's aging population is increasingly undergoing surgery, and older adults are at higher surgical risk partly due to anticholinergic use. POPS is a relatively new initiative aimed at reducing ACB in this demographic, but the sustainability of these reductions is not well understood. This service evaluation aims to fill this gap and suggest solutions for maintaining reduced ACB levels.

Methods: Retrospective data from 75 patients from 2022-2023 who met the criteria for ACB evaluation pre- and post-POPS review, with follow-up at ≥6 months, were included.

Results: Post-POPS, ACB was reduced in 34% of patients, with a median decrease of -2. However, ACB increased again in 50% of patients at ≥6 months, with re-initiation of amitriptyline and furosemide contributing to the rise in 67% of these cases.

Conclusions: CGA effectively reduces ACB in older surgical patients, but sustaining these reductions poses significant challenges. Communication difficulties at the POPS-primary care interface likely contribute to the re-initiation of medications, indicating a need for standardised discharge summaries and a universal system for evaluating and flagging high ACB patients to maintain improvements.

POSTE

2751. Clinical Quality - Clinical Effectiveness

Improving Identification and Management of Sarcopenia by Physiotherapists in Older People's Medicine.

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The Newcastle-upon-Tyne Hospitals NHS Foundation Trust

Introduction: Sarcopenia is common in hospitalised older people and is associated with unfavourable health consequences. Identification of sarcopenia risk with the offer of resistance exercise are key to improving outcomes and recommended in clinical practice guidelines. Previously, there was no sarcopenia testing on Older People's Medicine (OPM) wards highlighting a need for local improvement. This project seeks to translate and implement best practice to determine the possibility for physiotherapy staff working in OPM to offer a sarcopenia intervention as part of discharge planning. Improving sarcopenia care can help an ageing population maintain health and independence, bringing benefits for patients and the healthcare system.

Project aim: Within 3 months, to achieve a 50% increase in the number of patients offered a sarcopenia intervention.

Methods: Using the 'Plan-Do-Study-Act' approach, a sarcopenia assessment and therapy intervention was developed and introduced as part of the discharge process on an OPM ward. Measures: The weekly number of patients with a documented offer of the sarcopenia intervention was collected over 13 weeks and evaluated on a run chart. Cohort data were also recorded and described using descriptive statistics.

Results: At baseline, 0 patients were offered the sarcopenia intervention, this improved to 59/87 (68%). The mean age was 83 years (range 66-97) and 53 (90%) consented to be tested for sarcopenia; grip strength was measured in 51 (96%) and standardised 5*sit-to-stand in 5 (9%), with the latter typically not measured without upper limb support. There was a high prevalence of probable sarcopenia, (49 [92%]); 41 (84%) of those accepted the therapy intervention.

Conclusions: Physiotherapy staff can offer a sarcopenia assessment and therapy intervention as part of discharge planning of older people from hospital. Implementation may help to support older people to recondition after hospitalisation and achieve better health outcomes. Resources are necessary for sustainable and scalable application.

POSTE

2755. Clinical Quality - Clinical Effectiveness

The use of serum procalcitonin testing in hospital inpatients over the age of 80 years old

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Introduction: Serum procalcitonin levels increase in response to bacterial infections and decrease with successful treatment. Procalcitonin can, therefore, inform decisions around antibiotic use. For adults with suspected infection, using procalcitonin to start antimicrobials is not advocated but serial testing is suggested to aid with the decision to discontinue therapy.

Methods: A retrospective study was performed of adults over the age of 80 years admitted on a medical ward who had a serum procalcitonin completed between November 2022 and April 2023. Their electronic patient records were reviewed, with data collated and analysed using Microsoft Excel.

Results: Of 160 patients studied, median age was 85 with a median clinical frailty score of 6. The suspected sources of infection for the patients were chest (65%), unknown source (22.5%), urine (5%), cellulitis (3%), biliary (1.3%), osteomyelitis (1.25%), abdomen (0.63%) and infected haematoma (0.63%). Confirmed viral respiratory infection was present in 76 (47.5%) patients. Of all patients, only 62% were taking antibiotics at the time the procalcitonin was taken. Only 4 patients (2.5%) had serial procalcitonin testing (24-48 hours apart).

Conclusion: Procalcitonin was more likely to be used for suspected respiratory tract infection than other suspected infections. The majority of patient were taking antibiotics at the time the test was performed, which would indicate the tests being used to support a diagnosis of bacterial infection. Only a minority of patients (2.5%) had more than one procalcitonin result indicating that the clinical utility of this blood test to aid decision making in altering antimicrobial therapy was not occurring. Therefore, procalcitonin testing within an older adult population is being used in an inappropriate manner in the context of infection. Given a cost of £39.50 per test we anticipate that in its current use procalcitonin testing is not being used in a cost effective or clinically effective manner.

POSTE

2761. Clinical Quality - Clinical Effectiveness

Proactive care in independent living facilities - reducing unplanned demand on the health economy

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1. Southern Health Foundation Trust; 2. Southern Health Foundation Trust

Introduction: The Chandlers Ford, Eastleigh and Southern Parishes Frailty Support Team (FST) identified pockets of high referral rates within independent living facilities. It was hypothesised that this may be because independent living facilities do not have a contractual arrangement for proactive intervention, unlike care homes and nursing homes. This leaves individuals and carers unsure how, when and where to seek support. In turn, this potentially has a high healthcare burden through unplanned access to GP's, 999, 111 or admissions to hospital.

Methods: An independent living facility was identified, and participants were invited to have a proactive, holistic review. Medical notes were reviewed for 12 calendar months prior the project and all unplanned contacts recorded. Each participant then received a face-to-face review which identified, addressed and rectified any findings/ concerns. A follow-up review of medical notes and a telephone call to participants was completed 3 months later.

Results: This project has decreased unplanned medical contacts by an average of 85% in all participants which equates to an average saving of £453.67 per person

See poster for table.

Conclusions: The project suggests that in independent living facilities switching from a reactive to a proactive model may allow for better holistic care, in turn reducing the burden on the local health services. It is acknowledged that this is a small sample and therefore may not be representative or generalisable and a larger study is recommended.

POSTE

2781. Clinical Quality - Clinical Effectiveness

Improving MDT Efficiency and Staff Satisfaction in Frailty Unit

U Ekwegh

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Introduction: As part of a larger quality improvement project focused on improving the management of older people living with frailty attending the Manchester Royal Infirmary, a Frailty Same Day Emergency Care Unit (Frailty SDEC) was established. This would require the merging of three teams: the Front Door Frailty team, the Acute Therapy team and an established Nursing team on the allocated ward area. It became apparent that an intervention was required to improve team-working and efficiency among these clinicians who had never all worked together in the same space before.

Methods: Board Rounds are well established elsewhere in the hospital and are recommended by the Royal College of Physicians' Principles for Best Practice. We therefore tested, through four Plan-Do-Study-Act (PDSA) cycles, the approach to Multidisciplinary team (MDT) board rounds that would facilitate teamwork and efficiency in the team.

Results: Our main outcome measure was staff satisfaction. There is evidence that increased staff satisfaction improves patient outcomes; this is therefore an important metric. Furthermore, there would be other confounders on efficiency such that time to discharge would not have been an accurate measure of the impact of good board rounds. We therefore surveyed the MDT after 6 months of working through the PDSA cycles to compare the current practice with what had been the status quo at the start of the year. The overwhelming response (both quantitative and qualitative) was increased satisfaction with how the team was working together to improve patient care.

Conclusion: When setting up a new service, early attention must be given to how to ensure that newly created teams have their own personalised approach to collaborative MDT working, by establishing a Board Round culture that works for that team.

POSTE

2782. Clinical Quality - Clinical Effectiveness

Don't panic! How acute kidney injury and hyponatraemia can be safely managed on a Frailty Virtual Ward

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Introduction: Acute kidney injury (AKI) and hyponatraemia are common causes for hospital admission for frail, elderly people. Some patients could be managed at home using the Virtual Ward model, reducing risk of healthcare related adverse events. We aimed to show plausibility for this treatment model.

Method: We produced guidance for managing patients with AKI/hyponatraemia on the Frailty Virtual Ward (FVW). We then collected data from patients treated for AKI (N=12) and hyponatraemia (sodium <126mmol/L) (N=9) and compared with a similar inpatient cohort (AKI N=14, hyponatraemia N=16). FVW patients received remote vital signs monitoring, telephone consultations and blood tests.

Results: AKI: FVW patients had creatinine rise 30-101%, and pre-renal AKI. They had fewer adverse events and none died. None required intravenous therapy or Renal input. Most fully recovered by discharge, whilst some established a new creatinine baseline, and had community follow-up. Inpatients had more severe AKI and frailty contributing to higher mortality and adverse events. Hyponatraemia: FVW patients had asymptomatic/chronic moderately-severe hyponatraemia (sodium 120-126mmol/L). The most common cause was SIADH. They were less likely to undergo hyponatraemia investigations, but more likely to receive an explanation for hyponatraemia. They had fewer healthcare associated adverse events, readmissions, or deaths. Inpatients were more severely unwell. Three FVW patients received Endocrine opinions. Most FWV patients recovered (sodium >125mmol/L), except one who was admitted (sodium 120mmol/L) and one who had a follow-up plan for sodium 124mmol/L.

Conclusion: Mild AKI and moderately severe chronic/asymptomatic hyponatraemia can be managed under the Frailty Virtual Ward model with few adverse events compared with inpatient care. Underlying causes often require minimal medical intervention, such as medication review or fluid restriction. Specialist input is still possible. Work is needed to ensure FVW patients receive the same level of investigation as inpatients, and that they have a clear follow-up plan.

POSTE

2794. Clinical Quality - Clinical Effectiveness

A MUST to improve patient outcomes; a multidisciplinary approach to improving nutrition.

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Oxford University

Introduction: Malnutrition is a significant problem in the hospitalised population, particularly in those with cognitive impairment. Malnutrition has been shown to increase rates of infection, pressure sores, length of stay, readmission and morbidity. Malnutrition Universal Screening Tool (MUST) scoring identifies adults at risk of malnutrition and prompts dietetic referrals where appropriate. MUST score recordings across four Complex Medicine Units in the John Radcliffe Hospital were often inaccurate or incomplete, impacting on the identification of malnutrition and timely referral to dietetics. Multi-disciplinary teaching on MUST scores improved identification of malnutrition in this patient population. Further interventions are planned.

Methods: Electronic patient records for patients >/=75 years of age admitted to the Complex Medical Units at the John Radcliffe Hospital with a diagnosis of cognitive impairment were analysed. The percentage of patients who had either an incomplete or incorrect MUST score were identified. The percentage of patients that did not receive a referral to dietetics due to an underestimated MUST score and the reasons for the underestimation, were determined. Multi-disciplinary teaching interventions focussing on the identification of malnutrition in inpatients were implemented. MUST score recording was re-analysed following intervention.

Results: 71% of MUST scores underestimated risk of malnutrition. 67% of this cohort met criteria for referral to dietetics based on a corrected score, with only 33% of this group receiving the appropriate referral. Failure to identify weight loss in the preceding 3-6 months accounted for 88% of inaccurate scores. Multi-disciplinary teaching interventions improved MUST score accuracy by 14%, indicating improved identification of malnutrition risk.

Conclusion: Identification of malnutrition is important to improve patient outcomes. Changes to practise will include multi-disciplinary education, improved use of technology to generate accurate MUST scores and the utilisation of transfer boards with integrated weighing scales to ensure all new admissions have an accurate weight.

POSTE

2813. Clinical Quality - Clinical Effectiveness

An audit cycle evaluating the impact of a multidisciplinary teaching program on the safe prescribing and monitoring of patients on SGLT-2 inhibitors in the community

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Sheffield Teaching Hospitals NHS Foundation Trust

Introduction: In 2022 NICE guidelines [NG28] were updated for the prescribing of sodium-glucose cotransporter-2 inhibitor (SGLT2-i) as joint first line management of type two diabetes mellitus (T2DM) along with metformin to encompass a wider comorbid patient demographic with cardiovascular risk factors. In line with these new changes, a fully completed audit cycle was therefore undertaken in a small General Practice (GP) surgery.

Method: Firstly, we evaluated the GP surgery's current adherence to the updated guidelines to establish a baseline. We then repeated this following a multidisciplinary teaching program on T2DM and the safe prescribing and monitoring of SGLT2-i in the community. This pre- and post-intervention data was collected in order to evaluate the effectiveness of this intervention. The population targeted were all patients with T2DM with cardiovascular risk factors who did not have contraindications to SGLT2-i. The modern GP workforce employs a range of multidisciplinary health professionals who provide patient care. Therefore, the educational intervention was delivered to all members of this team at the practice.

Results: This audit demonstrated the positive impact this multidisciplinary teaching program had on increasing the number of patients on SGLT2-i, 15% to 17% of the target practice population. As well as also improving the monitoring of this medication in terms of renal function pre initiating treatment and regular monitoring, both increasing from 73% to 100% of the population on SGLT1-i. Qualitative feedback collected suggested that although some of the allied health professionals cannot prescribe themselves, this teaching program empowered them to identify appropriate patients for SGLT2-i therapy, facilitate appropriate drug monitoring and book follow-up appointments with a prescriber as required.

Conclusion: As the use of SGLT2-i in elderly and comorbid populations is increasing this project demonstrates the benefit of multidisciplinary teaching programs in improving the safe prescribing and monitoring of SGLT2-i.

POSTE

2814. Clinical Quality - Clinical Effectiveness

Improving Patient Care and Staff Wellbeing through the introduction of a Ward Doctors' Folder.

E Finch

Sheffield Teaching Hospitals NHS Foundation Trust

Introduction: When working in complex systems, such as hospitals, specific local knowledge is often essential for the completion of day-to-day tasks, not just medical competence. The rotational nature of junior doctors' training programs exacerbates this, resulting in frustration for junior doctors and delays in patient care. A solution was therefore proposed with the aim of equipping junior doctors with the necessary tools to navigate an unfamiliar complex system effectively, improving staff experience and patient care.

Method: Using Plan Do Study Act quality improvement methodology, relevant stakeholders were identified and consulted in order to determine the nature of the problem, tailor an intervention and encourage engagement. The proposed intervention, a physical ward doctors' folder, aimed at junior doctors on a Geriatric ward to improve access to resources and local pathways, as well as readiness for electronic system failures. Pre- and post-intervention questionnaires, employing Likert scales and free-text sections, were completed by junior doctors at a variety of stages in training to assess the impact on both themselves and perceived impact on patients under their care.

Results: This fully completed audit cycle evidenced statistically significant positive change for both junior doctors (in terms of efficiency and wellbeing) and patients (in terms of timely care and discharge). Positive responses were shared across all levels of training from foundation year doctors to senior registrars, as well as being particularly useful for locum doctors. This intervention also improved awareness of pathways to continue to work in the event Trust IT systems were to stop functioning.

Conclusion: Following the positive results of this project plans are in place to roll a digital version of this folder (using QR codes and short URL links) out across multiple medical ward's so they can also benefit.

POSTE

2817. Clinical Quality - Clinical Effectiveness

University Hospitals Dorset Frailty Virtual Ward: establishing a service.

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University Hospitals Dorset NHS Foundation Trust

Introduction: University Hospitals Dorset (UHD) wants to provide hospital level care to patients with frailty, in their own home. Our frailty virtual ward (VW) team consists of a consultant geriatrician, lead nurse, pharmacist, advanced nurse practitioner, nurses and therapists. We have a capacity of 20 patients across Bournemouth, Christchurch and Poole localities. Our patients receive care at home for acute medical conditions supported by remote monitoring, blood testing, face to face assessments and daily Geriatrician input. We are collaboratively working with our community partners seeking to provide complete CGA in the patient's home.

Methods: Establishing the service was non-linear and required multiple improvement cycles. Our VW fits alongside our frailty SDEC, day hospital and interim care team. We developed a SOP, a patient flow pathway and processes for medication prescribing and delivery supported by the Royal Voluntary Service. We screened our frailty wards for suitable patients and in May 2023 we tested by taking our first patient home. Subsequently our processes have developed around the patient's needs. Through multiple PDSA cycles we tested various screening techniques, 7-day Geriatrician input, nurse recruitment, remote monitoring and used patient feedback to guide further service development and improvement.

Results: We are an established frailty virtual ward with 20 beds.

Conclusion: The UHD Frailty VW has developed out of a need for an early supported discharge and admission avoidance for our older patients. Through multiple PDSA cycles, we have established a virtual model that we feel is providing safe, hospital level care for patients with acute medical presentations. We hope to expand through recruitment and funding with an aim to deliver excellent quality care to patients with frailty in their in their own home. Our ambition includes closely working with South West Ambulance Service for further admission avoidance and developing a home IV pathway.

POSTE

2822. Clinical Quality - Clinical Effectiveness

Improving bone health assessments in Parkinson's clinic

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King's Mill Hospital

Introduction: People with Parkinson's disease are more likely to have osteoporosis and falls. They also have a higher risk of fractures, and their outcomes are poorer than in the general population. Despite this, only half of the patients seen in Parkinson's clinic have a bone health assessment. The aim of this project was to improve bone health assessments in the Parkinson's clinic at Mansfield Community Hospital.

Method: One plan-do-study-act cycle was completed with the implementation of a Parkinson's fracture risk assessment tool in the clinic. 19 clinic notes were evaluated over an 8-week period. The notes were scored on whether bone health was addressed using the assessment tool. Feedback was collected from the clinicians about utilising the assessment tool in clinic. The FRAX (Fracture risk assessment) tool was also used to calculate the risk of fractures in the patients selected.

Results: 16/19 (84%) notes had used the risk assessment tool in clinic. There was an improvement in the bone health assessments in clinic from 5% (1/19) at baseline to 29% (5/17). The Parkinson's risk assessment tool's identification of individuals who were high risk of fractures, correlated with those identified as high risk using FRAX. The clinicians had positive reviews of the tool, but they highlighted the time constraints.

Conclusion: Whilst the use of the assessment tool has shown some improvement in the number of bone health assessments happening in clinic; it hasn't resulted in all patients having an assessment. This is likely due to the time constraints in clinic. This project was successful in highlighting the current problem to the clinicians and has led the development of a further separate clinic, where bone heath can be addressed. The risk assessment tool plays an important role in identifying high risk patients who would be referred into this service.

POSTE

2825. Clinical Quality - Clinical Effectiveness

Embedding the Anticholinergic Burden score and deprescribing into a collaborative community and secondary care frailty clinic

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Background: This clinical improvement project took place at a community frailty clinic. The primary and secondary care collaboration clinic comprised of an MDT including a physiotherapist, HCA, social prescriber, consultant geriatrician and GPwER in older people's medicine. Older adults with a Rockwood score of 5 or more were assessed using the CGA domains.

Introduction: Anticholinergic burden (ACB) is defined as the cumulative effect of taking one or more medications with anticholinergic effects (e.g. opioids, antimuscarinics and trycyclics). ACB score is a method of quantifying this. Higher ACB scores (3+) are associated with cognitive decline, risk of admissions with falls/ fractures and increased mortality. The aim of the study was to quantify reduction in ACB score following structured medication review. The goal was to determine whether the frailty clinic was an appropriate setting for this.

Methods: Over a 5-month period the consultant geriatrician and GPwER calculated each patient's ACB score. A medication reconciliation within their appointment facilitated deprescribing of high-risk medications. The HCA recorded ACB scores for all patients before and after medication review.

Results: 54 patients attended the clinic. 18 patients had an initial ACB score of 0. The remaining 36 patients had an ACB score of at least 1. Their mean reduction in ACB score was 1.2 points. Most pertinently, of the 19 patients with ACB scores of 3 or more, 12 left the clinic with a lower score and the mean reduction was 2.1 points. One patient achieved a drop in score from 9 to 0. Only 2 patients left with increased anticholinergic burden (in both cases, only increasing by 1 point).

Conclusions: Embedding the ACB score into patient medication reviews at the frailty clinic was easily achieved. This process was documented in clinic proformas, letters and the MDT discussion. This would be simple to transfer to similar settings.

POSTE

2827. Clinical Quality - Clinical Effectiveness

Getting the BASICS right improves recognition and management of incontinence in a hospital setting

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Introduction: In hospital incontinence increases length of stay (1), in orthopaedic patients is associated with increased likelihood of discharge to an institutionalised setting (2) and can have a major negative impact, with many rating bowel and bladder incontinence as a health state the same or worse than death (3). Yet of the Geriatric Giants, it is given relatively little attention.

At a busy teaching hospital, we sought to raise awareness and improve management of incontinence across our 167 beds, by using a standardised, multi-disciplinary approach involving identification of patients and use of the components of BASICS (Bladder diary, A physical assessment, Symptom profile, Infection and Constipation check and a bladder Scan, figure 1).

Method: Baseline data of a sample of 14 patients with new urinary incontinence with their aspects of continence assessment were added to a cumulative audit. Alongside checklists, a poster was designed and placed on each ward, a local teaching session about incontinence was delivered, and data shared at our local governance meetings. Following this, a further cycle of audit was performed. Reversible causes were identified and addressed appropriately.

Results: Between cycle 1 and 2 (February and June 2024), significant improvements were seen in most aspects of BASICS assessment with notable increases in use of the bladder diary (7 to 50%) and medical examination (7 to 57%). See figure 2 for breakdown. As a consequence, there were multiple interventions aiming to improve patient symptoms.

Conclusion: Paying consistent and sustained attention to this neglected area of practice has demonstrated a change of culture is possible. We are now incorporating continence assessment into our medical trainee audit programme to support a sustained multi-disciplinary approach and maintain improvements.

POSTE

2831. Clinical Quality - Clinical Effectiveness

Improving Delirium assessment in the Elderly; a systematic approach using 4AT as a screening tool for delirium

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Introduction: Delirium, characterised by disturbances in attention and consciousness, is common in individuals with pre-existing medical conditions, particularly the elderly, but can affect people of any age. It can lead to significant morbidity, mortality, prolonged hospital stays, increased healthcare costs, and long-term cognitive decline. Despite its impact, delirium is often underdiagnosed and undertreated, underscoring the need for better diagnostic strategies. The 4AT tool, recognized by NICE, is valued for its rapid delirium assessment, unlike the AMT-10, which is more suited for chronic cognitive disorders.

Objective: This study was conducted to assess the usage of the 4-AT tool in the assessment of delirium to aid in the early detection of delirium in the elderly population.

Method: The retrospective review of medical records over six months was conducted and divided into two cycles to evaluate delirium assessment using the 4AT. Initially, data from 59 patients 49 at FPH and 10 at WPH established a baseline of 4-AT usage across the trust. Post-intervention, 60 patient records were reviewed to reassess 4AT usage.

Interventions included:
1. In-person Training sessions in completing 4AT
2. Informative posters placed in ED and Medical wards (AMU and Elderly-care)
3. Continuous reminders to enhance early detection.

Results: Before the intervention, only 6.8% of patients were assessed using the 4AT tool, 55.9% with the AMT, and 37.2% without assessment. Post-intervention, the overall assessment rate rose to 62.7%, significantly increasing 4AT usage. Among 28 delirium-diagnosed patients, only 14.3% were screened with the 4AT, indicating room for further improvement.

Discussion and Conclusion: The increased use of the 4AT tool post-intervention highlights the effectiveness of educational initiatives in improving delirium screening. Early detection through the 4AT facilitates timely interventions and better patient outcomes. However, the small sample size and underutilisation among diagnosed patients suggest the need for ongoing efforts to improve its usage.

POSTE

2833. Clinical Quality - Clinical Effectiveness

Quality Improvement Project on increasing Antimicrobial Stewardship and Patient Safety

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Broomfield Hospital, Mid-South Essex NHS Foundation Trust

Introduction: National surveillance shows an estimated 58,224 people in England had antibiotic-resistant infections in 2022, a rise of 4% since 2021 (ESPAUR report). Between 2022-23, our Trust had 2nd highest *C.difficile* rates in the country. Geriatric population is particularly vulnerable to inappropriate antimicrobial prescribing, leading to prolonged hospital stays. As part of anti-microbial stewardship (AMS), a Quality improvement project was carried out between February-May 2024.

Methods: Six geriatric wards (n=168) were audited between 14-16th February 2024. Indication, route, duration, choice of antibiotic and compliance to Microguide was measured. Interventions included introducing weekly microbiology consultant led ward rounds, junior doctor, nurse and consultant education (individual and group) and streamlining IT access to Microguide were implemented. AMS meetings were introduced, which included lead microbiology consultants, chair of medicines safety group, lead antimicrobial pharmacist, geriatric consultants and incorporating prescribing into simulation sessions were sought. Plan-do-study-act (PDSA) cycle was carried out, with repeat cycle carried out in June 2024.

Results: In total, 99 patients were on antibiotics with compliance to Microguide ranging from 39-65% (mean = 53%) in 1st cycle. Co-amoxiclav (n=45) and Tazocin (n=14) were the most used antibiotics. After the PDSA cycle with interventions implemented, compliance increased from range 70 to 90 % (mean = 83%m n=71). Areas such as prescribing of co-amoxiclav for UTI, Tazocin use without micro approval were targeted. There was increase in the indications and duration mentioned on drug charts (89 to 95%).

Conclusion: Local drivers of change with existing resources can significantly improve AMS. This ultimately leads to less *C.difficile* infections and improved patient safety. Junior doctor education and weekly ward rounds can be implemented in other areas of our trust to improve AMS.

POSTE

2837. Clinical Quality - Clinical Effectiveness

Learning from deaths; Embedding education in the process of certification of death during rollout of the Medical Examiner service

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Introduction: The recent introduction of the Medical Examiner (ME) service changed the process for Medical Certificate of Cause of Death (MCCD) completion across Wales. This offered opportunity for local process redesign and embedding of team-based education and reflective practice, whilst reducing delays in MCCD completion for bereaved families.

Methods: We produced a process map and discussed with key stakeholders - ward teams, bereavement staff and the ME Office. We developed a team–based Proposed Cause of Death form (several PDSA Cycles) to prompt and stimulate early medical team discussion/reflection and to aid a clear formation of a proposed cause of death, in advance of ME review. This was piloted (paper form) on 2 wards (A&B) in 2022, followed by a further 3 wards (C,D&E) in electronic form in 2023. We collected data on numbers of deaths, forms completed and time between death and MCCD completion. Feedback sought from teams, bereavement, and the ME service re usefulness of the intervention.

Results: The process was successfully adopted on 2 of the 5 pilot wards. For the 2 wards adopting the process, the educational discussion and form were completed in 71% (27/38) of deaths on ward B, and 60.9% (14/23) on ward C. Time from death to MCCD completion was not significantly increased by this additional step. Feedback from adopting teams was positive, commenting on educational opportunities and improved communication between the ward and bereavement teams.

Conclusions: Facilitators of adoption were ward level consultant engagement, availability of notes and prompting of the medical team by the bereavement team. Barriers to adoption were a perception of extra work and being unable to perceive usefulness of the process. Adoption of the process led to improved team ownership of cause of death decisions, educational opportunities and better communication with the ME and bereavement teams.

POSTE

2849. Clinical Quality - Clinical Effectiveness

Managing Acute Hyperkalaemia in Frail Individuals Using a Modern Potassium Binder Sodium Zirconium Cyclosilicate (Lokelma®)

V Debnath

Medway NHS Foundation Trust

Background: Hyperkalemia is a common life-threatening electrolyte abnormality present in acutely unwell frail patient, often in context of Acute Kidney Injury (AKI), background of Chronic Kidney Disease (CKD) and a variety of medications such as renin-angiotensin-aldosterone system (RAAS) inhibitors. NICE TA 599 guidance recommends the use of a modern K+ binder such as Sodium Zirconium Cyclosilicate (SZC) in the acute setting alongside standard of care. This case series was carried out with a view to gain clinical experience specifically in acutely unwell frail older individuals presenting to a District General Hospital in UK.

Methods: Eight patients presenting to ED at Medway NHS Foundation Trust over 3-week period between 7th June - 11th July 2023 with Hyperkalemia were treated with SZC, data was collected retrospectively.

Results:
- Sex: Male:4, Female 4, Mean age 86 years (range: 69-105 years)
- Clinical Frailty Score: ≥ 6 in all cases
- Average serum K+ on admission: 5.75 mmol/l (range: 5.6 – 6.3 mmol/l)
- Comorbidities: CKD: 6/8, T2DM 5/8, Hypertension 5/8, CCF 4/8

AKI present in 6/8, Sepsis present in 4/8

Management: SZC 10 g tds was managed to correct hyperkalemia alongside established standard of care measures for acute hyperkalemia management. Fluid resuscitation, antibiotics and discontinuation of culprit medications was carried out where indicated.

Effectiveness of SZC:
- Normokalaemia was achieved in 4/ 8 of cases within 24 hours of admission
- In the remaining 4 patients, 3 achieved normokalemia within 48 hours and in 1 patient serum K+ was normalised in 72 hours after commencing treatment with SZC

Conclusions:
- Clinicians gained familiarity with prescribing SZC, in managing acute hyperkalaemia in frail patients
- Demonstrated effectiveness of SZC specifically in frail elderly population
- Change in local guidelines for acute hyperkalaemia management: SZC (Lokelma®) is now available in ED, on all acute medical wards

POSTE

2851. Clinical Quality - Clinical Effectiveness

Reducing the number of unplanned admissions to hospital through a multidisciplinary single point of access pre-hospital

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Frailty Hospital at Home, Kent Community NHS Foundation Trust

Background: East Kent has 38,101 people over 80 years, 39, 021 living with moderate or severe frailty and 304 care homes. This population have high levels of unplanned admissions which can put them at risk of long hospital stays, reduced mobility and increased delirium. East Kent Ambulance services (SECAMB), Acute hospitals (EKHUFT) and Community Services (KCHFT) have piloted a single-point of access consisting of an ED consultant, community frailty clinician, Urgent care senior nurse, advanced paramedic practitioners. They sit together at the ambulance bases, 10am-6pm Monday to Fridays. This team reviews all patients awaiting ambulances to assess whether there are alternative services to ED which would meet the individuals' needs.

Method: The MDT assesses all patients listed as awaiting an emergency ambulance. Clinical records can be accessed from all services including GP records. If patients would benefit from treatment by alternative services, rather than conveyance, the paramedics are asked to call the MDT. This allows clinical assessment, history and investigation results to be taken into account in planning care. Patients and Carers are involved in deciding how they would like to receive medical care via a video or phone link with clinicians.

Results: Conveyance to hospital pre pilot 62% post pilot less than 50%
Ashford catchment: admissions save weekly 27.3, bed days saved weekly 179.2
Thanet Catchment: admissions saved weekly 19.1, bed days save weekly 106.9

Conclusion: Many people can be treated effectively without conveyance to hospital through pre-hospital triage, consultation and planning by senior clinicians in a multi-disciplinary team.

POSTE

2853. Clinical Quality - Clinical Effectiveness

A Frailty Education Programme for care home staff

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Introduction: We wished to improve the knowledge of care home staff in Leeds in identifying frailty and managing frailty related problems

Method: We developed a frailty education course (www.leedsfrailtyeducation.co.uk) which was then refined and modified to target care home staff. We engaged key stakeholders at the council and the ICB to help develop and promote the course. The course was delivered across 4 venues in Leeds by geriatricians, a pharmacist and a community nurse.

Results: We had 128 attendees across the four days. From the feedback taken immediately after the study day (n=69):

- 100% of attendees found that the content was useful and well delivered.
- 97% of attendees improved their knowledge of frailty and 100% improved knowledge of CGA.
- CGA, assessing delirium and positive approaches to managing dementia were the 3 most common things attendees intended to take away for their future practice.

From the follow-up feedback (n=19):
- 95% (18/19) 'extremely agree' with the statements "Attending the training day has improved my understanding of frailty" and "I would recommend my colleagues attend this course"
- 42% (8/19) have implemented frailty assessments as part of standard care in some form

Attendees also valued the multi-sector, multi-professional expert presenters alongside the opportunity to meet and interact in-person.

Conclusion(s): A dedicated study day for care home staff was well received by attendees and feedback received demonstrated self-reported lasting change to practice. Key enablers to the success of the course were: the reputation of the course locally which had been piloted and delivered in different formats previously, tailoring the material to the audience, and delivering the course in several different locations. More regular frailty teaching days can be implemented to capture more care home staff and ultimately improve care for residents.

POSTE

2868. Clinical Quality - Clinical Effectiveness

Improving Bone Health: A Quality Improvement Journey implementing Scottish Hip Fracture Audit Recommendations

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Introduction: Hip fractures, predominantly affecting older adults, represent a significant health concern due to high morbidity, mortality, and healthcare resource utilisation. This ongoing Quality Improvement Project within Forth Valley Royal Hospital aims to enhance adherence to recommendations from the 2023 and 2024 Scottish Hip Fracture Audit. It specifically focusses on the timely administration of Vitamin D and IV Zoledronic Acid to frail patients with hip fractures.

Method: A retrospective and prospective cohort study design was employed, analysing the records of 165 inpatients under orthogeriatric care from November 2023 to May 2024. Initial data analysis indicated low rates of IV zoledronic acid and vitamin D administration, primarily due to clinician unfamiliarity and process inefficiencies. Subsequent interventions included staff education sessions, process standardisation, and the introduction of tracking tools such as Bone Health stickers and whiteboards. Formal referral pathways and decision-making protocols were implemented to ensure comprehensive and timely patient care.

Results: The interventions led to substantial improvements in adherence rates. Between November 2023 and March 2024 vitamin D administration rates increased from 14.71% to 100%, and IV Zoledronic Acid administration rose from 12.12% to 95.45%. These improvements were achieved through systematic tracking, enhanced clinician education, and standardised care processes. Despite these gains, challenges remain in achieving 100% adherence to IV Zoledronic Acid administration and addressing initial data capture inaccuracies due to inconsistent use of referral systems.

Conclusion(s): The project demonstrates that targeted interventions and standardised care pathways substantially improve adherence to national guidelines for hip fracture patients. Sustained efforts in education, process refinement, and collaboration with the Hip Fracture Audit Team are essential to maintain these improvements. Future proposals include integrating Vitamin D and Adcal-D3 doses into an electronic prescribing protocol and conducting detailed statistical analyses to identify further areas for improvement.

POSTE

2870. Clinical Quality - Clinical Effectiveness

Improving Multidisciplinary Team Meetings on an Elderly Medicine Ward at Leeds Teaching Hospitals Trust

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Introduction: Within our ward multidisciplinary team (MDT) meetings we noted that there was often a lack of attendance from key disciplines, inconsistent content, and an overly medical emphasis. We wished to create an MDT that was structured, with consistent input from nursing and therapy teams, covering components of comprehensive geriatric assessment (CGA).

Methods: On one pilot ward, we agreed a new structure to MDT meetings. Clinical leadership was required to facilitate staff sharing their observations, with clinicians speaking less. We used an A0 poster as a clear visual prompt for maintaining structure. A survey on teamworking and safety was performed on the pilot ward by the Improvement Academy. We had several iterations, but a standardised structure with key ingredients for MDTs was rolled out across five other Elderly Medicine wards. A further survey was performed examining opinions on quality of MDT working.

Results: After our interventions, CFS, 4AT and mobility went from being discussed 0% of the time in July 2021 to 100% of the time on the pilot ward between January and July 2024. Mobility went from being discussed from 0% in July 2021 to 71% in May 2024 across all wards. 90.5% of the pilot team thought that decision making utilised input from relevant team members. In a further survey in May 2024, 82.6% agreed that the relevant team members opinions were listened to.

Conclusion: A structured MDT process was successful in incorporating key elements of CGA whilst improving MDT teamworking. Starting with a single ward allowed others to gain confidence in the success of the process and enable natural spread. Key stakeholders including organisational leads were consulted and involved in improvement work, such that this is now a standard way of working. The lessons learned are being used to contribute to a digital dashboard tracking MDT progress.

POSTE

2874. Clinical Quality - Clinical Effectiveness

An Assessment of Analgesia and Laxative Prescriptions for Patients Admitted with Neck of Femur Fractures

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Introduction: Neck of femur (NOF) fractures can cause significant morbidity in elderly patients. Adequate pain control is essential for early mobilisation and improved outcomes. Health board prescription protocols exist offering a multi-modal analgesia approach as well as laxatives on the electronic platform (HEPMA). The aim of this quality improvement (QI) project was to assess adherence to these protocols.

Methods: Patients over 65 with isolated NOF fractures admitted to trauma wards from ED at a single district general hospital were included. Baseline data was collected from patients admitted between October to December 2023. Post-intervention data collected from April to June 2024. Prescriptions for regular and breakthrough opioids, regular paracetamol and laxatives on admission to the trauma wards were audited. Day 3 and day 5 review of pain and bowel status were also audited.

Intervention: An information session was delivered at the time of staff change over to senior house officers and junior clinical fellows to ensure they were aware of the NOF fracture analgesia and bowel protocol and available electronic prescribing bundles.

Results: A total of 169 patients were included. 84 prior to the intervention and 85 post intervention. Prior to the intervention accuracy for regular opioid prescription was 72.6%, PRN 83.3%, laxatives 81.8%, Paracetamol 88.1%. Post intervention respectively 87.1%, 94.1%, 92.9% and 91.9%. We demonstrated statistically significant change ($p< 0.05$) in regular, PRN opioid and laxative prescribing. No change in paracetamol, Day 3 and 5 pain and bowel reviews was found.

Conclusion: A positive change in prescribing accuracy was demonstrated. Potential barriers to appropriate analgesia prescribing may be lack of awareness of protocols and hesitancy in prescribing opioids in elderly frail patients. Information sessions will continue to run to ensure appropriate prescribing for NOF patients on admission. Further data will be available following further educational and poster interventions.

POSTE

2878. Clinical Quality - Clinical Effectiveness

The adoption of a Frailty Early Discharge Scheme is beneficial in reducing length of stay

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Introduction: Hospital-Associated Deconditioning Syndrome (HADS) can lead to prolonged length of stay (LOS). Evidence indicates that early intervention may reduce HADS and LOS. (British Geriatrics Society, Deconditioning, Healthy Ageing, 11 May 2017, Dr Amit Arora, NHS England, 24 January 2017, Time to Move).

The Acute Frailty Team (AFT) at Eastbourne District General Hospital piloted a Frailty Early Discharge Scheme (FEDS) in the Frailty Unit for 8 weeks between May-June 2023 with the aim of providing early mobilisation and discharge planning to reduce LOS.

Methods: Patients were admitted to either FEDS or Non-FEDS (NFEDS) beds depending on the bed availability. FEDS patients were provided with additional early assessments and interventions including discharge plans from day 1 after admission, offering early, continuous and active mobilisation by a trained FEDS team of a registered Nurse and Health Care Assistant. The FEDS team worked in conjunction with the medical team to actively promote discharge planning while patients were still receiving acute medical treatment, before patients becoming medically fit for discharge (MFFD). NFEDS followed the standard care plan, usually initiated after patients were declared MFFD. Data was collected for all patients, comparing FEDS 12 beds with NFEDS 12 beds.

Results:
83 patients were enrolled 45 FEDS, 38 NFEDS
Discharged within 48hrs FEDS 11.11%, NFEDS 2.63%
Discharged within 7 days FEDS 44.44%, NFEDS 28.94%
LOS 8.07 days FEDS, 11.36 days NFEDS (30 day trim point)

Conclusions:
1. Increased rate of discharge within 48 hrs and 7 days.
2. Reduced LOS within 30 days.
3. The benefit is mostly noticed within the first 7 days indicating the need to apply the intervention early
4. The adoption of a FEDS-project in all frailty wards could be beneficial for elderly patients.

POSTE

2880. Clinical Quality - Clinical Effectiveness

Reducing Emergency Re-attendance in Frailty SDEC Patients

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Background: Frailty Same Day Emergency Care (FSDEC) is a service designed to identify and manage frail older people at the hospital front door with a view to provide early Comprehensive Geriatric Assessment, implement management and where appropriate support a same day discharge home.

Introduction: In September 2023 the FSDEC service opened with 6 assessment spaces adjacent to A&E. This project aimed to quantify the rate of re-admission for patients seen in FSDEC and explore approaches to improve performance.

Methods: This QIP utilised a PDSA approach. Baseline re-admission data was collected from a 2-week period in October 2023. Notes were reviewed for all patients seen in FSDEC during this timeframe and reviewed for evidence of any 30-day emergency re-attendances. Cases were then reviewed to identify any links between the 2 attendances and any preventative measures that could have been taken. Following PDSA cycle 1 frailty nurse telephone follow up was implemented. PDSA cycle 2 was a stress test of this (limited) service during winter pressures. PDSA cycle 3 followed expansion of Community Integrated Response Hub (CIRH) and discharged patients being able to self-refer for support once discharged.

Results: FSDEC 7-day re-attendance reduced from 10% to 5% after introduction of frailty nurse follow up. This was not sustained over challenging winter months with variable staff availability but did recover in Summer 24. There has also been a gradual improvement in 30-day re-admission by PDSA cycle 3 following roll-out of self-referral to CIRH.

Conclusion: Emergency re-admissions have reduced following implementation of frailty nurse telephone follow up and expansion of community services including patient access to CIRH for help following discharge from FSDEC. Addressing staffing model could allow for a more consistent follow up service. There is scope to trial this approach on geriatric ward discharges.

POSTE

2887. Clinical Quality - Clinical Effectiveness

Transforming Advance Care Planning with the rollout of EPIC in post-acute geriatric medicine wards

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Introduction: Advance care planning (ACP) allows patients to prepare for their future and articulate their care preferences. Despite it being a major policy focus there are significant barriers that affect ACP delivery, including paperwork burden and information sharing difficulties. Electronic Health Records (EHRs) are fundamental to how ACP conversations are recorded and communicated. We present data from inpatient geriatric medicine unit during a change in trust-wide EHR (namely, EPIC) and a contemporaneous ACP educational drive.

Methods: Clinical notes for all patients on three geriatric wards were analysed on a single day in July 2023 and April 2024. EPIC was rolled out in October 2023. Demographics including age, admission and discharge destination, clinical frailty score (CFS) and social circumstances were retrieved, and notes were reviewed for ACP decisions. Teaching took the form of regular small group seminars for ward teams, and departmental sessions to build confidence and optimise ACP documentation using the new software.

Results: 83 and 85 patients were identified in July 23 and April 24 respectively. Demographic data were similar between groups including mean age (82; 84), CFS of ≥6 (67%; 61%). In July cohort, one patient had an ACP. In April, 20 patients had an ACP and 8 patients had a Universal Care Plan.

Conclusion(s): Significant improvements were noted in ACP delivery and documentation. Following the launch of EPIC alongside targeted teaching to staff members, the proportion of patients with an ACP increased by 23% and UCP by 10% over a 9-month period. EPIC includes improved ability to search for relevant information and dedicated space to document ACP plans, both of which may have contributed to these results. Future work aims to expand this learning into GSTT community services and across other trusts, capitalising on the potential of improved EHR technology in the NHS.

POSTE

2890. Clinical Quality - Clinical Effectiveness

Exercise Practitioner-Led Physical Activity in Hospitalised Older People: Saints Foundation – University Hospital Southampton

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Introduction: University Hospital Southampton (UHS) and Saints Foundation (SF) have partnered to test and deliver rehabilitation to hospitalised older adults via a non-registered Exercise Practitioner (EP) to promote physical activity (PA) and address hospital associated deconditioning. Now in its third phase, the project has evolved in response to patient and staff feedback. It delivers regular gym-based exercise classes and additional interventions, which have maintained or improved patients' dependency levels on discharge.

Method: From September 2023, the EP has delivered daily gym-based group interventions as well as 1:1 rehabilitation to hospitalised older adults. In addition, exercise prescription education for staff and signposting to community-based interventions is provided. Interventions take place in the acute therapy gym or wards.

Results: Between October 2023 and February 2024, the EP reviewed 115 patients, with a mean age of 86yrs. 90 (78%) underwent group-based intervention whereas 25 (22%) received 1:1 input. 100 (87%) patients maintained or improved their predicted to actual discharge destination, compared to 13 (11%) whose physical capability declined and 2 (2%) who died. 20 (17%) were readmitted within 30 days of discharge. Elderly Mobility Scores (EMS) improved from a mean of 13.42 to 13.97. Most patients were reviewed twice or more. Most patients (79% after 2 interventions) maintained a 4m gait speed score of >0.8m/s. Patient satisfaction and confidence in function rated high.

Conclusion: Intervention via a non-registered EP continues to have a positive impact on older adults' ability to maintain or improve function during an acute hospital stay. Factors such as outbreaks of infectious illness, staff absence and vacancies and high patient acuity prevent more frequent EP led intervention. Although overall strength and functional gains are limited, patient confidence in function remains high. Our future aim is to expand the project across UHS and bridge the gap to community rehabilitation services.

POSTE

2706. CQ - Clinical Quality - CQ - Efficiency and Value for Money

Enhancing Physical Rehabilitation to Prevent Hospital-Acquired Deconditioning: A Quality Improvement Project

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Introduction: Hospital-acquired deconditioning (HAD) leads to functional decline, extended hospital stays, increased fall risk, and higher readmission rates, resulting in a significant cost burden on the NHS. Preventing HAD through early and regular physical rehabilitation is crucial for improving patient outcomes and reducing healthcare costs. This Quality Improvement Project , conducted in a ward, aimed to evaluate and enhance the implementation and effectiveness of physical rehabilitation programs to prevent HAD.

Method: The project began with administering questionnaires to both staff and patients to assess their knowledge about HAD, its significance, and the importance of physical rehabilitation. Following the initial data collection, educational leaflets and teaching sessions were provided to both groups to raise awareness and improve understanding. Post-intervention data were collected using the same questionnaires to evaluate changes in awareness and practices.

Results: The post-intervention data showed significant improvements. Staff awareness of deconditioning risks increased (3.8x post-intervention vs. 1.4x pre-intervention), and the time spent mobilizing patients increased (4.7 hours per shift vs. 3.5 hours per shift). Patients showed a better understanding of the importance of sitting out (9.0 to 9.6/10) and engaging with physiotherapy (5.6 to 9.7/10), along with heightened awareness of the dangers of bed rest (8.5 to 9.5/10). These outcomes indicate that the intervention effectively enhanced both staff and patient awareness and practices regarding physical rehabilitation.

Conclusion: This intervention significantly improved staff and patient awareness, mobilization efforts, and understanding of rehabilitation's importance, effectively reducing the risk of HAD in the ward. Sustaining these improvements requires ongoing staff training, regular audits, and continuous education for both patients and healthcare providers. By preventing HAD, these efforts enhance patient outcomes and reduce the NHS's financial burden due to readmissions and prolonged hospital stays. The study highlights the crucial role of education and structured rehabilitation programs in combating hospital-acquired deconditioning.

POSTE

2764. Clinical Quality - Efficiency and Value for Money

Optimising Blood Sugar Monitoring in Frail Diabetic Inpatients

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Introduction: 1 in 6 hospital beds in the UK is occupied by someone with diabetes1. Keeping diabetic patients safe during hospital stays is a priority, and in 2023 the Joint British Diabetes Societies (JBDS-IP) published guidance on managing Diabetes in Frail inpatients2. An audit at our hospital later that year found that 70% of Capillary Blood Glucose (CBG) testing was non-compliant with guidelines resulting in unnecessary patient intervention, use of staff time and consumption of non-recyclable resources. The main aim of our project was to improve compliance with these guidelines and establish potential time and cost saving resulting from this.

Method: Focus on medical education with teaching sessions, information cards for lanyards and prompt posters around the inpatient ward areas. Worked with electronic prescribing team to establish use of an order-set for CBG testing to allow medical team to accurately communicate with nursing colleagues. In addition, engaged nursing staff via ward bulletins and observed CBG testing on ward.

Results: There was a reduction in CBG frequency for all diabetic patients of 27.9%. We identified that those patients with diet-controlled diabetes were commonly over tested, and in this sub-group the number of CBG tests performed was reduced by 51.9%. Average time for CBG testing was 147 seconds with anticipated cost savings from staff time and equipment use.

Conclusions: The use of default four times a day CBG testing results in unnecessary intervention in our frail inpatients. Through education and use of electronic systems we can reduce these interventions based on national guidelines, but more work needs to be done. Reducing CBG testing reduces use of healthcare assistant time, costly non-recyclable materials and overall reduces unnecessary patient intervention.

POSTE

2765. Clinical Quality - Efficiency and Value for Money

Reducing Avoidable Discharge Delays on an Elderly Admissions Ward

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Introduction: Our aim is to improve clinical efficiency by reducing avoidable discharge delays, increased number of discharges and availability of specialist Frailty beds. We intend to undertake 8 PDSA cycles with a new idea.

Background: 23 bedded Acute Frailty Short Stay Unit (AFU). Patient group defined as those admitted to the unit from April '24 to current. Our initial spot-audit analysed 18 patients; the mean total avoidable delay was 31.52 hours (range 4.73- 123.3 hours). Initial analysis demonstrated that delays became longer throughout the course of the day.

Methods: We evaluated staff opinions on the discharge process with a survey. Outcome measure identified as number of weekly discharges and appropriate patient flow to the AFU. Balancing measure identified as number of readmissions within 48 hours.

PDSA cycle 1 allocated a doctor to write discharge letters during MDT. PDSA cycle 2 allocated a suitcase symbol to a potential discharge in the next 24 hours. We then adapted the suitcase with colours to differentiate between ready and awaiting investigations/ aim home in 24 hours. The next involved allocating a discharge doctor to review patients with an amber suitcase from the previous day first.

Results: Initial staff feedback has been positive. Data demonstrated an increase from the baseline (from below 20 to an average of 25 discharges a week). This then dipped throughout May, during which time there was an unusual level of escalation, staff absences and annual leave. The data has begun to recover to a high of 27 discharges in the week of the start of June.

Conclusions: Utilising the MDT has been vital in the sustainability of the project. On-going staff surveys and regular meetings will help to ensure sustainability. Ongoing focus and further cycles are on encouraging junior members of the team to be involved with the intervention.

POSTE

2841. Clinical Quality - Efficiency and Value for Money

Moving CGA Closer to the Front Door in St Georges Emergency Department. 'Impact on Length of Stay and Other Outcomes.'

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St George's NHS Foundation Trust

Introduction: Emergency departments are increasingly seeing more older adults living with frailty. Between 5% and 10% of all those attending EDs and 30% of acute medical units are older adults living with frailty. The consequences of this on the system manifests as increased patient length of stay, poorer patient experience and clinical outcomes such as mortality and morbidity are measurably worse.

The Acute Frailty team aimed to move and expand its resource to provide a service to frail, older adults in both the Acute Medical Unit and the Emergency Department. This aligns with a key National objective that recommends all type 1 EDs have 70 hours access to a Acute Frailty Service. The team are a liaison service and therefore work alongside the ED and medical teams.

Method: Quality improvement methodology was applied utilising multiple PDSA cycles. An incremental increase in provision of an Acute Frailty service within the ED. A stakeholder group was set up, KPIs were set. The team worked alongside the ED team to improve early CFS scoring for over 65s and embedded the Nationally agreed same day frailty criteria of CFS/4AT, EWS and the presence of a frailty syndrome to identify appropriate patients for the service with the ED. The CGA was initiated in parallel with the ED assessment.

Results:
Time between admission and CGA decreased by ave. 30 hours
Time between CGA and dc from hospital decreased by ave. 1.6 days
Acute Frailty team activity increased in the ED and decreased in the AMU
No increase in re-admission rate was seen

Conclusion: A CGA initiated in the ED had a positive impact on length of stay and the earlier dc did not increase readmission rates.

POSTE

2847. Clinical Quality - Efficiency and Value for Money

Frailty Hospital at Home (H@H): Numbers Needed to Treat to Avoid an Unplanned Admission to an Acute Hospital.

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Introduction: East Kent Frailty H@H provides an alternative to admission to an acute hospital for frail people who are acutely unwell. Treatment at home is often the preferred option for People living with frailty and prevents some of the complications associated with hospitalisation such as environmental delirium, loss of function, isolation from usual contacts and infection.
However, it was not known whether H@H also reduced the workload of the acute hospital.

Method: Frail people who are acutely unwell are offered treatment in H@H instead of admission to an acute hospital. Referrals were made by community clinician e.g. Primary care, community nurse, Single point of access, paramedics etc. Interventions include CGA based assessment, point-of-care blood tests, ultrasound, urgent outpatient x-ray, CT and MRI scans, Intravenous therapies etc.

Data were collected using electronic patient records for the community and hospital services. The data collection period was April 22-Dec 23 Patients of 69 and over were included. SPA charts were generated for results.

Results: Before the introduction of H@H the number of non-elective admissions plus the corridor activity closely matched the predicted number of admissions. Since the introduction of the H@H there is a significant drop in the number of non-elective admissions plus the corridor activity compared to predicted admissions. This number (~400 per month) is similar to the number admitted to H@H.

Conclusion(s): H@H Data validated by NHS England has demonstrated that for every 1.03 patients treated 1 non-elective admission to the acute hospital was avoided.

POSTE

2852. Clinical Quality - Efficiency and Value for Money

A Proactive Multidisciplinary Approach to Reviewing Health and Care Needs of Nursing Home Residents in a Primary Care Network

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Introduction: We proactively reviewed nursing home residents using a multidisciplinary team (MDT) approach within a Primary Care Network (PCN). We aimed to enhance care coordination, reduce inappropriate medication use and ensure all residents had current advanced care plans in place.

Method: An MDT comprising a geriatrician, prescribing pharmacist, general practitioner, and nurse reviewed residents proactively. This involved reviewing the residents' current health and care needs, falls risk, medication regimens and advance care plans. We then performed medication reviews, reviewed advanced care plans, and identified the need for further interventions. When we repeated the process, we used a proforma that could be pre-populated prior to the meeting by the pharmacist and geriatrician to improve efficiency of the discussion.

Results: The initiative was piloted in two residential nursing homes with a total of 65 residents reviewed, of which 86% (n=56) received interventions. There was a 47% (n=29) increase in completed advanced care plans. 62% (n=40) of residents had medicines optimised, with polypharmacy being reduced in 46% (n=30) by an average of 2 medications per resident. 8% (n=5) were referred to additional services and 8% (n=5) required further investigations.

Conclusion(s): This proactive MDT model effectively addressed the needs of residents whilst demonstrating immediate positive outcomes. Key facilitators to good practice were teamwork, clarifying the objectives of the MDT, prior reviews of patient records, and ensuring staff who knew the residents well were present. We will use this approach with other nursing homes within the PCN and share our results with colleagues. This has the potential to reduce costs of medications and hospital admissions, as well as improve quality.

POSTE

2871. Clinical Quality - Efficiency and Value for Money

Empowering Community Partners to Provide Post-Diagnosis Support (PDS) for Persons with Dementia

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Background: Dementia is a prevalent condition in an ageing population. Persons with dementia and their caregivers are often uncertain about what to expect after an initial diagnosis. Previous studies conducted on the experiences of informal caregivers show a clear demand to address these: providing adequate information, psychosocial support and access to services.

Introduction: The diagnosis of dementia is usually made by specialists in the hospital. Resources in an acute tertiary hospital are valuable and need to be carefully distributed. To better allocate resources and relieve the manpower situation, we have collaborated with our community partner to provide PDS.

Methods: A PDS team consisting of an allied health professional and a caregiver peer is established with our community partner. They conduct home visits to provide psychoeducation to help persons with dementia and their caregivers to understand more about dementia, develop personalised care plans, and coordinate support services to provide psycho-emotional support.

Close communications are maintained between the PDS team and the acute hospital referral team. Multidisciplinary team meetings involving the geriatricians, nurses, case managers and community partners are also held quarterly to provide regular updates about the progress of the patients and facilitate learning.

Results: A total of 95 persons who were newly diagnosed with dementia in the previous 1.5 years were referred. 53 patients were eventually enrolled under the PDS programme and received psychoeducation and made personalised care plans. 72% were given caregiver support and 66% were linked up to community services. The average duration between date of referral to date of first home visit is 13 days.

Conclusions: In an ageing population where there is high healthcare utilisation, it is efficient to utilise services instead of duplicating them. By collaborating with community partners, we are empowering them to play a better role in supporting persons with dementia.

POSTE

2545. Clinical Quality - Improved Access to Service

The Burden of Frailty in a West London Hospital: A Case for an Acute 'Front Door' Team with Robust Links with Community Services

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Introduction: Global estimates indicate over half of individuals aged 85 and older are frail(1), costing the UK healthcare system approximately £5.8 billion annually(2). Locally, over 6,500 patients aged 65+ are admitted to West Middlesex University Hospital (WMUH) every six months. The proposed frailty team aims to implement early comprehensive geriatric assessments (CGAs) through a multidisciplinary approach. Timely CGAs can increase the likelihood of patients remaining in their own homes at 6 and 12 months (3), reduce length of stay (LoS), and lower healthcare costs, contingent upon available community infrastructure. WMUH serves multiple boroughs, necessitating coordination with various community services to support discharges. These services include Hospital at Home and Integrated Community Response Services.

Objective: To gather baseline data on frail patients admitted before the introduction of a 'Front Door Frailty' team.

Methods: Data were collected for all medical admissions to WMUH from 1st to 14th July 2022, including:

- Patients aged ≥65 years
- Numbers with a frailty syndrome
- Clinical Frailty Score (CFS)
- Admissions in the previous year
- Length of stay
- Mortality at 5, 9, and 12 months

Results: From 459 admissions over 2 weeks, 278 patients (61%) were ≥65 years old. Among these patients:

- 54% had a CFS ≥ 6
- 44% presented with a frailty syndrome
- 83%, 72%, and 67% were alive at 5, 9, and 12 months respectively
- Mean LoS was 11.0 days
- 37% had ≥1 admission in the following 6 months
- Of those with a CFS ≥ 6, 63% had ≥1 admission in the previous year

Conclusions: A high percentage of acute admissions at our hospital are characterised by frailty. Through early identification, multidisciplinary management, and improved links with local community services, the new acute frailty team aims to decrease length of stay and improve patient experience.

POSTE

2752. Clinical Quality - Improved Access to Service

Reducing the Wait for Dementia Diagnosis: Another Use for Day Hospitals

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Introduction: The Assessment and Rehabilitation Centre (ARC) in Edinburgh sees around 600 new patients a year who are beginning to demonstrate signs of frailty, principally around mobility and balance. When taking a comprehensive geriatric assessment, we commonly identify concerns around cognition. We noted in some cases people were already waiting to be seen by the Memory Clinic Services, the current wait for which is approximately 10 months. We decided to see what ARC could do to help.

Method: From within existing resources, alongside the Psychiatry of Older Age (POA) Team, the ARC multi-disciplinary team coproduced a pathway that involved an initial assessment comprising identification of potentially cognitively frail patients, taking a corroborative history, performing cognitive and imaging investigations. Each step was added to a shared spreadsheet enabling us to chart progress of diagnostic information steps.

Then once assessment complete, a POA colleague reviewed the evidence and made a diagnosis with treatment recommendations. The ARC team then discusses the outcome with the patient and their family, arranges a medication tolerance follow-up in ARC, then refers onward for ongoing community support.

Results: Between March 2023 and 2024, 52 patients completed the Memory MDT process, 34 (65%) of which were diagnosed with a dementia, 20 (33%) of which were started on dementia medication. 16 were removed from the Memory service waiting list (2.5%) and a further 18 avoided the need to be referred.

Conclusion: We identified a group of patients with a common underlying pathology that had resulted in them being referred to multiple specialities. By arranging our services around this vulnerable patient group rather than the other way around, we reduced their need for multiple hospital attendances and freed up resource in the memory service. Work is underway to spread and scale up.

POSTE

2762. Clinical Quality - Improved Access to Service

The introduction of Self-Assessment CGAs for Patients Ages 65 to 74 Years of Age in the Emergency Department

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Introduction: Currently only patients aged 75 years and older are targeted in Lewisham Hospital's Emergency Department by the Frailty Practitioners for a Comprehensive Geriatric Assessment (CGA). This is due to limited staff resources. However, it is well understood that CGAs are beneficial from the age of 65 years. We therefore trialled a Self-Assessment CGA (SACGA) which was given to the patients aged 65-74 years to complete on an I-pad. Results were reviewed by the Frailty Practitioners, who then conducted a brief discussion with the patient and health promotion for healthy aging.

Method: Patients were identified on the Emergency Department's dashboard who fell within the targeted age range, within the Frailty Practitioner's working hours. If they consented, they were given an I-pad to fill out a CGA independently. Some patients did require assistance with completion due to a variety of reasons.

Results: 50 patients were included in this trial. Initially the aim had been to include 100 patients but due to the volume of work generated it was scaled down for this cohort. The key emerging issues were falls, memory problems, pain, poor foot health, challenges accessing their GP and a requirement for social prescribing. Interestingly a small but significant proportion of the patients had a confirmed Learning Disability. This may be considered an emerging area of clinical need as this population of patients progresses into old age.

Conclusion: The SACGA was a useful tool identifying multiple issues that could be addressed to stop or limit progression of frailty. There was a plethora of referrals to other clinical services generated than initially anticipated. With the appropriate infrastructure and staffing it is felt that the SACGA is an efficient intervention in combating the challenges of an aging population. There is also scope for it to be used in other healthcare settings.

POSTE

2780. Clinical Quality - Improved Access to Service

Avoiding Acute Admissions by Working in a Multi-Disciplinary Team alongside Paramedics in the West Kent Clinical Navigation Hub

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Introduction: Home Treatment Service (HTS, a Frailty Hospital at Home model that provides Comprehensive Geriatric Assessment, diagnostics and treatments to avoid hospital admission for people with frailty) within Kent Community Health NHS Foundation Trust has increased links with the Acute and Ambulance Trusts. The MDT interacts with visiting paramedics within a clinical navigation hub (CHUB).

Method: 61 HTS referrals from the CHUB were compared with 61 direct clinician referrals from December 2023 to February 2024. The NEWs score, length of stay (LOS) and Advance Care Planning (ACP) documents were analysed.

Results: The average LOS under HTS via the CHUB was 2.61 days and 3.65 days for direct referrals. 27% of NEWS scores from the CHUB were high compared with 14% from direct referrals.

48 out of the 61 (78.6%) patients identified as requiring HTS by the CHUB had no ACP documents (the presence of a DNAR was not counted as this does not give community options). 37 out of 61 (60.6%) had no ACP on direct referral to HTS triage.

Conclusion(s): Referrals directed to HTS proactively from the CHUB have a higher percentage of NEWS scores that would require hourly observations and/or escalation to medical assessment. The CHUB explores community options while weighing benefits and risks of transfer to hospital in real time.

The LOS between the two referral sources is not hugely different and suggests that we are identifying patients requiring similar management regardless of source of referral. The CHUB gives options to patients who have fewer advance decisions recorded to support the direction of their care at the point of an emergency response. The CHUB allows HTS to access a different group of patients who may not have had routes to HTS enabled previously.

POSTE

2797. Clinical Quality - Improved Access to Service

Continuing Therapy from Intermediate Care Units to Home: Why Wait?

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Background: Patients triaged as routine, discharged home from Intermediate Care Units (ICUs) in East Sussex wait 4 weeks until rehabilitation continues by the Community Therapy Team (CTT).

Introduction: NHS England (2023a) and NHS England (2023b) call for minimal delays, effective coordination processes and sharing of information for timely rehabilitation in intermediate care settings. Local patient feedback indicated poor patient satisfaction and increased clinicians' anxiety regarding risk of deterioration due to long waits (Lewis A., Harding k., Snowdon D., BMC Health Service Research, 2018 18(1) 869).

Aim: To improve average wait times for routine ICU patients' discharge, for ongoing community therapy input, to within 1 week by July 2024, while maintaining patient safety and improving patient satisfaction

Method: Quality improvement methodology, using stakeholder engagement was used to determine the cause for long wait times for home therapy. PDSA cycles were engaged to determine if improvements could be made without a loss of quality of care, or impacting patient safety, while improving patient experience. These involved formal communication channels between teams and using a therapy assistant for an initial home assessment where full assessment had already been undertaken by registered therapists. Patient satisfaction surveys were undertaken to understand the experience of transition home.

Results: Baseline data indicated that waiting time for home therapy varied between 18 - 59 days, from discharge. After the initial PDSA cycle, waiting time reduced to between 4 - 10 days, and after the second cycle waits reduced further to between 3 - 7 days. Patients' satisfaction improved significantly with shorter waiting times for therapy once home.

Conclusion: Therapy assistant initial visits at home reduced waiting times to within a week, and patients' satisfaction improved with shorter waiting times. Patient safety was not compromised as there were clear protocols for appropriate escalations for unregistered staff.

POSTE

2812. Clinical Quality - Improved Access to Service

Local Radiological Reporting of Vertebral Fragility Fractures: A Missed Opportunity for Early Osteoporosis Intervention?

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Introduction: Vertebral fragility fractures (VFFs) are the most prevalent form of osteoporotic fracture, with an incidence of >20% in women >70 years old1. While often clinically silent in isolation, VFFs are associated with future osteoporotic fractures, decreased quality of life and an 8-fold increase in age-adjusted mortality2. Radiologists may facilitate early diagnosis of VFFs, allowing for more cost-effective intervention with greater patient outcomes 3. However, a national audit in 2019 demonstrated widespread failings in the radiological recognition and reporting of VFFs1, according to criteria outlined by the Royal Osteoporosis Society4. Crucially, only 2% of reports in patients with moderate-severe VFFs recommended referral to Fracture Liaison Services (FLS), compared to the national target of 100%. Here, we evaluate local VFF recognition and reporting performance, relative to the Royal College of Radiologists (RCR) targets5.

Methods: Single-centre retrospective analysis of all CT thorax, abdomen and pelvis scans in >50-year-olds. Two cycles were completed, with implementation of educational posters and a quick-code reporting alert between cycles. The proportion of reports meeting best practice criteria were measured. The criteria included: assessment of bony integrity (target 100%), correct identification of moderate-severe VFFs (target 90%), use of correct terminology in reports (target 100%), referral of moderate-severe VFFs to the FLS (target 100%).

Results: Bony integrity was assessed in 100% in both cycles. Identification of moderate-severe VFFs improved from 37% to 64% between cycles. Correct terminology was used in 63% and 56% of reports in the first and second cycles respectively. 0% of patients were recommended for FLS referral in both cycles.

Conclusion: This audit demonstrates local shortcomings in VFF recognition and reporting. While there was an improvement in identification of VFFs between cycles, RCR targets were still not met post-intervention. This reflects a nation-wide issue in the under-diagnosis.

References available on request.

POSTE

2883. Clinical Quality - Improved Access to Service

Quality Improvement Initiatives to Improve One Year Follow Up as per FLS-DB National Recommendations in a Welsh Health Board

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Introduction: Fracture liaison services (FLS) aim to prevent secondary fractures by ensuring high-quality care to all patients with fragility fractures above 50 years. The standard recommendation by FLS Database (FLS-DB) is to identify 80% of the expected fragility fractures, commencing treatment for 50% and monitoring 80% at 16 weeks and 52 weeks.

Methods: FLS team noted that only 18.4% (n=92) patients were followed at one-year of the total 875 patients identified in the year 2021 (National benchmark=22.3%). Whilst FLS team identified 42.6% (n=1649) patients in the year 2022, an 88% increase as compared to the year 2021. But there was reduction in the one-year follow-up from 18.4% to 13.8% (n=149) in 2022. Quality improvement methodology based on the model of improvement; Plan-Do-Study-Act cycles, was used. Process mapping for the existing FLS showed that follow-up was only ad-hoc and not formalised. Our objective was to improve follow-up at one-year.

Results: Process mapping supported the development of a separate clinic code for annual review of patients, led by a geriatrics specialty trainee and supported by the FLS Clinical Lead. The patient lists were drawn from the FLS-DB and new patients booked for one-year follow-up clinic. FLS identified more fragility fracture patients (n=2181, 61.4%) in 2023, a further increase of 32.2% as compared to previous year. Clinical leadership and dedicated one-year follow-up clinic supported improved performance (21.4%, n=310) in the year 2023, which is comparable to the national benchmark (22.2%).

Conclusion: Several challenges were identified including lack of accurate telephone numbers for many patients; patients are transferred to primary care at one-year but there but the is osteoporosis knowledge gap in the community and need for dedicated time for follow-up clinic. This quality initiative has streamlined our follow-up clinics but need dedicated time to meet the service demand and increased capacity.

POSTE

2893. Clinical Quality - Improved Access to Service

Telemedicine Unreadiness in an Older Frail Population Attending the Geriatric Day Hospital

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Introduction: Telemedicine uses communications technology for remote healthcare. Unreadiness includes difficulties with hearing, speaking, cognitive issues, vision problems, lack of internet-enabled devices, or no recent use of digital communication. Telehealth can enhance access and convenience, especially for rural patients, but faces challenges such as technology issues and impacts on patient-provider relationships, examination quality, care quality, and patient satisfaction. The COVID-19 pandemic has accelerated telemedicine adoption to protect medical personnel and patients, with significant promotion of video visits for home-based care.

Objective: This study aims to evaluate telemedicine unreadiness in an older, frail population at a geriatric clinic. Patients were contacted from February 1st to March 14th, 2021, during Ireland's COVID-19 "third wave," with up to three contact attempts made.

Method: Statistical analysis was conducted using STATA 14. 84 patients attended the Geriatric clinic, with 33 excluded for various reasons, leaving 51 participants (67%) who completed the survey. The mean age was 81.7 years, with 49% female. Most referrals were for cognitive issues (59%), followed by BPSD (13%), weight loss (9%), and falls (7%). The median Clinical Frailty Score was 4, indicating moderate to severe frailty. Regarding mobility, 77% were independent, 21% used an aid, and 2% were immobile. Cognitive assessments revealed 25% had normal cognition, 18% had mild impairment, and 57% had dementia.

Results: Only 10% of patients were ideal for teleconsultations, while 90% faced significant barriers, such as environmental impairments (26), sensory impairments (2), and both (18). Additionally, 25% lacked computer, and only 10% used the internet regularly. Despite 59% having family assistance, overall, 82% had some form of environmental impairment. Sensory impairments were common, with 29% using hearing aids but 37% still experiencing issues. Visual impairments were better managed, with 76% wearing glasses.

Conclusion: Telemedicine adoption has accelerated due to COVID-19, but significant barriers for geriatric patients highlight the need for better support.

POSTE

2608. Clinical Quality - Patient Centredness

Improving the Uptake of Telephone Interpreter Services for Non-English Speaking Patients in South Yorkshire

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Introduction: Language is a social determinant of health, as constituted by the World Health Organisation (WHO) back in 1948. UK migration rates have risen exponentially recently, and with it the inability for patients to speak functional English is a growing concern. Poorer health information and avoidance of service use creates fundamental health inequity within this demographic. The UK's ever-changing sociodemographic landscape necessitates a growing focus on health outcomes within non-English speaking patients.

Aim: To explore the barriers towards interpreter service use within South Yorkshire and how to improve communication with non-English speaking patients.

Method: Data was collected in a mixed quantitative-qualitative approach. A yes/no approach was adopted to answer the study objectives (i.e. whether family members had translated on behalf of relatives or if interpreter service use was documented). Observational comments from the notes were used to contextualise the data for further discussion. This was compared to available UK guidelines.

Findings: There was a widespread reliance on family members to interpret on patients' behalf, seen in 75% of non-English speaking patients on the sampled wards. Only 50% of these patients had documented use of interpreter phone lines across the wards, significantly below the audit's standards.

Discussion: Barriers to interpreter services may be attributed to inefficiencies within its online nature, including queues and connectivity issues. This discourages its uptake, especially in the face of increasing hospital pressures. The high reliance on family members requires ethical considerations. These include issues with confidentiality, poor safety netting and disjointed communication of diagnoses when family members are used to translate. Ultimately, reliance on family members should be actively discouraged. This project recommends a language assessment tool and identification charts to guide NHS staff to appropriate interpreter services, preventing care delays.

POSTE

2651. Clinical Quality - Patient Centredness

UHS SHINE Service: Haematology is Looking to Establish a Novel MDT Approach for the Management of Elderly Non-Hodgkin's Patients

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Introduction: In conjunction with Roche, an 18-month project was proposed to facilitate a more holistic approach in managing this patient cohort post-diagnosis and in turn improve outcomes, reduce length of stay and improve patient experience.

Method: The aim of the project was to design the MDT, ensure there is sufficient clinician capacity for implementation as well as develop accompanying pathways. The patient cohort was all patients with a diagnosis of Non-Hodgkin's Lymphoma over the age of 65. Whilst all patients meeting these criteria would potentially be eligible to be reviewed by the MDT, the patients would first complete a comprehensive frailty assessment at the end of which the clinician will assign a clinical frailty score (CFS). Any patient scoring 4 or above with a clinical concern will be added to the MDT for review. The MDT itself will aim to address all aspects of the patient's health care journey post diagnosis. To this end, the roles that have been defined as critical are: Haematologist, Geriatrician, Pharmacist, Physiotherapist/Occupational Therapist, Dietician, Clinical Nurse Specialist and Support Worker.

Results: Currently over 90 patients assessed. Over 60 discussed in MDT, with over 170 total reviews. Further qualitative TBC.

Conclusions: Currently at UHS there is limited provision of frailty services. This unmet need manifests as e.g. reduced rates of treatment completion or increased treatment modifications, increased length of stay for post treatment episodes, missed appointments and non-elective admissions. All of which subsequently impact the patient's prognosis and NHS resources. Evidence shows centres with a geriatric oncology service have seen increased success in completion of treatment for patients and length of stay reduced by an average of 4.5 days. This pilot has enabled the Trust to collate evidence of this being the case locally, ultimately facilitating improved patient experience, better patient outcomes and reduced.

POSTE

2659. Clinical Quality - Patient Centredness

Setting up a Frailty Virtual Ward: Opportunities, Successes and Challenges

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Introduction: The Gloucestershire Frailty Virtual Ward (FVW) is a novel multidisciplinary collaborative project which seeks to improve care for frail older patients. We describe our experience, reflect on lessons learnt and plans for future service development.

Methods: The Gloucestershire FVW was started in early 2023. It arose from an understanding that the needs of frail patients can often be better met in their own homes, by utilising a combination of digital technology combined with improved working across organisational boundaries at the primary/secondary care interface.

We reviewed data from all patients admitted onto our FVW between October 2023 and March 2024.

Results: 66 patients were included. The majority of patients were 'step-down', having been in hospital prior to FVW admission. The minority were 'step-up', having been referred from community colleagues. Clinical frailty scores ranged from 2-8, with a mean of 6.

During this period, our FVW managed a range of different clinical problems. The most common reason for FVW admission was infection, then heart failure, delirium and acute kidney injury.

Most patients were admitted for the management of a single problem (58%), although a significant proportion had 2 or more problems (42%).

Our FVW conducted a variety of interventions, including blood tests, face-to-face reviews, amending medications including antimicrobials, diuretics and analgesia.

Our FVW was also involved in decisions around the withdrawal of active care and initiation of a palliative approach.

Conclusions: Our FVW has helped facilitate early discharge and avoid hospital admission, with associated benefits to both patients and the acute trust. As a new service which aims to sit between primary and secondary care, we have encountered logistical and governance challenges associated with working across organisational boundaries. Additionally, we have found that the use of digital technology can cause anxiety for patients and place additional strain on carers.

POSTE

2666. Clinical Quality - Patient Centredness

End of Life in Care Homes: What are the Common Prescribing Patterns for Residents in their Last Phase of Life?

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Introduction: End-of-life (EOL) care in care homes includes patients experiencing "ordinary dying" from dementia or frailty, alongside those with chronic diseases and cancer. Recognising non-specific decline is complex. The One Weston Care Home Hub (CHH) implements comprehensive EOL care, achieving 95% of deaths in the preferred place and prioritising a "good death". Whilst "Just in Case" (JIC) injectable medications are commonly prescribed, a broader understanding of prescribing patterns is useful for learning about medicines waste and recognition of dying. This study investigates the prevalence of common prescriptions and explores the need to re-evaluate anticipatory medications for care home residents.

Method: A qualitative audit evaluated EOL care prescribing practices in 100 care home deaths by examining medication management in patient notes. Data were collected retrospectively on parameters including the completion of palliative drug charts, issuing JIC medications, and the timeline from prescribing JIC medications to death. Information on medications administered within the last two weeks of life and the cause of death was also recorded.

Results: 34% received no additional medications. Antibiotics were the most commonly issued medications; 31% patients received them, half in liquid form. Other prescriptions included oral or topical analgesia (21%), laxatives (9%), benzodiazepines (8%), and oral steroids (5%). Liquid preparations comprised half of the issued medications. 74% of patients had JIC medications issued a median of 23 days before death (range: 1-1244 days).

Discussion: The use of antibiotics in this cohort is complex: are they prescribed for successful treatment, or could braver decisions be made not to prescribe when recovery chances are limited? Injectable JIC medications are a timely proxy for recognising the terminal phase, but 26% of patients who died did not have these in place. Further study is required to determine if they were indeed not needed and how many of those prescribed were used.

POSTE

2722. Clinical Quality - Patient Centredness

Improving Advance Care Planning within Residential Homes

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Introduction: As care home residents are living with advancing frailty and multi-morbidity, it is important to initiate advance care planning as part of the comprehensive geriatric assessment and create universal care plans (UCPs). There is evidence that it can reduce inappropriate escalations of care, reduce hospital admissions, increase the proportion of residents dying in their preferred place and improve both resident and relative satisfaction.

Method: Retrospective audit in June 2024 of residents within the five residential homes covered by the newly formed enhanced health in care home (EHCH) team who had an initial comprehensive geriatric assessment (CGA) between March 2022-May 2024 to review if they had a universal care plan in place (UCP).

Further sub-analysis to review whether they had an existing UCP prior to EHCH review or this was created/edited by the EHCH team. Both the CGA and UCP would have either been completed by the EHCH matron or consultant geriatrician.

Results: There was an average increase from 26% to 89% in the number of residents with a UCP following an EHCH CGA. We have created/edited a total of 117 UCPs across the care homes in addition to those already in place across the 177 CGAs completed over this time period.

Conclusions: Advance care planning is a vital part of a comprehensive geriatric assessment and it is often not completed for many reasons including its time-consuming nature, lack of awareness and apprehension in having these discussions both amongst residents, relatives and staff and a lack of training and education. As an EHCH team, we have managed to improve the number of residents with UCPs to 89%. We hope this will mean a greater proportion of residents receive appropriate personalised care according to their wishes in their chosen place as well as dying in their place of preference.

POSTE

2731. Clinical Quality - Patient Centredness

Evaluation of Practice of Advanced Care Planning in GIM wards in Queen Alexandra Hospital/Portsmouth Hospitals University trust

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Introduction: In today's healthcare practice, many patients live longer with multiple health issues, often in a frail or terminally ill state. Their quality of life doesn't necessarily improve. These patients require optimal supportive care that respects their dignity. Advanced Care Plans (ACPs) are crucial here, facilitating person-centred discussions about future care preferences while the patients have the mental capacity for meaningful participation. We aim in this study to assess how many patients in General Internal Medicine department would benefit from ACP and compare that to our current practice in implementing ACPs

Method: This cross-sectional retrospective study was done in 2 instances, 1 month apart from 29/03/23 to 01/05/23.

The Sample size was 300 patients. The eligibility criteria were life expectancy of 12 months or less, age of 80 years and above, Clinical Frailty Scale (CFS) 8 or more, advanced dementia, and end-stage disease.

Result: 33 patients (11%) met the eligibility criteria for ACP. 8 patients (24.2%) were above the age of 85. 25 patients (75.8%) had a Clinical Frailty Scale score higher than 7. 12 patients (36%) had terminal cancer. ACP was done for only 6% of the cases that meet the eligibility criteria. Within three months, 90% of these cases passed away. It is important to mention that in 57.6% of the cases, ACP was discussed with the patient and the next of kin (NOK) but was not formally documented.

Conclusion: Our findings revealed that only 6% of the eligible cases had evidence of ACP. This aligns with the study “advanced care planning in patients referred to the hospital for acute medical care: Results of a National Day of Care survey” which showed 4.8% had an ACP.
The absence of ACP in the vast majority of re-admitted patients represents a significant missed opportunity to improve care.

POSTE

2759. Clinical Quality - Patient Centredness

Cardiogeriatrics – What is the Impact on End of Life Care for Older Cardiology Patients?

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Background: Royal Bolton Hospital is a district general hospital in Greater Manchester. In 2023, a Cardiogeriatrics service was introduced to deliver comprehensive geriatric assessment for older cardiology inpatients with frailty.

Introduction: Our aim was to evaluate the Cardiogeriatrics service with respect to the impact on end-of-life care for older cardiology inpatients.

Methods: Audit standards were defined using metrics for quality in end-of-life e care. All patients between the year 2021 and 2024 aged 75 and over who died as an inpatient or within 30 days of discharge were included. Patients who died following procedural interventions were excluded. Patient's casenotes were audited and compared before and after the initiation of the service.

Results: Casenotes for 88 inpatient deaths were audited (66 prior to introduction of the Cardiogeriatric service, 22 following). The Cardiogeriatrician initiated end of life care in 31.6% of inpatient deaths. This corresponded with a reduction in unexpected deaths from 25.8% to 13.6%, and a reduction in patients initiated on end-of-life care by the on-call team, from 28.6% to 10.5%. Junior doctors on Cardiology began to initiate resuscitation conversations with patients. Casenotes for 44 deaths within 30 days of discharge were audited. The majority (72.1%) of discharges were via standard discharge pathways rather than palliative pathways.

Conclusion: After introduction of the Cardiogeriatrics service, there was improved recognition of patients who were approaching end of life, and more proactive management of this. As many patients audited were not seen directly by the Cardiogeriatrician, we believe the service has contributed to a cultural change in the Cardiology team more widely towards more proactive recognition and management of end-of-life issues in older Cardiology patients. There remains a need for better utilisation of palliative discharge pathways and we plan to address this through further quality improvement work.

POSTE

2771. Clinical Quality - Patient Centredness

Improving collateral history taking in the geriatric population

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Introduction: The geriatric population has a high incidence of dementia, delirium and frailty meaning often these patients cannot give comprehensive histories themselves. We are left with missing pieces of the puzzle; we might not know their 'normal' and frequently ask: 'Are they always like this?'.

A collateral history becomes a valuable tool, contributing to a Comprehensive Geriatric Assessment and assisting the whole MDT to make informed decisions for patient-centred care. The primary aim of this project was to improve the quality of collateral histories taken for patients admitted to the geriatric wards, with content measured against 8 domains. A secondary aim was to encourage timely collateral histories within 48 hours of admission to the ward.

Method: Using PDSA methodology, collateral histories were analysed before and after implementation of a poster and teaching session.

Results: At baseline each domain was covered a mean of 40.5% of the time (range 9% - 81%). Following intervention this increased by 22% to 62.5% (range 18% - 89%), demonstrating a significant improvement (paired t-test, $P<0.05$).
It was already common practice to take collateral histories within 48 hours of admission to the ward (91%) which was sustained post-intervention (88%).

Conclusion: Use of a poster as a prompt, and delivering teaching, led to more thorough collateral histories. This suggests two barriers are knowing what to ask and perceived importance, elements which could be integrated into early postgraduate education. The impact on patient care has the potential to be significant and multidimensional but further work would be needed to understand this.

POSTE

2790. Clinical Quality - Patient Centredness

Changing the culture of personalised care plans in care homes: The Bromley experiment

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Introduction: Care home residents have a greater incidence of frailty and co-morbidities. Polypharmacy and inequitable access to integrated healthcare are confounders to positive outcomes in this cohort. Providing proactive care through the Enhanced Health in Care Homes (EHCH) Framework seeks to address these inequalities using multidisciplinary team (MDT) working.

Method: A pilot MDT intervention was delivered across eleven older peoples care settings with the most ambulance conveyances in a London borough known for its aging population. MDT members were from general practice (including pharmacist), geriatrics, ambulance service, district nursing, palliative care, psychiatry, social care, integrated care board and senior care home staff.

The intervention was refined iteratively over five months via a Plan-Do-Study-Act cycle. The MDT undertook comprehensive geriatric assessments, advance care planning and structured medication reviews. Outcomes were documented in personalised care and support plans (PCSP).

Results: Sixty-nine of the most complex patients were selected to receive the intervention. 100% of these patients had a PCSP created post-intervention. A resultant system culture change led to a three-fold increase in the number PCSPs across all care settings.

There was a reduction in 999 calls for 57% of MDT patients (across 8 settings) and there was 24% fewer 999 calls and hospital conveyances across the wider patient group in all MDT care settings. MDT professionals and care home staff reported high satisfaction and valued shared learning and clinical decision-making.

Conclusion(s): This intervention addressed health inequalities of care home residents with a clear thread of advocacy for patients. Proactive personalised care planning offered opportunities for earlier diagnoses, treatment, and swifter recognition of the dying phase of life. Primary care interventions within EHCH framework could be augmented by this MDT approach for a more complex cohort of care home residents with severe frailty and greater co-morbidity profile including dementia.

POSTE

2807. Clinical Quality - Patient Centredness

Lonely-less: A Quality Improvement Project Addressing Loneliness in the Elderly Following Neck of Femur Fracture

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Introduction: Loneliness affects nearly a third of adults aged >70. It increases the risk of conditions including depression, coronary artery disease and stroke. Lonely individuals are at increased risk of falls, hospital attendances and prolonged admissions. Following hip fracture, patients are particularly at risk and pre-fracture loneliness is associated with poorer outcomes. An inpatient stay offers the opportunity to screen for and address pre-fracture loneliness.

Aims: 100% of patients to have a University of California Los Angeles (UCLA) 3-item loneliness score by day 5 post-operatively. A score of 6 or above necessitates referral for community befriending services.

Study population: Patients aged >70 admitted with femoral neck fractures to orthogeriatric wards.

Methods: The project followed a Plan-Do-Study-Act approach. Electronic records were reviewed weekly for documentation of loneliness scores and referral to community befriending.

Interventions: 1. Doctor education session on loneliness and the UCLA 3-item loneliness scoring. 2. Inclusion of the loneliness score in the pre-populated ward round proforma.

Results: Of 102 patients, 63% of patients were female, mean age 85. At baseline, 0% had a loneliness score documented. This improved to 57% following intervention 1, returning to 0% after 2 weeks. Following intervention 2, this improved to 56% but fell to 25% after 6 weeks. Of 23 patients with completed scores, 5 (22%) had a high loneliness score and 4 patients were referred for befriending services.

Conclusion: High rates of loneliness were demonstrated, in line with national predictions. Assessment improved following interventions but was not sustained. Investigation suggested this was due to rapid turnover of doctors, and successive cohorts were unaware of quality improvement programmes before moving on. We believe this to be an important finding, with wider implications for research into improving patient care. Further steps include discussion of loneliness in weekly departmental meetings with the wider Multi-Disciplinary Team.

POSTE

2819. Clinical Quality - Patient Centredness

Improving Ortho-Geriatric Outcomes: Reducing Immobility and Post-Operative Hypotension in Patients with Neck of Femur Fractures

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Introduction: National guidance suggests that all patients with neck of femur fractures (NOFF) should be mobilised day one post-operatively (NICE, 2023, QS16). This reduces rates of delirium, pneumonia and length of stay (*Sallehuddin & Ong, Age and Ageing, 2021, 50, 356-357*). Hypotension is a leading cause of immobilisation post-operatively. National guidance advises appropriate fluid resuscitation and review of polypharmacy when indicated (British Orthopaedic Association, 2007). This quality improvement project aimed to reduce post-operative hypotension and improve day one post-operative mobilisation in NOFF patients.

Method: Three months of NOFF patients were retrospectively reviewed pre-intervention. Those who did not receive surgical intervention were excluded. The proportion of NOFF patients that were unable to mobilise due to post-operative hypotension on day one was identified. We reviewed if intravenous fluids were given pre-operatively and if anti-hypertensives were held. An intervention was then implemented including educational posters and teaching sessions for doctors and nurses to encourage prescription of fluids on admission, holding of antihypertensives pre-operatively and detection and escalation of oliguria or hypotension post-operatively. Data were then re-collected in a three-month period post-intervention to ascertain if there was any change in practice.

Results: 70 patients underwent NOFF repair pre-intervention compared to 54 patients who underwent the procedure post-intervention. There was a decrease in the proportion of patients unable to mobilise day one post-operatively due to hypotension from 15.7% pre-intervention to 9.3% post-intervention. There was an increase in the proportion of patients who received pre-operative intravenous fluids from 64.3% pre-intervention to 77.8% post-intervention. Of those patients who took anti-hypertensive medication, a higher proportion had this suspended pre-operatively, increasing from 82.9% pre-intervention to 88.2% post-intervention.

Conclusion: Simple educational interventions can reduce post-operative hypotension in NOFF patients. Developing local guidelines may facilitate persistent clinical change, as improvements following poster distribution and teaching sessions may be transient.

POSTE

2843. Clinical Quality - Patient Centredness

Evaluating Dementia Pathway Services: A Sussex-wide Patients and Carers' Perspective.

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Introduction: As the prevalence of dementia continues to increase across the UK, understanding the lived experience of patients and carers affected by dementia becomes paramount. There is an established dementia pathway in Sussex for people living with dementia (PLWD) and their carers. To improve care and inform future commissioning priorities, the Brighton and Hove Health Watch (BHHW- a community interest company) surveyed the opinions of a group of PLWD and their carers around initial diagnosis and subsequent support.

Methods: PLWD and their carers receiving social support and willing to provide feedback were included in this survey. Using a topic guide, BHHW volunteers conducted a telephone interview with this group exploring their experience with their general practitioner (GP), and the memory assessment service (MAS) in relation to diagnosis, and post-diagnosis support. Transcribed interviews were analysed using qualitative thematic analysis (inductively and deductively) using Braun and Clarke's method.

Results: Forty-five participants were interviewed, 37 carers and 6 PLWD (average age 78.2 range 64-95 years) between December 2022 and May 2023. Thirty-nine participants (86%) were of white-British ethnicity. Participants reported a range of different experiences with no consistent pattern by age, gender or location. Participants were generally satisfied with the initial GP care they received. The waiting time to access MAS was six weeks on average, an acceptable timeframe for the group. Some participants reported waiting as long as two years since the initial GP consultation before a dementia diagnosis was eventually made. Participants were generally satisfied by the thorough MAS review. Most participants felt that the information material they immediately received after dementia diagnosis was complex and overwhelming. Social support offered post-diagnosis was commendable.

Conclusion: The lived experience of PLWD and their carers in Sussex was generally positive. However, a tailored approach to post-diagnosis information provision is required.

POSTE

2865. Clinical Quality - Patient Centredness

Revamping ReSPECT: A qualitative assessment of the documentation in the 'clinician recommendations' section in ReSPECT forms

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Background: This project is based in the geriatric department of Wye Valley NHS trust which serves Herefordshire and mid-Powys.

Introduction: In frail, older patients, cardiopulmonary (CPR) resuscitation has low rates of success. Lack of appropriately completed ReSPECT forms leads to futile attempts of CPR, repeated readmissions and patient harm.

This project aims to improve patient centred advance care planning (ACP), and the quality of their documentation in the 'clinician recommendations' section in ReSPECT forms through development of new educational tools.

Methods: The Supportive and Palliative Care Indicator Tool (SPICT) was used to identify patients benefitting from ACP in the department. Data was collected on how many patients had ReSPECT forms and how well they were completed against standards adapted from the Resuscitation Council guidelines.

Plan-Do-Study-Act (PDSA) cycle 1 was completed developing an aide-memoire (ReSPECT tool), and an interactive workshop. PDSA cycle 2 lead to design of the project poster titled 'Revamp your ReSPECT discussions' which was displayed on the wards and shared on social media. PDSA cycle 3 was conducted to measure response and aid direction.

Results: PDSA 1 showed 71% patients meeting SPICT criteria had ReSPECT forms. This improved to 82% by PDSA 3. PDSA cycle 1 revealed that only 32% of ReSPECT forms were completed to audit standards, by PDSA 3 this improved to 43%. The project received engagement from the wider healthcare community on Twitter/X where the project poster garnered over 36,600 views and has been shared in the trusts latest issue of safety bites.

Conclusions: Our work led to an improvement in the quality of documentation and illustrated a novel approach to communicating the standards expected when delivering patient-centred ACP. The interest received via social media highlighted the importance of sharing this experience. We plan on building on this success through wider communication of the standards.

POSTE

2877. Clinical Quality - Patient Centredness

Can we make Comprehensive Geriatric Assessment (CGA) person-centred? A Quality Improvement Project using the CGA-Questionnaire

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Introduction: CGA is the gold-standard intervention for older adults living with frailty. A challenge is providing person-centred, time-efficient CGA. The CGA-questionnaire (CGA-Q) aims to facilitate person-centred CGA, allowing patients/carers to highlight concerns. We describe a two-site multi-cycle QIP implementing the CGA-Q.

Methods: CGA-Q is a 19-item questionnaire covering seven CGA domains. It was adapted from the validated CGA-GOLD questionnaire. Between March 2023-June 2024, CGA-Q was established in a London and Scottish NHS Trust using 'Plan-Do-Study-Act' methodology. Cycle 1-3 involved designing and establishing CGA-Q at one London geriatric clinic. Cycle 4 assessed feasibility in multiple London geriatric clinics. Cycle 5 examined implementation of CGA-Q in a Scottish day-hospital. Person-centredness refers to inclusion of person-selected concerns in clinic letters, and not including person-excluded concerns.

Results: Across cycles, cohorts were comparable in age, sex, frailty and cognitive status. In cycles 1-3 (n=174), CGA-Q completion rates improved from 39% to 83%. More CGA-Q questions were addressed especially cognition, mood, continence and falls. Inclusion of person-selected concerns increased from 60% to 70%; exclusion of person-excluded concerns remained ~70%. In cycle 4, completion rates varied by clinic: renal-CGA 100% (12/12); CGA 42% (13/31); bone-health 14% (10/60). >50% of questionnaires were completed by patients, except in bone-health where two-thirds were completed by staff. Staff feedback highlights CGA-Q is a useful discussion prompt. In cycle 5 (n=41), a similar breadth of CGA-Q questions was addressed among respondents compared to baseline. With CGA-Q, continence and pain were addressed more frequently. Inclusion of person-selected concerns was 62%; exclusion of person-excluded concerns was 71%.

Conclusion: CGA-Q has been successfully implemented across multiple sites and clinics. It can improve person-centeredness and breadth of CGA, but early results vary across subspecialty geriatric medicine clinics with their unique processes. Ongoing work will determine the experience of patients and carers of this approach.

POSTE

2888. Clinical Quality - Patient Centredness

De-Prescribing Anti-Hyperglycemics in the Elderly - A Quality Improvement Project

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Introduction: There has been a recent shift in guidelines regarding HbA1c targets in the frail population. NICE (June 2022) advocate individualised HbA1c targets for frail patients with diabetes in circumstances where the long-term benefit is uncertain or when a tight glycaemic control would increase the risk of poor clinical outcomes. This is backed up by randomised control trials that have showed that Hba1c levels < 53 mmol/mol (7%) because of anti-hyperglycaemic therapy are associated with increased morbidity and mortality in frail patients with diabetes. This led us to explore the current standards with regards to HbA1c review and consequent anti-hyperglycaemic deprescribing in frail patients in Hereford County Hospital.

Methods: Two audit cycles have been completed from March - June 2024 with a total sample size of 28 patients. Inclusion criteria were patients aged over 65 with a history of diabetes and a Rockwood Frailty score of 5 or more.

Results: The results of the first cycle showed that only 20% of the study group had their HbA1c reviewed. Only one had evidence of de-prescribing considerations. After the first cycle, a poster was created highlighting the importance of considering deprescribing for frail patients. The results of the second cycle indicated improvements following the poster display with 22% of the study population having had their HbA1c reviewed with subsequent considerations to de-prescribe. Furthermore, the poster generated positive informal feedback and stimulated conversations with colleagues about deprescribing.

Discussion and conclusion: For frail diabetic patients presenting to the Emergency department, deprescribing their diabetic medications is often not considered. They may be on medications that could be potentially causing more harm than benefit. Staff education appears to have a positive benefit, but more work needs to be done to ensure that deprescribing is considered for these patients.

POSTE

2889. Clinical Quality - Patient Centredness

Pain Control in Musculoskeletal Injuries of the Elderly

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Introduction: Musculoskeletal (MSK) injuries are a common factor in acute presentations to the emergency department (ED). Effective pain management is crucial for patient comfort and recovery, yet pain control for MSK injuries admitted under the medical team often falls short of optimal standards. This quality improvement project aims to evaluate and enhance the prescription practices for pain relief in elderly patients with MSK injuries at the Wrexham Maelor Hospital (WMH) ED.

Methods: A two-cycle project was completed in which patients with MSK injuries were identified and reviewed regarding any pain relief they may have been prescribed (regular or PRN). Following cycle 1, interventions were put in place and prescribing practices were reassessed with a second cycle. Inclusion criteria: >60 years of age with MSK injury described in notes. Each cycle of data collection lasted a week, with a sample size of 17 and 14 patients respectively.

Results: Cycle 1 No pain relief- 33% PRN Only- 6% Regular Only- 50% Both- 11% A significant number of patients were not receiving adequate pain relief, highlighting the need for improved pain management protocols.

Interventions- Educational posters were displayed around the emergency department and the frailty hub, and a presentation was given to the frailty team.

Cycle 2 (post intervention) No pain relief- 14% PRN Only- 29% Regular Only- 21% Both- 36% Post-intervention results showed a marked improvement in pain management, with fewer patients receiving no pain relief and an increase in the combined use of PRN and regular pain relief.

Conclusion: The quality improvement project highlights the necessity for targeted interventions to enhance pain management for elderly patients with MSK injuries in the ED. Preliminary results suggest that increased awareness and education among medical staff can potentially improve pain relief prescription rates.

POSTE

2441. Clinical Quality - Patient Safety

Reducing Anticholinergic Burden in Older Adults from an Acute Geriatric Ward – A Quality Improvement Activity Using Education

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Introduction: In older adults, anticholinergic burden (ACB) is associated with serious adverse effects including delirium, falls, functional decline, cognitive decline and death. We carried out a quality improvement project in an inpatient acute geriatric ward, aiming to reduce the percentage of older adults with high ACB scores on discharge by 15% from a baseline of 48% over a period of 3 months.

Method: A pre-interventional analysis of all patients discharged from a single acute geriatric ward in Changi General Hospital was performed. A pre-intervention survey was conducted to assess awareness among physicians of ACB and tools used. Fish-bone diagram, pareto chart and driver diagram were used to identify root causes, highlight the barriers and to prioritise interventions. Interventions in the form of educational posters on ACB, non-pharmacological management of delirium and behavioural symptoms of dementia were made available at the ward. ACB scores were generated for all patients on discharge, using an online ACB calculator[1], which combined the use of 2 validated scales: anticholinergic cognitive burden scale[2] and the German anticholinergic burden scale[3].

Results: 396 patients were included in the analysis. Median percentage of patients with high ACB scores (≥3) on discharge was reduced from 48.4% pre-intervention to 16.1% post-intervention. Out of 14 physicians surveyed pre-intervention, 21.4% was unaware of the term “ACB” and availability of ACB scoring systems.

Conclusion: An education approach is effective in raising awareness and reducing use of anticholinergic medications in an acute geriatric ward. This highlights the importance of incorporating ACB awareness and the tools into geriatric department teaching programmes.

References:

1. ACB Calculator. (n.d.). https://www.acbcalc.com/
2. Boustani M, et al. Ageing Health. 2008. 4(3). 311-320.
3. Kiesel EK, et al. BMC Geriatr. 2018. 18. 239.

POSTE

2535. Clinical Quality - Patient Safety

Anticoagulation in Atrial Fibrillation

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Introduction: A Clinical Audit was recommended by the ME following identification of potential safety signal because of possible non-compliance with guidelines on Anticoagulation in AF. The audit data collection tool was developed in discussion with the Chief Pharmacist and took account of up-to-date prescribing guidance from the Integrated Commissioning Board (ICB).

Aim: of the audit was to identify if, as per NICE guidelines patients had:

- Risk for stroke (CHA2DS2-VASc) and bleeding (ORBIT) is assessed upon new diagnosis of AF?
- Made aware of their risk assessments and involved in discussion regarding risk -vs-benefit of anticoagulation.
- Anticoagulation prescribed as per national recommendations.

Objectives: To ensure that patients with new diagnosis of atrial fibrillation are assessed for stroke and bleeding and involved in discussion regarding anticoagulation which is prescribed as per national recommendations.

Method: This local audit was carried out by analysis of both electronic and paper-based patient records using an Excel spreadsheet for analysis. Data was then analysed with the help of the Senior Clinical Effectiveness Advisor.

Results and highlighted risks: It was observed that in most cases (82%), patients were not made aware about the condition and associated risk of stroke due to underlying AF. They were also not involved in discussion regarding commencing lifelong anticoagulation, and not explained the benefits and risks of anticoagulation.

Omittance/Ignorance of anticoagulation upon new diagnosis of AF hence increasing the risk of stroke with lethal consequences of preventable death in 21% of patients.

Recommendations and Conclusion: Formulation of “AF Anticoagulation Checklist” (based on NICE guidelines) ensuring every patient with a new diagnosis of AF has a repeat ECG for confirmation of diagnosis, CHA2DS2-VASc and ORBIT scores for risk assessment, their renal functions and coagulation profile checked, followed by discussion with patient regarding results of risk assessment and risk vs benefit of anticoagulation.

POSTE

2601. Clinical Quality - Patient Safety

Comparison of Learning Themes from Falls Incidents Resulting in Moderate Harm and Above with Those Resulting in Low Harm, review

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Introduction: Our falls group reviews investigations of falls graded moderate and above to identify learning themes. PSIRF model highlights that learning is also available from low harm falls. Within our Trust 97% of falls are low harm. This presents a problem of volume when reviewing.

Method: We reviewed 30 falls graded low harm were investigated using an After-Action Review (AAR) model to identify contributing factors and learning. This was compared to the learning from 384 falls graded moderate harm or above between 2017 and 2023, 48 Datix investigations of falls graded moderate harm 2023-24 and 26 AAR investigations graded severe harm 2023-24.

The learning was similar across all harm levels identifying issues relating to:
-lying and standing blood pressure
-supportive observation
-dementia and delirium
-use/ availability of mobility aid
-bedrail and bed height configuration

By continuing to review our 3% of falls graded moderate and above at our weekly falls group, we have assurance that we are also identifying the main learning themes from low harm falls.

Results: Our falls specialist nurses complete a Rapid Review of around 75% of all falls regardless of harm rating. We found that the advice they provide is acted upon in 68% of occasions, providing assurance that our Rapid Review model is reasonably effective.

Conclusion: We believe our falls incident review process as described, provides a simplified, evidence-based pathway that can be generalisable across NHS providers. The pathway is supported by templates to proportionately manage safety incidents from Datix collection through to Duty of Candour communication whilst focussing efforts on those incidents for which maximal learning may accrue.

POSTE

2668. Clinical Quality - Patient Safety

Polypharmacy in the elderly: Are addressing the medication burden?

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Introduction: Polypharmacy represents a significant challenge in the vulnerable elderly population, where concurrent use of multiple medications increases the risk of interactions and adverse reactions, often precipitating acute events and complicated hospital stays.
This necessitates thorough medication reviews to mitigate these risks; a hospital admission allows for such opportunities.

Methods: This project aimed to evaluate and address the medication burden among elderly patients, following WHO's Global Patient Safety Challenge: Medication Without Harm.
50 patient's medications were reviewed on a elderly care ward over the space of 3 months.
A ward pharmacist and a senior member of the medical team critically evaluated inpatient charts on a twice weekly basis. Any changes made to the medication regimens were documented; additionally, the general practitioner was informed of any changes.

Results: Initial data indicated that 66% of patients were on five or more medications, with a high incidence of falls and a notable anticholinergic burden. On review of the 50 patients a total number of 36 drugs were de-prescribed, 38.9% were inappropriate anti-hypertensives, 13.8% vitamins amongst others.

Conclusions: This project has been an enlightening endeavour, teaching us the critical nature of addressing polypharmacy. We have learned that interdisciplinary collaboration, regular medication reviews, and patient education are key to managing this complexity.

To ensure long-term sustainability, we plan to institutionalise pharmacy board rounds and implement mandatory medication reviews. We aim to work closely with primary care to maintain continuity post-discharge. These efforts are expected to foster a culture of mindful prescribing and medication safety.

POSTE

2669. Clinical Quality - Patient Safety

Diagnosing Delirium on the Care of the Elderly Ward: A Quality Improvement Project

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Introduction: Delirium has a significant impact on morbidity and mortality. It is also associated with an increased level of institutionalisation at discharge and increased length of stay. Therefore, a diagnosis of delirium should always be considered with an assessment of risk factors. The aim of this project was to ensure 100% of patients on Geriatric wards have a diagnosis of delirium considered via the 4AT as per NICE guidelines.

Methods: A Plan-Do-Study-Act methodology was utilised with an initial audit exploring identification and documentation of delirium diagnosis. A Lanyard Prompt Card was then distributed to all physicians with the 4AT score illustrated. A departmental teaching session about Delirium was delivered to all juniors. A re-audit was conducted to assess impact.

Results: Of the 41 patients evaluated initially, 50.7% (21) were suspected to be delirious. Of these, 9.5% (2) had been assessed for delirium on the same day delirium was suspected. Of 38 patients, post-intervention audit revealed 36% (14) were suspected to be delirious and of these patients, 43% (6) had a 4AT score on the same day.

Key conclusions: This project revealed 4AT assessments were approximately tripled in patients suspected to be delirious post-interventions. There remains scope for improvement in confidence and skill of documenting assessments to meet the NICE recommendations and potential to explore barriers. Ultimately, we aim to expand across all medical and surgical wards to upskill all MDT members on identification and management of delirium.

POSTE

2766. Clinical Quality - Patient Safety

The 'Frailty Opportunity Identifier' - A Practical Tool Utilising Data to Identify Opportunities for Improvement

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Key to managing frailty is to first measure it. Until recently, there was no hospital coding for frailty, which meant that it was not visible to commissioners in routine datasets, despite the wealth of studies highlight poor outcomes for older people living with frailty. AFN has created the Hospital Frailty Risk Score (HFRS), which generates a frailty risk from routine codes included in NHS datasets. This allows commissioners and providers to 'see' frailty across their system. We have designed and implemented easy to use tools that allow any NHS staff to look at frailty risk profiles in any NHS organisation, to support improvement activity. The HFRS tool has been downloaded by 122 health systems in England.

Patient safety is fundamental to AFN and reducing the harm older people are exposed to in hospital is the main aim of the programme and sites participating in the network. To achieve this and spread best practice the AFN delivery team use a specific QI approach, primarily the Model for Improvement, focusing on Plan-Do-Study-Act cycles to build change in local systems. The team deliver events each year for all participating teams to support teams and enable sharing of experience. Site visits comprise discussion about the local context, plans for change and a discussion about possible barriers, as well as a walk-though the patient pathway with patient safety as the absolute focus. Each participating hospital has an allocated QI Associate to support the team to plan, deliver and measure improvements.

AFN has linked closely with other campaigns that support the safety and improve the care of older people, such as 'end PJ paralysis' and 'no decision about me without me'.

POSTE

2791. Clinical Quality - Patient Safety

Sharing Learning from Incidents and Complaints through Whole Team In-Situ Simulation Training in Older Person Medicine

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Introduction: Incidents and complains are an important form of learning for healthcare institutions. The learning is often shared via huddles, handovers, emails and learning alert bulletins. In the older persons medicine (OPM) department at James Cook University Hospital, we identified that there may be a role for whole team in-situ sim to not only facilitate learning around important and highly relevant topics but also improve the education provision for nurses and healthcare assistants who have less access to education compared to their doctor colleagues and improve whole team communication.

Methods: Initially a working group including a consultant, advanced clinical practitioner, SIM training facilitator, liaison psychiatry nurse, teaching fellow and ward manager was set up to organise a pilot session. Following the success of this session the training was initially organised to be monthly, arranged by the advanced clinical practitioners, facilitated by the sim technicians. The ward managers fully supported the training and facilitated the attendance of the ward staff. The clinical director identified topics for learning from incidents and complaints and there was support from the OPM registrars and teaching fellow. It quickly became so popular amongst staff that the session frequency was increased first to fortnightly and is now run weekly.

Results: The feedback was excellent. From the attendees to the sim trainers, it was said that the OPM department had been the most enthusiastic about ward-based training. The anonymised and entirely positive feedback from the sessions was that they were interesting, informative, and relevant to clinical practice.

Conclusion: Using in-situ simulation training on the older persons medicine wards to share learning from incidents and complaints is not only practical, but incredibly well received by staff of all disciplines.

POSTE

2838. Clinical Quality - Patient Safety

Evaluation of the use of the National Early Warning Score (NEWS2) for Delirium Identification in Welsh Hospitals

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Introduction: The National Early Warning Score (NEWS) (2017) incorporated new confusion as a category for consciousness. NEWS2 is evidenced to have high specificity but low sensitivity in detecting delirium.

Methods:
Morriston Hospital
261 patients assessed. Consciousness, overall NEWS2 score and AMT4 recorded.
227 NEWS2 charts available. 208 patients recorded as alert. 44% (n=87) scored less than 4 on AMT4 ,55% (n=48) didn't have documented past medical history (PMH) of cognitive impairment. Data missing for 14 patients.

Ysbyty Gwynedd
178 patients assessed.161 recorded as alert. 58.4% patients scored less than 4 on AMT4, 77% had no PMH of cognitive impairment. Data missing for 15 patients.

University Hospital Llandough.
40 patients; 38 patients were marked as Alert, 2 were excluded from observations.32.5% (n=13) had a diagnosis of possible or definite delirium.

An electronic survey coupled with training delivery of 103 Health Care Workers (HCW) and 112 Registered Nurses (RN) was undertaken at Morriston. 39 HCWs (37.8%) and 31 RNs (27.6%) weren't confident in the use of NEWS2 in regards to acute confusion. Training was offered on a 1 to 1 basis for these 215 staff members.

Results: Post intervention, 221 patients were assessed at Morriston, 209 marked as alert. 2 patients had been identified as having a new confusion and 10 patients did not have their consciousness recorded. Of the 209 marked alert 42% (88 patients) scored less than 4 on AMT4; 53 had no PMH of cognitive impairment. Training yielded little benefit.

Conclusion: The accuracy of recording consciousness has wider implications on the use of the NEWS2. NEWS2 uses routine observations and delirium assessment is variably implemented meaning routine information is not always available. The NEWS2 should be used in conjuction with other tools developed for delirium e.g 4AT and SQiD.

POSTE

2854. Clinical Quality - Patient Safety

A Change Initiative to Improve Patient Safety in Inpatient Fall Management through Enhanced Compliance with the PFMA Document

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Introduction: The local issue tackled was the suboptimal compliance with the Patient Fall Management Assessment (PFMA) on the Electronic Patient Record (EPR) due to assessments being completed on alternative electronic documents. The goal was to emphasise on this to improve patient safety.

Methods: Audit data was collected by reviewing incident reports of inpatient falls across various complex care wards over a 12-month period each, with 109 notes reviewed in the first cycle and 204 in the second.

Interventions: The approach involved conducting repeated training sessions for all grades of training doctors within the trust.

Results: The first audit cycle revealed fair compliance with the PFMA document (87%), documenting events (94%), examinations (87-96%), further investigations and management (80-86%). However, these were lacking for past medical history (61%), medications, especially anticoagulation/antiplatelets (58%), although antihypertensives/sedative reviews were better (75%). The interventions led to a small (2%) increase in the use of the PFMA document but a 100% compliance in recording fall events and a 13% improvement in documenting histories. Review of blood thinners and other medications improved by 17% and 8% respectively. Significant improvements were also seen in examinations and developing management plans. Despite these advancements, 14% of patients experienced recurrent falls, indicating a need for ongoing efforts.

Conclusions: The audit highlighted the effectiveness of continuous training to ensure regular understanding of the importance of completing the PFMA. Given the frequent rotation of junior doctors as well as the increasing variety of allied health care professionals reviewing patients, especially out of hours, this presents a particular challenge. Future efforts will focus on more sustainable methods of increasing awareness of the PFMA such as discussion at multi-disciplinary staff inductions and welcome packs. Sustaining these improvements will involve regular audits and feedback loops as well as feedback on the document itself to assess for future improvements.

POSTE

2800. Scientific Presentation - BMR (Bone, Muscle, Rheumatology)

25-hydroxyvitamin D and Inflammation in Older Acute Hip Fracture Patients

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Introduction: Preoperative systemic inflammation has been shown to worsen postoperative outcome in emergency surgical patients. C-reactive protein (mg/L) /Albumin (g/L) ratio is a well validated inflammation marker. Studies have shown an inverse relationship between 25-hydroxyvitaminD level and markers of inflammation. Vitamin D deficiency has been previously shown to be associated with inflammation.

Aims and Objectives:
• To determine the relationship between 25-hydroxyvitamin D level and CRP/Albumin ratio in older acute hip fracture patients.
• To explore the impact of gender on this relationship.

Methods: A retrospective review of electronic notes from the hip fracture database was carried out on hip fracture patients attending a single trauma centre from January to December 2022. Anonymized data were extracted from the database. Patients aged 60 years and older who sustained an acute hip fracture were included. Patients with incomplete data were excluded. The IBM SPSS 29 software was used for statistical analysis. Descriptive statistics was used for baseline characteristics. Linear regression was used to determine correlation.

Results: A total of 293 patients were analysed: 82 males and 211 females with a mean age of 81.6(SD 8.28) and 83.2(SD 7.85) years respectively. Mean 25-hydroxyvitamin D levels were 39.1 (SD 25.0) and 49.7 (SD 29.01) nmols/L respectively. Mean CRP/Albumin ratio was 0.94 (SD 1.51) and 0.71 (SD 1.34). There was a negative, statistically significant correlation between 25-hydroxyvitaminD and CRP/Albumin ratio in male patients but not in the females ($r = -.274$; $p = .013$ & $r = -.035$; $p = .61$) respectively.

Conclusion: In this study, 25-hydroxyvitamin D levels are inversely correlated with markers of inflammation (CRP/Albumin ratio) in older male hip fracture patients but not older female hip fracture patients. More studies are needed to clarify whether vit D lowers inflammation or inflammation lowers 25-hydroxyvitamin D concentrations and to investigate the gender difference.

POSTE

2850. Scientific Presentation - BMR (Bone, Muscle, Rheumatology)

Multicomponent Tailored Intervention for Nursing Home Residents at Risk of or With Sarcopenia: A Mixed Methods Feasibility Study

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Introduction: Sedentary behaviour and physical inactivity increase the risk and progression of sarcopenia among nursing home residents. This study aims to investigate the feasibility and acceptability of a multicomponent tailored intervention targeting these behaviours to support residents at risk of, or with sarcopenia.

Methods: Single-group pretest-post-test design, guided by a Theory of Change logic model developed from a systematic review, qualitative study, and stakeholder workshops. The intervention was tailored to residents' nutritional status and physical performance and was delivered by nursing home staff. Feasibility was assessed using participant flow, intervention delivery and receipt, and interview data. Behavioural, physical and psychosocial outcomes were measured at baseline, 6 and 12 weeks.

Results: Eighteen participants from an urban nursing home (n=13 residents, n=5 staff) were recruited. Recruitment (81% eligible recruited) and retention (89% at both 6- and 12-week follow-up) were acceptable. Residents' adherence to the sedentary behaviour and physical inactivity interventions was 89% and 84% respectively. Intervention elements of tailored activities based on capabilities, incorporating enjoyable components, face-to-face and group-based delivery were highly favoured. Behavioural and physical outcomes improved in 11 and 8 residents, respectively. Most residents perceived psychosocial benefit from the intervention. No burdens associated with the intervention or outcome measurements were reported by residents nor staff.

Conclusions: It is feasible and acceptable for nursing home staff to deliver this multicomponent tailored intervention to residents at risk of, or with sarcopenia. Further research with a larger sample and cluster randomised design is needed to test effectiveness.

POSTE

2368. Scientific Presentation - Cardiovascular

Analysis of Lipid Variables Involved in the Prognosis of Geriatric Patients in a South American Hospital with Heart Failure

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Introduction: Hypertriglyceridemia (HTG) is linked to heightened cardiovascular risk, yet its significance in geriatric patients is poorly comprehended. This study analysed the association between HTG, cardiovascular risk factors, and renal complications in high-risk geriatric individuals.

Methods: 100 geriatric patients (mean age 68.7 years) underwent extensive clinical evaluation including Framingham risk scoring, anthropometric measurements, blood pressure, full lipid profile, kidney function tests, and carotid intima-media thickness measurement. HTG was characterised as triglycerides ≥1.7 mmol/L.

Results: 73% of patients necessitated HTG drug treatment although 59% were already on lipid-lowering therapy. Compared to normal triglycerides, HTG patients had substantially higher body mass index, type 2 diabetes prevalence, systolic and diastolic blood pressure, carotid intima-media thickness, total cholesterol, LDL-C, creatinine, phosphorus, C-reactive protein and significantly lower estimated glomerular filtration rate (eGFR) (all $p<0.05$). 41% had intermediate-high TG levels (1.7-2.3 mmol/L) and 32% very high levels (2.3-5.6 mmol/L). Patients with highest triglycerides and moderate risk with intermediate-high levels exhibited very high Framingham risk scores ($p=0.0021$). HTG displayed significant correlations with obesity, hypertension, atherosclerosis, inflammation, dyslipidemia, and impaired kidney function.

Conclusions: HTG has substantial associations with increased cardiovascular risk factors namely obesity, diabetes, hypertension, atherosclerosis, inflammation, dyslipidemia, and poorer renal function in high-risk geriatric patients. Additional research should determine HTG's importance in this population. More aggressive HTG treatment may help reduce cardiovascular events, mortality and renal complications in this high-risk group.

POSTE

2638. Scientific Presentation - Cardiovascular

First Study of Cardiovascular Risk Estimation Using Globorisk in a Latin American Geriatric Cohort with COPD

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Introduction: It is expected that by the fourth decade of the 21st century, chronic obstructive pulmonary disease (COPD) will become the third leading cause of death worldwide. These data require awareness among treating physicians of these patients.

Methods: A pilot study was conducted from January 2020 - December 2022 in a South American health institution in which cardiovascular risk was estimated using GLOBORISK and ATP-III criteria. Data derived from the metabolic profile included in the ATP-III criteria were collected. Quantitative variables are presented as mean ± standard deviation or median (interquartile range) according to their distribution and qualitative variables as percentages. Student's t-test was performed to evaluate differences between two variables. All statistical analyses were performed with (SPSS for Windows, v.22.1; Chicago, IL).

Results: The present study showed that metabolic syndrome variables in these patients were elevated. Male sex was 77% and female 23%, smoking 61%. The GLOBORISK equation found mostly patients with low to moderate cardiovascular risk. It was found that there was a higher cardiovascular risk in those patients with FEV1 less than 30%, showing a statistical correlation of this alteration for the GLOBORISK scale.

Conclusions: This is the first pilot study that estimates cardiovascular risk using GLOBORISK in the COPD population. We consider integrating national and international networks to compare the results found here

POSTE

2826. Scientific Presentation - Cardiovascular

The Effect of Age and Frailty on Outcomes for Older Adults Admitted with Acute Coronary Syndrome: An Analysis of MINAP Registry

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Introduction: Frailty, independent of age, is associated with adverse outcomes following admission with Acute Coronary Syndrome (ACS) but is often not accounted for in risk stratification scores. Those identified as frail may not be considered for invasive interventions despite evidenced benefits (1) and are at risk of worsening geriatric syndromes on discharge.

Purpose: We aimed to assess clinical outcomes in older adults admitted with ACS, with or without frailty to suggest if there is a role for geriatrician input in improving healthcare usage and preventing adverse events.

Method: Anonymised data was obtained from an NHS trust's MINAP registry of patients admitted with ACS between April 2022 to March 2023. Baseline demographics, Clinical Frailty Score (CFS), GRACE and HEART scores, total length of stay (LOS), days as inpatient pre- and post-procedure, adverse events during admission, readmission rates and all-cause mortality rate at 30 days and 1 year were calculated.

Results: 288 patients over age 65 admitted with ACS were included in analysis.
Median age was 73 [IQR 67-80.75]. Patients over 75 years had higher rates of frailty (38.5% of 75-84 years and 50.0 % over 85 years had CFS ≥ 5 versus 14.9% 65-74 years ($p<0.00001$)).
253 (87%) patients underwent invasive angiogram during admission. Although age was not a limiting factor, frail patients were less likely to have an angiogram: 24.9% of CFS ≥ 5 versus 57.1% of CFS ≤ 3 ($p=0.00199$).
Mean LOS was 9.02 days with a median of 7[IQR 4-12]. There was a trend for longer LOS post-angiogram particularly for patients with CFS 4-5 versus CFS ≤ 3 (11.3 days v 8.92 days $p=0.053$).

Conclusions: Input from geriatricians and wider multidisciplinary team may help to optimise decision-making and care of patients admitted with ACS with mild to moderate frailty.

1. Damluji et al. J Am Heart Assoc. 2019;8:e013686

POSTE

2884. Scientific Presentation – Diabetes

Protein for Breakfast: A Simple Dietary Change Can Bring Glucose Stabilisation Benefits in Care Home Residents

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Introduction: One in four Care Home (CH) residents have diabetes, making diet crucial for controlling glucose levels (GLs). Continuous blood glucose monitoring (CGM) now offers deeper insights into GL fluctuations. Diabetes in severe frailty is often overtreated, particularly with insulin, posing risks such as hypoglycemia, avoidable hospital admissions, and labour-intensive clinical supervision. While protein and vegetables can slow glucose absorption, dietary advice for CH residents typically emphasises carbohydrates and may not be tailored to their frailty. This study investigates the impact of modifying protein intake in insulin-using diabetics to improve glycaemic control.

Method: A small pilot study assessed if protein-rich foods (e.g. eggs, peanut butter) given for breakfast stabilise GLs throughout the day. Eight diabetic CH residents using insulin were randomly selected over four months. A diabetic frailty pharmacist monitored GLs with the CGM device (Freestyle Libre) and analysed GLs after a protein-rich breakfast. Descriptive analysis and t-tests were conducted using R before and after the food intervention, and ANOVA was used to analyse significant differences in GLs.

Results: Six out of eight patients showed statistically significant reductions in GL spikes, sustained throughout the day. For the remaining two patients, the food intervention helped maintain target GLs. This led to the discontinuation of insulin in one patient, and in the second, problematic frequent hypoglycemia was mitigated by the food intervention. Clinical decisions on patient safety influenced outcomes for these two patients but were not excluded from analysis.

Conclusion: Six of the eight residents given additional protein at breakfast showed significant GL reductions, leading to decreased insulin dosing and simpler regimes. Carers reported improvements in mood, sleep, and energy levels anecdotally. A holistic dietary approach in managing diabetes in CH residents, emphasising increased morning protein intake, should be considered to enhance GL control and allow deprescribing. A larger study is planned.

POSTE

2625. Scientific Presentation - Ethics and Law

Navigating Morally Challenging Scenarios in Advance Care Planning: A Survey Study

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Introduction: There are abundant anecdotal reports of healthcare professionals undergoing strain, specifically moral distress, in advance care planning (ACP) related work. This study measured perceptions of morally challenging scenarios (MCS) faced by ACP facilitators and frontline clinicians.

Method: An online survey, which is currently ongoing, was sent to the ACP community and also frontline clinicians in Singapore. Purposive and snowballing sampling approaches were employed.

Result: Participants rated their opinions on 23 MCS in ACP-related work that were earlier identified from 30 interviews. Findings showed that the top three MCS perceived to go against one's conscience were: (i) providing treatment not in concordance with wishes of patient, (ii) being uncertain if decisions by family members were driven by ulterior motives and (iii) taking the view of dominant family members as the final decision. Most commonly encountered MCS were dilemmas related to (i) perceived medical best interest, (ii) honouring of patient's preferred place of death, and (iii) having to deal with collusion. Each of 14 MCS were encountered by at least 50% of our participants and 66% of all who had encountered at least one MCS agreed that their psychological health was affected. Guidance from mentors and support from peers were rated most favourably out of the 15 coping strategies to deal with moral dilemma in ACP work. Coping strategies were largely positive with only a minority favouring the use of alcohol or giving in to demands of patients and families.

Conclusion: Findings show those who engaged in ACP-related work encountered a wide variety of MCS and perceived their psychological health as being affected. There is a pressing need to address the sources and risk factors of moral distress in such work, and to enhance the protective factors which can help ACP facilitators and frontline clinicians cope with moral distress successfully.

POSTE

2504. Scientific Presentation - Education / Training

Barriers Perceived by Medical Students when Considering a Career in Geriatric Medicine

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Introduction: Despite the UK's increasing life expectancy, and increase in the elderly population, there is an overwhelming lack of Geriatricians in the UK; as of 2022, there is only 1 consultant Geriatrician per 8,031 individuals over the age of 65 (BGS, 2023). To meet the complex care needs of this population, there must be a focus on increasing the interest that doctors have towards Geriatric Medicine, with the overall aim being to recruit more doctors into the speciality.

Method: The aim of this review was to investigate what factors medical students perceive as barriers to pursuing a career in Geriatric Medicine and then, from identifying these, generate a set of comprehensive suggestions as to how to tackle these barriers at a medical school level to increase the interest and ultimately uptake of Geriatric Medicine. The qualitative review contains literature published between 2003 and 2023 accessed using MedLine.

Results: Six themes were identified in answering our question: (a) high emotional burden, (b) caring for patients with complex needs, (c) negative preconceptions of non-clinical factors (prestige, salary, career progression), (d) negative influence of clinical educators, (e) lack of intellectual stimulation and (f) lack of exposure to the speciality and the elderly.

Conclusion: The barriers perceived by medical students when considering Geriatrics as a speciality are complex and multifaceted; these barriers must be tackled promptly in order to secure the next generation of Geriatricians. We suggest that this work can be used as a foundation for further qualitative studies with UK medical students to investigate barriers that are specific to UK students. From this, interventional courses designed to increase Geriatric Medicine uptake could be developed to strengthen the UK Geriatric Medicine workforce.

POSTE

2603. Scientific Presentation - Education / Training

Optimising the Research Capacity and Capability within a Multi-Disciplinary (District General Hospital) Elderly Care Department

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Introduction: Older adults, particularly those with multi-morbidity, frailty or cognitive impairment, are under-represented in clinical research studies. To facilitate inclusive research for this population requires empowerment of all members of the multi-disciplinary team to promote and advocate for this underserved population. However, understanding of the personal and organisational barriers to staff engagement with research within Elderly Care remains limited.

Method: Using an amended version of the research capacity and culture tool an anonymous online survey open to all staff members of an Elderly Care Department (n=351) in a District General Hospital was undertaken. The survey results were used to inform the departmental 5-year research strategy and launch a multifaceted educational and engagement programme.

Results: 107 responses to the survey were received with a wide multi-disciplinary contribution. Despite 89% of respondents stating research was not part of their job, 96% were willing to be more involved in research. Motivators to staff engagement in research included: dedicated time for research (74%), research skills training (73%), mentors (67%), research relevant to elderly care (62%), hearing from researchers within the department (54%) and local promotion of research studies (49%). Barriers to research included: lack of time (78%), unsure of opportunities (65%) and lack of skills (47%). As a result of the survey numerous departmental interventions have been staged: a multi-disciplinary research half day, research opportunity display boards, monthly departmental presentations, promotion of the associate Principal Investigator scheme, Q&A webinars and a section in quarterly newsletter.

Conclusion(s): Multi-disciplinary staff working within Elderly Care can be motivated to advocate and engage with research opportunities for older adults. Supporting their engagement through the provision of dedicated time, research skills training and promotion of opportunities is key.

POSTE

2661. Scientific Presentation - Education / Training

Hospital At Home - An Opportune Training Environment for Internal Medicine Trainees

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Introduction: Hospital at home (HAH) is growing apace in the United Kingdom, offering hospital-delivered treatments at home. In parallel, increasingly structured alternative training pathways are being created to enable doctors to train outside of formal specialty training programmes. With a need to train doctors to work in community settings, a HAH rotation within a locally developed internal medicine training (IMT) programme at one large NHS Foundation Trust was evaluated.

Method: A questionnaire was designed to review the alignment of HAH rotation experience with the IMT curriculum and its acceptability as a clinical rotation within an IMT stage 1 equivalent programme. The questionnaire was distributed to all doctors who had previously undertaken a HAH rotation at junior clinical fellow level in the previous five years. Free-text responses were analysed with thematic analysis.

Results: 23/27 responded (85%). 74% had pursued IMT following their non-traditional training year. 78% agreed that HAH would be a suitable placement for a 4-month IMT rotation, with 74% interested in a HAH role following completion of training. HAH offers core content in internal and geriatric medicine. Curriculum coverage within a HAH rotation included improved confidence in clinical decision making, leadership, risk management, multidisciplinary team working and increased exposure to advanced care planning and palliative medicine. Being part of contextual, personalised medicine with shared decision making central was also cited as beneficial over traditional hospital rotations. Disadvantages were a lack of exposure to core IMT procedural skills, resuscitation and fewer opportunities to attend outpatient clinic.

Conclusion: Whilst limited to one geographical service, results indicate that HAH is a prime learning environment for internal medicine training as part of a carefully balanced programme ensuring access to all curriculum competencies. Where sufficiently developed, HAH rotations can be included in IMT programmes delivering much needed generalist skills.

POSTE

2775. Scientific Presentation - Education / Training

Advancing Professional Development in Older People's Healthcare: A Survey of BGS and UKCPA Pharmacy Professionals

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Introduction: The British Geriatrics Society (BGS) highlighted the need for workforce improvement and development of a skilled multidisciplinary team (MDT) in older people's healthcare in their 2024 roundtable, "Transforming care for older people". This survey aimed to gather views from pharmacy professionals on career progression and how the BGS and UK Clinical Pharmacy Association (UKCPA) can support their advancement in this speciality.

Method: A Google Forms questionnaire was designed to collect data on demographics, education, working practices, and specialisation. Respondents were asked about the need for defined core competencies and an advanced curriculum for the speciality, as well as the support professional groups should provide. The survey was distributed through BGS and UKCPA communication channels.

Results: Thirty-eight pharmacy professionals responded, with pharmacists comprising the majority (n=37, 97%), working primarily in secondary (n=21, 55%) and primary care (n=12, 32%). Most respondents were female (n=31, 82%) and 61% (n=23) identified as white British. Over 80% (n=31) were at a senior level (band 8a or above), with 68% (n=26) having over 10 years' experience. Many identified as specialists in care of older people (n=29, 76%). There was unanimous support for an advanced pharmacist curriculum specific to older people's care for those seeking to credential at an advanced level, and 90% (n=34) agreed on the need for core competencies for all pharmacy staff in this area. Key themes to enable progression included structured support, mentorship, clear career pathways, accredited courses, and opportunities to share expertise.

Conclusion: The BGS and UKCPA are well-positioned to develop an advanced curriculum in older people's healthcare, aligned with existing professional pathways already implemented by the Royal Pharmaceutical Society. Joint initiatives to provide structured development opportunities could enhance the specialist workforce, ensuring high-quality pharmacy services are provided routinely as part of multidisciplinary teams caring for older people.

POSTE

2820. Scientific Presentation - Education / Training

A Survey Assessing Medical Professional's Confidence and Understanding of Iron Studies in Elderly People

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Introduction: Iron deficiency anaemia (IDA) is common in older people, but traditional ferritin cutoffs may not be applicable in older people and iron studies are increasingly being used to diagnose iron deficiency anaemia. We wish to update guidance for diagnosing IDA, but first wished to survey current knowledge.

Method: Clinical staff working with older people were asked to complete a survey. They answered questions relating to confidence in interpreting ferritin and iron studies. Their knowledge of interpreting iron studies was assessed with two multiple choice questions illustrating common scenarios.

Results: When asked on a scale of 1-5 how confident the 126 participants were at interpreting ferritin, the mean was 3.7. For iron studies, it was 3.26. Amongst consultants, the mean confidence in interpreting ferritin was 4.19, in doctors of other grades this was 3.55, and for other medical professionals (PAs, ACPs and pharmacists) 2.78. Regarding iron studies, the mean confidence in consultants was 3.68, 2.96 in doctors of other grades, and 2.84 in other medical professions.

85.4% of consultants and 72.4% doctors of other grades correctly answered the case on a patient with anaemia of chronic disease. 91.6% consultants and 82.7% doctors of other grades correctly answered the case on a patient with IDA. For both cases, 76.9% of the other medical professionals answered correctly.

Conclusions: The data suggests that clinicians of all grades felt less confident in interpreting iron studies than ferritin. A significant proportion of medical professionals did not correctly interpret iron studies. We have consulted with our colleagues in haematology and gastroenterology and drafted a revised guideline to help interpretation and suggest that IDA guidance should have advice on iron study interpretation. We will also examine IV iron prescription use and provide clear guidance on indications, tracking costs related to this.

POSTE

2846. Scientific Presentation - Education / Training

How Can Simulation Training be Used to Teach Skills in Human Factors (HF)?

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Introduction: Simulation training is a valuable resource to teach clinical skills and mimic emergency settings. Human factors (HF) are non-technical skills that are affected by human attitudes and behaviours. Weaknesses in human factors can cause fatal medical errors. We wanted to assess if simulation can be used as a tool to improve these. We conducted two simulation training days for medical higher specialty trainees (HST) focusing on HF.

Methods: 20 HSTs participated in 10 simulated scenarios. Scenarios involved using a high-fidelity manikin and actors. The scenarios were a mixture of long and short cases, including both clinical and non-clinical scenarios with a HF focus. Pre- and post-session questionnaires were used to rate confidence levels in a series of specific HF. A 10-point Likert scale was used.

Results: The majority of participants had a firm understanding of the importance of human factors in healthcare, especially the importance of teamwork, compassion, communication and situational awareness. 70% of participants felt that human factors training may not be adequately considered in current training pathways due to limited formal exposure, limited time, and its importance being underestimated. There was an increase in confidence in: managing disagreements (31%), negative emotions (38%), prioritisation (28%), delegation (23%), teamwork (34%) and leadership skills (30%), dealing with uncertainty (29%), challenging hierarchy (27%), anticipation (31%). 100% felt simulation training helped to develop their attainment of human factor skills.

Conclusion: This form of simulation training was successful in improving confidence and understanding of human factors in healthcare and showcased the value of using high-fidelity training to realistically recreate the clinical environment. Going forward, this type of teaching could be integrated within the specialty training curriculum to formally improve skills in human factors and therefore improve patient outcomes and relationships between team members, thus contributing to a more positive working environment.

POSTE

2864. Scientific Presentation - Education / Training

A System Wide Approach to Raising Frailty Awareness Through Tier 1 Training

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Introduction: The British Geriatrics Society "Joining the Dots" blueprint recommends delivery of inter-professional education aligned with the Skills for Health Frailty Core Capabilities Framework as part of a system wide frailty strategy. Our ambition is to educate and train the entire health and care system in frailty awareness through the Guildford & Waverley Frailty Academy (GWFA).

Methods: The GWFA developed a Frailty Awareness course aligned to Tier 1 Core Capabilities and introduced this as part of a system wide programme of education and workforce development in frailty. The course was embedded in e-learning platforms across Acute, Community, Ambulance services and Local Authorities. A blend of virtual and face to face (FTF) workshops were used in undergraduate University programmes, the Voluntary sector and care sector.

Results: Between April 2023 and July 2024, 2,195 people completed Tier 1 training.
- Care sector, voluntary sector, Fire service, trading standards: 147 through 7 virtual workshops
- Undergraduate students at the University of Surrey: 234 (FTF)
- Acute, community, Local Authority, Ambulance service: 1,814 people through e-learning

Feedback showed the following:
- 83% said they had good/significant improvement in knowledge after participating in virtual workshops.
- 79% of paramedic students rated their improvement in knowledge and skills as good/ significant as a result of attending their session.
- 90% of nursing students rated their improvement in knowledge and skills as good/ significant as a result of attending their session.

Qualitative responses showed participants felt more aware of frailty and had a better understanding of how to adapt their practice when encountering older people with frailty.

Conclusions: Tier 1 training is an effective method of raising awareness of frailty across a health and care system when applied as part of a broader system strategy using a variety of mediums for delivery.

POSTE

2475. Scientific Presentation - Epidemiology

Frailty in Older Adults Admitted to Hospital: A Six-Year Dual-Centre Observational Study of Over 100,000 Clinical Frailty Scale

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1. Brighton and Sussex Medical School; 2. Worthing Hospital

Aims: To examine electronically recorded frailty assessments using the Clinical Frailty Scale (CFS) scores in older patients admitted to hospital, and explore associations with age, sex, and admission status.

Background: Worldwide, the population is seeing an increased prevalence of frailty. Stratifying frailty can be beneficial for the identification of vulnerability and to inform individualised care. One pragmatic tool to assess frailty is the Clinical Frailty Scale (CFS), a well-validated aid for predicting outcomes of older hospitalised adults.

Method: All patients admitted into two district hospitals in the South-East of England between 1st January 2017 and 31st December 2022 ≥65 years old with a recorded CFS were included.

Results: Between 2017 and 2022, there were 100,933 admissions, representing 53,361 individual patients. A single admission was observed in 16,284 (30.5%), while 37,077 (69.5%) had more than one during the study period. The mean CFS was 4.62 (SD1.66) and 49.5% were considered at least mildly frail (CFS ≥5). Across all years, this percentage followed a downward trend, despite the Covid-19 pandemic. Females had a higher average CFS than males (4.74, SD1.62 vs 4.46, SD1.62, p<0.01,95% CI -0.31 to -0.25). Patients with one admission had a higher mean CFS than patients with subsequent readmissions (5.10, SD1.81 vs 4.40, SD1.54, p<0.01,95% CI 0.67 to 0.73).

Conclusion: In a large cohort of acutely admitted older adults, half of them were frail. Importantly, the average CFS remained stable despite the COVID-19 pandemic. Patients who were readmitted had a lower average CFS than patients who were not readmitted.

POSTE

2809. Scientific Presentation - Epidemiology

Assessment of the Zulfiqar Frailty Scale (ZFS) in Primary Healthcare

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Introduction: The primary aim of the study was to validate the Zulfiqar Frailty Scale (ZFS) and examine its concordance with the modified Short Emergency Geriatric Assessment (mSEGA) scale, Part A.

Methods: A prospective observational study was conducted in Guadeloupe (France) over a two-month duration (from 20 February to 20 April 2024), involving elderly individuals aged 65 and older, deemed self-sufficient with an ADL (Activities of Daily Living) score exceeding four out of six.

Results: Within this community cohort of 98 individuals, averaging 75 years in age, frailty according to the modified SEGA criteria was prevalent in 29%. Frailty according to the "ZFS" score was prevalent in 40%. Key predictors of frailty identified in our study included age, comorbidity (Charlson score), polypharmacy (total number of medications and therapeutic classes), and functional ability (ADL scores). Notably, experiences of falls and hospitalizations within the past six months significantly influenced the classification of frailty according to both ZFS and SEGA scales. Significant associations with the presence of home care aides ($p < 0.0001$), monopodal support test results ($p < 0.0001$), memory impairments ($p < 0.0001$), and recent hospitalizations ($p = 0.0054$) underscored the multidimensional impact of frailty. The Pearson correlation coefficient and its 95% confidence interval between the SEGA and Zulfiqar Frailty Scales stood at 0.73 [0.61: 0.81]. The discernment threshold for frailty was set at three out of six criteria, showcasing a sensitivity of 64% and a negative predictive value of 80%. The area under the curve (AUC) for the Zulfiqar Frailty Scale was reported as 0.8.

Conclusion: The "ZFS" tool allows for the detection of frailty with a highly satisfactory sensitivity and negative predictive value.

POSTE

2858. Scientific Presentation - Epidemiology

A Network Analysis of Morbidities Associated with Mental-Physical Multimorbidity among Brazilian Elderly People (ELSI-Brazil)

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Introduction: The coexistence of two or more morbidities, including at least one mental morbidity, is defined as mental-physical multimorbidity (MP-MM). It is linked to significant poor outcomes, such as a high burden of healthcare utilisation, particularly in the elderly.

Method: To evaluate the complex connections between the 16 physical and mental morbidities among Brazilian older people from the Brazilian Longitudinal Study of Ageing, we performed a network analysis (NA), a sophisticated multivariate statistical technique to estimate all relationships between morbidities represented by an undirected grafus. The objective was to estimate patterns in a complex set of multiple aleatory variables and display them in a network map within nodes and edges representing the variables and the interrelationships among them. In this study, we applied the NA to model interrelationships among chronic physical morbidities and depression. We utilised data from 6.104 participants of the second wave (2019-2020) of the Brazilian Longitudinal Study of Ageing (ELSI-Brazil). The data were adjusted according to the Ising model with the IsingFit function by R Software. Centrality and stability measures were assessed by the bootstrap method through the bootnet library.

Findings: In this network, depression, low back pain, and hypertension were the morbidities that had the most effects on the network's overall structure, according to an examination of the centrality metrics of the nodes (strength, proximity, and betweenness). Depression was the morbidity with the higher betweenness.

Conclusion: The model's interpretation indicates that depression is the illness that has the highest influence on the model and would likely be the most beneficial area for intervention.

POSTE

2789. Scientific Presentation - Falls, Fracture and Trauma

Patient Navigator Coordination of Transitions for Older Adults with Fractures: Family Caregiver Experiences.

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Introduction: Fall-related injuries such as fractures are on the rise as the older adult population grows in New Brunswick, Canada. These injuries can lead to hospitalization and transitions in care that are complicated for patients and families. The objective was to investigate the impact of patient navigators (PNs) working alongside the healthcare team on patient and family experiences, as compared to the usual standard of care (SOC), for adults aged 65 and older admitted with a fracture to an Orthopedic Unit at one hospital in New Brunswick.

Methods: A concurrent embedded mixed methods design, in which the quantitative randomized control trial had an embedded qualitative component. The results for the family caregiver qualitative component, which used an interpretive description approach, are presented.

Results: Semi-structured interviews were conducted and thematically analysed for 15 family caregivers (8 PN group, 7 SOC group). The SOC caregivers, six women and one man, had a mean age of 64.6 years (SD=6.9 years). The mean age of the 8 women in the PN group was 61.3 years (SD=10.1). All participants in both SOC and PN groups self-reported their ethnicity as white. Thematic analysis found that SOC group caregivers discussed patients relying on support from family and friends throughout their care journey, whereas caregivers in the PN group predominantly discussed finding PNs supportive and helpful. Both groups discussed the ongoing stress that they felt throughout the care journey of the patient for which they cared for; however, for the PN group this topic was less prevalent.

Conclusions: This study provides an understanding of the positive impacts a patient navigator can have on older adult inpatient care and transitions in care. Patient Navigators were shown to be helpful to families, particularly those of patients with higher care needs and fewer family supports.

POSTE

2792. Scientific Presentation - Falls, Fracture and Trauma

Hospital Outcomes Following Hip Fracture in Older Adults: Does Frailty Matter?

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Objectives: Older adults hospitalised with a hip fracture are at risk for adverse health outcomes depending on their level of frailty. This study examined how frailty levels prior to admission impacted length of stay (LOS), requirement for alternative level of care (ALC), returning home post-discharge, and mortality.

Methods: A random sample was generated from all hip fracture patients aged 65 and older admitted to a Level One Trauma Centre in New Brunswick, Canada from 2015-2019. This sample had their frailty level determined retrospectively using the Pictorial Fit-Frail Scale and the patients' hospital electronic health record.

Results: Our study included 189 patients (mean age: 83.2 ± 8.2, 73.0% female), representing 91 not frail to mildly frail (48.2%; NF-MF), 32 moderately frail (16.9%; ModF), and 66 severely frail (34.9%; SF) patients. The ModF patients had a longer LOS (median: 20.0 days, IQR=22.5) compared to NF-MF patients (median: 11.0 days, IQR=10.0, p=0.039, Kruskal-Wallis test) and SF patients (median: 8 days, IQR=5.5, p<0.0001, Kruskal-Wallis test). More ModF patients (56.3%) required an ALC stay in acute care compared to NF-MF (30.8%) and SF (28.8%) patients (p=0.016, Chi-square test). More SF patients (28.8%) died in hospital or within six months post-discharge compared to NF-MF (8.8%) patients (p=0.005, Chi-square test). Logistic regression revealed that both NF-MF (OR=8.11, 95% CI: [3.12-21.06], p<0.001) and ModF (OR=5.18, 95% CI: [0.85-0.95], p=0.007) patients had greater odds of returning home compared to SF patients when accounting for sex, age, and time to surgery.

Conclusions: A patient's level of frailty prior to hospital admission impacts various health outcomes following a hip fracture and may provide helpful information for guiding treatment as well as discussions about health care.

POSTE

2821. Scientific Presentation - Falls, Fracture and Trauma

The Feasibility of Delivering Evidence-Based Fall Prevention Exercise in the Voluntary Sector – A Mixed Methods Study

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Introduction: Highly challenging, regular strength and balance exercise classes (SBE) reduces fall risk but there are few options for long-term continuation. SBE could be delivered by the voluntary sector, but care is needed to ensure good fidelity. The feasibility of delivering evidence-based SBE outside the governance of health services is unclear.

A voluntary sector-led weekly SBE class 'Strong and Steady (S&S)', led by a level 4 qualified postural stability and funded via grants and fees, was set up in December 2022 alongside an existing community coffee morning.

Methods: Baseline measures and adherence were collected for all who commenced S&S. Two classes were observed using a standardised fidelity checklist. Interviews and focus groups were undertaken with class participants, a previous participant, the exercise instructor and lead volunteer.

Results: Since December 2022, 24 participants aged 59-95 (63% female) self-referred to S&S. Baseline measures, collected in 100% of assessments, (timed up and go, four-step balance scale and 60-second sit-to-stand) indicated performance slightly below age-matched norms with the exception of falls efficacy (FES-I). Three participants dropped out (1 died) and adherence was 67%.

Fidelity in both observed classes was good (mean score 21/24). Four themes emerged from thematic analysis of all the interviews and focus groups:
1. S&S was associated with a range of benefits to health and wellbeing that contributed to participant uptake, adherence and to staff satisfaction.
2. Limiting class size is necessary to maintain fidelity and safety.
3. The social element of the class was a key driver in participation.
4. The participants of S&S had high levels of self-efficacy and motivation to participate in exercise

Conclusion: Delivering SBE via the voluntary sector is feasible and can be delivered with good fidelity. The provision tends to attract people who have high levels of self-efficacy and motivation to exercise.

POSTE

2823. Scientific Presentation - Falls, Fracture and Trauma

Predictors of One-Year Postoperative Complications in Geriatric Hip Fracture Patients: A Retrospective Study at Tertiary Centre

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Hip fractures (HFs) are commonly found in the elderly following a fall or an accident, which might lead to chronic illnesses and mortality. Specifically, if there are postoperative complications (PCs) that might develop both during admission and following discharge due to physical vulnerability, comorbidity, and restricted movement of the elderly. However, there is lack of information on PCs following the implementation of a Clinical Pathway for Hip Fracture. Accordingly, this study aims to investigate the incidence of PCs in geriatric hip fracture patients (GHFPs) and predictors of the PCs.

Methods: A retrospective study was conducted using data retrieved from electronic medical records of GHFPs aged 60 years and over who underwent HF surgery and were admitted to an orthopeadic ward between January 2019 and December 2022. Data were collected using Case Report Form entailing demographics, comorbidities, medical histories, laboratory test results, fracture types, operation types, and admission records. Descriptive statistics and chi-square were conducted.

Results: Participants were 376 GHPFs with a mean age of 80 years (60-99 years). Within one year after HF surgery, 39.3% of the patients developed major clinical complications: 25.2% (95 patients) developed urinary tract infection (UTI), 10.6% (40 patients) developed pneumonia, 1.6% (6 patients) developed pulmonary embolism (PE), 0.8% (3 patients) developed deep vein thrombosis (DVT), 0.8% (3 patients) developed surgical site infection (SSI) and 0.3% (1 patient) developed hip dislocation. Significant predictors of the PCs consisted of gender and age (p<0.001), Charlson comorbidity index (CCI) (p=0.004); nutrition status (p=0.002); hemoglobin level (p=0.002), ASA Classification (p<0.001); waiting time for surgery (p=0.006); and Length of stay (LOS) (p<0.001).

POSTE

2787. Scientific Presentation - Health Service Research

Supporting Older Ethnic Minority Groups in Brighton and Hove to Engage with Research Through Digital Means

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Introduction: People from ethnic minorities are 1.5 times less likely to use digital technology. Within Brighton and Hove, 2021 Census reports that 26.1% described themselves as non-White-British categorised as other White (11.5%), Mixed Race (4.8%), Asian (3.7%), Black (2.0%), Chinese (1.1%), Arab (1.1%), and Other (2.0%). The aim of the project was to understand the lived experience of older ethnic minority adults in Brighton and Hove with digital technology, and how this experience affects their potential engagement with research.

Methods: Older people from ethnic minorities were identified through Brighton and Hove Health Watch, Bridging Change, Sussex Interpreting Services, and Black and Minority Ethnic Partnership. Using a mixed-methods approach, focus group and one-to-one meetings were held with 22 people, exploring their digital literacy, using a Likert scale, and preferences for research engagement using digital means. Meetings were transcribed and thematic analysis was undertaken.

Results: The group average age was 71.6 years. Six identified as male, 16 as female, and confidence with digital technology averaged 3/5 (5 representing high confidence). Variation of digital skills was observed, with older age and language barriers limiting digital access. Digital technology was used for social, transactional and health purposes (booking GP appointments, receiving test results, and GP consultations).

Trust and confidence in the research team enhanced the group's likelihood to engage digitally. Explaining the research in their own language would be an incentive. Younger family members can help explain digital elements. Offering choice of digital alongside traditional methods was important. There was a preference for initial research conversations to be in person. Willingness to engage is higher when the research topic is common in their community or they are personally affected.

Conclusions: Older people from ethnic minorities in Brighton and Hove are willing to engage in research using digital means if tailored to their social circumstances.

POSTE

2832. Scientific Presentation - Health Service Research

Understanding the Experiences of Older Residents Required to Relocate from One Nursing Home to Another: A Qualitative Study

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Introduction: As a response to the increased demand for nursing home services for older adults, there are new initiatives include building larger nursing homes to accommodate greater numbers of residents. This initiative can be detrimental to those older residents who required to be relocated from their current nursing home to a new one. However, there is limited understanding about how older residents adapt to this relocation, particularly on how they tackle the various issues after relocation. Thereby hindering healthcare personnel to identify appropriate strategies to support older residents during the process of relocation. The aim of this poster is to present the experiences of older residents in the immediate period after relocating to a new nursing home.

Method: A descriptive qualitative approach was adopted. Purposive sampling was used to recruit twenty-four older residents, who were relocated from existing nursing home to a new nursing home, upon ethical approval was sought. Semi-structured interviews were conducted based on the “process of adjustment” framework after consent was obtained. Each interview lasted for around thirty minutes and audio-recorded. Data were analysed using thematic analysis.

Results: Four themes were identified namely: adaptation to the new environment, interaction with other residents, interaction with healthcare personnel, and changes to their daily life. In particular, participants highlighted changes to their daily routines and interactions with others, but most of them expressed positivity about their relocation to the new nursing home.

Conclusion: The results illuminate the initial experiences of older residents required to relocate from their nursing ‘home’ to another with no choice. These findings will inform further interviews over time to help inform person-centred care for residents, the role of carers and service providers, and the care environment.

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POSTE

2788. Scientific Presentation - Neurology and Neuroscience

Exercise Trainers as Key Enablers in the Remote Delivery of Dementia Prevention Interventions in the Homes of Older Adults

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Introduction: Social support for physical activity is important for engaging older adults in physically active lifestyles. Few studies examined the impact of individual exercise trainers (IETs) in the context of dementia prevention interventions with physical activity. We aimed to assess the contributions of IETs in the remote delivery of a home-based dementia prevention program combining physical exercise and cognitive training targeting older adults at risk for dementia.

Methods: Convergent mixed-method analysis was conducted using data from SYNERGIC@Home, a feasibility study of a 16-week intervention that included one-on-one supervised physical exercise (3 sessions/week) fully delivered through Zoom. Quantitative data consisted of descriptive statistics, measures of adherence, participants' preference and satisfaction. Qualitative interviews centred on participants' experience and motivation were conducted post-intervention.

Results: Of the 60 participants randomized to one of four intervention arms (mean age 68.9, 76.7% female), 52 completed the interventions with high overall adherence (87.5%). Pre-intervention, participants expressed a clear preference for cognitive interventions, but post-intervention preference shifted to exercise. IETs (n=21) were part-time research assistants, each assigned to one participant after completing CSEP Certified Personal Trainer® or Clinical Exercise Physiologist™ certification as part of their training. One full-time Lead IET coordinated and supervised the other trainers. IETs worked the closest with study participants, also working closely with study coordinator and with study physician for adverse event monitoring. Interviewed participants (n=15) often described the positive relationships that developed with their IET. Trainers were instrumental in participants' motivation and enjoyment, personalising the sessions and addressing technological issues. Satisfaction rates with IETs (n=54 exit survey respondents) were high.

Conclusions: Exercise trainers played crucial roles that extended beyond the supervision of exercise sessions and contributed to participant engagement in the interventions. Access to these allied health professionals should be featured more prominently in strategies/programs promoting active lifestyles among older adults.

POSTE

2860. Scientific Presentation - Neurology & Neuroscience

Can Clinical Assessments be Administered in a Remotely Delivered Clinical Trial Targeting Older Adults at Risk for Dementia?

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Introduction: Research suggests that physical and cognitive exercise can have a positive effective on those with dementia, but less is known about such interventions in those at risk for dementia. Understanding the feasibility of administering clinical assessments remotely using Zoom for HealthcareTM in the context of a dementia prevention trial for at risk older adults is not well understood.

Methods: SYNERGIC@Home/SYNERGIE~Chez soi (NCT04997681) is a home-based, remotely delivered clinical trial targeting older adults at risk for dementia. Participants underwent a screening/baseline assessment and were randomized to one of four physical and cognitive exercise intervention arms for 16 weeks (3 times per week). They were reassessed immediately post-intervention and 6-months later. The standardized assessments of cognition, physical activity, mobility, mental health, nutrition, sleep, and quality of life were done at all three points. A research coordinator completed the assessments on a one-on-one basis via Zoom for HealthcareTM. The quality-of-life questionnaire was mailed to the participant.

Results: Forty-eight of 60 participants (80%) (mean age 68.7 ± 5.7 years, 81.3% female) completed the study. Most participants (75.0%) were cognitively intact with at least 2 dementia risk factors. No participants withdrew from the trial because of difficulty with the remote delivery of the assessments. There were no statistically significant changes in any of the assessments of cognition, physical activity, mobility, mental health, nutrition, sleep, or quality of life throughout the study.

Conclusion: This study demonstrates it is possible to administer standardised clinical assessments of cognition, physical activity, mobility, mental health, nutrition, sleep, and quality of life remotely in the context of a clinical trial. The study was not powered to detect meaningful differences in these assessments. Nevertheless, this confirms the feasibility of remotely administering clinical assessments to older adults at risk for dementia.

POSTE

2866. Scientific Presentation - Neurology and Neuroscience

Clusters of Multimorbidity and Subjective Cognitive Decline (The ELSI-Brazil Study)

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Introduction: Subjective cognitive decline (SCD) is defined by cognitive complaints expressed by the individual, without evidence of cognitive impairment on objective neuropsychological tests. Studies have analysed SCD among patients with specific groups of diseases. An increased understanding of the association between disease patterns and subjective cognitive decline is essential to develop targeted interventions for these groups.

Method: Using data from the baseline of the Brazilian Longitudinal Study of Aging (ELSI-Brazil), this cross-sectional study included 2,508 participants. Subjective Cognitive Decline (SCD) was assessed using the Subjective Cognitive Decline Initiative Working Group's criteria. Multimorbidity (MM) was defined as the presence of two or more of 14 self-reported health conditions. Clusters of MM were identified based on the most prevalent dyads and triads of diseases within the sample. Robust Poisson regression models were used to estimate adjusted prevalence ratios (PR) for the association between MM clusters and SCD, accounting for potential confounders.

Results: The following dyads of chronic conditions were associated with higher prevalence of SCD: ophthalmological problems/osteoporosis (RR: 1.497 p=0.042), heart problems/stroke (RR: 2.33, p<0.001), and hypertension/asthma (RR: 3.309, p=0.013). No triads had positive association with SCD, although the triads of ophthalmological problem/hypertension/osteoporosis (RR: 0.367, p<0.001) and hypertension/cardiac problems/dyslipidemia (RR: 0.545, p=0.012) were negatively associated with the prevalence of SCD.

Conclusion: Our study demonstrated an association between SCD and MM clusters, which is important for developing and managing care for individuals with cognitive decline and/or those multimorbidity patterns. The results could also provide a foundation for future research exploring the causality between these variables.

POSTE

2839. Scientific Presentation - Other medical condition

Decision Aids for the Care of Patients with Multimorbidity: A Systematic Review

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Introduction: Clinical decision making for older adults with multimorbidity can be complex and demanding. When facing complex decision-making, patients may experience decisional conflicts, leading to low treatment adherence, adverse health outcomes, and increased utilization of health services, etc. To address these issues, patient decision aids (DAs) have been developed and utilized in the decision-making process to facilitate informed decisions. The aim of this study is to identify DAs developed for patients with multimorbidity and assess their quality.

Method: We searched full-text papers on nine databases. Any article utilising a DA for patients with multimorbidity was eligible and DAs for making medical decisions at any point were eligible. We used the International Patient Decision Aid Standards (IPDAS) checklist to assess the quality of DAs.

Results: In total, ten articles including six DAs were included. Two DAs targeted for the older patients with multimorbidity. Most DAs didn't focus on specific treatment choices but rather aimed at improving the overall quality of life for patients with multimorbidity. The targets of these DAs are including setting goals about health care, preparing for conversation with doctors and taking ownership for the decisions. IPDAS checklist revealed that only one DA met all qualifying criteria and provided comprehensive choice. Three DAs were deemed to have poor quality due to their failure to provide the pros and cons of decisions. The quality of the remaining DAs was difficult to judge due to incomplete versions.

Conclusions: DAs for patients with multimorbidity were few and had poor quality. Designing DAs for this patient population presents challenges given the complex nature of multimorbidity and its lack of specific treatment options. Future development should focus on adhering to the IPDAS checklist, provide more information and possibility, and aim at improving the quality of life for patients with multimorbidity.

POSTE

2483. Scientific Presentation - Other medical condition

Hyponatremia In Elderly : A Systematic Review and Meta-Analysis

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Introduction: Hyponatremia is the most common electrolyte imbalance caused by serum sodium level of less than 135mmol/L, prevailing 15 and 30% among hospitalized patients [*Zhang X, Li XY. Eur Geriatr Med. 2020;11(4):685-692*]

Methods: PRISMA guidelines were followed for this study. Pubmed was searched with the search term: (hyponatremia) AND (treatment OR control OR management [MeSH]) AND (elderly [MeSH]) with filters, timeline: 2000 to 21/07/2023, free full text articles and human species. Data extraction was done using Covidence app and depicted in PRISMA Flow diagram. Quality assessment was done by Cochrane Risk of Bias version 1. Odd's ratio with 95% confidence interval was calculated for dichotomous outcomes. Mantel-Haenszel statistical method along with random effects model was used. Cochrane Q test was employed and I2 index was computed. Forest and Funnel plots were plotted. The analysis was done by Cochrane Review Manager.

Results: Out of 3222 results, 9 studies were included with total 980 patients. Eight were of vaptans and 1 of empagliflozin. Three studies had low risk of bias and were included in meta-analysis. Mean age and BMI were 70.55(SD=14.5) years and 24.73(SD=3.95) kg/m2 respectively. Most frequently occuring etiology, comorbidity and symptom were congestive heart failure, hypertension and fatigue/malaise respectively. Mean baseline serum sodium was 124.89 mmol/L and mean rise was 9.142 mmol/L.

Meta-analysis showed that placebo was significantly associated with achieving normonatremia as compared to treatment group(OR=2.5, 95%CI:1.54,4.04, p=0.0002,I2=0%).

The most frequent reported side effects were nausea, dry mouth, pyrexia and thirst. Side effects both mild/moderate (OR=1.12, 95%CI:0.69,1.81, p=0.65, I2 =0%) and serious (OR= 1.51, 95%CI: 0.77,2.98, p=0.23, I2 =0%) showed no difference between treatment and placebo groups. Treatment was not associated with rapid risk of overcorrection (OR=1.65, 95% CI:0.57,4.81, p=0.36, I2 =0%). None showed osmotic demyelination syndrome.

Conclusion: We conclude that vaptans and Empagliflozin, although safe, show limited efficacy in hyponatremia treatment.

POSTE

2629. Scientific Presentation - Other medical condition

A Feasibility Study Examining the use Of Wearable Technology among Older Delirious Adults Recovering from Acute Illness

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Introduction: Wearable technology that continuously monitors physiological metrics has become increasingly popular and allows remote patient monitoring in virtual ward settings. Wearable technology has been shown to be effective in disease monitoring among younger adults. However, its use among older adults, including those with cognitive impairment, is yet to be explored.

Aim: We aim to explore the acceptability of remote monitoring using wearable technology among older adults with delirium.

Methods: Participants were recruited from an in-patient rehabilitation unit. Inclusion criteria included documented delirium and age over 65 years. Participants were enrolled until delirium resolved or until discharge. Wearable technology was worn continuously, except when being charged or the patient was washing. Device data was recorded every minute.

Premorbid Barthel index and Hierarchical Assessment of Balance and Mobility (HABAM) was collected for each participant. Participants were assessed daily for delirium and mobility using the Memorial Delirium Assessment Scale and HABAM respectively. At point of discharge from the study, participants completed a questionnaire to gather feedback on their experience.

Results: 20 participants were included, with a mean age of 83.0 years and an average premorbid Barthel's index of 72. 6. Mean data capture from the wearable technology was 44.1% (12.8-65.8). None of the participants could independently manage the device. Three participants stated that the device interfered with their normal activities with five reporting the device uncomfortable to wear. However, nine participants stated they would wear the device again if asked to by a healthcare professional.

Conclusions: Our findings demonstrate that wearable devices are tolerated by delirious older adults with delirium. We found that this group cannot manage these devices independently and need support from either a carer or healthcare professional. These results provide useful information to help pilot these devices among older adults with delirium in virtual ward settings.

POSTE

2622. Scientific Presentation - Other medical condition

Systematic Methods Overview of Community Based Complex Interventions Targeted at Sustaining Independence in Frail Older People

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Introduction: Sustaining independence is a primary objective of community-based complex interventions for older people, but there is currently insufficient guidance about which outcome measurement instruments (OMIs) to implement. Thus, the aim was to accumulate evidence on the current OMIs used to measure independence in older people with frailty using an existing core outcome set for frailty.

Systematic methods overview: I reviewed all randomised controlled trial (RCT) and cluster RCT papers from the systematic review and network meta-analysis conducted by the Academic Unit for Ageing and Stroke Research. Outcome domains and outcomes were taken from an international Delphi consensus process used to determine a common data element and core outcome set which was conducted by the Canadian Frailty Network. Outcomes domains included were physical performance, physical function, physical health, cognition and mental health, socioenvironmental circumstances, frailty measures and other. A data extraction spreadsheet was used to collect the outcomes and OMIs recorded in the papers from the systematic review and NMA. Information extracted included mode of measurement of OMI, if an outcome was recorded and publication year and title of each article.

Results: The methods overview identified that many different OMIs have been used to measure the same outcomes across different trials. This is more apparent for specific outcomes. There has been more work conducted to develop OMIs focusing on physical performance and physical function which has contributed to these being more commonly used. The wide variety of OMIs assessing cognitive function indicates a lack of standardisation compared with physical performance and physical function.

Conclusion: More research into the standardisation of OMIs for each outcome is required. The next steps in my research are to conduct a quality assessment of the measurement properties used for each OMI and to adapt consensus methods to finalise a set of OMIs for this area of research.

POSTE

2773. Scientific Presentation - Other medical condition

Co-designing an intervention for older adults with multiple conditions, using changes in physical activities to predict decline

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Introduction: Multiple long-term conditions (MLTCs) are common in the population, which increase with age and are associated with increased hospital admissions. Identifying early signs of decline, such as restricted physical activity, could help reduce avoidable hospitalisations, however it is not clear how best to do this.

Aim: To co-design with patients, caregivers and primary care professionals (PCPs), an intervention aimed at identifying changes in activity in order to recognise decline in older adults with MLTCs.

Methods: The Person-Based Approach was followed to plan and develop this intervention. Qualitative interviews were conducted with older patients with MLTCs, caregivers, and PCPs to examine perspectives on an intervention measuring changes in physical activity.

A prototype app was developed, using these results and patient and public involvement. This was further optimised through iterative think-aloud interviews with patients, caregivers, and PCPs.

Results: Thirty-six interviews were conducted comprising of 17 patients (mean age 79-years, 23% female), eight caregivers and 11 PCPs (GPs, nurses, occupational therapists, and pharmacists). Interviews were recorded, transcribed, and thematically analysed.

Findings highlighted the importance of restricted activity as an indicator of decline. Patients often described their experiences of decline through non-specific symptoms, including changes in physical activity. PCPs emphasised the value of knowing about such changes to clinical decision-making. Different technology options for measuring activity were explored, considering data quality, and acceptability of passive/active data collection.

The initial prototype intervention was designed for iterative testing and think-aloud interviews will be completed by November and presented.

Conclusion: This study highlights the utility of measuring changes in activity in older patients, and some benefits and lessons learned from co-design. A proactive approach to detecting early decline within community settings may provide opportunities to unplanned hospital admissions.

POSTE

2786. Scientific Presentation - Other medical condition

Defining Advanced Multimorbidity: A Scoping Review of Research, Policy and Practice

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Introduction: As people are living for longer with multiple long-term health conditions (MLTCs), there are also more people dying with and from MLTCs. Dying with/from MLTCs can be unpredictable, lead to uncertainty for patients, caregivers and healthcare professionals, and hinder timely conversations around future care planning.

There is no universally accepted definition informing the identification of individuals with MLTCs who may be approaching the end of life (advanced multimorbidity). This scoping review synthesised how advanced multimorbidity is defined in research, policy and practice.

Methods: Using the Arksey and O'Malley framework and relevant updates, scoping review methodology was used to search multiple databases and Grey Literature, summarised via the PRISMA-ScR. Two reviewers selected final study texts, which underwent content analysis. Stakeholder consultations with clinicians, academics and public participants ensured context and relevance of findings.

Results: From 10,316 unique publications, 38 final texts were included. Most (33/38) were published in the last decade. Many were quantitative (18/38) though a variety of other study types were included. Participants were mainly elderly - mean age 78.5years. Only 4/38 studies integrated patient and public involvement.

Forty-four different definitions of advanced multimorbidity were identified across the 38 studies, with only 2 definitions used across multiple studies. Definitions varied in the type and number of conditions included. Twenty-six definitions incorporated multiple variables to define advanced multimorbidity, while the remaining 18 used a single variable. Variables were conceptualised as discrete (functional assessments, age, healthcare utilisation etc) or holistic (self-assessment, clinician assessment, assessment tools). Stakeholders preferred definitions that were user-friendly and clinically driven.

Conclusions: The lack of consensus around an advanced multimorbidity definition creates unwarranted heterogeneity and barriers to advancing research in this field. This review highlights the need for a standardised approach that is context-appropriate and meaningful to practice and care, to facilitate proactive realistic conversations and decision-making.

POSTE

2806. Scientific Presentation - Other medical condition

Assessing Medication Self-Management in Older People at Hospital-To-Home Transition: A Systematic Review of Measures and Tools

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Introduction: Adverse drug events from medication-related harm (MRH) can lead to hospital readmissions, compromised quality of life, and even death. After hospital discharge, older people can experience heightened vulnerability and are often unprepared for self-care and medication self-management. Effective medication self-management involves more than adherence; it requires patients to monitor their condition(s), build routines, recognise errors, seek help, understand when to alter medications, and discuss these issues with healthcare professionals. Determining medication self-management capability in older people can guide supportive interventions and improve medication-related outcomes. This systematic review identifies measures which assess medication self-management capability for older people transitioning from hospital-to-home.

Method: A comprehensive search was conducted in electronic databases (Medline, EMBASE, PsychINFO, CINAHL, Cochrane Library of Systematic Reviews, and PROSPERO) for articles from database inception to 2023. Eligible studies included participants aged 65 or older experiencing a hospital-to-home transition, and measures containing at least one medication self-management component. Data extraction was performed using a standardised form. Characteristics of measures were tabulated and summarised descriptively. This review is registered with PROSPERO (CRD42023464325).

Results: 14 studies were included, identifying 12 unique measures. These measures predominantly had an adherence-focus, with other medication self-management components included to a lesser degree. Timing of measure administration and the individual administering the measure varied greatly across studies. Medication self-management capability was assessed through physical and cognitive skills. The number and type of skills assessed differed between measures. None of the measures considered all medication self-management components, with self-monitoring and adaptability specifically lacking.

Conclusion: Current measures for medication self-management capability assessment primarily focus on cognitive and physical skills, with significant emphasis on medication adherence. This can lead to other important skills being overlooked. Findings further highlight the importance of comprehensive definitions when considering medication self-management across the hospital-to-home transition, and recommendations are provided for developing future measures.

POSTE

2815. Scientific Presentation - Other medical condition

Cross-Cultural Adaptation and Psychometric Properties of the Yoruba Version of the Clinical Frailty Scale

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Background: This cross-sectional study aimed to assess the socio-demographic, anthropometric, and patient characteristics of 94 Yoruba speakers aged 60 years and older, and to validate the Yoruba version of the Clinical Frailty Scale (CFS).

Methods: This study used a cross-sectional design with a purposive sampling technique and a sample size of 94 participants. This study also made use of the World Health Organization methodologic guidelines on cultural adaptation of clinical scales. Convergent validity was assessed by evaluating the context that the Clinical frailty scale (CFS) relates to the Edmonton frailty scale, using the Spearman rank correlation coefficient. The known group validity was assessed using one-way ANOVA.

Results: The mean age of participants was 70.81±8.11 years, with a mean BMI of 27.04±5.61. The cohort included 38 males (44.4%) and 56 females (59.6%). Educational attainment varied, with 20.2% having no education and 9.6% holding postgraduate degrees. The validated CFS has excellent content validity (S-CVI/AVE=0.96; S-CVI-UA=0.78). Convergent validity demonstrated a moderate correlation between the CFS and the Edmonton Frail Scale (Spearman's rho=0.61, $p<0.01$). Known-group validity indicated significant associations between frailty, age ($p=0.02$), and BMI ($p=0.007$).

Conclusion: The Yoruba version of the CFS is a valid tool for assessing frailty in elderly Yoruba-speaking populations.

POSTE

2784. Scientific Presentation - Other medical condition

Respiratory Syncytial Virus Hospitalisation Burden in Older Adults in Europe: Preliminary Results from a Systematic Analysis

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Introduction: The disease burden of respiratory syncytial virus (RSV) in older adults is substantial but not well quantified previously. We aimed to estimate country-specific hospitalisation burden of RSV-associated acute respiratory infection in older adults (>60 years) in Europe.

Methods: We collected published data (through a systematic review) and unpublished data (from GSK-sponsored studies and international collaborators) on RSV hospitalisation burden. We used multiple imputation for missing age bands. We applied stepwise statistical adjustment to account for case under ascertainment related to the variations in case definitions, clinical specimens and RSV diagnostic tests in individual studies. We reported country-level RSV hospitalisation rates for countries with ≥1 eligible study reporting point estimate and 95% confidence interval (CI) of the rates (a random-effects meta-analysis was conducted when ≥2 studies were available). As an alternative method, we additionally included studies not reporting 95% CI and calculated the median of the rate point estimates.

Results: Seven studies were included from five countries: Denmark (1), Finland (1), Netherlands (1), Spain (1) and UK (3). Denmark and Spain had the highest and lowest adjusted RSV-associated hospitalisation rate (408/100000, 95% CI: 319-516; and 176/100000, 137-226) in >60 years, which was about 2.4 times the unadjusted estimate. The alternative method with 5 more studies added had similar estimates for the five countries; another country (Norway) was added and it had the highest adjusted hospitalisation rate (742/100000). RSV-associated hospitalisation rate increased with increasing age across all countries.

Conclusions: With RSV vaccines now approved for use in older adults, our findings help inform the need for country-level RSV prevention.

POSTE

2502. Scientific Presentation - Pharmacology

Prevalence of Anticholinergic Burden across a Cohort of Frail Older Adults in a District General Hospital in South West Wales

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Background and Objectives: Polypharmacy is common in frail older adults who often live with multiple co-morbidities. This polypharmacy can carry a significant anticholinergic burden. Frail older adults are particularly sensitive to the anticholinergic side effects of medications which can include constipation, urinary retention and dry mouth. Medications with a high anticholinergic burden scores have also been evidenced to contribute to an increased frequency of falls, cognitive decline and increased mortality. For frail older adults, a medication review, considering anticholinergic burden, is therefore an essential part of Comprehensive Geriatric Assessment. A local frailty census was completed for all medical inpatients over the age of 65 years old and as part of this anticholinergic burden scores were collated.

Materials and Methods: As part of this whole hospital frailty census, an anticholinergic burden score (ACB) was calculated for 77 inpatients. This was calculated using the Anticholinergic Cognitive Burden Scales and Anticholinergic Burden scores.

Results: The average age of the patients was 80.19 (± 9.35). 80.01% of patients were taking one or more medications with an anticholinergic burden. Of those, 40.25% had a significant ACB score of 3 or more (3-8). The patients with the highest ACB scores were those with multi-morbidity, an already established diagnosis of dementia and patients with recurrent falls.

Conclusions: The ACB score for patients included within this frailty census appeared to correlate with certain co-morbidities as would be expected from the known complications associated with these medications in frail older adults. The proportion of our inpatients with a significant ACB score informs us that we need to develop a more robust approach to delivering polypharmacy reviews as part of Comprehensive Geriatric Assessment within our hospital and will help us to inform future service planning and delivery.

POSTE

2624. Scientific Presentation - Pharmacology

Exploring the Experience of Older People in Care Homes with the Administration of Oral Medication

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Introduction: Residents of care homes for older people experience multi-factorial problems when being given oral medication. A systematic integrated mixed-methods review of the literature revealed that practices of modifying tablets, crushing and mixing with food, in attempts to administer medication, remain widespread internationally. There is a high prevalence of swallowing problems. Care home routines are time pressured, and there are incidences of disempowering practices and language associated with processes of medication administration. The literature presented very little from the residents' experience, largely representing them as passive recipients in the activity.

Objective: The aim of this study was to explore the experience of residents of care homes for older people who need help from care staff to take their medication. Its purpose was to answer a single research question, 'What is the experience of residents of care homes when oral medication is administered?'

Methods: Observation of an episode of medication administration and semi-structured interviewing were conducted with eight residents between the ages of 84 and 95 from care homes in Scotland. Data was analysed in accordance with a Gadamerian philosophy of hermeneutics, with a commitment to understanding and representing the participants' experience.

Results: Four themes emerged from the data, 'Being in control/relinquishing control', 'Being comfortable in routine', 'Trusting', and 'Swallowing'. Interpretive exploration of these themes revealed the importance of facilitating individual routines when taking medication, and that a trusting relationship with staff and with the medication can be an indicator of vulnerability. The risks to autonomy in relation to taking medication, and an imbalance of power for care home residents who are given medication to take emerged as an overarching concept.

Conclusion: Recommendations focus on the potential for empowering practices in relation to taking medication, both for those who provide care, and for those who prescribe medication.

POSTE

2660. Scientific Presentation - Pharmacology

Drug Classes Associated with Geriatric Readmissions: The Canary in a Coal Mine

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Introduction: Older adults are at increased risks of drug-related problems, contributed by increasing incidence of multimorbidity with age, and the consequent polypharmacy. We aim to investigate the drug classes associated with 30-day readmissions in hospitalised older adults.

Method: We prospectively studied patients aged 65 years and above admitted to a general medical department in Sengkang General Hospital, Singapore, between October 2018 and January 2020. Medication lists were obtained from electronic medical records at admission. Unplanned readmission within 30 days of discharge was tracked through the hospital's electronic health records. Medications were classified according to the World Health Organisation's Anatomical Therapeutic Chemical classification system. Univariate logistic regression was performed for the association of drug classes with 30-day readmission.

Results: We recruited 1507 consecutive admissions with follow-up data. 30-day readmission occurred in 331 patients (22.0%). Greater length of stay, higher comorbidity burden, hospitalisation in the year preceding index admission, frailty and polypharmacy were more commonly observed among patients who were readmitted within 30 days of discharge. Admission diagnoses associated with 30-day readmission include infections, fluid overload, acute coronary events and constipation. Drug classes associated with a higher risk of 30-day readmission include drugs for acid-related disorder (OR=1.62, 95%CI 1.27-2.07), drugs for constipation (OR=1.96, 95%CI 1.41-2.73), antithrombotic agents (OR=1.40, 95%CI 1.09-1.79), antianaemic preparations (OR=2.22, 95%CI 1.68-2.91), cardiac therapy (OR=1.70, 95%CI 1.23-2.34), diuretics (OR=1.41, 95%CI 1.04-1.90), beta-blocking agents (OR=1.55, 95%CI 1.21-1.99) and analgesics (OR=1.56, 95%CI 1.02-2.39).

Conclusion: Drug classes associated with 30-day geriatric readmissions include drugs for acid-related disorder, constipation, antithrombotic agents, antianaemic preparations, cardiac therapy, diuretics, beta-blocking agents and analgesics. Patients on the above drug classes should herald a higher index of scrutiny during admissions and necessitate closer follow-up upon discharge.

POSTE

2763. Scientific Presentation - Psychiatry and Mental Health

Process Evaluation of the BASIL+ Trial: Addressing Low Mood among Older People

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Introduction: During the COVID-19 pandemic, older adults were at risk of being socially isolated or experiencing loneliness, increasing the risk of depression. We adapted the delivery of Behavioural Activation (BA), an effective evidence-based intervention for depression in older adults and people with multiple long-term conditions (LTCs), so it could be delivered remotely under COVID-19 restrictions.

Method: The qualitative study was nested within the BASIL+ definitive randomised controlled trial (https://www.thelancet.com/journals/lanhl/article/PIIS2666-7568(23)00238-6/fulltext). Semi-structured telephone interviews were conducted with 24 older adults, two caregivers and 16 BASIL Support Workers (BSWs). They were digitally recorded and transcribed professionally. Data were analysed thematically using constant comparison.

Results:

- Some participants did not feel they had low mood and found it difficult to engage with BASIL initially. However, those willing to give it a try went on to benefit, which suggests it could be used to prevent deterioration as well as to address low mood.
- Few participants reported loneliness, despite the social isolation imposed by COVID-19 restrictions, perhaps because everyone was subjected to them.
- Participants drew on intervention components in different ways, highlighting the flexibility it offered.
- Most participants described the intervention as having had a positive impact on their mood, which they credited to changes in their behaviour. Many reported enjoying increased sense of self-reliance.

Conclusion: Findings suggest a BASIL+ style intervention should become more widely available for older adults with LTCs and low mood, given its positive impact on most participants and its remote delivery by non-specialist practitioners.

POSTE

2796. Scientific Presentation - Psychiatry and Mental Health

Improving physical health care in older people in mental health settings: The ImPreSs-Care Qualitative Study

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Background: The overlap between physical and mental health is a common challenge for older adults, and many live with co-occurring physical and mental health disorders. Different service models have been adopted; however, the majority provide specialist mental health input to older adults with physical health needs in acute hospital trusts. Few service models are available providing comprehensive physical health input to older adults in secondary mental healthcare settings. Furthermore, little information is available regarding specific physical healthcare needs facing older people receiving specialist mental healthcare. The aim of this qualitative study was to determine the facilitators and barriers to delivering physical healthcare for older adult patients, their carers, and staff within specialist mental health settings (inpatients and community).

Methods: 54 semi-structured interviews (REC:22/IEC08/0022) were conducted with different stakeholders (staff (n=28), patients (n=7), carers (n=19)) across two mental health trusts (Leicester, Nottingham). Interviews explored the facilitators and barriers to delivering physical healthcare to older people (aged >65 years) receiving secondary mental healthcare (dementia and functional disorders) with combined physical health needs. Interviews were audio recorded and transcribed verbatim. Data were analysed thematically, drawing on an underpinning framework of integrated care for individuals with multimorbidity (SELFIE).

Results: Three main themes were identified: 1) service delivery; focussing on care coordination and communication between services, 2) workforce; focussing on training and skills alongside support and availability of physical health expertise, 3) the individual with multimorbidity; focussing on mental-physical health interplay and patient experience.

Conclusions: The findings from this study can be used to inform service development to improve the provision of physical healthcare for older people receiving secondary mental healthcare in the UK, focussing on improving care coordination and communication between physical and mental health services, and upskilling and training mental health teams in physical health provision with appropriate support from physical health experts.

POSTE

2855. Scientific Presentation - Psychiatry and Mental Health

Dementia in Elderly Individuals with Depression: A Systematic Review and Meta-Analysis of Longitudinal Studies (2013-2024)

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Introduction: With population aging comes challenges like dementia, prompting the urgent identification of risk factors and its associations with other psychiatric disorders. This review aims to explore the connection between depression and the onset of mild cognitive impairment (MCI) or dementia through recent literature analysis.

Methods: Systematic review and meta-analysis, following PRISMA recommendations, with studies from 2013 onwards. The search strategy "Depression" AND "Dementia" AND "Aged" was employed in the Cochrane, Embase, LILACS, PubMed, Scopus, and Scielo databases. Cohort studies in Portuguese, English, or Spanish were included, while reviews or clinical trials were excluded.The meta-analysis was conducted using RevMan software, employing unadjusted OR effect measures for exposure in the Forest Plot graph. Study heterogeneity was calculated using the I^2 statistic, with a cutoff point of >75% indicating high heterogeneity.

Results: The search strategy identified 3,394 articles, screened by title and abstract. Of these, 187 were fully read, and 26 were included in the review. The most used tool for assessing depressive symptoms was the Geriatric Depression Scale (38.4%), while the Mini-Mental State Examination was the most frequently used tool for assessing symptoms of MCI and dementia (26.9%). The quantitative analysis included 14 studies evaluating dementia and 8 studies evaluating MCI. The likelihood of older adults with depression developing dementia was 1.75 times higher than in the non-depressed population (OR = 1.75; 95% CI 1.46 - 2.11). Additionally, a twofold increase in the likelihood of developing MCI was found in depressed older adults (OR = 2.03; 95% CI 1.44 - 2.88). All analyses revealed high heterogeneity.

Conclusion: Depression was found to be associated with higher likelihood of developing MCI or dementia in older adults. Understanding this complex relationship with new studies and reviews is crucial for developing targeted interventions and improving the prognosis for individuals affected by both conditions.

POSTE

2785. Scientific Presentation - Planned and ongoing trials

Protocol for a Feasibility Randomised Controlled Trial of the OUTDOOR Mobility Intervention for Older Adults after Hip Fracture

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Introduction: A high proportion of patients do not regain outdoor mobility after hip-fracture. Rehabilitation explicitly targeting outdoor mobility is needed to enable older adults to resume activities that they value most. The aim of this study is to determine the feasibility of a randomised, controlled trial intended to assess the clinical and cost-effectiveness of an intervention enabling recovery of outdoor mobility post hip-fracture (the OUTDOOR intervention).

Method: OUTDOOR is a multi-centre, parallel group, randomised, controlled, feasibility trial. Adults 60 years and older, admitted to hospital and planned discharge to home; with self-reported outdoor mobility three-months pre-fracture, surgically treated for hip fracture, who are able to consent and participate, are eligible. Individuals requiring two or more people to support mobility upon discharge are excluded. Screening and consent (or consent to contact) will take place in hospital. Baseline assessment and randomisation will follow discharge. Participants will receive usual care (physiotherapy, occupational therapy), or usual care plus the OUTDOOR intervention. OUTDOOR intervention includes a goal-orientated outdoor mobility programme, therapist-led motivational dialogue supported by a past-patient led videos sharing recovery experiences; and support to transition to independent recovery. Therapists delivering the OUTDOOR intervention will receive training in motivational interviewing, and behaviour change techniques. Patient reported outcome measures - health-related quality of life, daily activities, pain, community mobility, falls related self-efficacy, resource use, and readmission; will be collected at baseline, 6-weeks, 12-weeks, and 6-months (if enrolled early in the trial) post-randomisation. Exercise adherence and intervention acceptability will be collected. Subset of 20 participants will support accelerometery data collection for 10 days at each time point.

Trial received approval from East of England – Essex Research Ethics Committee (REF: 23/EE/0246) and the Health Research Authority. Findings will be disseminated to patients, the public, health professionals and researchers through publications, presentations, and social media.

Trial registered at ISRCTN16147125.

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