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012 INVESTIGATING COGNITIVE IMPAIRMENT IN THE EMERGENCY DEPARTMENT: THE ROLE OF THE INFORMANT HISTORY

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Background: The informant history is a crucial investigation in clarifying the nature, extent and appropriate follow-up of cognitive impairment in older adults presenting to the Emergency Department (ED). However, very little research has been published on its use to date (1).

Methods: A convenience sample of older adults (aged ≥70 years) underwent detailed cognitive assessment in the ED of a tertiary referral hospital. Cognitive assessment consisted of tools for delirium (CAM-ICU) and a general cognitive screener (MoMSSE). In individuals where either of these were positive, an informant history was sought and the AD8 informant interview for dementia administered.

Results: Two hundred and twenty patients were included (mean age: 78.8 ± 6.16). Of those screened positive on the CAM-ICU (11.8%, 26/220) or MoMSSE (41.8%, 81/194), informant histories were available in just under two-thirds (61.1%). In 39% (26/66), informant histories were consistent with previously undiagnosed dementia. The majority of informants were immediate relatives (62/66, 94%) with a mean interview duration of 6.1 minutes. The vast majority were rated very high in “informant confidence” (96.9%, 64/66) and “contribution to patient’s care” (93.9%, 62/66). Following a review of the attending physicians’ notes, a reference to an informant history was only documented in 5.6% of cases.

Conclusions: The informant history is a crucial investigation in the complete cognitive assessment of older adults. The informant history provides a ready source of reliable information to the assessing physician warranting further emphasis on both undergraduate and postgraduate medical curricula.

Reference:

024 CAREGIVING CAPACITY AND FUTURE CARE PLANNING OF FAMILY CARERS FOR OLDER PEOPLE WITH AN INTELLECTUAL DISABILITY IN IRELAND

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Background: Within contemporary Irish society, families within their homes are the primary providers of caregiving support for people with an ID. However, as people with an ID age so too do their families, making family caregiving more difficult and complex.

This study examined the caregiving capacity and future care plans of parent and sibling carers for their ageing family member with an ID.

Methods: Surname of parent and study population of IDS TILDA (Intellectual Disability Supplement to The Irish Longitudinal Database on Ageing), a qualitative study design was employed with a purposive sample of parent and sibling carers (n = 17) of older people with an ID. Five focus groups and semi-structured interviews were conducted and analysed.

Results: Family caregiving capacity was compromised by limitations and anomalies in contemporary care support systems, particularly the reduced and varied availability of carer’s allowance, day care and respite care.

Few carers have definitively formulated future care plans with their family member with an ID or the wider familial network, and where plans do exist these are predominantly aspirational in nature.

Sibling caregivers in particular felt physically, psychologically, and intellectually restricted in their family carer role. Furthermore, the majority of families articulated that they represented the last remnant of family caregiving capacity existing within the family. Families anticipated future crisis management and foresaw a strong possibility of their family member with an ID requiring residential out-of-home family care provision at some point in the future.

Conclusion: Carers allowance, day services and respite care are key to improving the quality and sustainability of family caregiving for older people with an ID.

Families’ future care planning and the future need for formal residential service provision for the older cohort of people with an ID necessitates clarification, costing and policy planning.

035 THE EVALUATION OF THE OLDER PEOPLE REMAINING AT HOME (OPRAH) PROJECT: A MIXED METHODS STUDY

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Background: The National Positive Ageing Strategy aims to enable older people to live at home for as long as possible. However in 2013, over 21,000 older people resided in Irish nursing homes, 35% of whom were classified as low to medium dependency. The Older People Remaining At Home (OPRAH) project was established to support older people at-risk of nursing home admission, to remain living at home.

This study evaluates the impact of the OPRAH project on participants’ service utilisation patterns and experiences within the project.

Methods: A sequential explanatory mixed methods design was operationalised. Quantitative data for each participant (n = 146) was collected by trained nurses on each site using the InterRAI HC form and a survey. STATA v13 was used to analyse the data from the ‘before’ and ‘after’ time-point using McNemar and repeated-measures ANOVA tests.

Data from the Irish Longitudinal Study on Ageing (TILDA) were used to compare changes in the OPRAH pilots to changes occurring nationally. Semi-structured qualitative interviews were used to explore the experiences of the OPRAH clients (n = 12), Support Coordinators (n = 4) and the Project Manager (n = 1) within the OPRAH project.

Results: A gap was identified in provision for the psychosocial needs and care planning needs of older people. These needs can be addressed through the provision of a Support Coordinator. However, inadequate levels of community services and inflexible budget models, meant services could not be accessed at the right time.

Conclusions: New ways to support older people to live at home which address aspects of care planning, must be facilitated by financial supports.

036 FREQUENCY AND STABILITY OF MOTOR SUBTYPES IN OLDER MEDICAL INPATIENTS WITH INCIDENT DELIRIUM

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Background: Delirium is highly prevalent, and serious, yet remains under-recognised. Although patients presenting with hypoactivity have the worst prognosis, they are most commonly missed or misdiagnosed. Most studies of motor subtype have been conducted using cross-sectional methodology, however longitudinal studies are required to truly understand motor course, given the dynamic nature of delirium. Older patients are particularly vulnerable to delirium, however little is known about motor profile in this group.

We aimed to investigate the frequency and stability of motor subtypes in incident delirium in older medical inpatients.

Methods: Medical inpatients of ≥70 years were assessed for delirium within 36 hours of admission, using the Revised Delirium Rating Scale (DRS-R98). Consenting patients without prevalent delirium then underwent daily assessment for the first week of admission for the development of delirium. The Delirium Motor Subtype Scale-4 (DMSS-4)
A key recommendation of current national guidelines for preventing malnutrition is to use the Malnutrition Universal Screening Tool (MUST) 5 steps screening tool. The ‘MUST’ is a method of identifying the patient at nutritional risk and assignment of a risk score which leads to a subsequent plan of care.

Methods: The multi-professional QI Project Team used the Model for Improvement (MFI) as an approach to improve rates of screening using the ‘MUST’ tool on an acute ward. Combined with the Plan, Do, Study, Act (PDSA) cycle the model is a simple, yet powerful tool for accelerating improvement.

A baseline audit was undertaken showing the rate of ‘MUST’ completion was 20%. Over 8 weeks a number of PDSAs were introduced including:

- Nurse education
- Introduction of an admission checklist
- Availability of equipment

Sampling methods were used to collect data weekly which was plotted on time series run charts.

Results: The team set a SMART aim to increase screening rates by 60% over 8 weeks. An actual increase of 80% was achieved.

Conclusion: A significant improvement in screening rates for malnutrition using the ‘MUST’ was achieved using the MFI and PDSA cycles. Screening is now embedded into the admission process and dietician intervention takes place earlier in the patient’s journey. This lead to the development of a national guidance document: Malnutrition screening using ‘MUST’: A brief guide for improving. This is available on the HSE website.
PROFILING COMMUNICATION ABILITY IN PEOPLE WITH DEMENTIA: DEVELOPMENT OF A NEW INSTRUMENT TO INFORM MANAGEMENT OF COGNITIVE COMMUNICATION DIFFICULTIES

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Background: Communication difficulty is an integral part of dementia, a major age-related syndrome, leading to limitations in functioning and social isolation. Although much can be done to maximize communication abilities, no instrument focuses on the communication abilities of people with dementia that is sensitive to change across time and linked with specific strategies to support communication. Profiling Communication Ability in Dementia (P-CAD) was devised in 2015 and shows promise in clinical practice. The aim is to validate the P-CAD to direct individualised advice, support and therapy for people with dementia and their carers. It will detect changes in communication and will be a robust outcome measure to evaluate efficacy of current and new communication interventions in dementia.

Method: There are two phases to this study. Phase 1 involved revising and amending the earlier version of the P-CAD based on feedback from carers, people with dementia, medical professionals, speech and language therapists and occupational therapists (SLTs). Nine SLTs used the P-CAD in clinical practice over a 6-week period.

Results: Phase 1 is complete. Feedback was obtained through questionnaires and focus groups. Overall, the response was positive. Participants suggested some amendments to familiar and communication strategies. Changes made were to the scoring system to an additional accessible profile summary form was also included. The new instrument comprises 8 sections, which includes cognitive, linguistic and functional communication parameters. It objectively evaluates cognitive communication abilities and provides support strategies.

Conclusion: The P-CAD has been extensively revised following feedback with the final P-CAD ready for validation. The focus remains on the abilities of people with dementia and carers across different stages of the condition. Phase 2 involves validation of the final P-CAD with 100 people with dementia and carers across Ireland and Canada.

STOPPFRAIL (SCREENING TOOL OF OLDER PERSONS PRESCRIBING IN FRAIL ADULTS IN NURSING HOMES) CONSSENSUS VALIDATION

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Background: To validate STOPPFrail, a list of explicit criteria for potentially inappropriate medications (PIMs) in frail older adults with limited life expectancy. A Delphi consensus survey of an expert panel (n = 17) comprising specialists in geriatric medicine, clinical pharmacology, palliative care, psychiatry of old age, clinical pharmacy and general practice.

Methods: STOPPFrail criteria were initially created by the authors based on clinical experience and appraisal of the available literature. Criteria were organised according to physiological system. Each criterion was accompanied by an explanation. Panelists ranked their agreement with each criterion on a 5-point Likert scale and invited to provide written feedback. Criteria with a median Likert response of 4/5 (agree/strongly agree) and a 25th centile of non-responders were included in the final criteria.

Results: Three Delphi rounds were required. All panelists completed all rounds. Thirty criteria were proposed for inclusion; 26 were accepted. No new criteria were added. The first two criteria suggest depressurising medications with no indication or where complication is poor. The remaining 24 criteria include lipid-lowering therapies, alpha-blockers for hypertension, anti-platelets, neuroleptics, proton pump inhibitors, H2-receptor antagonists, anti-spasmodics, theophylline, leucotriene antagonists, calcium supplements, bone anti-resorptive therapy, selective oestrogen receptor modulators, non-steroidal anti-inflammatories, corticosteroids, 5-alpha reductase inhibitors, alpha 1 selective blockers, muscarinic antagonists, oral diabetic agents, ACE-inhibitors, angiotensin receptor blockers, systemic oestrogens, multivitamins, nutritional supplements and prophylactic antibiotics. Anticoagulants and anti-depressants were excluded. Despite incorporation of panelists’ suggestions, memantine and acetyl-cholinesterase inhibitors remained inconclusive.

Conclusion: STOPPFrail comprises 26 criteria, which have been judged by broad consensus, to be potentially inappropriate in frail older patients with limited life expectancy. STOPPFrail may assist in depressurising medications in these patients.

EXPLORE THE HOUSING NEEDS OF MARGINALISED OLDER PEOPLE: A COMPARATIVE SURVEY OF THOSE LIVING IN ‘MAINSTREAM’ OR ‘SHELTERED’ SOCIAL HOUSING

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Background: The house we live in and where we live has a major impact on our physical and mental health; this is particularly true for people who tend to spend more time at home, including older adults. Older people living in social housing are even more vulnerable than their counterparts in the general population, and are at risk of experiencing poorer health and lower life expectancy. With an ageing population, it is critical that the most suitable housing model is identified. However, it’s unclear whether supporting people in their own homes (‘ageing-in-place’) or in specially designed ‘sheltered’ accommodation is the better method. This research aimed to explore the housing needs of older people in social housing, comparing those in mainstream or sheltered schemes.

Methods: The population studied was tenants of Clúid Housing aged 60 years and older. Two surveys were designed, for ‘mainstream’ or ‘sheltered’ social housing tenants. A stratified sampling method was used to reach a geographically representative sample across Ireland.

Results: The response rate was 47.2% (n = 380/805). Older people across the schemes had similar housing needs. Unsuitable homes led to fear and anxiety, especially around using the bathroom and stairs. One-in-four experienced fuel poverty. Tenants in mainstream housing were less likely to have necessary adaptations in place. Sheltered housing tenants were happier with their home (90% ‘completely’ or ‘somewhat’ satisfied) and had more social contact than mainstream tenants.

Conclusions: Tenants living in mainstream houses reported more disability/illnesses, worried more about the future, and felt less safe in their neighbourhood, than those in sheltered housing. However, few wanted to move, and even of those who would consider moving, few viewed sheltered accommodation as an option. This suggests a lack of knowledge about housing and support options.

IMPACT OF DEMENTIA CAREGIVING ON COGNITION, DEPRESSION AND STRESS BIOMARKERS: BENEFITS OF STRESS REDUCTION TECHNIQUES

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Background: Although there is evidence for modest efficacy for the use of atypical antipsychotic medications in treating behavioural and psychological symptoms of dementia (BPSD), growing concern regarding the potential for harm has led to calls for more judicious use (Ballard et al. 2006). Recent practice guidelines published by the American Psychiatric Association further stress the need for targeted use, with prioritisation of non-pharmacological measures and routine review (Reus et al. 2016). Our study aimed to assess the prevalence of antipsychotic prescribing in an Irish urban older persons’ community nursing unit.

Methods: We reviewed medication prescriptions across four wards of a publicly-funded older persons’ community nursing and psychological symptoms of dementia (BPSD) unit, including one ward specifically designated for people with dementia. This facility has onsite Geriatrician-led medical cover, with all residents receiving quarterly standardised reviews, including review of psychotropic medications.

Results: Prescriptions of 100 long-term residents were reviewed (69% female). The mean age was 84.7 years. 41% were prescribed either an acetyl-cholinesterase inhibitor, memantine, or both. 32% were prescribed a regular oral antipsychotic (97% of which (31/32) were atypical antipsychotics) with 40.6% (13/32) also prescribed additional PRN antipsychotics.

Conclusion: These results indicate significant utilisation of antipsychotic prescribing in this setting. The management of BPSD remains a particularly complex challenge, with shortcomings in the allocation of resources for non-pharmacological measures and a need to balance quality-of-life considerations with known harmful effects on physical health related outcomes. This is combined with increasing involvement of family and carers in healthcare-related decision making for people with dementia, with a formalisation of this advocacy role set out in the recent Assisted Decision-Making (Capacity) Act 2015. Since completing this study, we have implemented a formal structure of regular multi-disciplinary review of antipsychotic prescribing (including senior medical registrars and senior nursing staff) with a view to promoting cautious reduction where appropriate.
current study aimed to examine the cognitive neurobiology and mental well-being of dementia caregivers.

Methods: We conducted a systematic review to gauge the currently known biological impact of family dementia caregiving. We examined mental well-being and cognitive performance in dementia caregivers and non-caring controls. Participants were recruited through advertisements and caregivers were recruited via clinics at St. Finbarr’s Hospital, Cork. Participants completed validated tests of stress, anxiety, and depression. Participants also completed cognitive tasks from the CANTAB battery. A sub-set of caregivers completed both a carer training program and mindfulness-based stress reduction (MBSR) program. Each program was delivered in a group setting by an experienced instructor and lasted 6-8 weeks.

Results: Our systematic review indicates altered hypothalamic-pituitary-adrenal axis activity and impaired attention in caregivers, and that interventions to attenuate stress may improve cognition. Our preliminary study results suggest the presence of higher levels of stress and depressive symptoms in caregivers (N = 31, mean age = 56.1, 20 females, 11 males) compared to controls (N = 18, mean age = 55.8, 11 females, 7 males). Caregivers also made a higher number of errors on the paired associates learning task (PAL), which engages the hippocampus, suggesting poorer visuospatial memory, as well as impaired performance on rapid visual information processing, suggesting poorer sustained attention. However, following both carer training and MBSR, caregivers’ performance improved on both tests.

Conclusions: Dementia caregiving is associated with heightened biomarkers of stress, high self-reported levels of stress and depression as well as impaired cognition. Carer training and MBSR may be beneficial in improving cognitive performance. A comprehensive physiological phenotyping of dementia caregivers is required to better understand the mechanisms of these effects.

EXP96 EXPERIENCES OF PROVIDING FORMAL HOME AND COMMUNITY DEMENTIA CARE IN IRELAND: ADVOCATING FOR A HOLISTIC SYSTEMIC APPROACH

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Background: Access to formal dementia care services varies widely within and across European countries. This paper presents Irish data from one study within the Access to Timely Formal Care (Actifcare) JPND-funded research project. This study explored the professional experiences, and perceived barriers and facilitators in accessing formal home- and community-based health and social care from the perspectives of healthcare professionals and expert stakeholders in a unique position to influence dementia policy in Ireland.

Methods: An exploratory qualitative design with purposive sampling was used. Three focus groups were conducted with healthcare professionals from a variety of backgrounds (n = 18; years experience M = 11.35, SD = 7.22). One group took place in a rural setting, one in south and one in north Dublin. Seven interviews with policy and political decision makers also took place. Discussions followed an agreed structure, were audio-recorded, transcribed, and analysed using inductive content analysis.

Results: Narratives revealed a wide range of themes describing barriers and facilitators for the use of formal dementia care at (1) an individual level – relating to every person and their personal circumstances such as need, capacity and rights; (2) a system level relating to the Irish health and social care systems, such as service design, service availability and case management; and (3) overarching aspects that were important on both levels, such as education, awareness, influence and community engagement. Conflicting views emerged between healthcare professionals regarding the most appropriate time for care, and among experts regarding the definition and location of any case management support.

Conclusions: These findings are interpreted in the context of the 2014 National Dementia Strategy and they support the increasing body of evidence that highlights the very clear gaps that exist between the formal home- and community-based care that is available in Ireland, and the care advocated for by health professionals and policy makers alike.

EVALUATING A DAY HOSPITAL SUPPORT GROUP AT AN OLD AGE PSYCHIATRY SERVICE: PATIENT AND STAFF PERSPECTIVES

Aisling Davis
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Background: Carew House Geriatric Day Hospital offers an off road assessment service to out patients within the community. The assessment process involves obtaining detailed collateral regarding driving history/need for driving, formal cognitive assessment, completion of the Adelaide Self Efficacy Scale (and a proxy version if patient accompanied) and completion of the Rockwood Driving Assessment Battery (RDAB). The latter assesses the core neuropsychological skills needed to drive. It is used as a tool to aid a medical practitioner’s decision regarding fitness to drive.

Methods: A retrospective chart audit was conducted over a 6 month period. A total of 21 patient’s charts were selected as they included an Adenbrookes Assessment (ACE-R) and RDAB completed.

Results: Patient’s results on the RDAB were grouped into three as per manual’s guidelines. Group A (score of 1-5 on RDAB)- indicates nil significant concerns regarding driving ability. 3 patients.

Group B (score of 6-10 on RDAB)- suggests a level of impairment that may reduce driving ability and on road assessment is advised. 8 patients.

Group C (score of 10 + on RDAB) - this is considered a fail and is associated with a 90% chance of failing an on road assessment. 10 patients.

CANCANMBERROOKES ASSESSMENT SCORES PREDICT PERFORMANCE ON ROCKWOOD DRIVING ASSESSMENT BATTERY? AN AUDIT OF AN OUT PATIENT DRIVING ASSESSMENT SERVICE

Aisling Davis
St Vincent's University Hospital, Dublin 4, Ireland

Background: Carew House Geriatric Day Hospital offers an off road assessment service to out patients within the community. The assessment process involves obtaining detailed collateral regarding driving history/need for driving, formal cognitive assessment, completion of the Adelaide Self Efficacy Scale (and a proxy version if patient accompanied) and completion of the Rockwood Driving Assessment Battery (RDAB). The latter assesses the core neuropsychological skills needed to drive. It is used as a tool to aid a medical practitioner’s decision regarding fitness to drive.

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Group C (score of 10 + on RDAB) - this is considered a fail and is associated with a 90% chance of failing an on road assessment. 10 patients.
Background: Depression and antidepressant medications (ADTs) negatively affect bone health, but little is known of the relative impact of different ADTs, nor has their effect been studied in an elderly Irish population. We aimed to establish the bone health implications of ADTs for elderly patients attending our osteoporosis clinic.

Methods: We identified patients prescribed ADTs: Venlafaxine, citalopram, escitalopram, fluoxetine, sertraline, paroxetine, mirtazapine, duloxetine, amitriptyline, clomipramine, lofepramine, dothiepin and trimipramine. We compared them with a random control group not prescribed ADTs. We examined DXA bone mineral density (BMD) and T-scores, and fracture history.

Results: 1578 individuals 522 on ADTs; 1056 control. Mean age 66.93 (SD 14.56); 79.2% female; mean BMD total hip 0.795 g/cm² (SD 0.156); mean BMD spine 0.908 g/cm² (SD 0.189).

Patients on ADTs had significantly higher BMD than controls: BMD hip 0.025 g/cm² lower in ADT group (SE 0.010, 95% CI 0.011–0.048, p < 0.002), adjusted for age, gender, BMI. BMD spine did not differ significantly between groups (p = 0.856). Those on ADTs had higher prevalence of hip fracture: OR 2.18 (95% CI 1.68-2.83, p < 0.001). BMD hip was significantly lower in patients on ADTs who had never had hip fracture: BMD mean difference 0.121 g/cm² (SE 0.017, 95% CI 0.087-0.154, p < 0.001).

There was significant variation in prevalence of hip osteoporosis between different ADTs, p < 0.001, chi-squared test. Highest rates were in mirtazapine, 50% (n = 20); citalopram, 45.9% (n = 10); lowest rates in fluoxetine, 6.7% (n = 30). OR for hip osteoporosis, comparing citalopram to fluoxetine was 11.86 (95% CI 2.65-52.29, Pearson’s chi-squared test p < 0.0001).

Conclusions: We confirmed in an elderly Irish population that ADTs are associated with lower BMD hip, and higher risk of hip fracture. While no single drug was clearly linked with reduced BMD or increased fracture, some evidence indicates that fluoxetine may be associated with a less-negative impact on bone health compared with other ADTs.
Methods: We collected quantitative and qualitative data using a mixed methods research approach. Data from patient records, carers, and staff were gathered through structured and unstructured interviews. The factors influencing the achievement of our aim were represented on a driver diagram. A fishbone diagram displayed the causes of deficiencies in the current discharge process. Quality improvement interventions based on these models were tested and introduced by rapid Plan-Do-Study-Act cycles. We developed a measurement dashboard comprising of relevant run charts to assess improvement.

Results: Our results indicate that one third of 28 day readmissions are potentially avoidable. Some reasons for avoidable readmissions were not within a hospital’s control. Nevertheless, the majority of reasons related to inadequate discharge planning. During our project a multidisciplinary discharge planning checklist, a pathway for frail older patient assessment and a complex discharge round were introduced. Individualised discharge plans and early telephone follow-up for complex discharges were used. Focused educational sessions on discharge planning were started in the hospital. Avoidable readmissions fell from 9.8% during the baseline period to 8.1% by the end of the project.

Conclusion: Managing readmissions is a complex task. Multi-component interventions, with early multi-disciplinary review for complex discharges, focused patient education, and medication reconciliation can significantly reduce readmissions. Overall, a more effective pathway is developed for all patients and patient safety is improved. Reducing avoidable readmissions has great potential to improve quality and lower spending through-out the healthcare service. A person-focused approach understanding the unique issues of each high-risk individual admitted to the hospital is crucial.

Background: Osteoporosis is a significant health and socioeconomic threat to a large proportion of the population. People with ID are at greater risk of experiencing overall poor health. Many barriers exist from difficulty in expressing their own health need to lack of empirical evidence on health determinants.

Methods: The sample was drawn from The Intellectual Disability Supplement to The Irish Longitudinal Study on Ageing (IDS-TILDA). Bone quality was measured using a GE Lunar Achilles as part of an objective health suite of assessments. Assessment was supported with accessible material. Ethics was granted by Trinity College Faculty Ethics committee and by the service providers involved in the study. All participants provided consent prior to engaging in assessment. A decision tree-based statistical classification algorithm for identifying variables responsible for the occurrence of poor bone quality was utilised.

Results: Overall 575 participants had QUS performed. The prevalence of osteoporosis was identified at 41% among this cohort. For osteoporosis the model classified 70.8% of the sample with difficulty walking (p < 0.0001), antiepileptics (p = 0.004) and proton pump inhibitors (p = 0.0043) as the strongest predictors to emerge.

Conclusion: The findings supports a need for robust risk assessment and for clinical practitioners to not only consider the obvious risks but also specific concerns for people with ID in order to better target preventative strategies.

Background: Intracerebral haemorrhage (ICH) is associated with worse outcomes than ischaemic stroke. Counter-intuitively this has not improved in recent years. We postulated that increasing age of the population and usage of anticoagulants represent a possible explanation.

Methods: St. Vincent’s University hospital is a tertiary referral hospital serving a population of approximately 300,000 in Dublin, Ireland. We excluded ICH associated with trauma or other secondary causes. We analysed changes in age distribution, clinical characteristics, medication usage and case fatality (30 day mortality) over the 12 year period. Fisher’s exact test was used to assess for significant differences between percentages.

Results: 3,547 stroke patients presented between 2003 and 2014; 11.1% (394) were due to ICH. Median age was 77.2 years. ICH patients aged ≥90 years increased from 1.9% in 2003–2006 to 7.3% in 2010–2014. Anticoagulation use in this group increased from 0% in 2003–2006, to 11% in 2007–2010 to 19% in 2011–2014. There was no change in case fatality or location of ICH over the 12 years. There was an increase in case fatality with increasing age; 11% in under 75 s, 24% in 75–89, 38% in over 90 s, p < 0.0001. Lobar ICH was associated with higher case fatality than deep ICH; lobar in case fatality with increasing age; 11% in under 75 s, 24% in 75–89, 38% in over 90 s, p < 0.0001.

Conclusion: We have shown no decrease in case fatality, despite advances in management of ICH over this period. There may be relation to the increasing use of anticoagulants. Further research will focus on identifying factors, both clinical and radiological, associated with both short-term mortality and longer term functional outcome.

Background: Advance Planning (ACP) encompasses a process by which people may express and record their values and preferences for care and treatment should they lose the capacity to communicate them in the future. Our aim was to identify the effects of Advance Care Planning (ACP) interventions on nursing home residents.

Methods: A comprehensive literature search was conducted using Embase, Medline, PsychINFO and CINAHL. Reference lists of all included articles were reviewed. Inclusion criteria included randomised controlled trials (RCT), controlled trials, pre/post study design trials and prospective studies. A narrative synthesis was compiled as the hetrogeneous nature of the interventions and results precluded meta-analysis.

Results: Initial search yielded 4,654 articles, thirteen fitted inclusion criteria. ACP intervention included: five evaluating educational programmes; five introducing/evaluating a new ACP; two introducing an ACP programme with a palliative care initiative; one observing effect of Do Not Resuscitate orders on respiratory infection treatments. ACP decreased hospitalisation rates by a range of 9–43% without increased mortality. ACP increased the number of residents dying in their nursing home by 29–40%. Medical treatments were consistent with wishes increased with ACP. ACP was associated with decrease in overall health costs. ACP was associated with increase in community palliative care use but not in-patient hospice referrals.

Conclusions: ACP has beneficial effects in the nursing home population. The types of ACP interventions vary and it is difficult to identify superiority in effectiveness of one intervention over another. Outcome measures also vary considerably between studies although hospitalisation, place of death and actions being consistent with resident’s wishes are by far the most common. Very few studies with high quality methodology have been undertaken in the area with a significant lack of RCT. More robust studies, especially RCT are required to support the findings.

Background: Systematic review shows that advance care planning has many effects on residents of aged care facilities, including decreasing hospitalisation. (1) The Residential Aged Care Facility (RAF) “Goals of Patient Care” (GOF) form is a medical treatment order that incorporates aged care residents’ advance care plans or wishes. The form helps guide healthcare decisions made on behalf residents in planned and emergency situations.

Methods: We performed a cluster randomised controlled trial in three pairs of RACFs. Inclusion criteria were all residents from participating facilities for whom written informed consent could be obtained. We recorded baseline characterisics from all partici pants. We completed the Goals of Patient Care form with participants in the intervention facilities as compared with usual care in control facilities. Our primary outcome is the effect on Emergency Department reviews and admissions at 6 months. Secondary outcomes include change in hospitalisation rates at 3 months amongst others.

Results: We selected 6 RACFs from 45 invited to take part. We recruited 337 participants across 6 sites of which 72% were female. The mean age was 86.5 years. 61% had an existing advance care plan. The three month event rates for Control facilities were (1) 0.23, (2) 0.15 and (3) 0.45 versus Intervention facilities (1) 0.21 (2) 0.11 and (3) 0.25. The six month event rates for Control facilities were (1) 0.53, (2) 0.3, (3) 0.73 versus Intervention facilities (1) 0.46, (2) 0.28, (3) 0.46 with the event rate being the number of admissions per total residents per time period.

Conclusions: Within each cluster pair, Intervention facilities showed reduced event rates versus Control. The Goals of Patient Care medical treatment order showed positive trends towards reducing Emergency Department reviews and admissions at both three and six months. We feel this and further analysis will support the use of our GOF form in RACFs.

Acknowledgements: This research was funded by National Institute for Health Research and the European Commission. DOH awarded the programme grant to the lead researcher. A fully independent research ethics committee oversaw the study. We are grateful to the residents, friends, carers and staff at participating facilities, to the statutory partners who supported and worked with our teams, and to the research managers, academics and students who contributed to the project. We are grateful to the residents, friends, carers and staff at participating facilities, to the statutory partners who supported and worked with our teams, and to the research managers, academics and students who contributed to the project.
Background: Personhood in dementia refers to treating the individual with dementia as a person, in a manner which supports and promotes their sense of self, role and social connectedness. An overarching principle of the Irish National Dementia Strategy is to ensure personhood by enabling people with dementia to maintain their dignity, identity and resilience when faced with the disease (Department of Health, 2014).

Methods: This paper explores the origins and implications of personhood as an overarching principle for dementia policy in Ireland. It examines the impact of personhood on dementia care services, outcome measurement and regulatory frameworks within dementia. A content analysis of submissions made by stakeholders in developing the National Dementia Strategy, examines the rhetoric and substance of personhood within the public discourse and its relevance to priority setting within dementia care. An examination of the use and status of personhood models in international dementia strategies provides a comparative framework for the Irish Strategy.

Results: Differing concepts of personhood appear in national and international dementia strategies. This does not always lead to personhood-led action in care provision, outcome measurement and regulation. The extent to which the personhood principle is reflected in service delivery, outcome measurement and regulatory instruments in Ireland is varied, resulting in ambivalence and disappointment when assessing how the Strategy has responded to one of its overarching principles.

Conclusions: If the principle of personhood is to have meaning in dementia care in Ireland, much more work is needed on operationalising the concept in relation to the context of dementia care programmes, outcome measurement and the development of appropriate regulatory instruments.


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FRAILTY IN AN EMERGENCY DEPARTMENT: PREDICTORS AND POINT PREVALENCE OF FRAILTY AND PRE-FRAILTY IN AN IRISH COHORT

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Background: Although frailty is common among older adults presenting to the Emergency Department (ED), its prevalence is not well described. Likewise, little is known about the characteristics and prevalence of vulnerable ‘pre-frail’ patients attending ED who may benefit from early identification and intervention to prevent transition to established frailty.

Methods: We assessed consecutive older adults, aged ≥70 years, attending a large university hospital ED, 24-hours/day for a two week period in March 2016, for frailty using a battery of frailty measures including the FRAIL Scale. Clinical Frailty Scale, Groningen Frailty Indicator, Mini-Nutritional Assessment (MNA), body mass index (BMI), Alzheimer’s disease 8 (AD8) cognitive test, the Euroqol-5D and the Caregiver Burden Scale (CBS). Instruments were administered by trained clinician raters. Frailty status (frail, pre-frail and robust) was determined by a consultant geriatrician.

Results: In all, 307 patients were available. Of these, 280 were included with a median (interquartile) age of 78 (73–73 = +/−10) years. Most, 148/280 (53.6%) were female. The number considered globally frail by physician assessment was 161, a point prevalence of 58%.

Conclusions: The number considered globally frail by physician assessment was 161, a point prevalence of 58%. Using the FRAIL scale alone, the point prevalence of frailty (cut-off ≥3/5 but <5/5) was 29% and 41% respectively. Frail patients were significantly more likely to be older (p = 0.003), have lower MNA (p = 0.001), higher AD8 (p < 0.001), poorer Euroqol-5D scores (p < 0.001), and a higher CBS (p = 0.01) compared to those not frail (pre-frail or robust). There were no differences in gender or BMI. Pre-frail patients had significantly better MNA, AD8, Euroqol-5D and CBS scores than frail patients but were similar in age, sex and BMI.

Conclusions: The point prevalence of frailty and pre-frailty in an Irish university hospital ED is high. Frail and pre-frail older patients report more cognitive impairment, are more likely to screen positive for malnutrition, report lower quality of life and have higher caregiver burden scores.

AN EVIDENCE SYNTHESIS OF RESILIENCE IN DEMENTIA CAREGIVING: A SYSTEMATIC REVIEW

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Background: The majority of people with dementia live in the community and receive care from family members or other informal carers. Family caregivers experience caregiving differently and have varying levels of personal resilience when acting in the caregiving role. Defined as a set of personal qualities, resources and factors which allow an individual to maintain normal or enhanced functioning during times of adversity (Windle, 2011), resilience, contributes to the carer’s well-being and the quality of care provided to the person with dementia. The aim of this systematic review is to examine the concepts attributing to resilience in dementia caregiving and to outline interventions that enhance resilience in dementia caregivers.

Methods: A systematic literature review was conducted to examine resilience, as it applies to caregiving, and to identify non-pharmacological intervention studies examining dementia caregivers published between 2006 and 2016. The systematic review was conducted using six databases (Cochrane, PubMed, CINAHL, EMBASE, PsychInfo, ASSIA). Two reviewers pre-screened search results and conducted data abstraction and quality appraisal.
**PRELIMINARY RESULTS OF THE FRAIL ELDERLY PILOT PROGRAMME IN CONNOLLY HOSPITAL BLANCHARDSTOWN 2016**

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**Background:** The Specialist Geriatric Services (SGS) Model of Care aims to improve quality and efficiency of care for older people with complex health care needs. The Frail Elderly Pilot Programme commenced in Connolly Hospital Blanchardstown (CHB) in January 2016 to achieve these aims. It involves the early identification of the ‘frail older person’ with confusion, falls, poor mobility, poly-pharmacy and social factors which may warrant a comprehensive geriatric assessment (CGA).

**Methods:** The Frail Elderly Team was established within the emergency department (ED) and the acute medical assessment unit (AMAU) in CHB. Patients over 75 years were screened for frailty indicators during core hours. Frail Elderly care pathways and guidelines were implemented to improve quality, efficiency and outcomes for this cohort. To facilitate ED discharge, a rapid access pathway to the Day Hospital was established.

**Results:** 307 patients received input from the Frail Elderly Team while in ED. Referral reasons included functional, cognitive, social, dysphagia and nutritional assessment, falls and poly-pharmacy. Patients were categorised on average as moderately frail (Rockwood Clinical Frailty Scale). 60% of patients screened scored positively for delirium and/or cognitive impairment on the 4AT. 31% of patients were discharged on the same day from the ED or AMAU. The length of stay of patients seen by the Frail Elderly Team was on average 40% shorter than those who had not received input.

**Conclusions:** The Frail Elderly Team aims to improve the quality and efficiency of care of older people presenting to CHB. The SGS will continue to provide inpatient and community services. The Frail Elderly Team will facilitate ED discharge, a rapid access pathway to the Day Hospital. Improvements such as these will continue to provide care for older patients in CHB.

**References:**
1. HSE and RCSI (2012) National Clinical Programme for Older People; Specialist Geriatric Services Model of Care. Dublin.
SEXUAL ACTIVITY AND RELATIONSHIP QUALITY IN IRISH OLDER ADULTS

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Background: Sexual activity in later life is a growing area of research. Existing evidence suggests sexual activity is an important source of satisfaction in older couples but it can also serve as a source of conflict. The study aimed to assess whether sexual activity and couple mismatches in the importance attributed to sex are associated with relationship quality in older Irish adults.

Methods: Data from 2,398 married/cohabiting respondents in Wave 2 of The Irish Longitudinal Study on Ageing (TILDA) was used. A scale of relationship quality, ranging from 0 to 24, was derived. Frequency of sexual activity, measured categorically, the importance each couple attributed to sex (1–5 scale) and mismatch between members of the couple in this importance (0–4 scale) were estimated. Associations were assessed using negative binomial regression.

Results: The majority of respondents in this partnered sample were sexually active (79.2%), with over half reporting sexual activity at least once a month (57.8%). Frequency of sexual activity was positively associated with relationship quality for men and women. Over half of couples (59.2%) experienced some mismatch in importance attributed to sex (≥1), and this was associated with worse relationship quality for both men (Incidence Rate Ratio (IRR) per unit increase in mismatch = 1.16 [95% CI: 1.11–1.21]) and women (IRR = 1.17 [95% CI:1.11–1.23]). When accounting for importance of sex and couple mismatch, overall frequency of sex remained important for men (p < 0.05), but lost some of its association with relationship quality for women (p = 0.05).

Conclusion: Results showed that frequent sexual activity and attributing importance to sex were associated with better relationship quality within spousal relationships. Associations appear to work differently for men and women. Mismatch between partners was consistently related to worse relationship quality. Continued research in this area is needed.

EARLY SUPPORTED DISCHARGE FOR STROKE: COMPARING THE CHARACTERISTICS AND OUTCOMES OF URBAN AND RURAL PATIENTS

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Background: Early Supported Discharge (ESD) services after stroke have demonstrated their efficacy in reducing length of stay and improving outcomes for a select cohort of patients. The evidence to date is strongest in relation to domiciliary-based rehabilitation in urban areas, as the only study carried out among a rural population did not find a significant benefit for ESD when compared with in-patient rehabilitation (Fisher et al).

In response to the high numbers of rural dwellers within our catchment area, an alternative ESD service model was developed, which combines domiciliary and out-patient rehabilitation. This model is provided to approximately one-third of the ESD cohort.

Methods: A total of 51 patients participated in ESD from Jan 2014 to May 2016. A retrospective audit was completed comparing urban and rural participants for the following variables: demographic profile, length of hospital stay, length of time on ESD, bed days saving and functional outcome.

Results: A full dataset was available for 37 patients. The urban/rural demographics were as follows: 23/14 participants, mean age 64/69.7 years, female gender 48%/29%.

The groups did not differ in number of bed days saved or length of stay on the ESD programme. There was a trend towards a shorter hospital length of stay among the rural population (mean of 20.9 compared to 29.8 days) but this did not reach statistical significance.

The Functional Independence Measure was used to measure functional status and outcome. We found no statistical difference between the groups at baseline, at discharge or for overall gains.

Conclusions: Rural dwellers in our ESD service had equivalent functional outcomes to those within the traditional ESD population. Our findings suggest that further exploration of this service model should be considered within the Irish context.

THE PATTERNS AND PREDICTORS OF PHYSICAL ACTIVITY CHANGE IN IRISH OLDER ADULTS: TILDA

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Introduction: Physical activity (PA) in older adults is extremely important in the maintenance of independence, improvement of quality of life and the prevention and protection of many non-communicable diseases. Older adults are recommended to do at least 150 minutes of moderate-intensity PA; however over 60% of the world’s population fail to meet current guidelines with age considered a major factor for reduced PA. Although predictors of PA behaviour in older adults have been well researched and documented in cross-sectional studies, longitudinal research exploring the predictors of PA change has rarely been examined, particularly in the old.

Methods: Data presented are from 2782 community dwelling older adults aged 65 and over who participated in both wave 1 & 2 of the Irish Longitudinal Study of Ageing (TILDA). PA was assessed using the IPAQ and dichotomized at baseline and follow-up based on activity levels according to the WHO guidelines: “active” (≥150 mins) and “inactive” (<150 mins). Detailed information on demographic, social and health circumstances were collected. Four multiple logistic regression models were run to examine the predictors of PA change.

Results: Four patterns of PA were identified. Active maintainers (AM) (46.7%), sufficiently active at both time points; Inactive maintainers (IM) (23.1%) inactive at both time points; Inactive improvers (Iin) (13.2%) becoming active and Relapsers (Rel) (17.0%), becoming inactive. Older age, female gender, reporting a disability and fear of falling were less likely to be AM. Higher education, better quality of life and endocrine, nutritional or metabolic disease was associated with AM. Over 80, female gender, reporting a disability, fear of falling and respiratory disease were associated with IM. Retired, female gender and anxiety were associated with Rel.

Conclusion: Policies and practice need to be aware of the factors associated with PA change to help maintain PA and protect this vulnerable population from chronic disease.

SELF-REPORTED UNSTEADINESS PREDICTS FEAR OF FALLING AND ACTIVITY RESTRICTION AT TWO YEARS FOLLOW-UP

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Background: Fear of falling (FOF) is common in older adults and can lead to restriction of everyday activities. A recent conceptual model proposes that FOF may result from a realistic self-appraisal of one’s own balance abilities (Hadjistavropoulos et al. 2011). In this study, we examine if self-reported unsteadiness during walking is independently associated with the development of FOF and/or activity restriction at two years follow-up.

Methods: Data were obtained from the first two waves of The Irish Longitudinal Study on Ageing (TILDA). Community-dwelling adults aged ≥265 years, with Mini Mental State Examination score ≥21, who participated in a health assessment and who did not report FOF at baseline were included in this analysis (n = 1,659). Unsteadiness was based on reports of feeling slightly steady, slightly unsteady or very unsteady (as opposed to very steady) during walking. Participants were asked if they were afraid of falling and to what extent (no FOF, somewhat afraid, very much afraid). Participants were then asked if they restricted their activities as a result of this fear (yes/no). Ordinal logistic regression and poisson regression analyses were used to obtain the relative risk of reporting FOF or activity restriction at follow-up after adjusting for socio-demographics, physical and mental health, self-reported sensory function and gait speed.

Results: 24.6% of this sample (mean age 71.4 years; range 65–93) reported unsteadiness. Unsteadiness was independently associated with an increased risk of developing FOF (IRR = 1.53 [1.92–2.08], p = 0.008) and fear-related activity restriction (IRR = 1.59 [1.26–2.03], p = 0.003) after adjusting for variables listed above.

Conclusion: Self-reported unsteadiness is easily obtained and may be a useful indicator of existing or future balance dysfunction. Its inclusion in a clinical assessment presents an opportunity to target interventions aimed at improving balance and thus, reduce the development of FOF.

References:
ACUTE HOSPITAL ADMISSIONS IN NURSING HOME RESIDENTS: A TRIGGER TO THINK AHEAD!

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Background: Nursing Home Residents (NHRs) have complex healthcare needs due to advanced age, multiple comorbidities and high levels of dependency. Acute hospital admissions of older people are associated with risks and complications. Despite this, transfer of NHRs to hospitals remains common. This study aims to examine the relationship between acute hospital admissions and survival benefits among NHRs.

Method: Retrospective analysis of NHRs with unscheduled admissions to a tertiary hospital over a 2 year period, from 2014 to 2015.

Results: There were a total of 1219 unscheduled admissions from 929 residents. This represented 4.8% of 25,386 unscheduled admissions in the time period. 62% were women and mean age was 85 years. Of all admissions, 36% were recurrent admissions. 293 residents had more than one admission.

The overall 6 month mortality of NHRs after hospital admission was 34%, 18% (n = 167) died during their hospital stay, with 81% of deaths occurred within the first 15 days. Following hospital discharge, a further 16% (n = 124) died in nursing homes within 6 months. 40% of this cohort died within 1 month of hospital discharge.

NHRs with more than 1 admission had poorer outcomes. Their overall 6 month mortality was significantly higher at 37.5% vs 28.5% in residents with single admission (p = 0.006). In-hospital mortality among re-attenders was 20.5%, compared to 16.8% in those with single admission (p = 0.17). Following hospital discharge, NHRs with more than 1 admission had significantly higher nursing home mortality at 6 months, compared to those with single admission (21% vs 13% p = 0.009).

Among re-attenders who died in hospital, 73% (n = 45) died on their second admission. Of re-attenders who died in their nursing homes, 60% (n = 43) died after their second admission.

Conclusion: Acute hospital admissions are associated with poor survival outcomes among NHRs. Hospital admissions, in particular recurrent admissions, should prompt early discussions regarding appropriate end of life care.

INCIDENCE AND COURSE OF DEMENTIA IN PEOPLE WITH DOWN SYNDROME: FINDINGS FROM 20 YEAR LONGITUDINAL FOLLOW UP

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Background: The prevalence of Alzheimer’s Dementia (AD) in people with Down syndrome (DS) increases dramatically with age. However the early clinical presentation, nature and course of decline and risk factors for mortality are poorly understood. Aim: To investigate the characteristics of age related clinical changes, risk factors for dementia and mortality in adults with DS.

Method: Seventy-seven people with DS aged 35 years and older were followed over a 20 year period in a specialist memory clinic for people with an Intellectual Disability.

The diagnosis of dementia was established using the modified International Classification of Diseases, Tenth Revision (ICD-10) criteria, comprehensive diagnostic work up and a combination of neuropsychological and informant based tools and instruments.

Results: Over the 20 year period, 97.4% (75 of 77) developed dementia. The risk for dementia was established, at 23% at age 50 years; 45% at age 55 years and 88% risk at age 65 years. The average age of diagnosis of dementia was at 55 years (median = 56 years). Of the 56 people who died with a diagnosis of dementia, they had a mean duration of dementia 26.59 years.

The presence of dementia was strongly associated with new onset epilepsy. Within two years after dementia diagnosis, 72% (54 of 75) had a diagnosis of epilepsy. A subject with epilepsy was over 11 times (95% CI = 2.0, 41.9) more likely to have died than a subject without diagnosed epilepsy when adjusted for age of onset of dementia and level of ID.

Conclusion: The previously reported high risk levels for dementia among people with DS was confirmed. The memory clinic approach utilised here is capable of tracking change suggestive of dementia and potentially supported earlier diagnosis thus helping to ensure earlier access to appropriate treatments and programme redesign.

CREATING LIFE STORIES THROUGH DIGITAL TECHNOLOGY AS A MEANS OF SUPPORTING PERSON-CENTRED RELATIONSHIP BASED CARE ACROSS THE CONTINUUM OF DEMENTIA

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Background: Life story is a powerful tool for providing meaningful communication and facilitating genuine person centred, relationship based care across the continuum of dementia. Aim: The aim of this project was to build life story through digital technology to support people with an intellectual disability across the continuum of dementia.

Method: A multi-step approach was taken. First, a comprehensive survey in an easy to read format was distributed throughout the Dublin Service of the Daughters of Charity Disability Support Service to gather information and gauge interest among 380 people aged 40 years and over. A sub-cohort of people with Down syndrome who are at increased risk of dementia and/or had a diagnosis of dementia were purposefully included. Next, an exploration was undertaken of currently available Life Story and music apps and a suite of easy to use apps were identified and then pilot tested. A tailored suite of apps was sourced and supplemented with a ‘Train the Trainer’ manual. Instructions on the use of these apps and information on assistive technology options was introduced and evaluated in terms of their accessibility and user friendliness. An easy read instruction manual was developed to assist persons with limited literacy skills. With the support of the person’s family and close carers a personalised digital life story was created for each person using a combination of chapters which included personal photos, narration as well as favourite songs and video clips.

Conclusions: Digital life stories have been shown to be a very powerful means of facilitating meaningful communication and supporting relationship based, person centred care across the continuum of dementia. They have been shown to be very acceptable both to the individual, their family and staff carers. Structured training and easy read support material as well as organisational commitment are critical for sustainability.

AN EVALUATION OF SWALLOW SCREENING IN ACUTE STROKE CARE

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Background: Recommendations from the Irish Clinical Program for Stroke include that every stroke patient should have a validated swallow screen completed within the first 24 hours of admission. In 2015 The Irish National Audit of Stroke Care showed screening rates of 30%. We introduced in The Massachusetts General Hospital-Swallow Screening Tool (MGH-SST) screening tool in 2014. The aim of this study was to assess if swallow screening took place in those patients who subsequently developed aspiration pneumonia.

Methods: Medical records of consecutive patients admitted with stroke over a one month period were reviewed. We assessed if swallow screening was carried out, if a validated screening tool was used, referral rates to Speech and Language Therapy (SALT), timing of SALT review, aspiration pneumonia rates and death rates.

Results: 21 patients were admitted with stroke. The mean age was 71.6 years (SD 13.7). 19% (4) were diagnosed with aspiration pneumonia. 28.6% (8) had a swallow screening carried out within 24 hours of admission. 96.6% (2) had a validated screening tool used. 47.6% (10) were referred to SALT. Of these 80% (8) were seen within 48 hours of admission. Of the patients with aspiration pneumonia 50% (2) did not have a swallow screening test carried out within 24 hours and 25% (1) were not seen by SALT.

Conclusion: Swallow screening levels are well below national levels of 30%, which are themselves significantly below the optimum, which would involve all patients receiving screening. Only 2 patients were screened using a validated tool. This has the potential to lead to aspiration pneumonia. Staff involved in acute care are now undertaking training in the use of the MGH-SST to ensure all patients are screened within the recommended 24 hours.

A PROFILE OF MALE PATIENTS ATTENDING A SPECIALIST BONE HEALTH CLINIC

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Background: Osteoporosis and fragility fractures are not exclusive to post menopausal women. Osteoporosis is a common but often under recognised problem in older men. This study aimed to profile men attending a bone health clinic.

Methods: We conducted a retrospective chart analysis of all male patients attending a specialty bone health clinic between 2012 and 2015. DXA results, Vitamin D level and secondary work up for osteoporosis were all noted.

Results: Over the 4 year period, 17/157 (10.83%) patients attending the clinic were male with a mean age of 64.2 years (range 30.81 yr). Of the male subjects, mean T score was −2.16 at total hip and −2.37 at lumbar spine. In terms of risk factors for osteoporosis, 8/17 (47.06%) of male subjects had a history of vertebral fracture. Secondary risk factor work up for osteoporosis identified 1 subject with hypogonadism, 1 had a history of long term phenytoin use, 1 was a long term vegan and 1 had hypercalcaemia. 5/17 subjects had no identifiable risk factor for osteoporosis. 10 subjects had a Vitamin D level check with a mean level of 79.8 nmol/l.

Conclusion: Our results indicate that male patients are certainly under represented for diagnosis, screening and treatment of osteoporosis. The reasons for this need to be evaluated further and increased awareness amongst physicians of the importance of bone health in the male population need to be emphasised. However, the small sample size limits the generalisation of this study. In addition, the wide variety of risk factors identified for osteoporosis in men is illustrated in our results highlighting the importance of secondary work up. Interestingly, nearly half of the male subjects had a history of vertebral fracture.
FIVE YEAR MORTALITY RATE AND ASSOCIATED FACTORS POST HIP FRACTURE IN OLDER ADULTS

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Background:Hip fractures are associated with high risk of death during the immediate post fracture year. We investigated if a Nurse-led care package, incorporating early bone health clinic access at 3 months, with a multidisciplinary approach to falls risk and bone health, reduced post fracture mortality.

Methods: Hip fracture patients were followed for 5 years and invited to a RCT. 226 patients were included and randomised into intervention (118) and control (112) groups. Inclusion criteria were ≥60 years and MMSE ≥18. Mortality information was obtained from; hospital’s electronic patient’s records system (EPR); Registrars Office of Births Deaths and Marriages and online death notice site (nire). Randomisation carried out by computerised minimisation programme. Data analysed using SPSS.

Results: 396 patients attended study site. Mean age; 77 years, (40–96 years). 69% female. Overall mortality rates were 14%, 22%, 29%, 37% and 44% at 1,2,3,4, and 5 years respectively. Significant difference noted at 1 and 2 years. Intervention group mortality rates were 5%, 9%, 23%, 30%, 37% and in Control group 18%, 26%, 33%, 43% at 1,2,3,4, and 5 years respectively. Significant difference noted at 2 years (p = 0.02).

Risk factors for increased mortality were male gender (p = 0.02), older age (p = 0.04), reduced cognition (p < 0.001), admission from nursing home (p = 0.001), delay of >24 hrs to surgery (p = 0.008), increased length of stay (p = 0.001), discharge to LTC (p = 0.001), reduced pre-fracture mobility (p = 0.001), reduced ability to self care (p = 0.001), reduced Amended Barthel Score at 15 months (p = 0.001), HADS depression at 15 months (p = 0.001), at risk of malnutrition at 15 months (p = 0.003).

Conclusion: Intervention improved mortality rates in year 1 and 2 post fracture. Mortality was dependent on; pre and post fracture physical and psychological health status; and time to surgery.

EXPERIENCES OF STAFF AND FAMILIES OF INPATIENTS WITH DEMENTIA USING PERSONAL PASSPORTS TO SUPPORT CARE IN AN ACUTE SETTING

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Background: The National Dementia Strategy indicates that people with dementia represent up to 29% of acute hospital admissions. With the prevalence of dementia predicted to rise significantly, it is reasonable to assume that the number of people with dementia presenting at acute hospital services will also increase. Yet, the National Audit of Dementia Care in Acute Hospitals identified that inpatients with dementia had notably poorer care outcomes than inpatients without dementia. The effective use of personal passports for inpatients with dementia leads to more positive care outcomes and the provision of person-centred care.

Method: A qualitative descriptive approach, this study consisted of two parts:

Part 1: Six individual semi structured interviews with family members.

Part 2: Two focus group interviews with staff members.

Interviews were transcribed verbatim and thematic analysis was used to identify key themes:

Results: Part 1: Two themes emerged from the family interviews: Guardianship and Advocacy. Personal passports allowed families to give staff an insight into the person with dementia and highlight what is important to the person. Part 2: Two themes emerged from the staff focus groups: Care and Knowing the Person. Personal passports were important for communication, managing of responsive behaviours and recognising the humaness of the person.

Conclusion: Using personal passports enhances the provision of quality person centred dementia care. Families and staff differentiated this care from the delivery of clinical care tasks. Challenges, such as the acute care environment and lack of dementia awareness and education, inhibit using personal passports in acute hospital settings.

DEVELOPMENT OF AN ELECTRONIC FRAILTY INDEX USING ELECTRONIC HEALTH RECORD DATA AS A PREDICTOR OF OUTCOMES IN ACUTE ADMISSIONS

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Background: Frailty is an emerging geriatric syndrome, and its associations include falls, disability, morbidity, mortality and excess healthcare costs from consultations, polypharmacy, hospitalisations and institutionalisations. Numerous frailty assessment tools have been developed in clinical practice and research. Frailty index (FI) of deficit accumulation has been used widely to measure frailty in the elderly. FI relies on individuals with more health deficits are more likely to be frail. The concept of a FI has been increasingly accepted, reporting significant associations with risk of fractures, falls, disability, and mortality. Prolonged wait times in ED are associated with poorer outcomes for older adults.

Methods: Retrospective review of patients admitted to the medical assessment unit over a 42-day period. Data collected co-morbidities and functional status (21 measurements) and also included type of ED presentation, length of time in ED, length of stay, and discharge outcomes (including long term care (LTC)).

Results: 197 patients were assessed (Female: 50.8%). Mean length of stay (LOS) was 12.4 (+/- 3.05) days. Mean time in ED was 350 (+/- 27) minutes, with 60.9% of patients seen in <6 hours. Older adults presented later in day hours (p = 0.86), had prolonged stays in the ED (p = 0.242). Those with a prolonged ED stay were more likely require LTC (0.156). Patients with higher FI scores were observed in older adults (p = 0.001), had prolonged wait times in ED (p = 0.164), had longer LOS (p < 0.001) and likely to be discharged to LTC (p < 0.007).

Conclusion: The FI uses routine data to identify older adults with increasingly levels of frailty. The frailty index does not capture socioeconomic factors and care supports and thus a modification of this prospective model may enhance its predictive effectiveness. Routine implementation of the FI could target vulnerable frail adults in the ED and may improve their outcomes.

PERCEPTIONS OF SAFE FUNCTIONING WITHIN THE CONTEXT OF PEOPLE ATTENDING A MULTIDISCIPLINARY MEMORY ASSESSMENT SERVICE

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Background: Driving is an important aspect for the well-being of older people but may be affected by age related syndromes such as dementia. Earlier studies of memory clinics indicated relatively low levels of current drivers (26%) in a 2005 Irish study (1), however, the increased interest in the assessment at earlier stages of memory disorders may result in more current drivers attending and require a more focused approach to assessment and management. We assessed current driving practice in a cohort attending a multidisciplinary memory assessment clinic from 2014 to 2016 with an emphasis on earlier stages of memory impairment.

Method: Prospective study of a cohort attending a multidisciplinary memory assessment clinic in a university teaching hospital. Data was collected on current driving status, recommendations for driving assessment, presence, diagnostic formulation, and functional and psychometric tests.

Results: There were 31 men and 39 women, mean age 76.2 years (range 61–91). The diagnostic formulation was 40% (28/70) MCI, 42.9% (30/70) dementia, 12.9% (9/70) subjective memory complaints and 4.3% (3/70) other issues e.g. mood. Continued driving was reported by 56.6% (41/70), never driven by 17.1% (12/70), and prior driving cessation by 24.3% (17/70). Accidents since the onset of memory problems were reported by 7% in the informant history. On-road driving assessments were recommended to 18 participants.

Conclusion: Continued driving is considerably more prevalent in contemporary memory services compared to earlier estimates. Healthcare staff involved in the assessment and management of memory disorders need to develop assessment skills and pathways to ensure continued safe mobility for older people with memory disorders.


TIME TO INITIAL DETECTION OF ATRIAL FIBRILLATION [AF] WITH IMPLANTABLE CARDIAC MONITOR [ICM] IN CRYPTOCGENIC STROKE

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Background: An ICM is a small thin device inserted under the skin of the chest to record the activity of the heart. A number of studies have shown that Electrocardiogram [ECG] monitoring with ICM is superior for detecting AF in the investigation of cryptogenic stroke. However, the optimum monitoring duration remains unknown. The purpose of this study is to evaluate the use of ICMs at a tertiary referral hospital and the time to initial AF detection in patients with cryptogenic stroke using ICM.

Methods: This is a study of 212 Patients who had ICM inserted for long term cardiac monitoring between 04/08/2012 and 29/02/2016 in this Hospital. We were particularly interested in the proportion of these patients who had ICM inserted for evaluation of cryptogenic stroke. Cryptogenic stroke is brain infarction not attributable to a source of definable thrombosis, large artery disease, infection, cardioembolism or small artery disease despite extensive vascular, cardiac and serologic evaluation. Prior ECG monitoring failed to detect AF.

Results: The commonest clinical use of ICMs in this hospital was unexplained syncope [n = 117], palpitations [n = 51], presyncope [n = 23] and evaluation of cryptogenic stroke
ASSOCIATIONS BETWEEN MEDICATION USE AND FALLS AMONG OLDER ADULTS WITH INTELLECTUAL DISABILITY IN IRELAND

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Background: Despite a considerable body of evidence noting the link between medication use and falls in older adults, data is limited in studies of intellectual disability (ID) regarding the association between medication use and increased risk for falling. The present study set out (1) to investigate the association between the use of different medication types and falls in older adults with ID; (2) to identify the association between polypharmacy and falls in older adults with ID.

Methods: Data from The Intellectual Disability Supplement to The Irish Longitudinal Study on Ageing are reported. Data from 753 participants across all levels of ID are included. Data comprised of sociodemographic, medication type and use and a number of falls items. Medications were coded using the World Health Organisation Anatomical Therapeutic Chemical Classification (ATC) classification code. Ethics was granted by Trinity College Faculty Ethics committee and by all service providers involved in the study.

Results: 26.7% (n = 200) of the participants reported falling in the previous 12 months, 14.5% (n = 94) experienced one fall, with 16.3% (n = 107) reporting 2 or more falls. Medication use was very high among the sample with high rates of polypharmacy and excessive polypharmacy reported. Use of anti-epileptic drugs (AEDs) (p = .012), laxatives (p = .027) and analgesics (p = .049) were significantly associated with any fall in the previous 12 months. The use of AEDs (p = .003) and laxatives (p = .014) were significantly associated with multiple falls. Individuals reporting excessive polypharmacy were significantly associated with any fall (p = .000) and multiple falls (p = .004).

Conclusion: These findings are critically important for older adults with ID, service providers and healthcare practitioners. Medication review must be routinely and robustly included in the development of person centred care. Appropriate alternatives for the management of health conditions must be sought.

CEREBRAL WHITE MATTER INSULT CORRELATES WITH BLOOD PRESSURE VARIABILITY

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Background: Cerebral associations with blood pressure variability (BPV) include incident stroke and white matter disease, however, it is unclear whether these are associations or manifestations of BPV. We explored a causal relationship by interrogating regions of the brain susceptible to sudden fluctuations in BP, known as borderzone regions, in patients with high BPV.

Methods: Cases were compared with age and gender-matched controls using standard deviation (SD) of daytime systolic blood pressure (BP) from ambulatory 24-hr BP readings, and dichotomised based on values greater than or less than 22 mmHg. All underwent Diffusion Tensor MRI with interrogation of one white matter borderzone region (centrum semiovale) and of two white matter non-borderzone regions (internal and external capsule) according to fractional anisotropy (FA) values, which reflect white matter integrity.

Results: Forty-six patients were recruited in 1:1 case-control ratio. The mean age was 68.5 years (SD 10.8) and 22 (48%) were female. The mean SD of systolic BP in cases and controls was 27 mmHg and 17 mmHg respectively. Use of anti-hypertensive medication and the prevalence of stroke and diabetes was similar in both groups. The integrity of borderzone white matter region was significantly more damaged in cases than in controls; FA values 0.43 (SD 0.06) and 0.47 (SD 0.03) respectively, p = 0.01. Conversely one non-borderzone white matter region was more intact in cases than in controls and in the other both were equally intact; internal capsule FA in cases 0.54 (SD 0.05) and in controls 0.51 (SD 0.05), p = 0.03; External capsule FA in cases 0.41 (SD 0.04) and in controls 0.4 (SD 0.05), p = 0.44.

Conclusion: High BPV correlates with selective insult to regions of the brain vulnerable to flow change. Consequently BPV may directly damage white matter tracts, which may manifest clinically as vascular cognitive impairment, gait disorders and possibly incident lacunar stroke.
EVALUATION OF CONSTRUCTIONAL IMPAIRMENT IN THE INDEPENDENT ELDERLY POPULATION BASED ON MINIMAL MENTAL STATE EXAMINATION
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Background: The mini-mental state examination (MMSE) is a widely used screening test for cognitive impairment in older adults. During observation in clinical practice, a significant proportion of patients were found to have difficulty with the constructional ability question despite being intact in other cognitive domains. The aim of this study was to assess whether the impaired constructional ability noted in routine cognitive screening was reproducible in a formal analysis of older people living independently in the community with no documented dementia history.

Methods: 370 patient records of the Health inequalities in Aging in the Community Evaluation (HIMEC) study were reviewed after excluding patients with documented dementia. Basic demographics, original MMSE form and score were reviewed and scored according to Folstein guidelines. This was compared to the testers score and if any discrepancies were noted a new MMSE score was calculated. 295 had a completed and scored MMSE.

Results: 62% female, age range 60-92 years, 97% with a Barthel >18. 85% (294) had a documented score of 30. Discrepancies were found between the scoring of the construction question by the tester compared to the MMSE scoring guidelines in 11% (40) cases. 16% (59) incorrectly drew the pentagon. In 10% (37) this was the only incorrect question. Following adjustment for all discrepancies in scoring, 72% (213) actually scored 30/30. Therefore the major source of incorrect scoring was with pentagon analysis.

Conclusion: A significant proportion of older people living independently in the community have impaired constructional ability in the absence of documented cognitive deficit. Does this predict early cognitive decline, is it representative of normal ageing or is it an indicator of pre-morbid status?

DETERMINING THE UTILITY OF THE AMT4 IN THE EMERGENCY DEPARTMENT: UTILITY OF THE AMT4?
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Background: The Abbreviated Mental Test Score 4 (AMT4) is a brief tool recommended for cognitive screening of older adults in the Emergency Department. While it has been validated against the longer AMT10 and MMSE in isolation, its exact ability to highlight clinically significant cognitive impairment in the ED is yet to be determined.

Methods: A convenience sample of older adults (aged >70 years) presenting to the ED underwent detailed cognitive assessment including screening for delirium (CAM-ICU) and dementia (MMSE and AD8) using well validated tools in addition to the AMT4.

Results: One hundred and ninety-six patients were assessed (mean age = 78.5 ± 5.9). The AMT4 had a sensitivity of 0.53 (0.42–0.65) and specificity of 0.96 (0.89–0.99) in the detection of altered cognitive status (dementia/delirium). The AMT4 identified nearly all patients screening positive for delirium (92%, 24/26). In those with probable delirium, the AMT4 identified less than half (47.8%, 22/46). In those with probable cognitive impairment (not dementia), less than a quarter were correctly identified (22.2%, 6/27).

Conclusion: Acute post-operative complications and length of stay following hip fractures can be predicted based on pre-fracture morbidity and standard of care received. Nutritional status, frailty and co-morbidities are thus in all hip fracture patients in order to flag those who are at a higher risk of poor post-operative outcomes.

AGE DEPENDENT MORTALITY RATES IN WEXFORD GENERAL HOSPITAL
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Background: We examined age related discharges from the department of medicine at Wexford General Hospital from June 2014 to June 2015. We examined the mortality rates of various age groups in the hospital and compared our results to a similar audit we carried out in 2008-2009.

Methods: We wished to see if more older patients were being admitted and if their mortality rates had changed.

We obtained our data from HIPE data in the hospital. We examined mortality rates of the age groups <65yrs, >65yrs and <75, >75yrs and >85yrs and those >85 yrs. We also examined length of stay prior to death in these age groups.

Results: Our catchment population for adults >17yrs had increased from 2008 to 2014 by 10%. The 85+ age group make up 2% of the population but make up 11% of the discharges compared to 9.6% of discharges in 2008. The overall mortality rate for all age groups was 3% but for the 85+ age group it was 8.4%. This mortality rate is 0.33% less than what it was in 2008. The length of stay before death was 9.13 days for those <65 years and significantly longer at 16.4 days in those >85 years.

Conclusion: While our catchment population has increased, the very elderly make up a considerable percentage of our discharges. Our mortality rate for this age group has remained steady. Health planners need to take into account the substantial burden and demand that the very elderly are making in our acute hospitals.

DETERMINING THE UTILITY OF THE AMT4 IN THE EMERGENCY DEPARTMENT: UTILITY OF THE AMT4?
Adam Dyer, Robert Briggs, Shanis Nabeel, Desmonad O’Neill, Sean Kelly
Centre for Ageing, Neuroscience and the Humanities, Tallaght Hospital, Dublin, Ireland

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Conclusion: While our catchment population has increased, the very elderly make up a considerable percentage of our discharges. Our mortality rate for this age group has remained steady. Health planners need to take into account the substantial burden and demand that the very elderly are making in our acute hospitals.
WALKING IN HOSPITAL IS ASSOCIATED WITH A SHORTER LENGTH OF STAY IN OLDER MEDICAL INPATIENTS

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Background: Evidence suggests that inactivity during a hospital stay is associated with poor health outcomes in older medical inpatients. We aimed to estimate the associations of in-hospital physical activity with physical performance and length of stay in a sample of older inpatients.

Methods: Medical in-patients aged ≥65 years, pre-morbidly mobile, with an anticipated length of stay ≥3 days, were recruited to this observational study. Measurements included physical activity, continuously recorded by a Stepwatch Activity Monitor until discharge or for a maximum of five weekdays; co-morbidity (CIRS-G); frailty (SHARE F-1); and baseline and end of study physical performance (Short Physical Performance Battery). Linear regression models were used to estimate associations between physical activity (average daily step-count over 5 weekdays) and end of study physical performance or length of stay. Length of stay was transformed in the first model, and average daily step-count was log transformed in both models. Similar multivariable linear regression models were used to adjust for potential confounders.

Results: Data from 154 patients (mean 77 years, SD 7.4) were analysed. Based on the unadjusted linear regression estimates, for each unit increase in the natural log of average daily step count, the natural log of length of stay decreased by 0.18 (95% CI –0.27 to –0.09). After adjustment of potential confounders, the strength of the inverse association was attenuated, but the 95% CI still excluded the null hypothesis (β(0g(steps)) = −0.15, 95%CI = −0.26 to −0.04). Interpreted in absolute terms, a 50% increase in average daily step count was associated with a 6% shorter length of stay. There was no apparent association between average daily step count and end of study physical performance once baseline physical performance was adjusted for.

Conclusions: The results indicate that physical activity is independently associated with hospital length of stay, and merits further investigation.

PRURITUS IN OLDER HOSPITALIZED PATIENTS: PREVALENCE AND EFFECT ON SELF REPORTED QUALITY OF LIFE

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Background: Pruritic skin conditions are common in the older population. It is well known that itching impacts negatively on quality of life resulting in greater psychosocial morbidity. Our aim is to define the prevalence of pruritus in a cohort of hospitalised older adults and to determine the effect of pruritus on self-reported quality of life.

Methods: A prospective chart review was carried out on 50 consecutive patients over 75 years old admitted acutely under the geriatric medicine service. Data was collected on patient demographics, chronic disease burden and all medications. The total number of medications was examined including the use of drugs known to be associated with pruritus. We also noted whether the the issue of pruritus was recorded in the patient’s notes and if they received any treatment. Patients reporting itch completed the 5-D pruritus scale to quantify the impact on quality of life.

Results: Of the 50 patients reviewed, (mean age 85, 42% male) 34% reported itch. The level of chronic disease burden was high in our population, with 75% of patients having chronic disease affecting one or more organ system. Patients were on an average of seven medications each and 50% of patients were on at least one drug known to cause pruritus. Only 17% of patients reporting itch were on a treatment for pruritus, and none of these patients had the diagnosis recorded in the medical notes.

On the 5-D pruritus scale, patients described their itch severity from mild to severe. They generally scored less than six hours a day itching, but over half of patients with itch reported that it adversely affects their sleep.

Conclusion: Pruritus is a common, but often under recognised problem in hospitalised older adults. Itch can adversely affect quality of life, so clinicians must increase their diligence in identifying and treating pruritus.

VITAMIN D DEFICIENCY AND INSUFFICIENCY RATES IN THE WEST OF IRELAND: BETTER TARGETING OF AT RISK POPULATION REQUIRED?

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Background: A previous study (n = 149) reported high rates of vitamin D deficiency and insufficiency in females aged over 65 years residing in long-term care or admitted to University Hospital Galway (1). In this cross-sectional study, we evaluate age-related rates of vitamin D deficiency and insufficiency in patients attending general practice.

Methods: Vitamin D levels were measured from consecutive samples received at the UHG clinical biochemistry laboratory between January 2013 and December 2014. Vitamin D deficiency was defined as level <25 nmol/L and as insufficiency as level between 25 and 50 nmol/L. Samples were compared across four age groups (18–40 years, 41–60, 61–80 and >80years). We report median and interquartile range as Vitamin D levels were not normally distributed. Descriptive statistics were performed using STATA/MP 13.1 for Mac.

Results: Of 15,078 included samples, 7.36% were from females (n = 11,002), mean age 52.6 (16.5) years. Overall median Vitamin D level was 54 (IQR 35.7–64) nmol/L. By age group, median Vitamin D level was 50 (32–71) nmol/L for 18–40 years, 53 (36–72) nmol/L for 41–60 years, 61 (40–79) nmol/L for 61–80 years and 55 (29–79) nmol/L for those >80 years (p < 0.01). Sufficient Vitamin D level was most common in age 61–80 years (64%, n = 2,795), deficiency was most common in age >80 years (19.4%, n = 136) and insufficiency was most common in age 41–60 years (35.5%, n = 2,156/ (p < 0.01).

Conclusions: In this large, community-based study of patients attending general practice in the West of Ireland, sufficient Vitamin D levels were noted in almost two thirds of those aged 61–80 years. However, it is likely that those most vulnerable to Vitamin D deficiency (e.g. not attending GP for Vitamin D level check), were underrepresented in this cohort. Further study is required to increase the identification of affected individuals with better utilization of laboratory resources.

Reference:

AGE AND THE ECONOMICS OF AN EMERGENCY MEDICAL ADMISSION - WHAT FACTORS DETERMINE COST?

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Background: The ageing of the population may be anticipated to increase demand on hospital resources. We have investigated the relationship between hospital episode costs and age profile in a single centre.

Methods: All Emergency Medical admissions (33,732 episodes) to an Irish hospital over a 6-year period, categorised into three age groups, were evaluated against total hospital episode costs. Univariate and adjusted incidence rate ratios (IRR) were calculated using zero truncated Poisson regression.

Results: The total hospital episode cost increased with age (p <0.001). The multi-variable Poisson regression model demonstrated that the most important drivers of overall costs were Acute Illness Severity – IRR 1.36 (95% CI: 1.30, 1.41), Sepsis Status –1.46 (95% CI: 1.42, 1.51) and Chronic Disabling Disease Score –1.25 (95% CI: 1.22, 1.27) and the Age Group as exemplified for those > 85 or IRR 1.23 (95% CI: 1.15, 1.32).

Conclusion: Total hospital episode costs are a product of clinical complexity with contributions from the Acute Illness Severity, Co-Morbidity, Chronic Disabling Disease Score and Sepsis Status. However age is also an important contributor and an increasing patient age profile will have a predictable impact on total hospital episode costs.

DETECTION AND MANAGEMENT OF DELIRIUM IN NEW MEDICINE FOR THE ELDERLY ADMISSIONS: AN AUDIT

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Background: Delirium is a common but under-recognised occurrence in older hospitalised patients. It is associated with significant morbidity and mortality. This audit was conducted to assess the detection and management of delirium in Medicine for the Elderly admissions to St James’s Hospital as compared to current NICE guidelines. Our aim was to increase delirium recognition by implementation of the 4AT screening tool.

Methods: Data was collected on 50 consecutive patients admitted through Medicine for the Elderly. Patients were screened for delirium by being asked to say the months of the year backwards. Risk factors and subsequent diagnosis or treatment were established from admission notes in patient charts and the percentage of patients with delirium going undetected was calculated.

After the first audit, we introduced the 4AT screening tool and provided an information session on its use. The 4AT allows for rapid assessment of delirium and cognitive impairment by examining a patient’s orientation, concentration, alertness and acute fluctuation in behaviour. A re-audit was then completed.

Results: The first audit showed poor screening for and detection of delirium, with only 12% being screened on admission. The audit revealed 60% of patients with delirium were going undiagnosed on admission.

Following implementation of the 4AT screening tool re-audit results showed a significant increase, to 52%, in the number of patients being screened. The number of cases of delirium undiagnosed at admission also dropped to 36%.

All cases of diagnosed delirium were treated appropriately.

Conclusions: This audit showed that delirium was going largely under-diagnosed in the Medicine for the Elderly population in St. James’s Hospital. Following implementation of the 4AT screening tool, significant improvements were made. This audit concluded that


the 4AT was an effective tool, in combination with regular education sessions raising awareness, in improving the detection of delirium in the elderly.

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THE PREVALENCE OF POLYPHARMACY AND THE APPROPRIATENESS OF PRESCRIBING IN ADMISSIONS FROM A MEDICAL ASSESSMENT UNIT

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Background: Polyparmacy is highly prevalent among the older population with significant consequences for patient safety. Polyparmacy and inappropriate prescribing have been associated with an increased cost in healthcare and an increased risk of drug-interactions, adverse drug events, falls, decreased cognition and reduced functional capacity. The aim of this study was to examine the prevalence of polyparmacy in patients admitted through a level 2 hospital Medical Assessment Unit (MAU) and to evaluate the appropriateness of prescribing for each class of medication.

Methods: This is a cross-sectional study. Patients over the age of 18 who were admitted via the MAU over a 2 week period were included in the study. Polyparmacy was defined as patients receiving 6 or more medications regularly. The patient’s drug chart was reviewed on day 0 and day 2 of admission for total number of medications and the appropriateness of prescribing for each class of medication.

Results: A total of 55 patients were included in the study and the mean age was 69.7 years old (SD = 15.7). A total of 361 prescriptions were reviewed. The mean number of medications on admission was 6.6 (SD = 4.2), with patients over the age of 65 on significantly more medications than those under 75 (6.7 vs 4.4, P = 0.009). Of the 16 common drug classes a total of 241 prescriptions were identified with 50 prescriptions (20.7%) meeting criteria for inappropriate prescribing. In 61.5% of proton pump inhibitor prescriptions and in 87.5% of sedative/anxiolytic prescriptions there was no clear indication.

Conclusions: The results from this study suggest that elderly patients presenting to the MAU are more likely to suffer from polyparmacy. There were also a high number of potentially inappropriate medications identified in this study. Future studies should evaluate the benefit of using a screening tool to identify potentially inappropriate medications in the hospital.

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CORTICAL SUPERFICIAL SIDEROŚIS PRESENTING AS TIA MIMIC

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Background: Although rare, cortical superficial siderosis (CSS) is thought to be associated with an increased risk of future intracerebral haemorrhage and may be a marker for later development of cerebral amyloid angiopathy. Transient focal neurological episodes or amylod spells are associated with CSS and may represent focal seizure activity. A 74 year-old female without significant vascular risk factors or cognitive impairment presented with migratory left sided face, arm and leg motor/sensory symptoms whilst driving. This episode lasted 30 minutes with full resolution. She was admitted and managed initially as TIA and commenced antiplatelet therapy and statin.

Methods: CT Brain showed small linear area of hypodensity high in the right parietal area which was suspicious for small area of cortical infarction with subsequent minor haemorrhage. MRI brain with gradient echo sequence demonstrated small right parietal cortical/sub-cortical hemosiderin deposit most consistent with cortical superficial siderosis (CSS) involving two adjacent sulci. CTA of intra and extra cranial vessels was normal, with otherwise unremarkable stroke work up. EEG confirmed focal disturbance of cerebral function in this region without definite epileptiform features.

Results: In the subsequent few months, recurrent stereotyped events as described increased in frequency to 3-4 per day requiring readmission. Repeat MRI demonstrated stable appearances. Following counselling, antiplatelet therapy was discontinued with focus on blood pressure optimisation. In view of symptom burden levitiracetam was commenced and titrated with some improvement in symptom frequency. Advice was also focussed on blood pressure optimisation. In view of symptom burden levitiracetam was increased in frequency to 3-4 per day requiring readmission. Repeat MRI demonstrated an increase in the sulcal abnormalities.

Conclusions: These individuals have complex care needs and require a specialist nurse structured assessment including delirium assessment, ascertainment of a previous dementia diagnosis, and administration of an Abbreviated Mental Test (AMT). This data was linked to routine hospital admission and mortality data to evaluate associations between cognitive spectrum disorder and length of stay, mortality and readmission. Results: 1862/5603 (33.2%) had a cognitive spectrum disorder, 1041 (18.6%) had delirium alone, 248 (4.4%) delirium superimposed on dementia, 271 (4.8%) dementia alone, and 302 (5.4%) AMT score <8 but no delirium or diagnosed dementia. Outcomes were worse if diagnosed with a CSS compared to those without length of stay 25.4 days vs 11.7 days, in-hospital mortality 15.4% vs 9.4%, one year mortality 39.7% vs 27.1%, one year death or readmission 56.3% vs 45.7% (all differences significant p < 0.001), with little difference by CSS type.

Conclusions: This study of an unselected MAU population includes more older people than the total in all studies included in recent systematic reviews. Cognitive spectrum disorder is common in medical inpatients, and is associated with considerably worse outcomes. Healthcare systems need to manage this vulnerable population better.

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DECREASING BLOOD PRESSURE AND ANTI-HYPERTENSIVE MEDICATIONS IN VERY OLD PATIENTS WITH ADVANCED FRAILTY

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Background: Decreasing blood pressure is associated with increased mortality and stroke risk in very old patients with physical and mental disability (1,2). We examined the prevalence of mean systolic blood pressure (mSBP) less than 140 mmHg and 130 mmHg respectively and anti-hypertensive (aHT) medications in very elderly patients in 2 extended nursing care (ENC) facilities.

Methods: mSBP derived from BP values recorded routinely over the previous 3 months in patients 80 years and over in ENC wards in OLH and RHD. In addition, Barthel index (Bi), clinical frailty scale (CFS), vascular risk factors and aHT medication were obtained from medical records.

Results: There were 59 patients aged 80.97 years. Most were severely disabled (Bi score 0-5; OLH 75%, RHD 74%) with advanced frailty (CFS 7, 8, 9; OLH 94%, RHD 93%). Hypertension (OLH 47%, RHD 37%) and history of stroke (OLH 44%, RHD 67%) were most common risk factors whilst 25% had atrial fibrillation (Af). mSBP was <140 mmHg and <130 mmHg in 85% (50/59) and 64% (39/59) of patients, respectively. Of the latter group, 29% (11/38) were on aHT meds excluding diuretics and alpha blockers (benz blockers 4, CCB 6, ACE/ARB 6) alone or in combination. Most of these patients (82%) had other potential indications for aHT meds (AF 4, ischaemic stroke 4, diabetes mellitus 1).

Conclusion: mSBP in the majority of very old frail patients is less than 130 mmHg which is within the range associated with increased mortality and stroke compared to patients with higher SBP. Most of this group of patients on aHT medications had other potential indications for treatment. Reference: 1. Olgart G. G. et al. Blood pressure and 10-year mortality risk in the Milan Geriatrics 75+ Cohort Study: role of functional and cognitive status. Age Ageing 2015; 44: 932-937.


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ARE THE WARDS IN ST. VINCENT’S HOSPITAL DEMENTIA FRIENDLY? AN AUDIT

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Background: A significant proportion of the inpatients in SVUH have a dementia diagnosis. These individuals have complex care needs and require a specialist nurse structured assessment including delirium assessment, ascertainment of a previous dementia diagnosis, and administration of an Abbreviated Mental Test (AMT).

Methods: The “Is your ward Dementia Friendly?” Enhanced Healing Environment Assessment Tool (developed by the King’s Fund NHS) was used to audit 8 wards and 1 out patient setting in SVUH. This tool assesses the ward under 7 sections (Safe mobility, comfort, personal hygiene, Eating and Drinking, Meaningful interactions, Orientation, Calmness and security). This tool allows the user to “score” how dementia friendly the ward is against and ideal ward. It also highlights areas for improvement and acknowledges any initiatives already in situ.

Results: A total of 8 wards and 1 out patient setting were included in this audit. An “Ideal Ward” was also included, this represented a hypothetical ward that is completely dementia friendly and would receive full marks on audit. This was used for comparison purposes for percentages.

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PREVALENCE AND OUTCOMES OF COGNITIVE SPECTRUM DISORDERS IN OLDER PEOPLE ADMITTED TO AN ACUTE MEDICAL ADMISSIONS UNIT

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Background: Many older people admitted to hospital have cognitive impairment of some kind, but previous research has usually focused on single conditions (usually dementia, delirium, and delirium superimposed on dementia), and has often been carried out in highly selected groups. As a result, estimated prevalences in inpatients vary from 3-63% for dementia, and from 10-31% for delirium. Few studies have measured outcomes, with in-hospital mortality the most commonly studied. The aim of this study was to examine the prevalence and outcomes of cognitive spectrum disorders (CSD) in an unselected cohort of people aged 65+ admitted to a general hospital acute medical admissions unit (AMAU).

Methods: Between 01/01/12 and 30/06/13, 5603/7135 (78.5%) people aged 65+ admitted to the single general hospital AMAU had a specialist nurse structured assessment including delirium assessment, ascertainment of a previous dementia diagnosis, and administration of an Abbreviated Mental Test (AMT). This data was linked to routine hospital admission and mortality data to evaluate associations between cognitive spectrum disorder and length of stay, mortality and readmission.

Results: 1862/5603 (33.2%) had a cognitive spectrum disorder, 1041 (18.6%) had delirium alone, 248 (4.4%) delirium superimposed on dementia, 271 (4.8%) dementia alone, and 302 (5.4%) AMT score <8 but no delirium or diagnosed dementia. Outcomes were worse if diagnosed with a CSD compared to those without length of stay 25.4 days vs 11.7 days, in-hospital mortality 15.4% vs 9.4%, one year mortality 39.7% vs 27.1%, one year death or readmission 56.3% vs 45.7% (all differences significant p < 0.001), with little difference by CSD type.

Conclusions: This study of an unselected AMAU population includes more older people than the total in all studies included in recent systematic reviews. Cognitive spectrum disorder is common in medical inpatients, and is associated with considerably worse outcomes. Healthcare systems need to manage this vulnerable population better.
THE IMPACT OF A STRUCTURED EDUCATION PROGRAM ON THE KNOWLEDGE OF EVIDENCE BASED SECONDARY STROKE PREVENTION STRATEGIES: PRELIMINARY STUDY

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Background: People who have had a stroke are at increased risk of stroke recurrence, which is as high as 30% and can be more devastating. Secondary stroke prevention practices according to evidence based research if fully and effectively implemented can reduce the risk of stroke recurrence. This preliminary study aimed to explore the knowledge and the impact of a structured education program on current evidence based secondary stroke prevention strategies by the doctors working in a stroke unit.

Methods: The doctors in the National Rehabilitation Hospital (NRH) Ireland, were surveyed using paper based anonymised questionnaires before and after the delivery of a brief structured educational program on current secondary stroke prevention strategies. With the approval of the ethics committee, both surveys were carried out on all eligible doctors in the NRH. A brief structured educational program on secondary stroke prevention strategies was given over three sessions and the electronic copies of the teaching materials made available on the hospital intranet prior to the repeat survey.

Results: Although the doctors in the NRH showed appreciable knowledge of current secondary stroke prevention strategies in the first survey, the repeat survey showed an overall improved knowledge post the structured educational program.

Conclusion: Future studies are relevant to ascertain if the doctors’ improved knowledge and its sustenance ultimately translates to improved stroke management and secondary prevention practices. It was beneficial to leave the education materials for future intakes of doctors on the hospital intranet.

MAKING OUR COMMUNITY MORE ACCESSIBLE: AN OCCUPATIONAL THERAPY INITIATIVE TO INCREASE AWARENESS OF COMMUNITY MOBILITY IN SOUTH-EAST DUBLIN

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Background: Following multi-disciplinary assessment in Carew House Geriatric Day Hospital, many elderly people were advised to cease driving. As a result, this population, at risk of becoming socially isolated owing to a lack of accessibility in their local areas, to facilitate engagement in activities. Aims/Objectives: to develop a user-friendly, comprehensive information pack detailing public and private transport options for older people residing in the South-East Dublin and North Wicklow region. It is hoped that the information booklet will be used as a tool to improve older peoples’ accessibility in their local communities.

Methods: An internet search was conducted to source information regarding various modes of transport available within the area. Information regarding transport routes, timetables, fare prices, ticket information and customer services contact details were retrieved from online sources.

Results: A comprehensive and user-friendly information pack was developed to provide older persons’ with information regarding DART, Dublin Bus, LUAS and taxi services in the region.

Conclusion: The information booklet was piloted with a small number of elderly patients and positive feedback was received. It is envisioned that the information pack will increase the users’ awareness and knowledge of transport links and therefore facilitate engagement in social activities. This information booklet is available in Carew House Day Hospital and is provided to patients as appropriate.

CIRCULATING BLOOD BIOMARKERS IN OLDER ADULTS WITH FRAILTY: THE IRISH LONGITUDINAL STUDY ON AGEING (TILDA)

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Background: Several circulating blood biomarkers have been linked to phenotype frailty in cross-sectional studies and in longitudinal studies in women or the oldest old. In this study we examined the relationships between three frailty instruments and plasma biomarkers in older adults in Ireland.

Methods: Cross-sectional analyses were performed using data from community-living adults aged ≥ 50 years (n = 4548) from Wave 1 of Irish Longitudinal Study on Ageing (TILDA). Circulating blood biomarkers of micronutrient status (vitamin B12, vitamin D, lutein and zeaxanthin), inflammatory stress (CRP), metabolic function (HbA1c, total, HDL and LDL cholesterol) and renal function (creatinine and cystatin c) were transformed and standardized. For each biomarker, one unit increase represented an increase of 1 SD from the mean, this allowed comparability of associations across biomarkers.

Frailty was assessed using Phenotype Frailty (PF), Frailty Index (FI) and FRAIL. Scale (FS) instruments. Multinomial logistic regression determined associations between frailty and each biomarker adjusted for age, sex, education, smoking status, BMI, and the number of medications and supplements taken regularly.

Results: Adjusting for covariates, a unit increase in lutein was negatively associated with all three frailty measures: PF (RR = 0.59), FI (RR = 0.96) and FS (RR = 0.53). Higher levels of lutein were negatively associated with two of the frailty measures: PF (RR = 0.52) and FS (RR = 0.65). A unit increase in cystatin c was positively associated with frailty: PF (RR = 1.52), FI (RR = 1.16) and FS (RR = 1.34). Finally higher vitamin D was negatively associated with one frailty measure: PF (RR = 0.83), as was HDL cholesterol: FI (RR = 0.87).

Conclusion: Considerable variability exists in relation to associations between blood biomarkers and frailty, depending on the frailty instrument used. The identification of consistent cross-sectional associations with more than one frailty instrument strengthens the evidence that a biomarker may be correlated with frailty over time. However, caution cannot be inferred using cross-sectional data.

PREDOMINANCE OF MICRONUTRIENT, INFLAMMATORY STRESS, METABOLIC AND RENAL CONDITIONS IN FRAIL OLDER ADULTS: THE IRISH LONGITUDINAL STUDY ON AGEING (TILDA)

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Background: Circulating blood biomarkers have been linked to phenotype frailty in cross-sectional studies and in longitudinal studies in women or the oldest old. In this study we examined the prevalence of several health conditions among the frail using clinical reference values of circulating plasma biomarkers in older adults in Ireland.

Methods: Cross-sectional analyses were performed using data from community-living adults aged ≥ 50 years (n = 4548) from Wave 1 of Irish Longitudinal Study on Ageing (TILDA). The clinical reference values for circulating blood biomarkers of micronutrient status (vitamin B12, vitamin D, lutein and zeaxanthin), inflammatory stress (CRP), metabolic function (HbA1c, total, HDL and LDL cholesterol) and renal function (creatinine and cystatin c) were applied. Prevalence estimates of diabetes/pre-diabetes, chronic kidney disease, hypercholesterolemia, inflammatory stress and micronutrient status were then calculated by phenotype frailty status. Significant differences in prevalence estimates by frailty status were measured by multinomial logistic regression.

Results: The estimated prevalence of pre-frailty and frailty was 33% and 4% respectively. Among the frail there was a higher prevalence of diabetes (5.9% p < 0.01), pre-diabetes (18.1% p < 0.01), chronic kidney disease (39.1% p < 0.01) and inflammatory stress (70.4% p < 0.01) compared to the pre-frail or non-frail. The frail also showed significant differences in prevalence of micronutrients: lutein (51% p < 0.01), zeaxanthin (50% p < 0.01), and vitamin D (27% p < 0.01), but not vitamin B12 (7% p = 0.23). Hypercholesterolemia was significantly lower among the frail (32% p < 0.01). The pre-frail exhibited intermediate prevalence estimates of these conditions compared to the non-frail.

Conclusion: There are significant levels of several treatable chronic conditions among pre-frail and frail older adults in the community. This illustrates the loss of physiological reserve and complexity of need that exists, and emphasises the requirement for multidisciplinary and integrated care approaches to treatment among those at risk of frailty.

PERCEPTIONS OF RISK OF HOSPITAL ADMISSION AMONG CAREGIVERS AND DOCTORS

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Background: For elderly patients, an inpatient hospital stay is associated with 33% risk of functional decline, 17.6% risk of infection, 24.8% risk of fall and 20.7% risk of death. What is not known is the perception of this risk among patients, caregivers or staff, which can vary depending on their experiences in a hospital setting. Our aim was to compare these perceptions of risk.

Methods: We conducted a face-to-face interview with both doctors and caregivers, using a structured survey, in an outpatient setting in St. James’s Hospital. Data was analysed with SPSS Statistics Data Editor. The primary outcome was the proportion of doctors or caregivers who agreed with the statements: (i) In general, the hospital is a good place for older people to get better and (ii) In general, the hospital is a good place for an older person to wait while awaiting arrangements to go home or to a nursing home.

Results: We surveyed 51 doctors and 52 caregivers. There was no statistically significant difference between the two populations in the primary outcome. However, both groups over-estimated the actual risk for each outcome, except for death within 30 days, which was underestimated by 10%. Medians for both populations’ perception of risk were 45% for fall, 50% for infection, 40% for functional decline and 10% for death within 30 days. The number of doctors who disagreed with the hospital being a good place to wait while arrangements are made to allow a person go home or to a nursing home compared to the number of caregivers was highly significant (P = 0.0001).

Conclusions: While both populations over-estimated the risk of hospital admissions for elderly patients, it was clear from both their descriptions and their answers to Likert questions that caregivers had a more positive overall view of hospital compared to the doctors who work there.

**DIAGNOSTIC ACCURACY OF SIX BEDSIDE COGNITIVE TESTS FOR DELIRIUM SCREENING**

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Background: Delirium is prevalent and serious, yet remains poorly detected. Systematic screening could facilitate detection, however there remains no consensus as to the best approach. Our aim was to examine the diagnostic accuracy of six bedside cognitive tests in screening for delirium in older medical inpatients on admission: the six-item cognitive impairment test (6-CIT); clock-drawing test; spatial span forwards; months of the year backwards (MOTYB); intersecting pentagons (IP); and a verbal test of visuospatial function.

Methods: We conducted a cross-sectional study of prevalent delirium in older medical inpatients in two hospitals in Cork city, Ireland. Eligible patients were assessed for delirium using the Revised Delirium Rating Scale within 56 hours of admission. They concur- rently underwent testing using the six cognitive tests outlined above. Sensitivity, specificity, positive and negative predictive values (PPV, NPV) were calculated for each method. Where appropriate, area under the receiver operating characteristic curve (AUC) was also calculated.

Results: Of 555 patients approached, 470 patients were included, and 184 had delirium. Of the tests scored on a scale, the 6-CIT performed best with an AUC of 0.876 (95% CI 0.848-0.91), the optimum cut-off for delirium screening being 8/9 (sensitivity 89.9%, NPV 91.2%). Of the binary tests, both MOTYB and IPT also performed well: MOTYB (sensitivity 84.6%, NPV 87.4%), IP (sensitivity 92.7%, NPV 90.1%). Using stepwise discriminant analysis, 6-CIT was the only test to differentiate between those with delirium and those with dementia only, Wills’ Lambda=0.748, F=62.15, df11, df21, df3184, p < 0.001.

Conclusions: The 6-CIT measures attention, temporal orientation and short-term memory and shows promise as a screening test for prevalent delirium, particularly as it may differentiate between the cognitive impairment of delirium and that of dementia in older medical patients. For daily delirium screening on the ward however, a shorter, simpler test such as MOTYB may be more appropriate.

**GUIDANCE FOR HEALTHCARE STAFF: ADVANCE CARE PLANNING AND ADVANCE HEALTHCARE DIRECTIVES WITH PEOPLE WITH DEMENTIA**

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Background: Dementia is a progressive life limiting illness. People with dementia value getting better and (ii) In general, the hospital is a good place for an older person to wait while awaiting arrangements to go home or to a nursing home.

While both populations over-estimated the risk of hospital admissions for elderly patients, it was clear from both their descriptions and their answers to Likert questions that caregivers had a more positive overall view of hospital compared to the doctors who work there.

**GUIDANCE FOR HEALTHCARE STAFF: ADVANCE CARE PLANNING AND ADVANCE HEALTHCARE DIRECTIVES WITH PEOPLE WITH DEMENTIA**

**INVESTIGATING THE FINANCIAL IMPACT OF HIPE CODING FOR LIAISON OLD AGE PSYCHIATRY ASSESSMENTS**

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Background: Health care authorities are now assigning patients a code in relation to Diagnosis-Related Groups (DRGs) on review of charts following discharge. DRGs are determined by the complexity of each case – a more complex case draws a higher reimbursement for the hospital. Previous studies have found that psychiatric co-morbidities have not been correctly coded. This can have a financial impact for the service provider or hospital. To date, there have been no investigations at this centre to determine the accuracy of HIPE coding for cases assessed by the Liaison Old Age Psychiatry team.

Methods: Referrals to the service in the month of March 2015 were used for this investiga- tion. Using the Health In-patient Enquiry Scheme (HIPE) program we determined if diagnosis codes were in agreement with the diagnosis given by the Liaison Psychiatry team. We then calculated whether or not a Procedure Code “Mental (Neuropsychiatric) Assessment,” (MBA) was given for each of these cases. Cases with errors/omissions were re-integrated through the HIPE program to determine if correction would change the DRG.

Results: Of the 30 cases referred, 3 cases (10%) did not have an appropriate psychiatric diagnostic code. Only 10/30 (33%) cases had the MBA code documented. With reassign- ing of DRGs we found no change to the overall financial impact of these cases. The addi- tion of missing MBA procedural codes did not have an impact.

Conclusion: We were unable to detect financial differences when diagnostic/procedure codes were reassigned. This was due to the complexity of these cases whereby the addi- tion of a procedure or diagnosis had a proportionally small impact on the final cost of the inpatient stay. It is clear that liaison service input in geriatric cases is being missed by HIPE coding and should be addressed as it may have an impact on planning for service provision going forward.

**AN UNUSUAL CAUSE OF PUO IN AN ELDERLY PATIENT**

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Background: An 87-year-old man was admitted for investigation of a four week history of weight loss, anorexia and night sweats. He had no past medical history of note.

Methods: Other than pyrexia of unknown origin, clinical examination was unremarkable. Initial investigations revealed mild pancytopenia, normal biochemistry and normal chest X-ray. Serial blood and urine cultures were negative for growth. Mr. M was treated for sepsis of unclear source with broad spectrum antibiotics. He developed widespread generalised pain, minimally responsive to opioids. Liver function tests became deranged, in a mitochondrial pattern. Subsequent CT chest, abdomen and pelvis revealed splenomegaly and widespread lymphadenopathy. Further haematological investigations were: elevated LDH >1600, elevated ferritin >50,000. Bone marrow biopsy confirmed haemophagocytic lymphohistiocytosis.

Results: After review by haematology team, treatment was commenced with high dose dexamethasone. Mr. M made a dramatic improvement, with improved pain control, resolu- tion of pyrexia and a concomitant normalisation of liver function. Ferritin rapidly fell to 1190. He was well enough to be discharged to his own home one month post admission.

Conclusion: Haemophagocytic lymphohistiocytosis (HLH) is a rare but potentially fatal disease of normal or overactive histiocytes and lymphocytes. This results in activation of macrophages, leading to hyperferritinaemia. Fever, hepatosplenomegaly, pancytopenia, lymphadenopathy and rash are often the presenting clinical features. HLH has familial and acquired forms. Acquired HLH in adults is usually triggered by infection (e.g. EBV), cancer or autoimmune disease. In Mr. M’s case EBV serology confirmed past infection. Various approaches to treatment existchemotherapy or immunosuppression.

The aim is to achieve clinical stability: Care is with bone marrow transplantation.
Prognosis varies, and in the case of Mr. M was unclear, as ILH is rarely seen in the elderly. Sadly, less than one month post hospital discharge, Mr. M died of profound sepsis secondary to bowel perforation.

Background: The Stroke Training and Awareness Resources (STARS) is an e-learning programme, devised by NHS Education for Scotland to help enhance the knowledge, skills and confidence of all healthcare staff when responding to the needs of stroke patients and to facilitate a patient centred approach with enhanced quality of care. In 2013, an educational programme combining e-learning with an interactive study day was established to engender specific core competencies in all staff working with acute stroke patients. We aimed to assess the effectiveness of this programme.

Methods: Staff who successfully completed the STARS e-learning programme were allocated a place at a planned interactive multidisciplinary study day. The study day content was devised to reinforce the STARS programme and included lectures, practical demonstrations and interactive sessions. Representatives of multiple disciplines (physiotherapy, speech & language, occupational therapy, clinical nutrition, nursing and counselling) developed a comprehensive agenda addressing the 20 core competencies of the STARS programme. The training was approved by An Bord Altranais. Tests were devised to assess participants’ knowledge pre and post training. Tests comprised of 20 questions, 1 from each core competency.

Results: 87 staff members from a wide range of disciplines (including doctors, nurses, health care assistants, management, speech and language therapy, occupational therapy, physiotherapy, radiography, catering staff and students) have completed the training. 36% of participating members scored lower than 70% on the pre-test, while 64% scored higher than 80%. 100% of the participants scored 95% or above on the post test with 93% scoring 100%.

Conclusions: The programme enhanced the existing knowledge and clinical care skills of participants. The educational approach empowers participants to become autonomous learners and active partners in the care of stroke survivors.

Background: In July 2015 an urban nursing home (NH) provider notified the Health Information and Quality Authority (HIQA) of their intention to close. HIQA carried out an inspection in September 2015 finding that there were appropriate plans in place to ensure the care and welfare of the residents during the transition. In December 2015 the NH closed and residents were transferred to alternative places of accommodation.

Methods: Five months later a follow-up of the residents was carried out by a member of the geriatric team in the local tertiary hospital. A telephone call was made to the patient’s new place of residence in order to ascertain wellness, number of admissions to hospital since transition or deaths since transition. Online death notices were also utilised to obtain details surrounding deaths.

Results: Of the 29 residents to be relocated; 26 transferred to alternative nursing homes (ranging from 1–4 months prior to NH closure), 2 patients died in the NH (4 and 1 month respectively prior to closure) and 1 patient died in hospital (3 months prior to closure). Four deaths occurred post transition. The deaths following transfer to new nursing home occurred between 2 and 7 months post transition. Only one patient experienced an admission to an acute hospital post transition, the admission occurred 2 months post transition and the patient died one month later (in the new NH).

Conclusion: Care transitions are not without their risks. Appropriate advance care planning in situations such as this can minimise these associated risks.

Background: Stroke survivors (SSs) are largely inactive despite the benefits of exercise. Exercise professionals (EPs), with skills in exercise prescription and client motivation, may have a role to play in promoting exercise among SSs. However, the number of EPs working with SSs is estimated to be low.

Methods: The aim of this study was to investigate EPs’ opinions on working with SSs including their barriers and facilitators to working with SSs. The study also investigated EPs’ skills, interest and experience working with SSs and the relationship between EPs’ barriers and facilitators with their training on stroke. A descriptive cross-sectional study was conducted using a researcher designed online survey between October and December 2015. Purposive sampling was used to survey EPs on the Register of Exercise Professionals in Ireland (n = 277). Descriptive and inferential statistics were calculated.

Results: The response rate was 31.4% (87/277). Only 22.1% of EPs had experience working with SSs. The primary barriers identified by EPs were a lack of training on psychological problems post stroke (83.5%), unsuitable equipment for SSs (68.4%) and the level of supervision SSs require (56.2%). Facilitators included the availability of suitable equipment (97.2%), practical training (100%) and courses (93%) on stroke. EPs that had not completed training on stroke were more likely to agree with the barriers of lack of training on psychological problems post stroke and lack of disability-related policies. EPs (76.5%) were interested in one-to-one exercise sessions with SSs but only 52.6% were interested in group exercise sessions. EPs indicated having good motivation skills (81.0%) but 42.1% reported only acceptable skills when dealing with SSs with psychological problems.

Conclusion: EPs are interested in working with SSs despite their lack of experience and practical barriers. Training opportunities and access to suitable equipment have been identified as facilitators for EPs working with SSs.

Background: The Irish National Audit of Dementia Care in Acute Care identified a number of issues relating to the physical ward environment that impact on the wellbeing of people with dementia. Implementation of dementia friendly design principles including the use of colour, effective signage, lighting and noise reduction have been seen to impact positively on the experiences of people with dementia in the ward setting.

Methods: As part of a larger Genio funded project to develop an integrated care pathway for people with dementia in the acute setting a multidisciplinary subgroup was set up to apply dementia friendly design principles to a designated area of an acute medicine for the elderly ward. The aim was to use the environment design as a therapeutic tool to enable people with dementia to maintain their independence and promote wellbeing.

Results: Whilst there was space for patients, there was no dedicated area on the ward for patients to access; poor signage for toilets and bathrooms as well as no colour scheme available to assist the patient with dementia. In keeping with the audit’s recommendation for the physical environment, this will be incorporated in the room and throughout the ward.

Conclusion: The work to the room will be completed in August 2016 with training for 1:1 carers and ward staff in its use. It is anticipated for phase 2 that evaluation of the use of the room with patients, families, 1:1 carers and ward staff will commence from September 2016 onwards.

Patient demographics: cancer diagnosis and ECOG performance status (PS) were collected. Adverse events were assessed using the NCI CTCAE v4. The association between EFS and toxicity during systemic treatment was examined.

Results: Over six months, 48 patients (25 men, 23 women) of median age 72 years (range 66–92) were included. Patients had the following primary cancer diagnoses; lower gastrointestinal 25 (31%), breast 8 (17%), lung 7 (15%), upper gastrointestinal 6 (12%) and others 12 (25%). Patients were categorised as: no toxicity 25 (52%), possibly vulnerable 12 (25%), mild frailty 8 (10%), moderate frailty 2 (4%) and severe frailty 1 (2%). Only 6 (12%) patients had an ECOG PS of 2 or above. A positive correlation between EFS and PS was identified. A positive association between EFS and dose delay was seen (r = 0.26). During systemic treatment, 8 (16%) patients had treatments held, of whom 1 (12%) of patients had a baseline high frailty score (EFS=11). Overall, no statistically significant association was seen between EFS and dose delay (r = −0.04) or between EFS and hospitalisation (r = 0.19).

Conclusion: In this prospective study, frailty, as evidenced by EFS score, was associated with toxicity from systemic therapy. However, no adverse events were predicted for dose delay or hospitalisation. Concluding decisions are limited by relatively small numbers and heterogeneous patient population.
THE FEASIBILITY OF A NATIONAL DEMENTIA REGISTER FOR IRELAND

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Background: There is an acknowledged lack of information about dementia in Ireland, including very poor coding of dementia across all care settings. Yet with dementia prevalence set to increase as our population ages, there is an urgent need to gather valid epidemiological data that provides accurate and reliable national estimates of current and future dementia prevalence, and facilitates the development of robust and effective dementia health and social policy (Cahill, O’Shea, & Pierce, 2012). This study, commissioned as part of the Alzheimer Society of Ireland evidence-based policy series, examined the feasibility of developing a national dementia register for Ireland.

Methods: A rapid review of national and international patient registry literature was undertaken to identify registry functions, underlying design and process models, and best-practice guidelines for their development. A ‘landscape analysis’ identified the legal, ethical, clinical, technology, and financial issues relevant to the creation of an Irish dementia registry. Following ethical approval, we conducted two focus groups with people with dementia and twenty-one expert stakeholder interviews with clinicians and representatives from research, health, and social care organisations in Ireland and the UK, existing Irish patient registries, and international dementia registries. Discussions followed an agreed structure, were audio-recorded, transcribed, and analysed using inductive content analysis.

Results: Common themes emerged from the literature and stakeholder discussions with regard to: registry function; benefits and risks; data collection; data management; governance; legislation; barriers and facilitators; Irish complexities; and best-practice. Conclusions: The results provide an evidence-base on which to progress the issue of improved recording structures for dementia in Ireland. Given the strategic approach the government is now taking to address research and information systems as part of the 2014 National Dementia Strategy, it is opportune to examine the potential for a framework to collect information in a reliable, accurate, valid, complete, and timely way.

DOES ADMISSION TO SPECIALIST GERIATRIC MEDICINE WARDS LEAD TO IMPROVEMENTS IN ASPECTS OF ACUTE MEDICAL CARE FOR PATIENTS WITH DEMENTIA?

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Background: People with dementia are among the most frequent service users in the acute hospital, age-advanced comprehensive assessment of physical, mental health and social care needs on a specialist ward represents current best practice in this setting.

Despite this, there is little evidence demonstrating improved care processes specifically on specialist Geriatric Medicine Wards (GMW). Therefore, the aim of our study was to review whether admission to a specialist ward leads to improvements in important aspects of care for people with dementia.

Methods: We analysed combined data involving 900 patients from the Irish and Northern Irish audits of dementia care. Data on baseline demographics, admission outcomes, clinical aspects of care, multidisciplinary assessment and discharge planning processes were collected.

Results: Less than one-fifth of patients received the majority of care on a specialist GMW. Patients admitted to a GMW were less likely to undergo a formal assessment of mobility compared to non-geriatric wards (119/143 (83%) vs 635/708 (90%), OR = 0.57 (0.35 to 0.94)) and were more likely to receive newly prescribed antipsychotic medication during the admission (27/54 (50%) vs 95/2809 (36%), OR = 1.95 (1.08 to 3.51)).

Conclusions: Relative low numbers of patients with dementia received care on a specialist GMW.

There appears to be a more streamlined discharge planning process in place on these wards but they did not perform as well as one would expect in certain areas, such as compliance with multidisciplinary assessment and antipsychotic prescribing.

REFERENCES

2Reed, A., & Smith, V. (2010). A comparison of the provision of services for people with dementia in acute hospital wards across the UK. Age and Ageing, 39(2), 244-250.
A QUALITY IMPROVEMENT INITIATIVE FOR DEVELOPMENT OF AN INTERDISCIPLINARY AMPUTEE REHABILITATION PATHWAY IN A POST-ACUTE REHABILITATION UNIT

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Background: Quality improvement involves the implementation of initiatives that aim to monitor, assess and improve the quality of healthcare provided. These initiatives strive to continually optimise performance and patient care. Within a post-acute rehabilitation unit, the aim was to identify and develop an integrated, interdisciplinary amputee rehabilitation pathway to guide clinical practice and enhance quality of service provision for clients post lower-limb amputation.

Methods: The HSE Change Model, an evidence-based tool designed to support healthcare professionals in implementing change (Health Service Executive, 2008), was selected to guide development of the rehabilitation pathway. This model facilitates change by guiding the user through four phases: Initiation, Planning, Implementation and Mainstreaming. A working group, involving representatives from all disciplines within the unit, was first established. These key stakeholders guided the change process through actions including research into established rehabilitation pathways and clinical guidelines relating to post-acute amputee rehabilitation, appraisal of published evidence, site visits to a specialist amputee rehabilitation unit, and six-weekly interdisciplinary development meetings.

Results: The amputee rehabilitation pathway is reaching the final stages of development. This pathway includes evidence-based practice guidelines and information resources for all disciplines working with clients post lower-limb amputation within the following domains: 1) Referral, 2) Assessment, 3) Goal-setting, 4) Early rehabilitation, 5) Treatment/intervention, 6) Management of phantom sensation and pain, 7) Care of the remaining limb, 8) Prevention and management of contractures, 9) Return to mobility and adjustment and coping, 10) Falls management, 11) Environment and Equipment, 12) Wheelchairs and Seating, 13) Prosthetic Use, and 14) Discharge/Planning.

Conclusions: Using the HSE Change Model and through effective interdisciplinary team working, an integrated amputee rehabilitation pathway has been developed and is soon to be introduced to clinical practice within the rehabilitation unit. There is a strong commitment to continuing with the change process and ensuring best-practice for clients admitted for rehabilitation post lower-limb amputation.

APPLYING TOYOTA LEAN MANUFACTURING PRINCIPLES TO STROKE CARE IN AN IRISH UNIVERSITY HOSPITAL

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Background: Lean manufacturing principles, originally pioneered by Taiichi Ohno, from the Toyota Production System, aim to eliminate inefficiencies within production, leaving only the crucial steps that add value to the customer. In 2011, the concept of LEAN management was first applied to stroke medicine expediting time-dependent stroke care, without compromising safety. Given this, we adapted the concept for use within a 48 hours during ‘working hours’ (Mon to Sun 08:00-17:59) of ED presentation, which improved from 56.8% (n = 96/169) in 2014 to 72.3% (n = 107/148) in 2015. OrthoGeriatric preoperative assessment rates increased from 14.8% (n = 25/169) in 2014 to 27.9% (n = 43/154) in 2015. Development of pressure sores (excluding patients who died) decreased from 8.3% (13/156) in 2014 to 6.7% (n = 9/135) in 2015.

The proportion of patients who had a specialised falls assessment prior to discharge (excluding patients who died) increased from 72.4% (n = 118/163) in 2014 to 83% (n = 117/141) in 2015. Bone protection medication on discharge (excluding patients who died) remained essentially static at 61.3% (n = 100/163) in 2014 compared with 60.7% (85/140) in 2015.

Conclusions: Substantial improvements in hip fracture care have been documented in our hospital using the HIFD. Conclusions: Substantial improvements in hip fracture care have been documented in our hospital using the HIFD. However, there remains scope for ongoing care improvement.
AN AUDIT OF CAROTID DOPPLER ULTRASOUND PERFORMED IN AN ACUTE GENERAL HOSPITAL

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Background: Current guidelines suggest that carotid doppler ultrasound (US) assessment is indicated in patients presenting with a non-disabling stroke or TIA who are potential candidates for carotid endarterectomy, and those undergoing coronary artery bypass grafting (ACCAHAAA guidelines). There are written guidelines available in this regard, and prompts when the test is being requested. The aim is to determine the appropriate-ness of referrals for carotid doppler US in our institution, and to assess the disease findings based on age.

Methods: We retrospectively reviewed the radiology records of the most recent 100 patients to have US performed. Firstly, the order information of these was reviewed to determine whether the examination was indicated. Secondly, the overall findings were reviewed to establish whether there was stenosis, and the degree if so.

Results: One hundred patients were included in the audit, 39 female, 61 male. Eleven examinations were ordered by GPs and 4 were ordered from an outpatient clinic. Ninety one of those ordered were clinically indicated, 9 were not. Of the appropriate requests, 12 had findings of haemodynamically significant stenosis. Of the inappropriate requests, 2 had significant disease, but of note were asymptomatic. The highest number of US were performed in the 75–84 age group, and the most significant disease was found in the 65–74 age group. The ≥65 and >85 age groups had the least disease. Overall, significant disease was found in 14 patients.

Conclusions: Generally, carotid doppler US are being ordered appropriately, however, despite the existence of guidelines and online prompts when placing the order, almost 10 examinations are being performed unnecessarily. The most common inappropriate referrals were for investigation of a carotid bruit and a positive family history of carotid artery stenosis. The highest number of examinations were performed in the 75–84 age group, however the younger 65–74 age group had the most significant disease.

EXPLORING THE PALLIATIVE CARE AND SUPPORT NEEDS OF PEOPLE WITH PARKINSON’S DISEASE AND THEIR CARERS

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Background: Palliative care is recommended for non-malignant illnesses, including Parkinson’s disease (PD). However, referral rates to specialist palliative care (SPC) services are low, and research with healthcare workers in Ireland and the UK highlights unmet palliative needs in this population. Some healthcare workers perceive a ‘fear’ in their patients about palliative care. However less is known about the views of people with PD and their carers about palliative care.

Methods: Semi-structured interviews were conducted with people with PD (n = 19) and carers (n = 11), recruited from movement disorder clinics in Cork. Interviews were transcribed, and analysed in NVivo10 software using Thematic Analysis.

Results: People with PD and their carers are generally unfamiliar with the term palliative care; ‘fear’ was not evident in these interviews. When informed of the role of palliative care, most felt that they would benefit from this input. Patients and carers experienced a high illness burden, and wanted extra support. Those with more advanced disease were pragmatic about their health status and had already given much private thought to the future. Participants identified two key times of crisis: at diagnosis, and in advancing illness. Participants wanted more information about palliative care, and were open to any further supports to address their psychosocial needs.

Conclusions: The holistic and person-centred approach of palliative care can address the complex physical and psychosocial symptoms experienced by people with PD and their carers. A generalist palliative care approach should be adopted by all healthcare workers, with most palliative care needs responded to within existing disease management programmes, and SPC input where needed for more complex or refractory symptoms and needs. Further education about palliative care services among people with PD and their carers, and among healthcare workers, is essential so that people with PD can access these services as needed.

A QUALITATIVE EXPLORATION OF THE HOUSING NEEDS OF MARGINALISED OLDER PEOPLE IN SOCIAL HOUSING: FOCUS-GROUPS WITH ‘MAINSTREAM’ AND ‘SHELTERED’ TENANTS

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Background: It’s unclear what is the ‘best’ model of housing provision for older people: ‘ageing-in-place’ in the community or ‘sheltered’ housing schemes, especially designed for older or disabled people. Older people living in social housing are more vulnerable than those in the general population; it is particularly important to identify the housing model that best meets their needs while remaining cost effective to provide. We therefore designed a focus-group study to explore in depth two research questions: 1. What are the main housing and support needs of older people? 2. Which housing model is best suited to meeting these needs?

Methods: A schedule was developed based on our previous national survey results, to explore further some themes of the survey. Focus-groups were facilitated by two researchers, audio-recorded, and analysed with Content Analysis using NVivo 10.0 software.

Results: Thirty-one people participated in six focus-groups, (‘sheltered’ n = 3; ‘mainstream’ n = 3). Overall, 16 were female; the average age was 72 years (range 60–96 years). Most older people in both mainstream and sheltered housing were very happy with their home. Those in mainstream housing were happy with the quality of their home and ageing-in-place (apart from some) wanted to remain. Those in sheltered housing had even higher levels of satisfaction and attributed this to a number of benefits of sheltered accommodation: improvements in health-related and overall quality-of-life; houses are generally adapted for older and disabled people; increased social contact; support from local staff; increased safety and security with the individual home, housing complex, and neighbourhood.

Conclusions: Older people may be supported to live either in the community or in sheltered accommodation, provided that necessary physical adaptations and social supports are in place. Sheltered housing may be appropriate for people who feel particularly vulnerable and would like an extra level of support.

THE EFFECTS OF TIME-LIMITED HOME-CARE REABLEMENT SERVICES FOR OLDER PEOPLE: A COCHRANE SYSTEMATIC REVIEW

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Background: Reablement is one promising approach to home-care services for older adults at risk of functional decline. Unlike traditional home-care, reablement is frequently time-limited and aims to maximise independence by offering a interdisciplinary, person-centred, and goal-directed intervention.

Methods: We searched nine databases (April – June 2015) including CENTRAL, MEDLINE, and CINAHL for randomised controlled trials (RCTs), cluster randomised or quasi-randomised trials of time-limited (up to 12 weeks) reablement services for older adults (aged 65 or older).

Results: Two studies, comparing reablement with usual home-care services with 81 participants met our eligibility criteria. One was conducted in Western Australia with 750 participants (mean age 82.29 years), and the second in Norway (n = 61; mean age 79 years). Very low quality evidence indicates that reablement may improve functional abilities (lower scores reflect greater independence; SMD -0.30; 95% CI -0.53 to -0.06; P = 0.01, I² = 14%; 2 studies; 81 participants). Very low quality evidence from a single study (750 participants) indicates that the reablement group were less likely to need a higher level of care over the 24 month follow-up (RR 0.87; 95% CI 0.77 to 0.98; P = 0.02), reducing the aggregated health and social care costs (reablement: AUD 19,888; usual care: AUD 22,757).

Conclusions: There remains uncertainty regarding the effects of reablement as the evidence was of very low quality according to our GRADE ratings. There is, therefore, an urgent need for high quality trials across different health and social care systems due to the increasing profile of reablement services in policy and practice in several countries.

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LSVT BIG & LOUD BOOTCAMP, A PILOT STUDY

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Background: Lee Silverman Voice Treatment (LSVT) BIG and LOUD® are effective, evidence based physiotherapy and speech treatments for individuals with Parkinson
Of those that scored within the mild-moderate cognitive impairment (n = 37) 30% went home, 48% went for further rehab, 27% went to LTC and 3% died. The average length of stay for this group was 49 days.

Of those that scored within moderate-severe cognitive impairment, 12% went for further rehab, 63% to long term care and 25% died. Their average length of stay was 90 days, nearly five times longer than the first cohort.

Not every patient was able to complete a standardised cognitive assessment. 42% of these patients went to long-term care and 35% died. This cohort’s average length of stay was 82 days.

Conclusion: We have confirmed that early cognitive screening can help predict discharge destination and length of stay. Early cognitive screening is completed within 48 hours of admission. This means that at an early stage the multidisciplinary has a strong indicator of discharge destination and length of stay. We plan to use these scores prospectively to inform discharge arrangements and the timelines of interventions for newly diagnosed stroke patients.

"IT'S A VICIOUS CIRCLE": HOW INADEQUACIES IN THE IRISH HEALTHCARE SYSTEM IMPACT ON LONG-TERM CARE ADMISSIONS OF PEOPLE WITH DEMENTIA

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Background: The provision of homecare takes place within the context of the wider healthcare system. However, there is a notable absence of studies concentrating on healthcare system factors in long-term care admissions. We address this absence by examining how inadequacies in the healthcare system impact on long-term care admissions of people with dementia. This is done in the context of the Irish healthcare system.

Methods: Thirty-eight qualitative in-depth interviews with healthcare professionals and family carers were conducted. Interviews focused on healthcare professionals and family carers perceptions of the main factors which influence admission to long-term care. Interviews were analysed thematically.

Results: Long-term care admissions of people with dementia are affected by inadequacies in the healthcare system in three ways. Firstly, community care services appear to be insufficient and inequitable, which limits their effectiveness. Secondly, such limitations in community care increase acute care admissions. Finally, admissions of people with dementia to acute care can accelerate the long-term care journey.

Conclusions: Inadequacies in the Irish healthcare system have a substantial impact on the threshold for long-term care admissions. This study demonstrates that we cannot fully understand the factors that predict long-term care admission of people with dementia without taking into account how healthcare system factors impact on the continuation of homecare.

DANCING FOR PARKINSON'S: A RANDOMIZED PILOT TRIAL OF IRISH SET DANCING COMPARED TO USUAL CARE

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Background: For some people with Parkinson's disease (PD), Irish set dancing is argued to have beneficial effects on movement, balance and quality of life. The feasibility and benefits of Irish set dancing classes for people with PD has not been compared with usual care.

Methods: This pilot trial used a randomised controlled design, with participants randomised to Irish set dance classes or a usual care control group. The dance group attended a 1.5 hour dancing class each week for 10 weeks and undertook a home dance programme for 20 minutes three times per week. The usual care control group continued with their usual care and daily activities. The primary outcome was feasibility; determined by recruitment rates, attrition, adherence, safety, willingness of participants to be randomised, resource availability and cost. Secondary outcomes were motor function (UPDRS-3), health related quality of life (PDQ-39), functional endurance (six minute walk test) and balance (mini-BESTest).

Results: Ninety participants were randomized (n = 45 per group). There were no adverse effects or resource constraints. Although adherence to the dancing programme was 93.5%, there was more than 40% attrition in each group. Post-intervention, the dance group had greater improvements in quality of life compared to the control group. UPDRS-3 scores deteriorated in the control group. The exit questionnaire showed participants enjoyed the classes and would like to continue participation.

Conclusion: For people with mild to moderately severe PD, Irish set dancing is feasible and enjoyable and can improve health related quality of life.
THE INFLUENCE OF POTENTIALLY INAPPROPRIATE MEDICATIONS ON HEALTHCARE NEEDS AND MEDICATION USE: A RETROSPECTIVE CROSS-SECTIONAL STUDY

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Background: The use of potentially inappropriate medications (PIMs) is a common cause of adverse drug reactions (ADRs) among older patients. This study aims to describe medication use and healthcare services among older patients in Ireland, with and without prescribed PIMs.

Methods: A retrospective cross-sectional analysis of a primary care cohort. Subsets of the STOPP criteria were applied to the baseline data and those with and without PIMs were identified. Information on prescribed medicines and healthcare services use were extracted from patient records over 5 years (2011–2015) and were compared between the two groups.

Results: For the preliminary analysis, 100/2047 patients were randomly selected and analysed. PIMs were identified for 59/100 patients with a mean of 2.2 (SD 1.6) criteria per patient. There were fewer males in the PIM group than the non-PIM group (40.7% versus 68.3%, p < 0.05) but there was no difference in the age between the two groups (median age of 64 versus 65, p > 0.05). PIM patients were prescribed more medication in total (means ±SD: 9.3–12.8 ± 4.7–7.4, PIMs versus 3.8–5.8 ± 2.4–4.1 non-PIMs, p < 0.05) and also more new medications (1.3–4.4 ± 2.1–5.6 versus 0.6–2.2 ± 1.7–3.3). The PIM group were more likely to consult their GP (5.3–9.0 ± 3.8–6.9 versus 2.5–5.3 ± 4.0–3.9, p < 0.05), but there was no significant difference in the number of referrals, new diagnoses, investigations or hospital discharges between the two groups (all p > 0.05).

Conclusions: Patients prescribed PIMs are likely to be prescribed a higher number of medications in total as well as new medications, and to consult their GP more often. These preliminary findings highlight the need to target inappropriate prescribing in older patients to improve their medical treatment and reduce associated healthcare needs.

Reference:

TO DANCE OR NOT TO DANCE? A COMPARISON OF BALANCE, PHYSICAL FITNESS AND QUALITY OF LIFE IN OLDER IRISH SET DANCERS AND AGE-MATCHED CONTROLS

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Background: The population is ageing and regular exercise is advocated to promote progressive decline in balance, functional independence and quality of life. Set dancing is a popular form of exercise among older adults internationally. Yet, no study has examined participation in set dancing.

Methods: A retrospective cross-sectional analysis of a primary care cohort. Subsets of the STOPP criteria were applied to the baseline data and those with and without PIMs were identified. Information on prescribed medicines and healthcare services use were extracted from patient records over 5 years (2011–2015) and were compared between the two groups.

Results: For the preliminary analysis, 100/2047 patients were randomly selected and analysed. PIMs were identified for 59/100 patients with a mean of 2.2 (SD 1.6) criteria per patient. There were fewer males in the PIM group than the non-PIM group (40.7% versus 68.3%, p < 0.05) but there was no difference in the age between the two groups (median age of 64 versus 65, p > 0.05). PIM patients were prescribed more medication in total (means ±SD: 9.3–12.8 ± 4.7–7.4, PIMs versus 3.8–5.8 ± 2.4–4.1 non-PIMs, p < 0.05) and also more new medications (1.3–4.4 ± 2.1–5.6 versus 0.6–2.2 ± 1.7–3.3). The PIM group were more likely to consult their GP (5.3–9.0 ± 3.8–6.9 versus 2.5–5.3 ± 4.0–3.9, p < 0.05), but there was no significant difference in the number of referrals, new diagnoses, investigations or hospital discharges between the two groups (all p > 0.05).

Conclusions: Patients prescribed PIMs are likely to be prescribed a higher number of medications in total as well as new medications, and to consult their GP more often. These preliminary findings highlight the need to target inappropriate prescribing in older patients to improve their medical treatment and reduce associated healthcare needs.

Reference:

RESCUING THE PROCESS-BASED APPROACH TO NEUROPSYCHOLOGICAL ASSESSMENT: FOCUS ON STRATEGIES AND PERFORMANCE MECHANISMS RATHER THAN TOTAL SCORES WHEN ASSESSING OLDER ADULTS

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Background: A cognitive assessment strategy that is not limited to examining a set of summary scores will almost certainly be helpful in detecting and understanding cognitive functions in those suffering from neurodegenerative diseases such as Alzheimers. The goal of this study was, therefore, to identify widely used cognitive screening tools that may benefit from the inclusion of a process-based approach to complement traditional administration and scoring.

Methods: A rapid review of literature using different combinations of the terms “dementia”, “Alzheimer”, “cognitive impairment”, “post stroke”, “screen”, “primary care” and “community” was performed in order to update Callen et al’s (2007) review of screening tests for cognitive impairment. The search was complemented with additional combinations of words [e.g. “cognitive screening”, “systematic review”, “MCT”, “Boston Process Approach”, “qualitative error analysis” and “quantified process approach”] and was confined to studies of adults. Inclusion criteria for the final selection of tests were: (1) tests measure a minimum of 3 of the 5 cognitive domains mentioned in DSM-IV-TR; (2) tests are currently used for dementia assessment; (3) tests fulfill the Quality Assessment Tool for Diagnostic Accuracy Studies (QUADAS) (Whiting, 2003) and (4) tests do not require high professional qualification levels to administer, except when QUADAS criteria recommend their inclusion (and the test has potential to be adapted to a process-based approach).

Results: Initially, 160 screening and assessment tests were identified of which 114 had not previously undergone any form of process-based approach. After applying the inclusion and exclusion criteria, 21 screening tools that may benefit from a process-based approach were identified, their characteristics summarised and the potential for clinically useful modifications identified.

Conclusions: With relatively little effort, widely used cognitive screening tools may be enhanced by a process-based approach to scoring and interpreting results, and improved detection of cognitive decline and differentiation between different neurodegenerative conditions.

THERAPEUTIC BENEFITS OF AN ACTIVITY-BASED UPPER-LIMB GROUP IN A SPECIALIST GERIATRIC REHABILITATION UNIT

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Background: Occupational therapy (OT) is a client-centred healthcare profession which aims to promote health and well-being through engagement in meaningful occupation (World Federation of Occupational Therapy, 2010). The National Clinical Programme for Older People indicates that the ultimate goal is to facilitate the person in optimising their independence (Health Service Executive, 2012). When upper-limb function has been affected by illness, injury or disability, a person’s ability to maintain this independence by performing their activities of daily living can be restricted. This study was carried out to determine the effectiveness of an activity-based upper-limb group, in combination with 11 upper-limb programmes, in optimising client hand function and facilitating greater independence in daily functioning. Through the process, the psychosocial benefits of engagement in this group were also identified.

Methods: This is a retrospective, observational study of 10 clients admitted to a specialist, post-acute rehabilitation unit. A combined qualitative and quantitative approach was adopted. Quantitative data was gathered relating to gross grip strength, pinch grip strength, dexterity and changes in functional ability for 10 clients included in the upper
Background: Transdermal Lignocaine 5% patch (Versatis®) is licensed for symptomatic relief of post-herpetic neuralgia. In clinic practice, Versatis® is prescribed off-license as a adjunct analgesia in combination with simple analgesics for severe pain. We aimed to (i) determine the volume of appropriate and inappropriate prescribing according to the summary of product characteristics (SPC) (ii) calculate the cost of lignocaine patch pre-scriptions and (iii) compare the cost with other co-prescribed analgesics (Paracetamol, Tramadol, Ibuprofen, Oxycodone, Tapirgin®).

Methods: A retrospective multicentre audit across 5 geriatric medical wards (3 acute and 2 rehabilitation) at 5 hospital sites was conducted on a single calendar day using patient medication administration records. Data on patient demographics, co-morbidities and prescribed analgesia were collated. Price comparisons were made between Lignocaine patch and co-prescribed analgesics. Potential cost savings were extrapolated to predict annual savings.

Results: Data were available for 129 patients (>65years). Females predominated (67%), n = 86, with a mean age of 80.9years (range 65-97years). 26 patients were prescribed Lignocaine patches. None of the indications were in accordance with the SPC. Unlicensed indications included analgesia for Osteoarthritis and Fractures (34.6%, n=9 each), non-specific indications (n=5) and 3 undocumented. The total cost of the Lignocaine patches for one day was €109.20 (n=26), compared with €15.74 for all other analgesics combined. Over one year this would extrapolate to a cost of €7971.60 for Lignocaine patches relative to another analgesics combinations combined.

Conclusions: Inappropriate prescribing of Lignocaine patches is common. Substantial savings could potentially be made by adhering to licence-only prescribing. Greater awareness of the SPC licensed use and the cost of the patches could promote appropriate pre-prescribing of more effective and economical analgesics and thus decrease pharmacy costs.

THE IMPACT OF NUTRITIONAL SUPPLEMENTATION ON COGNITIVE FUNCTION AMONG INDIVIDUALS WITH MILD COGNITIVE IMPAIRMENT (MCI)

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Background: Improved longevity worldwide has resulted in a significant increase in age-related diseases. There has been an exponential rise in the incidence and prevalence of Alzheimer’s disease (AD), with over 100 million adults globally projected to develop dementia by 2050. Consequently, emphasis is now being placed on preventative strategies to delay the onset or reduce the risk of developing dementia. Emerging evidence suggests that targeted nutrition may play a key role in limiting the burden of cognitive impairment. The cognitive impairment study (CARES) is designed to investigate if nutritional supplementation improves cognitive function among individuals with mild cognitive impairment (MCI).

Methods: CARES is a double-blind, randomised clinical trial aiming to recruit 60 individuals with MCI and 60 controls. Both groups will be randomised to receive either an active intervention containing fish oil, vitamin E, and the carotenoids lutein (L), zeaxanthin (Z) or meso-zeaxanthin (MZ), or placebo for 2 years. Both groups will undergo a series of cognitive assessments designed to assess different cognitive domains e.g. attention, memory, learning and problem solving. The cognitive impairment study (CARES) is designed to investigate if nutritional supplementation improves cognitive function among individuals with mild cognitive impairment (MCI).

Results: Our research group recently found that AD patients had low levels of macular pigment (MP) (p < 0.001) and poorer vision (p < 0.05) versus controls. Located at the central retina, MP is important for vision due to its light-filting and antioxidant prop-erties. Of MP, MP is comprised of L and Z which are solely of dietary origin. In a subsequent trial, carotenoid supplementation improved MP and the visual function of AD patients. As no improvements in cognition were observed, we suggest that nutritional supplementation may play a key role in limiting the burden of cognitive impairment. The cognitive impairment study (CARES) is designed to investigate if nutritional supplementation improves cognitive function among individuals with mild cognitive impairment (MCI).
EXPLORING THE IMPACT A TRAINING PROGRAMME HAS ON HEALTHCARE STAFF ATTITUDES AND UNDERSTANDINGS OF DEMENTIA: A MIXED METHODS EVALUATION STUDY

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Background: Increased longevity is a worldwide development that demonstrates the benefits of improved socioeconomic and health care factors. Dementia is a condition associated with ageing but not unique to the aged. The term dementia refers to a group of diseases characterised by progressive and mainly irreversible decline in memory, language and comprehension. Dementia is a global health challenge. From an Irish context the number of people with dementia is expected to double by 2031.

The Irish government launched The National Dementia Strategy in 2014 and one of its aims included the provision of quality care for people with dementia. This challenges society to be dementia friendly. From a healthcare perspective, the strategy requires staff to be prepared to engage with people who have dementia, which in turn would lead to better outcomes for staff and patients.

The aim of this study is to explore the impact a training programme has on healthcare staff attitudes and understandings of dementia.

Methods: This is a mixed methods evaluative study which involves both questionnaires and semi structured interviews. Ethical approval has been granted for this study.

Results: Preliminary findings so far indicate that there was a significant shift towards a more positive approach to dementia care post the training programme. The majority of this shift had been accounted for by the items associated with person-centred approaches pre mean 47 and post mean is 52. However so far items associated with hope has had a negative effect pre mean 33 and post mean 31.

Conclusions: No previous study has formally evaluated this programme or its impact on participant attitudes to or understanding of dementia. The outcomes of this study have the potential to influence educational programme delivery, policy development and ultimately the healthcare experience of persons with dementia.

GPs’ PERSPECTIVES ON PRESCRIBING FOR OLDER PEOPLE IN PRIMARY CARE: A QUALITATIVE STUDY

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Background: As the main prescribers of medication in primary care, understanding the determinants of GP behaviour in relation to prescribing is a first step in the development of interventions to address the issue of medication related problems in older adults. Furthermore, GPs are an obvious source of information to better understand the complexities of prescribing for these patients.

The aim of this study is to explore the key determinants of GP prescribing behaviours for older adults in primary care with a view to developing a behaviour intervention to improve prescribing for these patients.

Methods: Qualitative semi-structured interviews were conducted with 16 GPs. Convenience sampling was supplemented by snowball sampling where necessary in order to recruit the participants. Qualitative interviews were fully transcribed and analysed using a framework approach. Three multidisciplinary researchers independently coded the data. Emerging themes were mapped to the Theoretical Domains Framework (TDF), a set of fourteen domains relating to theory of behavioural change.

Results: The following domains were identified as being important determinants of GPs’ prescribing behaviour: “Memory Attention and Decision Processes”, “Beliefs about Capabilities” and “Reinforcement”.

Participants described prescribing in primary care as a complex process and have to consider multiple factors when prescribing for older adults. Participants expressed confidence in the role of community pharmacists and acknowledged that they provide valuable support to the GP. Prescribing in primary care was highlighted as a concern due to its complexity and source of anxiety for GPs. Targeting the domains above may assist in addressing these negative associations and improve outcomes for patients.

Conclusions: These findings highlight that prescribing for older adults in primary care is a complex process and source of anxiety for GPs. Targeting the domains above may address these negative associations and improve outcomes for patients.

Reference:

THERE’S NO PLACE LIKE HOME! EARLY SUPPORTED DISCHARGE FOR OLDER ORTHOPAEDIC PATIENTS

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Impact of a Bespoke medication management system on medication safety in an Irish nursing home

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Background: Medication safety is a concern in all healthcare settings including nursing homes. Changes to medication management (MM) in this setting have been proposed as a means of improving safety. We sought to quantify the effect of a MM initiative on the rate of medication safety incidents in an Irish nursing home.

Methods: The MM initiative involved the introduction of a newly designed patient medication record and the use of the Biodose® system for all medications dispensed to residents. All medication incidents were recorded in hardcopy at the time of the incident and later recorded electronically. Records from 1st January 2013 to 31st December 2015 were analysed in order to capture the time period before and after introduction of the new MM system in May 2014. Data recorded included type of medication incident; implicated medication; time and date of incident; reporting of incident and follow-up actions.

A JOURNEY OF CHANGE: DEVELOPING EXCELLENCE IN END-OF-LIFE CARE IN RESIDENTIAL CARE SETTINGS

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Background: Each year in Ireland 25% of deaths, approximately 7,500, occur in a residential care setting. The Irish Hospice Foundation (IHF) believes no-one should face death or bereavement without the care and support they need. In order to ensure that each person who dies in residential care receives compassionate, dignified, person-centred end-of-life care, the IHF established A Journey of Change, a programme designed to embed a continuous quality improvement approach to developing excellence in end-of-life care.

Methods: In consultation with internal and external stakeholders, a programme framework was developed. Participating residential care centres (RCCs) engage with a series of onsite workshops to give them the skills, knowledge and resources to:

1. develop a unique vision for end-of-life care in their centre
2. continually review their own end-of-life care practices
3. invite feedback from bereaved friends and relatives as part of their review process
4. make meaningful sustainable change, where change is needed

Additional resources (both on-line and tangible) were developed to meet staff information needs and facilitate networking opportunities.

Results: Over 100 public, private and voluntary RCCs for older people are currently engaged with the programme, with approximately 300 staff taking part in multiple workshops. 95% of staff have rated the workshops as ‘very good’ or ‘excellent’. A number of bespoke change projects have been implemented in participating centres, while initial evaluation feedback suggests that participating in the programme also impacts positively on level of team-working and communication. A formal external evaluation of the programme is currently taking place.

Conclusions: Based on emerging evidence regarding best practice in end-of-life care, A Journey of Change is impacting on personal understanding, organisational culture and care practices around end-of-life care.

IMPACT OF A BESPOKE MEDICATION MANAGEMENT SYSTEM ON MEDICATION SAFETY IN AN IRISH NURSING HOME

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Exploring Community Living from a Lifecourse Perspective: Toward Lifecourse Policy Options

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Background: Ageing and disability are part of the lifecourse trajectory, with disability adding another dimension to the ageing process. Older people and persons with disabilities share a common vulnerability in respect of community living and in relation to maintaining autonomy and independence. Further, the ability of people belonging to each group to connect and interact is often stifled through inadequate policies that leave them susceptible to heightened risks of institutionalisation. The ageing-disability nexus provides the rationale for greater cooperation between actors in each sector in order to achieve common goals such as inclusive, accessible and age-friendly communities.

Methods: Desk-based research, involving documentary analysis of relevant community living policy in ageing and disability as well as evidence relating to community living.

Results: Evidence suggests that older people and persons with disabilities express a common desire to live and age in their communities. However, heretofore, policies have been developed in silo perspectives that do not necessarily support the aspirations of the people for whom they are enacted. A policy gap has been identified. Highlighting the commonalities in ageing and disability supports the pursuance of more holistic lifecourse policy options.

Conclusion: Understanding the conceptualisation of community living is important for policy innovation that seeks to support older people and persons with disabilities to realise, enhance and maintain meaningful community living. Exploring community living as refracted through the lens of the lifecourse perspective adds valuable depth of understanding with regard to the interpretation of the intent and purpose of policy and how it may be better translated into practice.

Maximising the Potential of Community Day Hospitals

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Background: Comprehensive geriatric assessment (CGA) needs to be provided in a variety of settings. There is an increasing need for CGA for frail older people in our community who wish to continue living at home. Day Hospitals provide an ideal “hub” around which to integrate hospital and community services for older people in their local community. Outreach services integrated with local day hospitals are one way of achieving this.

Method: We aimed to describe the demographics of the people attending one Day Hospital in our local community and their use of specialist geriatric services.

Results: Of 62 clients who attended the day hospital on a weekly basis, 11 males and 51 females. Mean age 85yrs (range 66-99yrs). Rockwood Frailty score was available for 58 patients. Mean Rockwood frailty score was 5.91 (range 4.7). All patients attending are reviewed daily by the clinical team in the day hospital. 28/62 (45%) patients were reviewed by the CMN, CNS and Geriatrician at the review meeting. Of the 62 clients, 30 (48%) previously attended the local hospital geriatric outpatient or Day Hospital. 6 of 28 (21.4%) patients discussed required re-referral for further assessment in our hospital. The mean Rockwood Frailty score of patients who were reviewed was 4.66. 23 clients had no documented contact with specialist geriatric services in the hospital. The mean Rockwood frailty score of this cohort was 5.53.

Conclusion: While day hospitals vary in the services they provide, they all provide a unique and important service for their local community. Closer collaboration between Specialist Geriatric Services and Primary Care teams will maximise the potential of these services, improve quality of life for older people identified as needing them while living at home, and reduce the over reliance on acute hospital services in certain situations. Further work is underway to outline and document these important benefits.

Single Centre Experience of PEG Tube Insertion in a Tertiary Referral Centre

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Background: Percutaneous endoscopic gastrostomy (PEG) tubes are an established procedure for long-term nutrition. International guidelines suggest that PEG tubes should be considered if patients require enteral nutrition exceeding 2-3 weeks but are rarely indicated in patients with short life expectancy or advanced dementia. Appropriate patient selection play an important part in good outcomes. We audited patients undergoing PEG tube placement to identify risk factors associated with morbidity and mortality.

Methods: The study population was selected using HIPE coding for admissions related to PEG tubes from 2010-2015.

Results: We identified 133 initial insertions of feeding tubes; 37 radiologically inserted and 96 inserted via endoscopy. 34 over 75 years old. 25% (34/133) were over 75 years old at the time of PEG tube insertion. Indications for insertion included malignancy (2), stroke (6), neurological conditions (3) and dementia (8). 6 patients (18%) died during admission, all within 30 days of PEG tube insertion.

Conclusion: Our study aimed to further our understanding and inform our discussion with patients and families. The 30-day mortality reminds us of the challenges in selecting patients in this group for PEG tube insertion. As guidelines will never be able to cover every clinical situation, clear compassionate communication with patients and their families will always play a crucial role when challenging decisions like these need to be made.

Fostering Collaboration in Amputee Rehabilitation: Acute Hospital, Post-Acute Specialist Rehabilitation Unit and Complex Specialist Rehabilitation Centre

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Background: Many patients require a variety of services to achieve optimal rehabilitation and quality of life post amputation. However, the transition between services is often complex, poorly developed and understood, and information sharing across rehabilitative services is often inconsistent resulting in increased burden for patients, families and staff.

This study involved a service development initiative to improve the transition process for patients post amputation across three sites; an acute hospital, post-acute specialist rehabilitation unit and a complex specialist rehabilitation centre.

Methods: Individual meetings were held with key members of the interdisciplinary team at each enrolled site. Current transition challenges, materials which could be shared across sites, and a range of strategies aimed at improving communication were identified. A focus group meeting was then held with key team members across all three sites and this information was pooled and discussed. Current communication pathways between sites and documentation were viewed. Key areas for improvements were identified and common strategies for improving the process of communication across all sites were agreed.

Conclusion: A shared and collaborative approach to patient rehabilitation across all three sites has resulted in a more patient centred flexible service and a more optimal use of scarce resources.

Acknowledgement: The Interdisciplinary team.

The Older Motorcyclist

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Background: Motorcyclists are vulnerable road users and are over represented in road fatality and injury statistics. We aimed to explore the trend of ageing motorcyclists, including patterns of use, factors in collisions, injury severity and fatality rates and to evaluate the disproportionate increase in older motorcyclist collisions and injuries.

Methods: Literature review using TRID, Cochrane Injuries, Medline, CINAHL, Cochrane Controlled Trials, PsychInfo. We obtained data from the Healthcare Pricing Office, the Road Safety Authority and the Central Statistics Office relating to Irish motorcyclists.

Results: Internationally and in Ireland, there has been a disproportionate rise in injuries and fatalities involving older motorcyclists in recent years. Older motorcyclists are more likely to be admitted to hospital, have more severe injuries, are more likely to require intensive care, have a longer length of stay and suffer more complications. Head and
thoracic injuries are more common in older motorcyclists and injuries at all sites are more severe in older adults. The presence of comorbidities and a reduction in physiological reserve predisposes older motorcyclists to higher mortality and more severe injuries. Also, older motorcyclists are more likely to ride motorcycles with larger capacity engines. They are more likely to crash on higher speed roadways and in rural areas. An increasing proportion of older motorcyclists are returning riders whose riding skill has likely depreciated over time but are riding on powerful machines.

Conclusions: Motorcyclists are getting older. The nature of motorcycling is changing and for many, especially older riders, it is primarily a leisure pursuit. In general, older motorcyclists are safer riders but in recent years there has been a significant rise in fatalities and injuries affecting older motorcyclists. Training and safety initiatives for older motorcyclists and returning riders may be effective in reducing injuries and fatalities.

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ANTICOAGULATION MANAGEMENT IN HIP FRACTURE PATIENTS ON WARFARIN AND DIRECT ORAL ANTICOAGULANTS
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Background: Blue book standards and Irish Hip Fracture Database (HIHF) guidelines recommend that hip fracture surgery should be carried out within 48 hours of triage to reduce morbidity and mortality. In our hospital, older hip fracture patients admitted on anticoagulation are managed on a case by case basis. The accepted INR for surgery is 1.4 or less.

Methods: Data was collected on therapeutic anticoagulation prescription pre admission for hip fracture patients, 65 years and older, over a 3 month period. For those on warfarin, data was collected on their admission INR and timing of INR testing pre surgery.

Results: 115 older hip fracture patients were admitted between 1st of February 2016 and 30th of April 2016. 27 had a diagnosis of atrial fibrillation. Of these 22 (81%) were taking some form of anticoagulation, 12 (55%) were taking warfarin and 10 (45%) direct oral anticoagulants (DOACs).

For those on warfarin, 6 (50%) had an admission INR within therapeutic range (2-3) and 6 (50%) were in supra therapeutic range (>3). The median time to the first INR result from presentation was 2 hours (range 1-3 hours). The median number of repeat INR tests pre surgery was 3 (range 2 to 6). Vitamin K was prescribed in an ad hoc fashion and the repeat INR timing was widely varied. Of 12 patients taking warfarin 3 (25%) were in theatre within 48 hours of triage time and 9 (75%) were greater than 48 hours. Of 10 patients on DOACs, 7 (70%) went to theatre within 48 hours and 3 (30%) over 48 hours.

Conclusion: Patients on DOACs were more likely to go to theatre within 48 hours than those on warfarin. This study highlights the need for a robust protocol for anticoagulation reversal pre hip trauma surgery to reduce avoidable delays to theatre.

CHARACTERISING AN IMPLEMENTATION INTERVENTION TO SUPPORT THE INTRODUCTION OF COMMUNITY-BASED FALLS RISK ASSESSMENT CLINICS
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Background: The effectiveness of falls prevention programmes among community dwelling older adults has been demonstrated. However, research is needed to determine how to increase implementation in healthcare settings. An implementation intervention, which refers to any strategies designed to support the implementation of a service, can address organisational and provider barriers, and increase the likelihood of successful implementation. Our aim is to characterise the content of an implementation intervention to support health professionals to deliver community-based falls risk assessment clinics (FRAC), using behavioural science methodology.

Methods: We are using multiple data sources to build a description of the implementation intervention. We are conducting semi-structured interviews with a purposive sample of stakeholders involved in the design and delivery of the intervention (n = 4). We are using non-participant observation to observe the delivery of one-to-one and group staff training sessions, and to observe information sessions with referring health professionals across groups. We are analysing documents including referral material, promotional/educational material and training packs. Data will be analysed using the Behaviour Change Wheel, a framework for understanding how an intervention produces its effects.

Results: A range of BCWs are being used to coach staff and support implementation including education, training, and environmental restructuring. While data from interviews and observations have identified those core ingredients, observation data have refined the exact techniques being employed, for example the use of feedback and instruction on how to perform the behaviour.

Conclusions: In health care, most implementation efforts are not formally reported or fully understood. Characterising the implementation of the FRAC in this systematic way facilitates evaluation, further refinement and effective implementation at other sites. The results will help us to understand how different strategies facilitate the introduction of new services in complex healthcare settings and inform future implementation intervention development.
Background: The national falls prevention strategy recommends a greater focus on falls prevention and rehabilitation for patients aged 65 and over. Falls prevention interventions are effective however, there are practical, clinical, and professional challenges to implementing such complex interventions. Our aim is to evaluate an integrated Falls and Fractures Prevention Pathway, a complex service intervention involving different existing specialist falls services, standardisation of falls prevention practices in community hospitals, and the introduction of new community-based falls risk assessment clinics (FRAC).

Methods: Our approach uses a mixed methods design. Semi-structured interviews will be undertaken with purposive samples from four stakeholder groups: 1) staff delivering the community hospital programme, 2) healthcare professionals referring to the falls pathway; 3) staff delivering the FRAC; 4) service users who have attended a FRAC. The number of clinics, referral rates, uptake and waiting times will be extracted from the clinic administrative database and analysed descriptively as indicators of uptake and adoption. Interviews are being analysed thematically to identify the barriers and facilitators to implementation, and to examine stakeholder perceptions of the appropriateness, acceptability, feasibility, fidelity and sustainability of the service.

Results: Pre-implementation interviews have been conducted with three staff at one FRAC. Preliminary results suggest there is a perceived need for this service locally. Staff are comfortable conducting the risk assessment in collaboration with colleagues from other disciplines however, the physical resources and space required to deliver a multidisciplinary service are constrained. Participants stressed the need for ongoing support to sustain the service. Iterative data collection and analysis is ongoing.

Conclusions: This study identifies the barriers, related to resources, and facilitators, relating to skills and stakeholder buy-in, which will be used to inform ongoing implementation efforts. Understanding the challenges to adopting and implementing the pathway will increase the likelihood of its success and sustainability.

BACKGROUND: The Irish Hip Fracture Database (IHFD) in 2015 started to collect data on patients with a Hospital Inpatient Enquiry (HIEP) secondary diagnosis of hip fracture in our hospital. We wished to review outcomes of patients with a secondary diagnosis of hip fracture related to an inpatient fall in our hospital.

Data was extracted from the HIPE coding system IHFD web portal for all hip fracture patients over the age of 60 with a secondary diagnosis of hip fracture discharged in 2015. Outcomes were compared with our hospital’s IHFD 2015 results.

METHODS: Data was extracted from the HIPE coding system IHFD web portal for all hip fracture patients over the age of 60 with a secondary diagnosis of hip fracture discharged in 2015. Outcomes were compared with our hospital’s IHFD 2015 results.

RESULTS: Twenty patients were coded by HIPE as having a secondary diagnosis of hip fracture of which 10 were recorded as being caused by inpatient falls. The average patient age was 81.3 years of age, 7 were female and were 3 male. Nine had surgery and 1 died without surgery been performed. Using X-Ray order time as the starting point for calculating the time to theatre: 66.7% (n = 6/9) were operated on within 48 hours with a mean time of 53.4 hours and median time of 35.7 hours.

Four patients were transferred to off-site rehabilitation, 1 was discharged home. Four patients died as inpatients and there was a 30-day mortality rate of 20% (n = 2/10). This compares with an inpatient mortality and 30-day mortality of 6.3% (n = 10/158) and 4.4% (n = 7/158) respectively for patients admitted via ED with a principal diagnosis of hip fracture discharged in 2015.

CONCLUSION: Our data highlights the high mortality rate of patients who fracture their hip secondary to an inpatient fall compared with patients with a principal diagnosis of hip fracture who are largely admitted from the community. We would suggest that at least equivalent standards should be applied to their care. We welcome the collection of this data via the IHFD.

Background: We aimed to describe the epidemiology and outcomes of patients admitted to our hip fracture centre, a national tertiary serving a national territorial referral centre with a catchment population for orthopaedic surgery of 300,000 people. From the national hip fracture database our knowledge of patients course and discharge location from acute hospital care has greatly improved. However more data on progress through the rehabilitation hospital setting is needed to help guide optimal management and resource allocation.

Methods: Patient’s baseline characteristics and hospital course are recorded prospectively on all those admitted with hip fractures. Admissions over a twenty-four-month period from September 2013 to August 2015 were examined.

Results: 124 patients were admitted following hip fractures over a 24-month period. The mean age was 82 (IQ range 77 – 90) years (76% were female) and 69.9% (65%) of patients’ fractures occurred indoors. The median LOS of patients was 37.5 (28 – 66). 94.4% (117) were discharged home; only 3.2% (4) were discharged to residential care. The median Barthel Index (BI) on admission was 13 (12-14), with a mean of 12.8 (+/- 3.8). The median BI on discharge was 17 (16-19), with a mean of 17.2 (+/- 2.1).

Conclusion: Our study highlights a very low rate of patients being discharged to nursing home care after referral to off-site rehabilitation. Patients also demonstrated a significant increase in BI (p < 0.0005). In the context of the Irish Hip Fracture Database (IHFD), National Report 2014, which showed 37% of patients being transferred to long-stay or nursing home care and 6% being transferred to external rehabilitation facilities it highlights the benefits of dedicated rehabilitation facilities. Of note compared to the IHFD there were a higher proportion of female patients 80.2% vs. 73%, and none of the patients were admitted from nursing homes versus 10% in the IHFD.

Background: It is commonly assumed that an older adult and their family meet admission to long-term care with some sadness. However, there is currently a dearth of literature surrounding the emotions experienced by elderly people when they reach this point in their lives. The purpose of this qualitative study was to gain an insight into the regrets reported by a group of elderly Irish people on the cusp of entering long-term care and some of the factors influencing this emotion.

Methods: Semi-structured, qualitative interviews were undertaken with older adults in an interim care unit of a large teaching hospital in Dublin. A MMSE, Geriatric Depression Scale (GDS) and Barthel Index score supported each of these interviews. Participants were included if their MMSE score was >20. Interviews gathered details of participants’ early lives, careers and relationships, their present regrets, greatest achievements and happiest memories. Detailed reports of participants’ responses were written up after the interviews and this data was subsequently analysed by the interviewer.

Results: Twelve older adults were interviewed. The mean age of participants was 82 years. Their mean MMSE was 27/30. Key themes that emerged in regards to the regrets experienced were relationship and family life regrets (not marrying, not having more children, losing touch with children) and career-related regret. Career-related regret was more common amongst the men interviewed.

Conclusions: Some patterns emerged in terms of the regrets experienced among this cohort. The interviews conducted raised interesting correlations between stability in child-rearing, losing touch with children and career-related regret. Career-related regret was more common amongst the men interviewed.

Background: The Nottingham Hip Fracture Score (NHFS) was developed and validated in 2007 as a predictor of 30 day mortality. Hip fracture in older patients is associated with a one month mortality of 7% (Mopper, I.K., BJAJ 2012).

The NHFS is a summative score of seven preoperative variables which give an estimated risk of 30 day postoperative mortality. The NHFS has a range of 0-10. Low risk for mortality post hip fracture is a score of 5 or below and high risk: a score of 6 and above. A score of 0 gives an estimated 30 day mortality of less than 1%, a score of 10 an estimated 30 day mortality of 45%.

Our aim was to review the NHFS for older hip fracture patients admitted to our unit and to review our 30 day mortality.

Methods: Information on the seven preoperative variables of age, gender, admission haemoglobin, AMTS, number of co-morbidities, nursing home residence and history of malignancy were collected on consecutive hip fracture patients, over 65 years of age, admitted between September 2015 to April 2016.

Results: 280 older hip fracture patients were admitted during this time, with complete data available for 270 patients. The median age was 83 years (65-101 years). The median NHFS was 5 (range 1-9). 143(53%) patients were considered low risk (score 0-5) and 127 (47%) high risk: (score above 6). The overall 30 day mortality rate for 270 patients was 3.7%. Of the patients who died, 90% had a NHFS of 6 or above (high risk).

Conclusion: NHFS is a useful predictive tool which highlights older hip fracture patients with an increased mortality risk. This prediction of risk improves informed decision-making and communication of this risk with patients and relatives.
INTRODUCTION OF SAFETY CROSSES: A TEAM APPROACH TO IMPROVING HIP FRACTURE STANDARDS FOR OLDER PATIENTS

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Background: A safety cross is a one month calendar view which provides an ‘at a glance’ view of live data which is presentable in a clear format. It is updated daily with either a green or red colour to reflect the presence or absence of an incident. Examples of the use of safety crosses include the monitoring of falls.

We have recently introduced safety crosses to review the time to surgery for our hip fracture patients. The safety cross is displayed on the orthopaedic ward. A green colour indicates surgery within 48 hours, a red colour surgery of over 48 hours (for one or more patients).

Hip Fracture Database and Blue Book standards are that the majority of patients should be in theatre within 48 hours of triage.

Methods: In order to help the team to understand and establish the safety cross, we retrospectively produced safety crosses of the time to surgery for hip fracture patients between 1st October 2013 and 30th September 2014.

Results: 398 patients had hip fracture surgery during this time with a range of 0.5 hip fracture operations per day. 61% of the patients had surgery within 48 hours (monthly range 45-83%). When plotted onto safety crosses this data resulted in 40% of the days being green (all patients having surgery in less than 48 hours), 37% red days (one or more patients having surgery in over 48 hours). 23% of the days there was no hip fracture surgery.

Conclusion: The introduction of safety crosses for time to surgery is helping to build a collaborative team approach to ensure that our times to theatre improve. We aim to continue this development by the introduction of safety crosses for all the Blue book standards for hip fracture patients on the acute and rehabilitation units.

OUTCOMES POST HIP FRACTURE: 12-MONTH MORTALITY DATA

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Background: Hip fracture in older patients is associated with a one month mortality of 8% and a one year mortality of over 25%. The Irish Hip Fracture Database (IHFDB) captures 90% of patients, but little is known about 12-month mortality data in an Irish hip fracture population. Our aim was to review outcome data for a group of patients in the 12 months post hip fracture.

Methods: We studied 149 consecutive patients (over 60 yrs) admitted with a hip fracture between April and August 2014. Deaths were recorded from the hospital integrated patient management system and an online death notices website.

Results: 30-day mortality was 6% (n = 9). 3.4% (n = 5) patients died within 30 days and during the hip fracture admission. 2.7% (n = 4) died within 30 days but after discharge from the orthopaedic unit (3 in Nursing homes). 12-month mortality was 22% (n = 33). 7.4% (n = 11) patients died during their hip fracture admission, 7.4% (n = 11) during a re-admission under another team, 7.4% (n = 11) were not in hospital at the time of their death.

Of the 7.4% (n = 11) patients who died during their hip fracture admission, the average length of stay was 49 days (range 2–124 days).

The mean age of the total group of 149 patients was 81 years (68% female, 32% male). The mean age of the 33 patients who died within 12 months was 84 years (48% female, 52% male).

Conclusion: This study is unlikely to have captured all deaths post hip fracture, yet still shows high 12-month mortality in keeping with other studies. One third of the deaths occurred during the initial hip fracture admission, but less than half of these deaths were in the first 30 days of admission. Further work will prospectively study the outcomes of all our hip fracture patients.

AN AUDIT OF SWALLOW SCREENING IN ACUTE STROKE PATIENTS

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Background: The UK guidelines recommend all patients presenting with acute stroke should have a swallow screen completed within 4 hours of admission. The Irish National Stroke Audit recommended swallow screening within 3 hours.

Aims: To assess the rate of swallow screening performed in patients within 4 hours of presenting to our Hospital with acute stroke.

Results: We reviewed the charts of 30 patients (n = 30) admitted with acute stroke over a two week period in January 2016, 12 M, 18 F. Mean age 76 years (range 57-94yrs), 10 patients (33.3%) presented over the weekend.

2 (6.67%) patients had a swallow screen documented within 4 hours of admission. These were completed by SALT (1) and Medical doctor(1).

19 (63.3%) patients were assessed by a Speech and Language Therapist (SALT) within 24 hours. Following SALT assessment 2 patients (6.7%) were placed Nil Per Oral (NPO). Neither of these patients had alternative feeding within 24 hours, one due to failed NG placement and in the other the reason was not documented. Modified diet was recommended for 10 patients (33.3%).

5 (16.7%) patients suffered an aspiration pneumonia, 2 of whom were on modified diet and 2 were NPO. Of the 30 patients, 7 (23%) were discharged to long term care, 7 (23%) to rehab and 14 (46%) were discharged home.

Conclusion: There is significant scope to improve the rate of swallowing screening performed in acute stroke patients. We aim to do this by training nurses in our emergency department and our stroke unit to complete swallow assessments. 63% of patients were assessed by SALT within 24hrs compared to 37% within 48 hrs in the National Stroke Audit. However, as in other studies we have shown 1/3 of stroke presentations are over the weekend when there is limited access to specialised assessment.

A STEP IN THE RIGHT DIRECTION: ACTIVITY LEVELS OF PATIENTS ON AN ACUTE STROKE AND CARE OF THE ELDERLY UNIT

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Background: A wealth of literature has emerged over the last number of decades highlighting the negative short and long term effects of bed rest on patients. Despite this however, we do not have data on how much patients walk while confined to a hospital ward. We measured activity levels of patients on an acute stroke and care of the elderly unit using pedometers. Additionally, we explored staff and patients’ opinions on mobilisation during hospitalisation, in particular what they perceived as barriers to mobilisation.

Methods: 26 patients volunteered to wear a pedometer for five days. A staff and patient survey was developed to examine opinions on mobilisation and to establish what factors nursing staff and patients felt were barriers to mobilisation.

Results: Mean daily step count was 456 steps per day, ranging from 48 to 1975. Patients who were independently mobile accumulated significantly more steps than those that required assistance, but on average accumulated only 771 steps per day. This is significantly short of the target of 10,000 steps per day. Staff recognised the benefits of patient mobilisation but felt they did not have time to help patients to mobilise. They also felt patient motivation was a barrier.

Conclusion: Patients took significantly fewer steps than the recommended guideline daily amount. In the literature, lower step count during hospitalisation has been linked to an increased risk of functional decline, discharge to a long term care facility, prolonged hospital stays and increased risk of mortality. We plan to adopt a phase three program, initially focussing on independently mobile patients who can easily increase their step count.

INTEGRATING THE OPERA INSTRUMENT TO IDENTIFY AND DIRECT THE CARE NEEDS OF FRAIL OLDER PATIENTS IN THE AMAU SETTING

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Background: Frail older patients represent an increasing proportion of those accessing acute hospital services. The aim of this study was to evaluate outcomes for patients aged ≥70 presenting to the acute medical assessment unit (AMAU) based on functional ability scores on admission.

Methods: A prospective cohort study was carried out. Data was collected on patients presenting between July 2015 and May 2016. Functional ability (FA) is routinely recorded as part of a novel 5-minute nurse-administered instrument – the Older Persons in ED/A＆M Audit Risk Assessment (OPERA) for those aged ≥70 admitted to the AMAU. The Delphi-derived OPERA instrument reviews premorbid comorbidity, functional ability (Mobility, self-care, speech and nutrition), and acute illness indicators. FA needs were scored 0 (independent) – 7 (dependent). A positive response to each question prompts an MDT referral to appropriate services for review.

Results: 1952 patients attended AMAU during this period. 28.4% (555/1952) were aged ≥70. 44.3% (246/555) scored 0 on FA. 18.1% (100/555) scored 1, 10.5% (58/555) scored 2, 10.2% (57/555) scored 3, 9.2% (51/555) scored 4, 5.7% (32/555) scored 5, 3.6% (20/555) scored 6 and 3.6% (20/555) scored 7. 956 MDT referrals were prompted. 70.3% (670/956) were admitted. The highest admission rate, 95% (19/20), was in the FA group, 20% (4/20) of whom were nursing home residents and a further 10% (2/20) were newly discharged to nursing homes. No patients in the FA group were discharged to mobile ranks only. Average length of stay increased in each category from 6.4 (0–52) days in the FA1 group to a maximum of 17.2 (2–125) days in the FA5 group. The highest in-hospital mortality rate was in the FA5 group, 15.0% (5/32).
IMPLEMENTATION OF NATIONAL STRATEGY AND BEST PRACTICE PHYSIOTHERAPY MANAGEMENT OF FALLS IN A LEVEL 4 TEACHING HOSPITAL

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Background: Achieve best practice physiotherapy management of patients at risk of falls (PROF) in an acute model 4 hospital in line with ‘The National Strategy’ (1) & best practice guidelines (2).

Methods:
• Medical chart audit completed, identified required improvements
• Developed physiotherapy self-assessment questionnaire
• Educational in-services conducted to enhance awareness & compliance with the strategy (1) & best practice guidelines (2).
• Enhanced & promoted pathway of care
• Developed concise, user-friendly, clinical prompt
• Resource pack made available
• Re-audit post initiative launch
• Sustainability ensured by inclusion of falls initiative in Accelerated Learning Programme & audit, education, re-audit

Results:
• Initial medical chart audit & self-assessment questionnaire identified areas for focused development.
• Initiative launched with in-services, care pathway, prompt tools & resource availability
• Re-audit of charts & questionnaire
• Identified improved access & management in accordance with guidelines
• Standardised falls leaflet provided to PROF
• Standardised subjective outcome measures used
• Created & promoted visual clinical prompt tool

Conclusions: Improved outcomes in self-assessment tool & medical chart audit post initiative with on-going audit & education.

References:

RECOGNITION OF CHRONIC KIDNEY DISEASE AND SECONDARY RENAL DISEASES IN A NURSING HOME POPULATION

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Background: Chronic kidney disease (CKD) is recognised as raised serum creatinine or low estimated glomerular filtration rate. The Kidney Disease Improving Global Outcomes (KDIGO) defines low eGFR as <60 ml/min/1.73m<sup>2</sup>, classifying CKD into stages: 3a (45–59), 3b (30–44), 4 (15–29) and 5 (<15). The prevalence of CKD in Ireland is approximately 11.8%, rising to 55.7% in over 80s.1 Nursing home residents with CKD are a particularly vulnerable population, but information, flexibility in assessment approach or affording time needed by each patient. Challenges included unsuitability of some standardised assessments for example grip strength when Autism or Challenging Behaviour was present. Special techniques were developed to address difficulties such as alternate communication, distraction and hand over hand techniques along with simplified methods of demonstrating and engaging people.

Methods:
• Disabling Supplement to TILDA.
• Engaging people with an ID in a suite of 8 objective health measures in the Intellectual Disability Supplement to TILDA.

Results:
• Mean age was 83.43 years (range 69-95years). Females predominated (58.3%), n = 56. 36 residents had gFRs ≤59 (37.5%). Documented rate of CKD was 19.44%. Anaemia was the most common secondary renal disease (44.4%). Mean haemoglobin was 10.52 for CKD residents versus 11.40 overall. In the CKD group mean calcium was 2.38 and phosphate 1.01 (2.36 and 1.05 respectively overall). 8.3% had hypocalcaemia. No CKD patients had hyperphosphatemia.

Conclusion: A significant proportion of nursing home residents had CKD. The majority of cases were unrecognised and some had secondary renal diseases. Increased recognition of CKD may reduce incidence of secondary renal disease and thus reduce comorbidity disease burden in this population.

References:

AN AUDIT OF TIME INTERVAL FROM PRESENTATION TO SURGERY IN ELDERLY HIP FRACTURE PATIENTS IN A LARGE TEACHING HOSPITAL

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Background: The current guidelines in Ireland recommend that patients presenting with acute hip fracture undergo corrective surgery within 48 hours and within normal working hours where it is medically safe to do so. However, there is increasing evidence that performing surgery within 36 or even 24 hours may have better outcomes. The aim of this audit was to look at how many patients presenting to a large hospital underwent surgery within 24, 36 and 48 hours.

Methods:
• In all patients presenting with an acute hip fracture within a 12 month period, the time of arrival to the Emergency Department and time of surgery were recorded.

Results:
• 902 cases were included. Of these, 89% were outside the current 48 hours target.

Conclusions:
• The majority of hip fracture patients in this audit underwent surgery within 24 hours. A small but significant number exceeded the 48 hour target.

AUDIT OF APPROPRIATE PRESCRIBING IN ELDERLY NURSING HOME RESIDENTS WITH CHRONIC KIDNEY DISEASE

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Background: The prevalence of CKD in Ireland is approximately 11.8%, rising to 55.7% in over 80s. Appropriate prescribing according to CKD is imperative to avoid adverse effects.
The incorporation of co-morbidity information improves risk estimation in older people with major trauma.

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Background: Trauma in older people is an increasingly important issue. In addition to recent escalation in absolute numbers of trauma presentations in the elderly, their higher rate of medical co-morbidities leads to increased complexity in management. Systems for estimating risk of short term mortality tend to perform worse in older than younger individuals. Risk estimation in older people could be improved through the incorporation of co-morbidity information. To assess the improvement in risk estimation with the addition of co-morbidity information, 860 major trauma patients enrolled in TARN at St. Vincent’s University Hospital (SVUH), a tertiary referral urban university hospital, between Sept 2013 and Aug 2015.

Methods: PSI2 estimates the risk of inpatient or 30-day survival in trauma patients based on Injury Severity Score (ISS), age, gender and Glasgow Coma Scale (GCS). The newer PS14 additionally includes co-morbidities, as a categorical variable defined by the number of co-morbidities present. PSI2 and PS14 were calculated for each individual. Discrimination of each system was compared using AUROC, separately in each age group.

Results: In the 419 individuals aged under 65 years, both systems showed excellent discrimination with AUROC of 0.97 (95%CI: 0.94 to 1.00) for PSI2 versus 0.96 (95%CI: 0.93 to 1.00) for PS12, for p for difference = 0.23. In the 450 individuals aged 65 years and over, discrimination was significantly better in PSI14 (AUROC 0.79 (95% CI: 0.70 to 0.88)) compared to PSI2 (AUROC 0.71 (95%CI: 0.61 to 0.82), p for difference <0.001. These findings were consistent when examining older age groups including those aged 75 to 84 years and those aged over 85.

Conclusions: For older individuals the addition of comorbidity has resulted in significant improvements. Further refinements including the addition of specific comorbidities, alcohol use and initial vital signs may yield further improvements in discrimination.

The implementation of an inpatient falls prevention programme using falls specific care bundle in an Irish university hospital.

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Background: Falls are a major patient safety issue for hospitals. The RCP Fallsafe (1) programme includes a falls specific care bundle for older in-patients and the empowerment of ward-based falls champions. This approach can reduce in-patient falls by up to 25% (2). We report on the introduction and early implementation of such a falls preventing programme in a Dublin hospital.

Methods: A multidisciplinary project team led this quality improvement project to define, analyse and improve our in-hospital falls prevention programme. The project was divided into a baseline, introduction and implementation periods (4 months each). Data on falls prevention processes were collected at baseline and then on a monthly basis throughout the project. Falls champions were recruited and trained. An evidence-based falls prevention care bundle was introduced for all admitted older adult patients to enhance assessment and prevention of in-hospital falls. Ward support and education was provided by the project team.

Results: Twenty-five falls champions, including nurses, porters and healthcare assistants, were trained. Baseline data showed deficiencies in falls assessment and risk factor management. Recording of falls history improved with just regular auditing from 37% to 65%. During the project, there were progressive improvements in basic falls prevention processes including access to call bells (41.5% to 65%) and access to safe footwear (69% to 77%). Improving the recording of “fear of falling” required changes to nursing admission documents. Reducing new night sedation prescriptions was more challenging.

Conclusion: The implementation of an evidence-based care bundle can improve practice in an Irish setting. Implementing such multifaceted change in hospital is complex and involves many disciplines. By continuing to implement and sustain these changes it is hoped to significantly reduce in-hospital falls.

References:

Reducing paper mountains: developing a comprehensive geriatric assessment (CGA) document.

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Background: The development of an integrated document for patients attending the day hospital for a Comprehensive Geriatric Assessment (CGA) was recommended following a tracer audit. Previously all members of the multidisciplinary team (MDT) had their own individual documentation that was filed either in the day hospital or the patient’s healthcare record.

An audit was completed to establish whether the introduction of a CGA integrated document rather than separate MDT notes would reduce repetition, improve patient experience, staff satisfaction levels and improve efficiency and quality of assessment.

Method: 1 week prior to the pilot of the CGA document, new patients were asked to complete a short questionnaire in relation to repetition during assessment, efficiency and quality of assessment and overall experience of the day hospital. Day hospital staff also completed a brief questionnaire in relation to the current documentation in the day hospital, time spent on documentation, efficiency and quality of assessment and satisfaction levels with documentation. Following the 8-week pilot of the CGA document patients and staff were requested to complete the questionnaires in relation to the new document.

Results: Combined time taken to complete documentation has decreased from an overall 110 minutes per patient to 60 minutes per patient. Staff satisfaction levels have increased from 42.5% to 91.25%. Patient’s perception of assessment repetition reduced from 84% to 6%. Average frequency of question repetition was reduced from 4 times to 1 time. 83% of patients rated their overall experience in the day hospital pre the CGA document as excellent or beneficial and this increased to 100% following the introduction of the CGA document.

Conclusion: The CGA is a vital part of geriatric medicine. Efficient use of time, proper documentation and communication between MDT members improves overall patient experience. The CGA document is a priceless tool to achieving above.

The staff and patients perceptions: introduction of a comprehensive geriatric assessment (CGA) document.

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Background: Approximately 600 new patients receive a comprehensive geriatric assessment (CGA) annually in a Dublin Day Hospital. Each member of the MDT had their individual documentation of the patient’s assessment that was filed either in the HCR or in the day hospital, totalling 36 pages. The National Clinical Programme for Older People (2012) recommends that the CGA should be documented in the patient’s permanent health record.

Method: A tracer audit was completed in 2015, recommending the development of an integrated care document for patients attending for CGA. Nurse Practice Development (NPD) collated the individual elements of our documentation, highlighting the many areas of duplication that occurred throughout the separate documentation.

The multidisciplinary team (MDT) drafted a CGA booklet that would follow the patient through their assessment in the day hospital. The aim of this document was to reduce duplication, reduce time spent on paperwork per patient, improve efficiency within the day hospital and improve overall quality of assessment. We sought approval from the Documentation Working Group to pilot the document. The document was piloted over an 8-week period. Following the pilot, the MDT recommended minor changes to the document.

Result: he final CGA booklet (16 pages) was approved by all the relevant committees and was launched in March 2016. The new document has improved communication between the MDT; patients are no longer asked the same question multiple times and time spent on paperwork has decreased significantly.

Conclusion: As CGA is evolving, steps will need to be made with our colleagues in ICT and in both primary and secondary care to ensure the information is available to all in the development of individualised care plans.

Reference:
Application of the GerontoNET ADR Risk Score to Assess the Risk of Adverse Drug Reactions in Patients over 65 Years

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Overview: Adverse drug reactions (ADR) are common, particularly among the elderly population, and are associated with significant morbidity and mortality. The GerontoNET ADR risk score is a tool designed to help identify those elderly patients most at risk of ADRs. The aim of this study was to assess this score to group of elderly patients and identify any correlations between an increased score and risk factors for developing ADRs.

Methods: Data was collected from chart review of 60 patients aged ≥65 years who were admitted to Beaumont Hospital through the Emergency Department over a two month period. Baseline patient characteristics, medical history and drug history were documented for each patient. An accurate medication list was obtained through medication reconciliation performed by a pharmacist.

Results: The mean age was 80.22 (+/- 6.36) years with 50% each of male and female. 67% of patients had ≥4 co-morbidities and 70% were prescribed ≥8 medications. There was a positive correlation between ADR risk score and both the number of co-morbidities and the number of medications prescribed.

Conclusion: The number of co-morbidities and the number of medications prescribed are significant contributors to an increased risk score. These risk factors should be recognized and patients subsequently managed with the potential for an ADR in mind. The GerontoNET tool is quick and easy to use and could be very useful for doctors not trained in Geriatric Medicine to get an idea of how at-risk their patients are.

Takotsubo Cardiomyopathy in an Octogenarian

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Background: Takotsubo (stress-induced) cardiomyopathy is an acute myocardial infarction mimic primarily affecting elderly females, characterised by transient systolic and diastolic left ventricular dysfunction often precipitated by an emotional or physical trigger. Here, we present the clinical outcome of an acute presentation of chest pain in an elderly female.

Case Report: An 81-year-old female who had been under physical and emotional stress on account of chronic lower limb ulcers and a recent decision for long term care presented with sudden onset chest pain and dyspnoea. Initial electrocardiogram showed ventricular tachycardia and subsequently ST-segment elevation with elevated cardiac markers. Coronary angiogram revealed non-obstructive coronary arteries and left ventriculography showed extensive wall akinesis in keeping with takotsubo cardiomyopathy. An echocardiogram done 12 days later showed complete resolution of the ventricular wall abnormality.

Discussion: Takotsubo cardiomyopathy has been increasingly reported in recent years. It predominantly affects elderly women with a female-to-male ratio of 9:1 [1]. Its treatment is essentially empirical and supportive [2]. It should be considered to be an acute heart failure syndrome which has serious in-hospital complications of which physical triggers has an increased incidence of acute complications. Geriatricians should be well aware of this syndrome in light of its predilections for the elderly, association with stress and its substantial morbidity and mortality.

References:

Exercise Beliefs and Contributing Factors Amongst Elderly Nursing Home Residents: A Cross-Sectional, Case Control Study

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Background: The number of Irish older adults residing in nursing homes is continually increasing. Nursing home residents are typically sedentary, leading to poor health and functional outcomes. There is a lack of research concerning the exercise beliefs of this inactive subgroup of older adults. This study aimed to examine the hypothesis that nursing home residents have poor outcome expectations and self-efficacy for exercise, compared to community dwelling older adults. It also aimed to analyse the association between these beliefs and patients’ age, functional scores, number of comorbidities and psychological health.

Methods: Twenty-two nursing home residents and twenty community dwelling elderly adults (≥65 years) completed a written survey: Primary outcome measures were: The Outcome Expectations for Exercise Scale (OEE), and the Self-Efficacy for Exercise Scale (SEE). Secondary outcomes were the Barthel Index of Activities of Daily Living (BI), number of comorbidities, and the Geriatric Depression Scale-15 (GDS-15).

Conclusion: Self-efficacy for exercise is lower amongst nursing home residents than in community dwelling older adults. Depressive symptoms are significantly associated with poor exercise beliefs. The presence of depressive symptoms may represent a significant barrier to participation in physical activity for older adults both in nursing homes and in the community.

Environmental Audit of a Typical Acute Hospital Ward in Supporting Patients with Dementia

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Background: The physical and social environment of a typical acute ward can influence the needs and abilities of people with dementia. A dementia-friendly environment helps people with dementia reach their full potential and can help avoid needless disability. The result is quality of life for people with dementia, their families and staff.

This study was undertaken to investigate whether the typical acute ward environment in an Irish hospital supports the care needs of people with Dementia.

Methods: 3 audits were carried out – Enhancing the Healing Environment (EHE) Kings Fund, Built Environment Audit Tool – Dementia (BEAT D), Queensland Health Falls Prevention Best Practice Guideline. The BEAT D was independently evaluated by assessors in Australia. The selected ward would be typical of an acute medical ward within the public Irish hospitals system.

Results: The three environmental audits demonstrated broad non-compliance with international best-practice guidance. The ward achieved <50% compliance with each of the domain guidelines contained within the EHE tool. These results were further investigated using the BEAT-D tool which demonstrated that the ward environment audited performed below normative standards in comparison to both purpose-built and non-purpose built facilities in Australia. The ward environment presented an increased risk of falls complying with just 13 of 35 relevant falls prevention measures in the Queensland guidelines.

Conclusions: The results presented here are likely to be valid in any Irish acute hospital ward. It is clear from these audits that current environmental configuration is not optimised for the confused adult. The audit outcomes however suggest that there is potential for positive change in the physical and social environment of a typical acute ward in supporting the person with dementia.

Look Before You Scope: Outcomes of Colonoscopies in Older Adults Being Referred with Iron Deficiency Anaemia

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Background: Colonoscopy is a simple procedure that can be performed in patients of all ages. However, diagnosis can be technically challenging since not all patients are able to ingest the large quantities of laxative preparations required to cleanse the colon adequately. The British Society of Gastroenterology (BSG) guidelines recommend that gastrointestinal investigations should be considered in males and post-menopausal women presenting with iron deficiency anaemia (IDA) and IDA should be confirmed by a<sub>2</sub> low serum ferritin, red cell microcytosis or hypochromia in the absence of chronic disease or haemoglobinopathies<sup>4</sup>. Aspirin and NSAIDs use can account for up to 15% of IDA in older adults.

Methods: Retrospective review of case notes in all patients >65 years who underwent colonoscopy for IDA in 2015. We reviewed blood investigations pre endoscopy, procedure completion rates and outcomes.

Results: 268 patients (120 females and 148 males) were reviewed. Overall mean age was 76.4 (SD±7.7) years, with 40.2% of patients being anaemic on referral. 53 patients were on aspirin and tended to have lower admission haemoglobin. 115 (42.9%) had an inpatient colonoscopy and were significantly older (p < 0.05) compared to those undergoing outpatient colonoscopy: 75 (28.0%) of colonoscopies had subtotal preparation, requiring further investigations. 219 (81.7%) patients were completed. 10 (4.6%) patients had a colon carcinoma identified.

Conclusions: Colonoscopy can be poorly tolerated in older adults. Almost one third of patients had an suboptimal procedure performed and was more common in older adults.
patients, multiple co-morbidities and those being referred for an inpatient colonoscopy. There was a low incidence of colon carcinoma identified (4.6%) in those with completed colonoscopies. Better pre procedure screening strategies may obviate the need for colonoscopy in a significant proportion of patients.

DURBAN FRIENDLY HOSPITAL DESIGN: USING THEMATIC ANALYSIS TO IDENTIFY KEY ISSUES FOR PATIENTS, FAMILY MEMBERS AND STAFF IN TALLAGHT HOSPITAL

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Background: Hospitals are complex and confusing environments for people with dementia, adding to their distress and disorientation, undermining family and staff support, and impinging on health outcomes. To address these issues Tallaght Hospital and TrinityHaus are being funded by the Health Research Board to research hospital design regarding people with dementia and their families, and to use the findings for evidence based dementia friendly design guidelines for Irish hospitals. The study presented here outlines the stakeholder engagement process undertaken in Tallaght and presents the key themes emerging from the research.

Methods: Structured interviews were conducted with patients and family members, while questionnaires were circulated to 100 patients who attend the Age Related Health Care Clinic and the Charlie O’Toole Day Hospital. Patients comprised a mixture of older people with dementia or those with memory problems. Semi-structured interviews were also conducted with staff members across the hospital who interact daily with patients with dementia. Thematic analysis was used to synopsise the feedback into key themes, these were refined into codes, and these codes were used to draw out themes.

Results: 41 completed questionnaires were returned, 11 structured interviews with people with dementia and their carers and 12 staff interviews were conducted. Key themes emerged from this study including perception and understanding of the built environment, challenges around site design, internal spatial layout, orientation and wayfinding, patient movement, and participatory design.

Conclusions: By adopting a grounded theory approach, the multiple perspectives captured in this study, including most importantly people with dementia, ensures that stakeholder needs are at the centre of design. Staff awareness about the importance of the built environment is encouraging and should be seen as a driver of dementia-friendly design. Lastly, the influence of the built environment as it relates to health outcomes of persons with dementia cannot be understated.

EFFECT OF DENOSUMAB IN IMPROVING ORTHOSTATIC HYPOTENSION

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Background: Denosumab is widely used for the treatment of postmenopausal women with osteoporosis at increased risk for fracture. It is a fully human monoclonal antibody to the receptor activator of nuclear factor-kB ligand (RANKL) that blocks its binding to RANK, inhibiting the development and activity of osteoclast, decreasing bone resorption, and increasing bone density1.

RANKL leads to the activation of antiprotease kinase and nitric oxide synthase and to Nitric oxide (NO) production in endothelial cells. RANKL acts as a potent vasodilator2. This is a pilot observational study for further longitudinal work on an interesting area.

Methods: Data of 30 patients with head-up tilt (HUT) test prior to denosumab treatment at 3, 6 and 12 months were analysed. 8 were excluded due to incomplete participation.

Results: 16 patients had OH prior to treatment and only two were on midodrine. Drop in systolic blood pressure varied between 20 mmHg to 101 mmHg and diastolic drop between 10 mmHg to 34 mmHg prior to treatment.

Following denosumab treatment, 5 of 16 patients had completely resolved OH. Magnitude of the blood pressure drop improved in 8 patients, 3 patients had worsened OH. Among them 2 had Parkinson disease and one was on antihypertensive treatment.

Of 6 patients who did not have OH pre treatment, 5 developed OH, in which 3 were on antihypertensive medications. 2 of 5 patients who developed OH at 6 months had resolution of OH after 12 months of treatment.

Conclusions: HUT test results after a year of denosumab treatment showed improvement in OH. Deterioration of OH in several patients was probably due to underlying Parkinson disease and anti-hypertensive medications. Thus, improvement in OH is expected in patients on longstanding denosumab treatment.
nursing care associated with Stroke & Older patients. Students identified specific learning opportunities and were given a clear understanding of the expectations of them in the clinical environment. Further evaluation of the orientation programme is required post clinical placement to ascertain if the programme facilitated the application of theory to practice.

**Blood Pressure Control in Post Stroke Patients: A Cause for Concern?**

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**Background:** Hypertension is a recognised risk factor for stroke, the reduction in blood pressure (BP) in hypertensive patients is of benefit in primary and secondary prevention of stroke. The BP can rise post - stroke and there is debate as to when to initiate treatment. International Guidelines recommend a BP of less than 140/90 in non-diabetic and 130/80 in diabetic patients.

**Methods:** Retrospective case note audit of 48 stroke patients discharged. The demographics, history of hypertension pre-stroke, and co-morbid conditions for each patient was recorded on a standardised proforma. BP on admission, at 7 days post stroke and at discharge was recorded, together with any drug intervention initiated. At their follow up clinic, the BP was again recorded.

**Results:** 48 (25 males) patients, mean age of 77.8 (Range 65 – 99) years. 44 patients were independent (Pre-stroke Rankin 0 – 2). 15 patients had a history of angina; 7 were diabetic and 1 patient had evidence of LVH. Pre-stroke 23 / 27 (85%) patients were on treatment for hypertension.

Admission mean BP was 152 / 83.6 (7 patients with a Systolic BP > 180 mmHg). 7 days, mean BP was 140.3 / 76.1 mmHg (1 patient Systolic > 180 mmHg). Discharge, mean BP was 130.5 / 74.8 mmHg (1 patient Systolic > 180 mmHg). Clinico, mean BP was 147.6 / 78.9 mmHg (4 patients with a systolic BP > 180 mmHg) 14 (29.1%) of patients had additional BP lowering treatment initiated. 25% of patients required at least two drugs to achieve BP control.

**Conclusion:** Immediately post stroke, the BP will climb before falling. On discharge, the majority of stroke patients had a normal BP. Post-discharge there was a rise in the BP. Therefore this suggests that secondary and primary care services need a coordinated strategy for stroke secondary prevention.

**Profiling Family Carers of People with Dementia: Results from a National Survey**

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**Background:** The majority of care for people with dementia is provided by family carers, many of whom are adult children and spouses. Caring for a family member with dementia can be demanding, stressful and challenging and carers sometimes have negative effects on the carer. This paper presents findings from a national survey of family carers in receipt of a carer’s allowance for care they provide to an older relative with dementia.

**Methods:** An anonymous postal survey was conducted with 4,000 recipients of a carer’s allowance for care of an older person and a total of 2,311 completed questionnaires were returned (Lafferty et al. 2014). Secondary analysis was conducted on a sample subset of 185 family carers who provided care to a person with a diagnosis of dementia. The aim of the analysis was to profile dementia caregivers, including information on their health and wellbeing and caregiving activities, and also to develop profiles of the carer-recipient service.

**Results:** Findings show that carers’ age ranged from 20 to 92 years with a mean age of 57.7 (SD=13.3). The majority of family carers of people with dementia were female (72.6%), married (65.3%) and 15% were the adult children of the care recipient. This paper presents findings from a national survey of family carers in receipt of a carer’s allowance for care they provide to a person with dementia, carers experienced greater symptoms of depression and carer stress. Over half of dementia carers (51.3%) were at risk of developing clinical depression, while just under half (46.8%) reported experiencing moderate to severe or severe levels of carer burden.

**Conclusions:** This paper provides important information about family carers of people with dementia, which can be used to inform health and social policy in Ireland, and move towards meeting the needs of this particular subset of family carers.

**Systematic Review of Literature of Systems and Models to Address Hospital Readmission Avoidance and Delayed Discharge**

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**Background:** Prolonged hospital admission and readmission lead to increased risk of adverse healthcare outcomes. A diverse spectrum of strategies have been proposed across multiple settings to address these patient important outcomes. We conducted a systematic review to identify evidence-based systems and models addressing readmission avoidance and delayed discharge.

**Methods:** We searched MEDLINE, CINAHL, PsycINFO, Psychology and Behavioural Sciences Collection, Social Sciences and SocINDEX with Full Text, limited to English language papers published between 2005–2015. Two authors independently assessed studies for inclusion and extracted data. Selected studies were those that explicitly addressed interventions in acute general hospitals.

**Results:** In total, 85 eligible papers were identified: meta-review of meta-analyses (n = 1), systematic reviews with meta-analyses (n = 8), systematic reviews (n = 36), and RCTs (n = 46). A wide variety of interventions exist to address delayed discharge and readmissions. Interventions were classified as clinical/medical, pre-discharge, transitional care, post-discharge, primary care, assessment/ambulatory unit interventions, hospital at home, home-based interventions, tele-healthcare/electronic interventions, and residential care interventions. Educational interventions were the most common clinical/medical interventions but their effectiveness was limited. Transitional care interventions had a generally positive effect, particularly on delayed discharge but less so for older adults. Likewise, primary care, assessment/ambulatory unit and hospital at home/home-based strategies. Existing systematic reviews of pre and post-discharge, tele-healthcare/electronic and residential care interventions suggest that there is limited evidence that these significantly influence outcomes.

**Conclusion:** Mixed results were found regarding the effectiveness of many types of interventions, which were heterogeneous between studies. The most effective interventions to tackle delayed discharge and readmission avoidance were those involving integrated systems across the hospital and community, multidisciplinary service provision, individualisation of services and hospital initiated discharge and follow-up by specialists.

**An Exploration of Nurses Perception of Barriers to Mobilising Patients on a Geriatric Medicine/Stroke Ward and Strategies to Improve This**

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**Background:** Early mobilisation is key in preventing deconditioning and maintaining function in the hospitalised elderly (Covinsky 2003) and this is most effectively done in combination with physiotherapy and nursing (Cassell 2005). Older people in hospital have a 23.3% risk of being unable to return home due to loss of function and ability to carry out activities of daily living, even during a short period of hospitalisation (Covinsky 2003).

Our study aimed to explore the perceived barriers to patient mobility experienced by nursing staff and develop strategies for increasing mobility.

**Methods:** A questionnaire was developed to examine attitudes to mobility. Questions were completed anonymously by nursing staff. A series of focus groups were completed with nursing staff to further explore barriers to mobility and strategies to facilitate better practice. A training programme was established.

**Results:** A total of 27 questionnaires were distributed with a response rate of 81% (n = 22). 68% reported difficulty motivating patients to mobilise. 58% felt not enough training was provided by physiotherapy. 65% perceived risk of patient injury and 78% perceived risk of injury to staff. The main outcome from focus groups was that staff felt patients’ mobility was not accurately handed over and that yearly training would be beneficial.

**Conclusions:** Upon identification of barriers to mobility, steps have been undertaken to address this. This could potentially lead to better outcomes from regular mobilisation.

The greatest perceived barriers to mobility are risk of injury to patients/staff and motivating patients to mobilise. Focus groups with physiotherapy, nursing staff and ward management have explored ways of addressing this issue. A programme has been developed by physiotherapy to provide optimal staff training, with plans to receive feedback from staff on completion of training. Work is in progress to develop a system for clear handover of patients’ mobility at ward level.
Background: Falls and fear of falling seriously reduce the quality of life of older people. Established evidence suggests that multifactorial assessment and tailored individual inter-
ventions are the most effective way to reduce falls among older people in the community. However, there are often many barriers to the implementation of evidence-based practice in healthcare. One of the recognised barriers to quality of healthcare is a lack of timely access to assessment and intervention. The aim of our project was to reduce the waiting time for patients attending our complex falls and blackout clinic from three months to two weeks.

Methods: We used a quality improvement methodology to define, analyse and improve our structure within and supporting the falls clinic. We used six principles for improving access: understanding the balance between supply and demand, re-calibrating the system, applying queuing theory, creating contingency plans, influencing the demand, and managing the constraints. We defined the baseline processes and optimised them on the basis of analysis.

Results: Over a period of 18 months we successfully reduced the waiting times for appointments from over three months to two weeks. This was achieved by developing a greater understanding between demand and supply and then changing processes and structures. An overall point of referral was established, a single point of contact was created, forming a multidisciplinary triage meeting, defining individual patient requirements and eliminating the consultant as a gate-keeper of other services we were able to create more appointment slots and eliminated the backlog of appointments. With greater engagement with referrers, the appropriate patients now get to the appropriate part of the service quicker.

Conclusions: Examining clinic processes and creating new structures can improve patient access without additional resources. We are now seeing more patients and seeing them quicker in our specialist falls services.

Background: The National Strategy for the Prevention of Falls and Fractures in Ireland (2008) set out a vision for a future free of falls and fractures for Ireland’s ageing popula-
tion. In keeping with this strategy, our region had a goal of implementing an integrated falls and fracture prevention project. The project has three main work streams: building community capacity for falls risk assessment; re-engineering specialist falls ser-
dices to improve access; and standardising continuing care assessments and prevention strategies. In this paper, we report on the change management involved in this complex integrated project.

Methods: Since 2012, a clinician group has worked with local management in our region to improve falls services. In 2015, funding was received to appoint a falls development post, an administrator, and a rehabilitation assistant to support the community care ele-
ments of the project. Separate funding was received for development of the continuing care component of the project. In general, the success of most projects is related to people factors. Therefore, in this wide-ranging project, a structured change management approach was taken including influence mapping, stakeholder management and commu-
nication plans.

Results: All stakeholders were classified according to their influence and support for the project. A communication plan for all stakeholders was devised. Key elements of our change management strategy were having senior management sponsorship, involving key influencers early in the process; providing sufficient training for the community teams; and involving appropriate personnel on the steering group. Internal champions were identified in each of the continuing care sites. There was continuous learning within the project, changing approaches to problems in subse-
quent community clinics set-up.

Conclusions: Health care systems are a complex collection of interacting elements. People are central to healthcare delivery and change. Successful projects must win the hearts as well as the minds for staff.
exercise, and recreational activity or standard medical treatment (control). Participants were followed for an average of 7.6 months.

**Results:** The mean age of participants was 69.4 years with 78% male, 18 patients were lost to follow-up. Experimental and control participants were matched for gender, education, occupation, living status, marital status, and severity of dementia. Using an intention to treat analysis the intervention group showed improvement in the primary outcome factor Geriatric Depression Scale (14.88±5.44 to 13.38±4.12; 95% CI (9.3, 2.6); Bristol Activities of Daily Living scale (23.14±6.19 to 17.56±4.78; 95% CI (3.8, 7.2); Modified Physical Performance Test (17.02±5.17 to 19.6±3.70; 95% CI (3.8, 7.2). Significant improvements were also noted in MMSE, BEHAVE-AD and the physical, psychological and environmental domain of WHOOQOL-BREF (p = 0.001).

**Conclusion:** This novel occupational therapy programme improves physical performance, functionality, mood, cognition, behavioural status, and quality of life in mild to moderate dementia patients at short term. A follow up study on a larger sample is required to ascertain the long term effect.

**References:**

**169 OPERATIONALISING ROUTINE DELIRIUM SCREENING WITH THE 4AT FOR OLDER PATIENTS ATTENDING AN AMAU**

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**Background:** Delirium is frequently associated with adverse outcomes, including prolonged inpatient stay, increased mortality, functional decline and increased need for residential care. Despite these outcomes recurrent studies have demonstrated challenges to delirium identification, thus limiting essential early intervention. The objective of this study was to incorporate and evaluate delirium screening on admission to an Acute Medical Assessment Unit (AMAU) and review its documentation and follow up on discharge.

**Methods:** Consecutive patients aged ≥65 presenting to the AMAU were prospectively screened from 15/2/16 to 08/05/16. Delirium screening was performed using the 4AT. The 4AT was integrated into the Symphony® electronic patient record, as a necessary step in the admission/discharge of all older patients. Discharge letters were evaluated in those scoring either 1-3 or ≥4 on the 4AT to assess documentation and follow up of acute delirium/possible delirium.

**Results:** 211 people aged ≥65 attended the AMAU during the allocated time. 19/211 (9%) scored ≥4 indicating likely delirium, 34/211 (16.1%) scored 1-3 suggesting possible delirium or cognitive impairment. Two patients in each category remained in hospital at the time of data collection and were omitted. 52.9% (≥4) and 18.8% (1-3) had known premorbid dementia. New diagnoses of dementia were made in 6.1% (3/49) all scoring 1-3. Delirium was documented on discharge in 47.1% (9/17) in 24 and 31.6% (1/32) in 1-3 and its management specified in 62.5% (5/8) in 24 and 100% (1/1) in 1-3. On discharge, formal cognitive assessments were documented in 6.3% (2/32) of 1-3, although 34.4% (11/32) of this group and 29.4% (5/17) ≥4 were referred for further evaluation of cognition on discharge.

**Conclusion:** Incorporating the 4AT as part of the AMAU admission pathway is feasible, and useful to support identification of delirium in older patients, thus allowing for timely management. Future strategies will focus on improving discharge documentation.

**170 A REVIEW OF ORTHOGERIATRIC ADMISSIONS TO AN ACUTE ORTHOPAEDIC UNIT**

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**Background:** There is limited literature describing non hip fracture orthogeriatric patients. Our aim was to study older patients admitted under the orthopaedic service to review the demographics, medical and functional problems of hip fracture and non hip fracture patients.

**Methods:** Data was collected on all patients over 65 years of age admitted to the orthopaedic department between 1st February and 30th of April 2016.

**Results:** 242 older patients were admitted acutely: 109 (45%) had a hip fracture and 133 (55%) a non hip fracture admission. The median age was 84 years (range 65-101) for hip fracture patients and 72.5 (range 65-94) for non hip fracture patients. The mean Barthel index was 14.6 (range 0-20) for hip fracture patients, 18 for non hip fracture patients. The mean Abbreviated Mental test score (AMTS) was 5 in hip fracture patients, 9 in non hip fracture patients. 27 (25%) of hip fracture patients and 2 (1.5%) of non hip fracture patients were admitted from a nursing home. 57 (52%) of the hip fracture and 35 (26%) of the non hip fracture patients transferred to an offsite rehabilitation unit. There was an inpatient mortality rate of 5 (4.6%) for hip fracture patients and 1 (0.8%) for non hip fracture patients.

The commonest non hip fracture admissions included: fractured radius and/or ulna (26%), joint or wound infection n = 12 (9%), dislocated hip and/or hip revision surgery n = 17 (13%), fractured ankle n = 16 (12%), fractured humerus n = 13 (10%), femur (non-hip) n = 14 (10.5%), spinal trauma n = 4 (3%), riba and/or fibula fracture n = 7 (5%), quadrieps rupture n = 5 (3.5%), pelvic fracture n = 2 (1.5%) and other n = 9 (6.7%).

**Conclusion:** This study demonstrates the diversity of orthogeriatric admissions. Over 50% of patients are non hip fracture admissions, who in general are less dependent than hip fracture patients. Nevertheless, many still require geriatric expertise.

**171 THE STUDY HIGHLIGHTING THE INCONSISTENCIES IN TRAINING AND EDUCATION OF STOOL ASSESSMENT (SHITESA) REVISITED**

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**Background:** The Bristol Stool Chart (BSC) is increasingly used to document bowel habit in hospitals. Current best practice guidelines state that three type 6 stool samples within three hours should warrant a stool sample being taken, and the patient should be considered for isolation pending microbiology results. The SHITESA study in Leicester found that there is a distinct lack of education regarding stool typing and quantifying. This observational study aims to replicate the original SHITESA study.

**Methods:** The SHITESA group produced a Type 5, + (moderate size) stool model according to the BSC description “soft blobs with clear cut edges” which was graded by a panel of experts. A photograph of this ‘stool’ was shown to clinical staff members. Participants were asked to identify the type (Bristol 1-7) and amount (small, moderate or large volume) of stool. They were also asked whether or not they would isolate the patient.

**Results:** 100 responses were included - 32 doctors, 44 nurses, 8 Health Care Assistants and 16 Other Allied Health Professionals. The stool was most commonly identified as type 5 (55%) and moderate size (64%). 25% of responders felt that isolation would be appropriate. Only 36% of responses matched the panel’s grading of the sample, 19% of these responses were from nurses. Nursing staff correctly answered all three questions in 43.2% of cases and Doctors only correctly answered in 34.4% of cases.

**Conclusion:** Similar to the SHITESA study in Leicester, our study demonstrated a distinct lack of education regarding stool education on the basis of typing and quantifying. One quarter of responders would have inappropriately isolated a patient. Inappropriate isolation would have a significant impact on frail, older patients and would burden the hospital financially and logistically. Our study shows that more standardised teaching around bowel habit and stool type is needed.

**172 A LOVE OF WATER, OR HOW TO DROWN ON DRY LAND**

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**Background:** Hyponatraemia is a common finding in the elderly and associated with higher morbidity and mortality. It can be an indicator of an unwell adult and is often multi-factorial. A meticulous approach to investigation is needed to fully elucidate any underlying cause or causes.

**Case Study:** An 83 year old lady presented to our emergency department after a fall. She had a background of hypertension, type 2 diabetes and oesophageal varices. On admission serum sodium was 112 mmol/L. She was assessed as hypoaldesine which was attributed to diuretic use and self reported diarrhoea. The diuretic was held and slow IV fluid replacement commenced over 5 weeks.

**Findings:** An 83 year old lady presented to our emergency department after a fall. She had a background of hypertension, type 2 diabetes and oesophageal varices. On admission serum sodium was 112 mmol/L. She was assessed as hypoaldesine which was attributed to diuretic use and self reported diarrhoea. The diuretic was held and slow IV fluid replacement commenced over 5 weeks.

**Discussion:** Further investigation revealed a serum osmolality of 250 mmol/L, urine osmolality of 138 mmol/L and urine sodium <20 mmol/L. She was noted to be producing large volumes of urine and no diuretics were noted. Serum fluid restriction <1 L/day was initiated. Despite apparent fluid restriction sodium continued to decline to 113 mmol/L. A urinary catheter was inserted to monitor urine output. She produced copious amounts of dilute urine with >2 L/day recorded. Chart review revealed an admission 2 years previously with a fall where sodium was 117 mmol/L. This had resolved with diuretic use and self reported diarrhoea. The diuretic was held and slow IV fluid restriction. On questioning the patient admitted to drinking excessive amounts of fluid despite fluid restriction even drinking out of the taps in the bathroom. A diagnosis of psychogenic polydipsia was made and sodium normalised with strict fluid restriction. She continued to demonstrate water seeking behaviour during the course of her admission. Psychiary for old age input was sought and she and her family were educated regarding the risks associated with her behaviour before discharge.

**Conclusion:** Hyponatraemia is an important prognostic indicator in the elderly, and this case demonstrates an unusual but important cause to consider.ii36
THE USE OF PROTON PUMP INHIBITORS AMONG INTELLECTUALLY DISABLED OLDER PEOPLE: AN OBSERVATIONAL STUDY

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Background: Proton pump inhibitor (PPI) use among older people is common. However information about PPI use in older people with ID is sparse and limited despite a high rate of gastrointestinal conditions such as Gastroesophageal reflux disease (GORD).

Objective: To investigate the pattern of PPI use among older people with intellectual disability.

Method: Data on PPI use and gender, place of residence, level of ID and age was analysed from TILDA-ID, Wave two. The sample consisted of 677 participants aged 40 years and above. Descriptive statistics and bivariate analyses were carried out.

Results: Just over a quarter, 27.3% (n = 185), of participants reported use of PPI, and 54% (n = 100) were female. The largest proportion of PPI users (58%) were aged between 50-64 yrs. Most of the PPIs were used in medium doses (70%). However only in cases of was 38% an indication reported (Peptic Ulcer or GORD) or an NSAID used concomitantly. Use among those in residential care homes (55.5%) was much higher than for those living independently or with family (9%). PPI use among those who have severe/profound ID level was 12% higher than those with moderate ID level. Information about the length of PPI use was missing for 30% but of those with data, just over half recorded using the PPI for more than a year. Omeprazole was the second most frequently used agent after Lansoprazole, although it has several potential drug interactions of relevance to this group.

Conclusion: PPI use among older people with intellectual disability is prevalent and frequently long term, often without a clear indication. PPI use needs to be assessed frequently, especially among those with severe/profound ID and those who live in residential care homes, in order to avoid inappropriate long term of use that could predispose them to additional comorbidities.

TRANSLATING NEW TECHNOLOGY INTO CLINICAL PRACTICE: SHOULD A DIRECT MEASURE OF CEREBRAL PERFUSION BE USED IN SYCONE AND FALLS ASSESSMENT?

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Background: Orthostatic hypotension (OH) when combined with symptoms on standing and a positive history of falls or syncope is thought to indicate risk of impaired cerebral perfusion. However age and cognitive impairment are known to reduce the perception of orthostatic symptoms and recall of syncopal and falls events, potentially affecting the validity of this approach. Here we examine if OH combined with self-reported orthostatic symptoms and a positive syncope or falls history is a marker of cerebral hyperperfusion.

Methods: A self-selected sample of N=80 older adults (age 87 (6.1) years; 73.5% female) were recruited from a nursing home population living in Ontario, Canada. All participants underwent an active stand (AS). Orthostatic symptoms were quantified using an 8-point orthostatic symptoms scale. Beat-to-beat blood pressure (mmHg) was recorded throughout using a calibrated volume clamp method, while near-infra red spectroscopy (NIRS) measured relative changes in regional cerebral tissue oxygen saturation ([rSO2] - %), oxyhemoglobin ([rO2Hb] - μmol/L) and deoxyhemoglobin ([rHb] - μmol/L) concentration.

Results: 9.3% reported a positive falls history, with 6.4% having sustained OH at up to 3 minutes after standing. 51.3% reported one or more orthostatic symptoms. After adjusted multivariate analyses (SPSS, V22) orthostatic symptoms were not associated with relative changes in [rSO2], [rO2Hb] or [rHb], while the presence of OH at 40 seconds after standing was associated with a decrease in [rSO2] (B = -4.562, P = 0.011) and decrease in [rO2Hb] (B = -1.88, P = 0.017).

Conclusion: Combining OH and self reported symptoms and a falls/syncope history did not strengthen these associations. Postural symptoms are an unreliable marker of cerebral perfusion in older adults, while orthostatic BP changes are a better, yet still limited surrogate marker of cerebral hyperperfusion. A direct measure of cerebral perfusion should be considered to assess cerebral hyperperfusion and will likely play an emerging role in syncope and falls risk.

OUTPATIENT SERVICES IN GALWAY - A SURVEY OF OLDER PEOPLE'S EXPERIENCES BY AGE ACTION GALWAY GLOR GROUP

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Background: In July 2014, Age Action held a meeting of its members in Galway at which the Galway Glor group was formed. The group has been meeting at least once a month since September 2014. The experience of older people accessing outpatient services was raised a number of times by the group. In order to present a comprehensive account of this experience, the group decided to conduct a survey of older people in Galway.

METHODS: Age Action’s policy team oversaw the development of the survey, with the group’s members deciding on the format and questions to be included. Online and printed copies of the survey were developed. In order to increase the response rate to the survey, members of the Glor group visited community groups around the county to encourage older people to complete the survey.

RESULTS: Many of the findings revealed older people had a positive experience of outpatient services, however, the continuing practice of hospitals block-booking appointments was problematic. Respondents reported that this practice often meant they were left waiting to see their doctor.

DISCUSSION: Following the publication of the survey findings, members of the Galway Glor group met with a key stakeholders to highlight the issue of block booking appointments and its impact on older people attending outpatient services.

ANALYSIS OF DELAYED DISCHARGE DATA AND THE IMPACT OF EXTERNAL ISSUES IN A LARGE URBAN ADULT HOSPITAL

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Background: The increasing recognition of the impact of delays in discharge from acute hospitals has led to a rise in the examination of processes and systems for supporting older persons following an admission to an acute hospital. The growth in the population over 65 and the corresponding requirement for increased supports both in primary and residential care has created extra financial demands on the health service. Funding allocations within the primary and social care divisions have a direct impact on the services available to older persons within the acute sector.

METHODS: An analysis of trends in delayed discharges being reported to the Health Service Executive Business Intelligence Unit from 2013 to 2016 was mapped against external factors to examine any causal links and the impact of these on the number of patients awaiting discharge from the acute hospital setting.

RESULTS: A direct correlation was found between external factors such as seasonal demands, funding allocations and withdrawals and availability of nursing home places within the catchment area of a large urban adult hospital.

CONCLUSIONS: Although internal process factors are essential to the flow of older patients within the acute hospital, external factors are equally influential and consistent engagement with primary and social care partners both at local and national level are key to optimising appropriate care for older patients and facilitating the best use of acute hospital beds.
**TIME TO REHAB: A ONE YEAR RETROSPECTIVE AUDIT OF A MEDICINE FOR ELDERLY REHABILITATION SERVICE**

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**Background:** St. Mary’s Hospital has a 22-bed specialised ward offering post-acute rehabilitation care to frail older adults. The skilled multidisciplinary team aim to optimise independence and aim for a timely discharge. The aim of this audit was to assess the rehabilitation service discharge outcomes over a 13-month period.

**Method:** A retrospective audit of all consecutive admissions from December 2014 to December 2015 was carried out.

**Results:** 156 patients were included in the audit. 90/156 (57.7%) were females. Median age was 84 years (59–102 years). Median Adenbrook’s Cognitive Examination – III was 65/100 (range 29–95). Median length of stay was 35 days (1–250 days). Main outcome measure used was Berg Balance Scale of which 111/124 (89.5%) showed a detectable improvement in mobility, 112/124 (89%) showed no changes while 2/124 (1.6%) showed a decline. 132/156 (83.4%) were discharged home (120/132 directly to their homes, 6/132 to a sheltered accommodation and 6/132 via transitional care). 14/156 (8.9%) were transferred back to the acute hospital, 7/156 (4.5%) were discharged to a nursing home and 6/156 (3.2%) died.

**Conclusion:** The audit shows the majority of patients achieve a successful discharge home in a time frame suggested as appropriate by the National Clinical Program for Older People.

**Reference:**

**RETURNED MEDICATION: AN OPPORTUNITY FOR ENHANCED MEDICINES REVIEW IN AN EXTENDED CARE SETTING**

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**Background:** An individual resident dispensing system is in place for four wards in an extended care unit. Excess/unused medicines are returned to the pharmacy department at the end of each month. The purpose of this study was to analyse the medicines returned to identify possible issues with their administration and to facilitate medicines review.

**Methods:** Records of returned medicines were retained in the pharmacy department. Details of items returned in 2015 were collated and reviewed. Pharmacists reviewed resident’s prescription charts to seek possible explanations for non-administration of medicines. In the absence of documented explanations, pharmacists worked with nursing staff to identify possible explanations. Nursing, medical and pharmacy staff collaborated to address any medicines management problems identified.

**Results:** In 2015, returned medicines constituted 4.5% (336/7024) of total medicines dispensed. Pharmacist review of resident’s prescription charts identified an explanation for 49% (164/336) of returns, accompanied by appropriate documentation of non-administration. In the remaining 51% (172/336) of returns full explanation could not be found and follow-up with nursing staff was necessary. Problems were identified with administration of medicines, resident adherence and documentation inaccuracies when medicines were not taken. An explanation could not be identified in 14.5% (48/336) of instances, which indicates the potential for undetected administration errors.

Of the total returns, 37% (124/336) were deemed sufficiently significant to warrant follow-up with medical staff, as they had the potential to impact on the resident’s care and future prescribing.

**Conclusion:** Analysis of medicines returned offers a unique insight into medicine use and provides an opportunity for collaborative working between medical, nursing and pharmacy staff to improve medicines management. These findings identify issues in relation to medication adherence and documentation of administration in the extended nursing care setting. Further investigation, focusing on the results of medicines review and impact on patient care is recommended.

**USE OF THE DRUG BURDEN INDEX IN OLDER ADULTS WITH INTELLECTUAL DISABILITIES**

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**Background:** The Drugs Burden Index (DBI) evaluates medications with anticholinergic and sedative effects and has been associated with poorer physical and cognitive function in community-dwelling older people (1). The study aims to examine the cumulative drug burden for older people with an intellectual disability (ID) and identify the association between DBI scores and clinical/demographic characteristics.

**Methods:** Data from Wave 2 of the Intellectual Disability Supplement to the Irish Longitudinal Study on Ageing (IDS-TILDA) were analysed. An inventory of medications was compiled and the DBI score for each individual was calculated and analysed.

**Results:** 177 (95.6%) participants had medication data available for analysis. 131 medications with anticholinergic and/or sedative effects were reported in the dataset. 78.6% of participants were exposed to a DBI medication. Mean DBI score was 1.3 (SD 1.2). There was an age gradient which was not statistically significant associated with a higher DBI score, with 63.3% of those over 65 years having a DBI score of 1 or higher (p = 0.206). Almost two-thirds (63.4%) of those in residential care and 73.9% of those with epilepsy had a DBI score of ≥1.

**Conclusion:** The DBI scores for this group were much higher than for studies of the general elderly population. Further work is needed to assess whether these scores are associated with poor health status. In particular, those ≥65 years, in residential care and with epilepsy had higher DBI scores and would benefit from review of medications to reduce their drug burden.

**Reference:**

**TRANSLATING EPIDEMIOLOGICAL RESEARCH INTO CLINICAL PRACTICE: EVALUATION OF NEW TOOLS FOR AUTONOMIC ASSESSMENT IN A CLINICAL ENVIRONMENT**

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**Background:** We recently proposed a clinical definition of impaired orthostatic blood pressure stabilisation (OH4/0) which is associated with incident falls. In developing this, a software tool for rapid quality assessment and feature extraction of phasic BP records was developed. As a step towards translating this work into clinical practice we applied these tools to audit the quality of records and the prevalence of OH/4(0) in a clinical cohort.

**Methods:** Active stand (AS) records from consecutive patients attending St. Mary’s Hospital, Dublin were obtained. Using the newly developed tool we assessed the quality of each record for: 1) data integrity and suitability for analysis; 2) protocol compliance; 3) presence of significant artifacts. Systolic BP(SBP) and diastolic BP(DBP) and heart rate (HR) responses to standing were extracted. The prevalence of OH/4(0), defined as a drop in SBP of ≥20 mmHg and/or drop in DBP of ≥10 mmHg at 40 seconds after standing was then assessed.

**Results:** N=97 patients records were obtained. The following issues with initial data integrity and protocol compliance checks were flagged: Height correction issue = 29.8% (29/97); rest period being too short 19.6% (n = 19/97); period being too short 30.0% (n = 30/97); baseline period being too short 1% (n = 1/97). Physical calibration issues 7.2% (n = 7/97). Six percent (n = 6/97); baseline period being too short 19.6% (n = 19/97); rest period being too short 1% (n = 1/97); Physiocal calibration issue 29.8% (29/97); rest period being too short 1% (n = 1/97); Physiocal calibration issue 29.8% (29/97); rest period being too short 1% (n = 1/97); Physiocal calibration issue 29.8% (29/97); rest period being too short 1% (n = 1/97); Physiocal calibration issue 29.8% (29/97); rest period being too short 1% (n = 1/97); Physiocal calibration issue 29.8% (29/97); rest period being too short 1% (n = 1/97); Physiocal calibration issue 29.8% (29/97); rest period being too short 1% (n = 1/97); Physiocal calibration issue 29.8% (29/97); rest period being too short 1% (n = 1/97); Physiocal calibration issue 29.8% (29/97); rest period being too short 1% (n = 1/97);

**Conclusion:** Automated phasic BP analysis tools support rapid quality assessment and analysis of AS records. Steps to improve protocol compliance and data quality during clinical AS assessment should be considered. Impaired blood pressure stabilisation is present in over one third of frailger patients and a significant future challenge for global health.

**AN EXPLORATORY STUDY OF SLEEP QUALITY IN OLDER ADULTS IN IRELAND**

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**Background:** There is increasing interest in the implications of sleep problems on health and cognition. Little is known about the sleep quality of older adults in Ireland. This study examined the prevalence of sleep problems in a nationally representative cohort of older adults living in Ireland.

**Methods:** Self-reported sleep duration and disturbances data from wave 2 of The Irish Longitudinal Study on Ageing (TILDA) was used for this study. Short was defined as ≤5 hours and long sleep duration as ≥9 hours. A sleep disturbance score was calculated from the sum of responses to questions about daytime dozing, trouble falling asleep and waking up too early. Scores ranged from 0–7, with scores of ≥4 categorised as disturbed sleep.

**Results:**
Results: Analysis included 7,202 participants (mean age 64.4 years, range 50-97). 13.0% reported short sleep, 9.4% reported long sleep. Mean score for sleep disturbances was 2.2, 21.7% of participants had disturbed sleep.

Short sleep (males: 14.3% vs females: 11.6%, p < 0.01) and disturbed sleep (23.1% vs 20.3%, p = 0.05) were more common in females than males. Long sleep was slightly more prevalent in (29.5% vs 30.7%, p = 0.22).

There was a strong age gradient: 6.2% of those aged 50-64 reported long sleep compared to 17.2% of those aged ≥75. Prevalence of disturbed sleep increased from 19.0% to 27.7%. Short sleep increased slightly from 12.3% to 13.4%. 31.6% of respondents who rated their health as poor reported short sleep, 44.7% reported disturbed sleep and 11.3% reported long sleep. Of those with a limiting disability, 20.5% reported short sleep, 33.4% reported disturbed sleep while 10.4% reported long sleep.

Conclusions: Short, long and disturbed sleep are common in the older population, increasingly prevalent at older ages and more common in those with poor self-reported health. Further research is needed to understand the impact of abnormal sleep patterns.

AN INVESTIGATION OF THE RELATIONSHIP BETWEEN SLEEP DURATION AND COGNITIVE FUNCTION IN OLDER ADULTS

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Background: Ageing is associated with changes in sleep duration. Previous research has shown sleep disturbances may contribute to the complexity of age-related cognitive decline, however, findings have been inconsistent. This study explored the relationship between sleep duration and cognitive function in older adults.

Methods: Data were from wave 2 of The Irish Longitudinal Study on Ageing (TILDA). Sleep-reported duration was defined as short (<55) hours, normal (6-8) hours or long (>9) hours. Multiple linear regression was used to assess the relationship between sleep duration and measures of global cognition from the Mini-Mental State Examination (MMSE), verbal fluency and immediate and delayed recall. Analyses incorporated known confounders including demographics, medications, depression and Body Mass Index.

Results: Analysis included 7,202 participants aged (mean age 64.4 years; range 50-97). 13.0% reported short sleep, 9.4% reported long sleep. After adjustment for all confounders, long sleep was associated with lower MMSE scores compared to normal sleep (β = −0.45; 95% CI = −0.60, p < 0.001). Long sleep was also associated with poorer verbal fluency (β = 7−1.04; 95% CI = 1.51, −0.56, p < 0.001), immediate recall (β = −0.21; 95% CI = −0.33, −0.10, p < 0.001) and delayed recall (β = −0.62; 95% CI = −0.61, −0.23, p < 0.001). Short sleep was only associated with lower MMSE (β = −0.16; 95% CI = −0.30, −0.03, p < 0.001) scores.

Conclusions: Long sleep is associated with lower cognitive function across all measures. Short sleep only showed an association with lower MMSE scores. This study highlights a relationship between sleep duration and cognitive function in this population and supports previous research suggesting long sleep has a stronger relationship to cognitive function than short sleep. Future work using longitudinal analyses will help to reveal the causal direction of this relationship.

AUDIT OF DIABETES MANAGEMENT IN A COMMUNITY NURSING UNIT

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Background: Diabetes mellitus (DM) is common with an increasing prevalence in our expanding older population. An individualised treatment approach is necessary in older people in order to prevent complications and avoid hypoglycaemia. The International Diabetes Federation 2013 guidelines for older people highlight specific targets for those who are dependent (frail or have dementia), or at the end of their lives. HbA1c range of 53–70 mmol/l is suggested for these groups. Our aim was to determine the prevalence of DM and the level of glycaemic control in a community nursing unit (CNU), which has 182 residents and a Geriatrician-led medical team.

Methods: We carried out a cross sectional audit of medical and nursing notes of CNU residents with a known diagnosis of DM.

Results: The prevalence of DM was 17.6% (32/182). 31 patients were included (1 was excluded as he was newly admitted). 65% were female. Mean age was 85 ± 7.6 years, 90% (29/31) had a diagnosis of dementia with mean MMSE of 14.5 ± 9.2. The majority of patients had high dependency levels with mean Barthel index of 5.2/20 ± 5.1.

19.5%(6/31) were on insulin, 45%(14/31) on oral hypoglycaemic agents (OHAs) and 35.5%(11/31) on diet alone.

74% (23/31) of patients had HbA1c measured within the last 12 months with mean of 52.9 ± 12mmol/mol.

39% had HbA1c within 53–70mmol/mol range, but 56% (13/23) had HbA1c <53 mmol/mol.

HOSPITAL FOOD – AN EVALUATION OF PATIENT SATISFACTION WITH LUNCHTIME MEAL AND AUDIT OF COMPLIANCE WITH STANDARDS

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Background: Whilst some patients can have positive experience of hospital, more negative appraisals of hospital inpatient experiences predominate (HSE Quality Improvement Division & Age Friendly Ireland, 2015). Public perception of Hospital food is generally negative. Patients are at risk of under-nutrition and weight-loss during their hospital stay (Dept. of Health & Children, 2009) impacting their wellness and recovery.

Method: St. Columcille's Nutrition Steering Committee established in 2010 introduced a Quality Improvement Plan to address the quality and safety of the food served as well as the mealtime experience of patients. These included: On-site preparation of Modified Consistency Diets (MCDs) and Food Moulding for Pureed Diets; Increasing Nutritional Value of meals; Annual MDT training and education sessions in nutrition and dysphagia; Meal Feedback Form; Protected Meal Times and Red Tray Protocol to identify those requiring mealtime assistance.

Audit and evaluation of patient satisfaction; compliance of lunchtime meal for Texture & Temperature and Provision of mealtime supports was conducted based on the descriptors of the Irish Nutrition & Dietetic Institute / Irish Association of Speech and Language Therapists, Food Hygiene Standards and National Standards for Care In Hospital Audit Tool 2009. Patients on three wards (N = 73) were observed during lunchtime meal and a dichotomous pass/fail grading scale was employed as well as recording patient's direct verbal feedback on satisfaction with the meal.

Results: In January 2016, 94% patients were satisfied with the lunchtime meal and 84% were consuming >90% of meal. Compliance with standards for all diets was 97% compared with 66% in 2010. Compliance with provision of mealtime supports was 98.4%.

Conclusions: Driving constant improvement in food preparation and mealtime supports yields high patient satisfaction ratings with lunchtime meal and significantly improved compliance with quality standards. Further exploration of factors impacting meal consumption including timing of the lunchtime is planned.
THE IMPLEMENTATION OF MEMORY BOXES TO IMPROVE STAFF KNOWLEDGE OF ELDERLY RESIDENTS WITH DEMENTIA IN A LONG-TERM CARE FACILITY

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Background: One of the core values of nursing the older person is “knowing the person” and using this knowledge to work in collaboration with the resident and their family to provide high quality nursing care. The aim of the research was to implement memory boxes on a 32 bedded unit caring for residents with mild to moderate dementia to improve staff knowledge, therefore enhancing person-centred care. Memory boxes are a format of recording an individual’s life story, known as life story work. They are created to store photographs and personal memorabilia that have meaning for the individual.

Method: Memory boxes were implemented through a co-operative inquiry, an action research methodology. The experience of the staff and clinical nurse managers was explored on the effectiveness of the memory boxes in improving staff knowledge. Focus groups and semi-structured interviews were undertaken. Transcripts were subject to conventional content analysis to ascertain the findings.

Result: The emerging themes from the transcripts indicated that memory boxes have the potential to: improve staff knowledge of the resident, enable the staff to see the person behind the dementia, improve communication and staff interaction, improve resident self-esteem and modify behaviours.

Conclusion: Memory boxes as a format for life story work have the potential to improve person-centred care for residents with dementia. The implementation of memory boxes could act as a guide for other long term care facilities to improve practice through the delivery of care that is resident focussed.

OUTCOMES FROM AN OFFSITE POST-ACUTE CARE SERVICE GOVERNED BY AN ACUTE TEACHING HOSPITAL

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Background: The acute hospital setting is increasingly appreciated as a suboptimal environment for long-term care (LTC) decision making, assessment and processing. The reasons for this include the constant pressures on the bed capacity, time constraints on care assessments and the need for individuals to fully recuperate from an acute illness. In 2011, an acute hospital developed an off-site post-acute care service with an embedded physiotherapy and occupational therapy team. The service aims for patients admitted to the acute hospital to benefit from a high quality patient centred care, rapid access to services, continuity, maintaining health & patient independence & reducing health costs.

Aims and Objective: To assess outcomes for patients admitted to the Rapid Access Centre (RAC) for admission in the first quarter of 2016.

Methods: We compared two sets of data which looked at hospital admissions before and after the RAC was established. Each set of data was collected over a 7 month period and included basic demographics, length of stay (LOS) and diagnosis. Data from a total of 441 patients was collected of which 346 patients were admitted to hospital via the traditional A&E route and 95 patients were admitted to the RAC.

Results: The average age of our patients from A&E and the RAC were 73 years old and 75 years old respectively. The data from the RAC patients showed that 56 patients (59%) were admitted to the ward and 39 patients (41%) being discharged. The average LOS of patients admitted by A&E was 5.6 days and those patients assessed for admission in RAC was 4.1 days. Comparison between LOS for individual diagnosis also showed on average patients from RAC had shorter length of stay than patients admitted to the wards by A&E.

Conclusion: We found that patients admitted via the RAC had shorter duration of stay than patients who had been referred directly from A&E. On average patients admitted through the RAC were discharged 1.5 days earlier than those who were direct admissions from A&E. Furthermore the RAC prevented further admission by discharging 41% patients via this Unit.

DO-NOT-ATTEMPT-RESUSCITATION (DNAR): THE IMPORTANCE OF PHYSICIAN AND NURSE UNDERSTANDING OF DNAR ORDERS IN A UNIVERSITY HOSPITAL AND ITS COMMUNITY

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Background: Following the introduction of DNAR orders in the 1970’s, there was wide-spread misinterpretation of the term amongst healthcare professionals. Objectives: To examine current understanding of the term DNAR, decision-making surrounding DNAR, awareness of success rates of cardiopulmonary resuscitation, current DNAR guidelines and advance care directives.

Methods: A questionnaire was distributed to doctors and nurses in an urban university teaching hospital and affiliated primary care physicians electronically via email and by hard-copy at medical, surgical, nursing and primary care educational meetings. A total of 519 completed the survey. The response rate in the hospital doctors group was 35.5% (187/527), 19.8% (292/1477) in the nurses group but 68.8% (150/218) in the specialist nurses group, and 40% (40/100) in the primary care physician group.

Results: In the setting of a DNAR order, 15.4% believed that the patient could not receive any or at least one of the less invasive treatment options including antibiotics, physiotherapy, intravenous fluids, pain relief, oxygen, nasogastric feeding or airway suctioning, with significant differences between groups of professionals (p < 0.001). 24.3% believed that a DNAR order would exclude a patient from receiving chemotherapy, radiotherapy, undergoing dialysis or surgery. Alarming, 13.3% reported that a patient with a DNAR order could not be referred to hospital from home or a nursing home, with variability evident between groups (p < 0.001). 33.1% of healthcare professionals markedly overestimated the success rates of resuscitation in out-of-hospital cardiac arrests and 59.7% overestimated success rates in in-hospital cardiac arrests. Participants were aware of their knowledge gap in relation to DNAR orders with 96.3% in favour of further education.

Conclusion: Our findings further highlight the misinterpretation of DNAR orders and are important in the context of advance care directives. Decisions on DNAR must be correctly understood to only apply to CPR and should not affect other aspects of care.

DEVELOPING A RAPID ACCESS UNIT (RAC) TO IMPROVE QUALITY OF CARE FOR ELDERLY PATIENTS ATTENDING THE LOCAL EMERGENCY DEPARTMENT

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Background: The number of people aged over 65 forms a sizable part of our local communities. The Rapid Access Centre (RAC) is a 6 bedded Consultant lead ward that was established in 2015 as a result of strategic drivers, national and regional direction, professional practices and consultation of local and regional population.

Aims and Objectives: The aims of the RAC include multidisciplinary team approach, high quality patient centred care, rapid access to services, continuity, maintaining health & patient independence & reducing health costs.

Methods: We compared two sets of data which looked at hospital admissions before and after the RAC was established. Each set of data was collected over a 7 month period and included basic demographics, length of stay (LOS) and diagnosis. Data from a total of 441 patients was collected of which 346 patients were admitted to hospital via the traditional A&E route and 95 patients were admitted to the RAC.

Results: The average age of our patients from A&E and the RAC were 73 years old and 75 years old respectively. The data from the RAC patients showed that 56 patients (59%) were admitted to the ward and 39 patients (41%) being discharged. The average LOS of patients admitted by A&E was 5.6 days and those patients assessed for admission in RAC was 4.1 days. Comparison between LOS for individual diagnosis also showed on average patients from RAC had shorter length of stay than patients admitted to the wards by A&E.

Conclusion: We found that patients admitted via the RAC had shorter duration of stay than patients who had been referred directly from A&E. On average patients admitted through the RAC were discharged 1.5 days earlier than those who were direct admissions from A&E. Furthermore the RAC prevented further admission by discharging 41% patients via this Unit.

A PHYSIOTHERAPY QUALITY INITIATIVE FOR THE PRE-OPERATIVE CARE OF AMPUTEE PATIENTS WITHIN AN ACUTE LEVEL 4 TEACHING HOSPITAL

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Background: Over 4,000 Irish people are currently living with an amputation (IrishHealth.com, 2010). In 2015, a profile of MMUH amputee patients showed 71.43% were over 65. The 2015 audit of the amputee service showed that 57.14% of patients were referred to physiotherapy pre-amputation. Best-practice guidelines state “Early assessment and planning of rehabilitation helps to prepare the patient for rehabilitation. A pre-amputation consultation also enables the physiotherapist to give appropriate advice, information and reassurance...” (BACPAR Guidelines, 2006).

Methods: Auditing all patients referred to physiotherapy for amputee rehabilitation in 2015.

Results: Of these 7 surgeries, 5 were referred to physiotherapy pre-operatively (71.43%), compared to 57.14% in 2015.

Conclusion: We found that patients admitted via the RAC had shorter duration of stay than patients who had been referred directly from A&E. On average patients admitted through the RAC were discharged 1.5 days earlier than those who were direct admissions from A&E. Furthermore the RAC prevented further admission by discharging 41% patients via this Unit.
200 RELATIONSHIP BETWEEN PREVALENCE (AND AWARENESS) OF AGE-RELATED MACULAR DEGENERATION AND PLASMA CONCENTRATIONS OF LUTEIN AND ZEAAXANTHIN IN AN OLDER POPULATION

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Background: Lutein (L) and zeaxanthin (Z) and meso-zeaxanthin (MZ) comprise of macular pigment, which protects against age-related macular degeneration (AMD) and optimises visual function. This study investigated the relationship between AMD (and awareness) and plasma concentrations of L and Z, in The Irish Longitudinal Study on Ageing (TILDA).

Method: Baseline demographic and health variables including the participant’s use of supplements and awareness of AMD were collected. Plasma was analysed for concentrations of L and Z by high-performance liquid chromatography. Retinal photographs were graded using a modified version of the International Classification and Grading System for AMD. For this report (n = 4563), we categorised participants into three groups: Group 1: grading-confirmed AMD (n = 70); Group 2: grading-confirmed AMD in those self-reporting no AMD (n = 264); and Group 3: grading revealed no presence of AMD and self-reported no AMD (n = 4229).

Results: Plasma L and Z were both significantly higher in Group 1, when compared with Group 2 (p = 0.003 and p = 0.017, respectively) and Group 3 (p < 0.0005 and p = 0.007, respectively). Interestingly, significantly more participants were supplementing in Group 1 (56.5%), compared with Group 2 (30.8%) and Group 3 (30.5%) (p < 0.0005). Participants with a known positive family history of AMD also had a higher prevalence of the condition (p < 0.005), and dietary supplementation was higher in association with a known family history of AMD (p < 0.005).

Conclusion: These findings indicate that plasma concentrations of L and Z were significantly higher in association with confirmed presence of AMD, awareness of AMD, and supplement use. Of the 334 participants with AMD, 264 participants (79%) were completely unaware they were affected by AMD, indicating that they were likely to be pertinent. The findings suggest potential undertreatment of AMD and highlights the importance of screening and awareness campaigns in older adults.

201 SPECIALIST COMMUNITY NURSING UNIT: EMERGENCY TRANSFER RATES TO ACUTE HOSPITAL

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Background: Our community nursing unit cares for 186 long stay nursing home residents. This unit has access to daily geriatrician led medical and multidisciplinary team input on a referral basis. Three monthly reviews ensure residents have access to comprehensive geriatric assessment and provide an opportunity for the team to discuss advance care plans. Extended care units have been criticised due to high transfer rates to the acute hospital. We investigated transfer rates in our nursing care setting.

Methods: We retrospectively reviewed the medical charts of all residents who had an emergency transfer from our facility from January 2015 to January 2016. We obtained baseline demographic information, indication for transfer, length of stay and survival rates post transfer. Number of medical reviews during study period was calculated. We determined the number of residents who had died, assessed place of death and DNR status of patients.

Results: In the study period, there were 21 patients who had 24 transfers. Our transfer rate was 12.9 transfers per 100 beds per year. Reasons for transfer were classified as medical (45%), surgical (30%) and ED review (25%). Mean length of stay in acute hospital was 5.8 days. 90% of patients survived their hospital admission and were transferred back. (n = 19). 2 patients died during their admission. Number of medical reviews by our onsite staff ranged from 5 to 46 in the year period. There were 58 deaths during the study period with 96% dying in our unit, all with advance care plans in situ.

Conclusion: The transfer rate of 12.9 is much lower than previous studies. Due to on site medical staff, the majority of medical problems are managed on site. The emphasis of advance care planning during our 3 monthly reviews has meant that the majority (90%) of the residents die in their home environment.

204 EXPLORING PATIENTS UNDERSTANDING OF ADVANCE HEALTHCARE DIRECTIVES: A SNAPSHOT FROM A CARE OF THE OLDER PERSON ASSESSMENT UNIT

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Background: An Advance Healthcare Directive (AHD) is an advance expression made by a person with capacity, outlining their wishes and preferences relating to medical treatment decisions, potentially arising if they were to subsequently lack capacity or couldn’t express preference. The Assisted Decision-Making (Capacity) Act 2015 provides a legislative basis for Advance Healthcare Directives in Ireland. This study aimed to determine if patients attending a Care of the Older Person Clinic were familiar with AHDs and assess if this was something they wished to discuss.

Methods: A questionnaire was designed with the following 3 questions 1) Have you heard of an Advanced Care Directive? 2) Would you like the topic discussed at this visit? 3) If yes, would you be interested in doing an Advance Care Directive in the future? A written explanation of an AHD was included. A Clinical Nurse Specialist assisted the patient in completion and provided further clarification. Patients attending clinics in the Assessment Unit over one month were invited to participate. Individual cognitive scores were also recorded. Questionnaires were excluded when the patient could not understand due to cognitive impairment.

Results: Thirty-nine patients consented to completing the questionnaire however 4 were subsequently excluded secondary to severe cognitive impairment. Of 35 patients, 94% (n = 34) did not know what an AHD was. Only 34% (n = 12) wished to discuss it further and of those 83% (n = 10) reported they would consider making one in the future. While 20% had normal cognition or mild impairment, the majority had moderate impairment on objective cognitive testing.

Conclusion: While the majority of patients had objective cognitive impairment, this is not unusual in Care of the Older Person Clinics, where advance healthcare directives are likely to be pertinent. The findings suggest poor baseline understanding of AHDs and in this cohort, little interest in making one.

References:

205 QUANTITATIVE TIMED UP AND GO TO MEASURE FALLS RISK AND FRAILTY LEVELS IN ELDERLY PATIENTS POST HIP FRACTURE

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Background: Falls risk assessment is necessary post-hip fracture and is recommended by NICE guidelines. The assessment of frailty is important in the rehabilitation of hip fracture patients as it can be predictive of outcome. The Quantitative Timed Up and Go (QFTUG) is a novel assessment which involves the use of inertial sensors and provides estimates of falls risk and frailty levels. The aim of this study was to compare the QFTUG falls risk and frailty estimates with clinical outcome measures of Tinetti Gait and Balance Assessment and Clinical Frailty Scale (CFS).

Methods: A prospective cohort study was conducted sampling participants post hip fracture recruited to a sub-acute rehabilitation unit (n = 16). Falls risk and frailty level estimates generated from QFTUG were compared to Tinetti and CFS at two time points, admission and discharge.

Results: There were significant improvements in both QFTUG falls risk and frailty level estimates and clinical outcome measures of Tinetti and CFS between admission and discharge (p < 0.05). There was a strong negative correlation between the QFTUG falls risk estimate and Tinetti scores on admission (r = 0.67, p = 0.004) and discharge (r = 0.76, p = 0.001), although QFTUG estimated a greater percentage of participants as at high risk of falls than Tinetti (QFTUG rated 12.5% as at high risk, Tinetti 0% as at high risk). There was no relationship between QFTUG frailty level and CFS on admission (r = 0.22, p = 0.41), however there was a strong correlation on discharge (r = 0.70, p = 0.003).

Conclusion: The QFTUG provides multifactorial falls risk assessment which may be more clinically useful than Tinetti, while the QFTUG frailty estimate was unable to distinguish between patients on admission but may be useful on discharge. Further research should investigate use of QFTUG for longitudinal follow up to assess predictive ability of falls risk and frailty level estimates.
Background: Recent evidence indicates that rural individuals show poorer cognitive performance than urban dwellers. Urban environments offer a wider range of cognitive stimulation, and are associated with higher levels of tonic arousal. A cross-sectional association between urban living and better performance in global cognition (Montreal Cognitive Assessment, MoCA) has been found after controlling for individual level factors (Cassarino, O’Sullivan, Kenny & Setti, 2015). Another study found a non-linear relationship between land-use mix and dementia. The present study aimed to assess whether the cognitive disadvantage of living in a rural environment may be compensated by modifiable lifestyle factors, i.e. physical activity. We hypothesised that levels of physical activity would modulate cognitive performance especially for rural dwellers, who most need cognitively stimulating activities.

Methods: Cross-sectional analyses of MoCA were conducted for healthy Irish people aged 50+ participating in Wave 1 of The Irish Longitudinal Study on Ageing, in relation to the interaction between levels of physical activity measured through the International Physical Activity Questionnaire, and residence either in urban, suburban, or rural areas, while controlling socio-demographic, health, and other lifestyle factors.

Results: The cognitive disadvantage of living in a rural environment may be compensated by modifiable factors, i.e. physical activity. Cross-sectional analyses of MoCA were conducted for healthy Irish people aged 50+ participating in Wave 1 of The Irish Longitudinal Study on Ageing, in relation to the interaction between levels of physical activity measured through the International Physical Activity Questionnaire, and residence either in urban, suburban, or rural areas, while controlling socio-demographic, health, and other lifestyle factors.

Conclusions: The results support the hypothesis that engaging in physical activity can compensate for urban-rural differences in cognitive performance in ageing. The findings have implications for the promotion of lifestyle initiatives tailored to the environment of rural residents.

References:
204 IMPROVING EFFICIENCY OF LONG TERM CARE REFERRALS TO THE MEDICINE FOR THE ELDERLY SERVICE

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Background: Differing pathways and processes exist throughout the country for an application into long term care. This invariably involves a Common Summation Assessment Report (CSAR) which identifies the need for long term nursing care.

Methods: This was a retrospective chart review of long term care applicants. Charts of patients who had a CSAR completed following Geriatric clinic review were audited over a three month period. Referral letters from Primary Care were collected and data extrapolated.

Results: Of the 30 charts reviewed, only 13 had specific referrals for LTC assessment. The majority of referrals had patient details and existing medical conditions. 2/30 reported whether a home care package existed. 1/30 gave an opinion on whether this package was sufficient or required optimization. 5/30 letters included the applicant’s wishes and 3/30 had details on whether the patient had the capacity to consent for LTC.

Conclusion: Primary care referrals for LTC consideration were shown to be sub-optimal regardless of the small sample size. Patients’ preferences, wishes and capacity must be conveyed in addition to reversible disease. Information on patients ongoing care needs is often not reported when referred.

The primary care team are ideally placed in the community to assess the increasing care requirements of their patients compared to those in hospital services and hence might be in the best position to complete LTC applications for those who have consented or have the capacity to refuse.

This would allow those patients requiring Geriatric Consultant input to assess capacity or investigate reversible disease to be expedited through the service.

215 INNOVATION OF AN ELECTRONIC EXECUTIVE DASH BOARD FOR A POST-ACUTE CARE SERVICE: CAPTURING ACTIVITY, QUALITY INDICATORS AND EVALUATING FUTURE SERVICE NEED

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Background: A 74-bed post-acute care service (PACS) was developed in 2011 to address the high proportion of acute beds that were being utilised by patients with complex discharge needs, no longer requiring acute hospital care. The aim of the service is to assist with alleviating the acute hospital, long-term care (LTC) avoidance and enable patient’s transition from hospital to home.

Methods: A small project team was set up including a clinical nurse manager, consultant geriatrician, operations managers and information analyst/statistician. The project team set out to identify required key data that could be automatically extracted from the hospital’s existing information technology system that would allow capturing of activity levels in keeping with quality metrics. The information display would allow planning and projection of future service provision. The project group also proposed that the dash board would collate information on the patient cohort with the most complex discharge needs.

Results: A functioning PACs dash board has been incorporated onto the executive high-level hospital dash board. The key metrics integrated include; average age, the percentage of patients discharged to LTC, percentage discharged home, admission source, discharge destination, eGFR, the length of stay (LOS) in PACS and overall LOS, from admission to the acute hospital setting to discharge from post-acute setting and number of deaths. To date, the implementation of the dash board has allowed management to monitor quality indicators such as the number of patients discharged to LTC.
and preempts future capacity requirements for the cohort of patients with complex discharge needs.

Conclusions: This innovative PACS’s dash board has been utilised as a mechanism to facilitate automated visual data and information that can be utilised in a multitude of different roles, including quality management, projecting capacity and in developing the future strategy for service improvement.

ASSOCIATION BETWEEN ANAEMIA AND OSTEOPOROSIS IN COMMUNITY DWELLING OLDER ADULTS

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Background: Scientific studies have reported that osteoblasts are involved in haematopoietic cell activity with osteoblastic ablation leading to loss of bone marrow cellularity. Osteoporosis is known to be associated with a reduction in osteoblast number and activity. Osteoporosis has also been shown to be associated with increased bone marrow fat content. This may relate to changes in mesenchymal stem cells differentiation to favour adipogenesis over osteoblastogenesis. This change in bone marrow type could result in a reduction in haemopoiesis. We therefore hypothesise that older, otherwise healthy adults with osteoporosis are more likely to have anaemia than those without osteoporosis.

Methods: DEXA scan and haemoglobin levels were obtained from 347 participants in the HIACE study which was a cross-sectional study of community dwelling older adults. Mean haemoglobin levels were compared in those with osteoporosis, osteopenia and normal DEXA scans. Univariate analysis was then carried out to adjust for the impact of BMI, folate and ferritin levels on haemoglobin.

Results: 356 patients were included. 212 (60.1%) were female. 39.6% (141) had a normal DEXA, 44.7% (159) had osteopenia and 15.7% (56) had osteoporosis. The mean haemoglobin was 14.31 (SD 1.3) in those with a normal scan, 13.91 (SD 1.43) in those with osteopenia and 13.46 (SD 1.13) in those with osteoporosis (p < 0.001). Following univariate analysis the adjusted means are 14.23 (SE 0.1) for those with normal scans, 13.93 (SE 0.3) for those with osteopenia and 13.58 (SE 0.2) for those with osteoporosis (p = 0.007).

Conclusions: Reduced bone mineral density is associated with a reduction in haemoglobin levels even when BMI, folate and ferritin levels are controlled for. The absolute differences in haemoglobin levels may become more relevant in those with anaemia of other causes.

THE IMPACT OF ELECTRONIC PATIENT MANAGEMENT SYSTEM (EPMS) ON POST-TAKE WARD ROUNDS AND THE PRODUCTION OF DISCHARGE LETTERS

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Background: Our department has used digital patient management systems since 1997. In 2014 we instituted a program integrating all current systems, collectively referred to as ePMS. The system is developed within the department by clinicians and has become an integral part of clinical practice, from the admission process to the ongoing management of patients and the development of a discharge summary. This study reports on the impact this system has had on overall efficiency of patient management.

Methods: The proportion of letters completed from 10th February 2015 to 10th April 2016 (post ePMS) was compared to those completed from 1st October 2013 to 31st December 2014 (pre ePMS) for a single Geriatric service. A visual analogue scale (0-10 with 5 being neutral), was used to rate doctors’ perception of benefit of ePMS in terms of efficiency of post-take handover and post-take ward round, quality of and ease of generating discharge letters and overall benefit to the ease of patient management from admission to discharge.

Results: From 2013-2014 35% of 1106 admission had completed electronic discharges. Since the introduction of ePMS 98.6% of 1321 admissions had a completed discharge letter. Using a visual analogue scale to assess the value of ePMS the post-take handover was perceived as neutral with ePMS and the overall efficiency of discharge lettering. Using a visual analogue scale to assess the value of ePMS the post-take handover was neutral to those with a 210% fall, “no-dippers” (n = 6) with <90% fall and “reverse-dippers” (n = 0) with >90% fall in the day time average BP.

Results: The prevalence of uncontrolled BP was 21% on ward evaluation and 86% on ABPM. This higher rate of pickup of hypertension was statistically significant as per Fisher exact test (p = 0.0018). It was found that 71% had daytime hypertension, 71% had nocturnal hypertension and 42% had a non-dipper profile. The prevalence of SAS was 28.5%. We found a statistically significant association between SAS and non-dipper profile (p = 0.015) however associations between SAS and day time and nocturnal hypertension were not statistically significant.

Conclusions: ABPM showed a 65% increased sensitivity compared to ward BP values at detecting poor BP control. SAS is strongly associated with the “non dipper” profile. This work reinforces the importance of ABPM in the control of hypertension which is the biggest risk factor for stroke. Our findings indicate that SAS is a significant cause secondary cause of hypertension in these patients which can be quickly screened for in a non-specialist setting.

RELATIONSHIP BETWEEN SKELETAL MUSCLE MASS AND ORTHOSTATIC HYPOPTENSION

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Background: Venous pooling is a normal phenomenon that occurs during standing. It is normally compensated for rapidly by vasocostriction and muscle pump activity. Skeletal muscle therefore plays an important role in promoting venous return and maintaining blood pressure (BP) during standing. We therefore hypothesise that reduced skeletal muscle mass would be associated with larger postural BP drops and more orthostatic hypotension (OH).

Methods: We retrospectively identified all patients that had a Whole Body DEXA and Head Up Tilt (HUT) test carried out in our diagnostic unit in a similar time period. Results of Active Stand (AS) were also recorded where done. Skeletal Muscle Index (SMI) was used to define sarcopenia.

Results: 37 patients had a Whole Body DEXA and HUT. 36 also had an AS. 18.9% (7) had sarcopenia. 85.7% (6) of sarcopenic patients had OH on HUT compared to 75% (23) of the controls (X2 = 1.67, p = 0.19). The mean drop in Systolic BP (SBP) was 30 mmHg in those with sarcopenia and 22 mmHg in the control group (p = 0.248). The mean drop in Diastolic BP (DBP) was 11.9 mmHg in those with sarcopenia and 8.3 mmHg in the controls (p = 0.254).

Conclusions: This study does not show any strong association between skeletal muscle mass and OH however this may be largely related to the small sample size. This study did not look at skeletal muscle function, which is also a key component of sarcopenia, and is likely to play a role in the skeletal muscle pump.

CHARACTERISATION OF MEDICATION ERRORS IN A NORTH DUBLIN REHABILITATION HOSPITAL

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Background: A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional, patient or consumer. We aim to characterise the types of medication errors detected in the over 65% transferred to a 160 bed rehabilitation hospital accepting admissions from Dublin acute hospitals.

Methods: A retrospective case series was conducted from January 1st to December 31st 2015 inclusive using patient medication administration records and medication incident reporting forms. Data on patient demographics entered the National Consulting Council for Medication Error Reporting and Prevention (NCC MERP) Index for categorising medication errors algorithm were collated.

Results: 1663 adults were admitted during the study period. 155 medication errors were identified with 12116 0.65% (average of 9.6/ month). Females predominated (58.6%, n = 68), with a mean age of 7.9 years (range 65–94 years). Orthopaedic and Geriatric Rehabilitation patient medication errors occurred with similar incidence (53.4% vs 46.6% respectively). NCC MERP categories were (i) A = 6 (ii) B = 32.8% (n = 38) (iii) C=56.0% (n = 65) (iv) D = 10.3% (n = 12) and E = 0.9% (n = 1;
Background: Polypharmacy, especially with FRIDs is a recognized risk factor for falls. FRIDs include antihypertensives, antidepressants, antipsychotics, antihistamines, antiepileptics, analgesics and hypoglycaemics. A medication review is a simple, cost-effective measure to decrease the risk of falls in older adults.

Methods: A retrospective review of admission and discharge prescriptions, over three months, of patients aged 65 and older, at a rehabilitation unit, linked to a tertiary hospital. Emphasis was placed on the prescribing and de-prescribing of FRIDs. The majority of patients were undergoing rehabilitation following a fall resulting in fracture.

Results: 32 of 34 patients were prescribed polypharmacy (defined as >4 medications) on admission. All 34 discharge prescriptions prescribed polypharmacy. 32 of 34 patients had FRIDs included in their prescription on admission, compared with 30 of 34 patients discharge. Overall, 23 FRIDs were de-prescribed, but 18 new FRIDs were prescribed. There was an absolute reduction of 17 FRIDs. The cumulative number of FRIDs on admission was 104. This was reduced to 87 FRIDs on discharge prescriptions. The average number of medications per admission prescription was 11.2 versus 7.2 of which were FRIDs, compared with 11.6 on average on a discharge prescription, 2.5 of which were FRIDs. The FRIDs most likely to be de-prescribed were antidepressants/antipsychotics. The FRIDs most likely to be prescribed was opioid analgesia.

Conclusions: Polypharmacy is common amongst elderly fallers. FRIDs are also frequently prescribed. In our practice, we de-prescribe FRIDs, evidenced by the lower average number of FRIDs on discharge than on admission. However, we also often introduce new FRIDs. We should focus on wearing opioid analgesia before discharge.

Background: Neurological deficits are common after hip fracture and have been strongly linked to cognitive impairment in older age. This study aimed to evaluate the correlation of prefracture cognitive impairment with the development of post-fracture cognitive impairment.

Methods: Prospective cohort study of 306 consecutive patients (age >65) admitted with hip fractures over a 2 month period. Pre-fracture functional and mobility outcomes were assessed using the FRS and Barthel Index (BI). Frailty was assessed using Clinical Frailty Scale (CFS). The 11 items FRS comprised of 3 components: basic activities of daily living (ADL), instrumental ADL and mobility. A score of 100 indicates complete independence.

Results: The mean age of the cohort was 83 years and 77% were women. 5 patients (17%) were Nursing Home residents. 47% (n = 14) were in the highest functional level pre-fracture (FRS 80–100) and 33% (n = 11) in the lowest (FRS <60). 37% (n = 11) scored 20/20 on BI, indicating full independence while 13% (n = 4) had high dependency (BI<10). 30% (n = 9) were placed on scales 1 to 3 in the CFS (very fit to managing well), and 23% (n = 7) categorised as ‘severely frail’. Correlation between FRGS, CFS and BI were analysed using Linear Regression model and Correlation Coefficient (r) calculated. We show that FRS is highly correlated with CFS (r = -0.91). Similarly, there is good correlation shown between CFS and BI with correlation coefficient (r) of -0.78. Conclusion: In patients with hip fracture, FRS yields important predictive information on clinical frailty. This allows early identification of frailty which will benefit the most from comprehensive geriatric care. FRS may be a better tool than BI to predict frailty in hip fracture patients.
WHAT ABOUT THE MEN? AN AUDIT OF DEXA SCAN DEMOGRAPHICS

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Background: Osteoporosis is the most common metabolic bone disease and is a leading cause of morbidity and mortality in older people. However, it often goes unrecognised and under-treated as it is clinically silent. It’s frequently forgotten about in males who are presumed less at risk than females. The current prevalence of osteoporosis in Ireland is 6.2% in males and 20% in females (Svedbom, 2013). Approximately 25% of fragility fractures occur in men (Finkelstein, 2015). Therefore, one might expect the proportion of DEXA scans to reflect the population incidence of fracture. The aim of this audit was to analyse DEXA scans performed in the Clinical Age Assessment Unit (CAAU) at our institution, to elicit the proportion of scans being done in male patients and to highlight any potential interval change over time. We also wanted to determine the age range of patients being scanned.

Methods: CAAU has maintained a database of all DEXA scans performed since 1997. A subset of this data from January 1st to July 31st for the years 2005 and 2015 was analysed using SPSS.

Results: There were 1771 DEXA scans performed in the first 6 months of 2005. 90.7% of these were in women with only 9.3% being done in men. In 2015 there was a total of 2377 scans performed between January and July, with women representing 89.9% and men a mere 10.1%.

Conclusions: Epidemiological data suggests 20-30% of fragility fractures occur in men, yet only 10% of DEXA scans performed at our institution were in men. Despite the increase in the total number of scans performed over the last 10 years, there has been no change in the proportion of male patients. While public awareness campaigns on osteoporosis have clearly been effective, more needs to be done in promoting awareness of this condition in men.

EXAMINING THE LINKS BETWEEN DOMAINS OF GAIT AND TESTS OF GLOBAL COGNITION: A FACTOR ANALYSIS APPROACH

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Background: Slow gait speed (Oh-Park et al., 2010) has been reported to precede cognitive dysfunction and progression to dementia (Watte et al., 2005). However, gait is multidimensional and cannot be fully captured by one characteristic alone. Individual gait variables can be grouped together to characterise gait performance on specific domains. This study examined the relationship between these gait domains and global cognitive function.

Methods: This study used baseline cross-sectional data from 4576 community dwelling, middle-aged and older adults (54% women, age ≥50 years, mean ± sd 62.4 ± 8.2) who participated in The Irish Longitudinal Study on Ageing (TILDA), a nationally representative study. Participants performed two normal paced walks on a GAITRite® mat. Factor analysis is a data reduction technique employed to reduce key correlated gait variables into a lower number of uncorrelated, independent variables (Pace, Rhythm, Variability). Participants are grouped dichotomously based on poor gait factor performance (defined as 1 standard deviation below age, sex, height and BMI adjusted means).

The individual associations between global cognitive assessment test scores (MMSE & MoCA respectively) to those classified with each poor pace, rhythm and variability were assessed using regression analysis (multivariate linear regression model). All patients were divided into tertiles for age, sex, and education.

Results: Those who classed with poor pace had lower MMSE (Coef. 0.02, p < 0.001) and MoCA scores (Coef. 0.06, p < 0.001) versus those without. Participants with poor rhythm also showed significantly reduced MoCA (Coef. 0.01, p < 0.05) and MMSE scores (Coef. 0.08, p < 0.001). In contrast, poor variability factor performance did not show significantly altered test scores.

Conclusion: The representation of gait through pace, variability and rhythm domains, generated from factor analysis is more descriptive than using gait speed alone.

Furthermore, by quantifying dysfunctional gait in this manner, associations were found with worse cognitive function. Future work is needed to investigate the benefits and clinical usefulness of this approach.

ELDER ABUSE CONTEXT AND THEORY IN FINLAND, IRELAND, ITALY AND ROMANIA

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Background: Sociodrama, Tackling Ageism, Preventing Abuse Project (ST. AGE funded by ERASMUS+) will develop new learning opportunities in the field of elder abuse prevention. The project draws on the theory of generational intelligence as the foundation for the development of an innovative approach to tackling this issue in Finland, Ireland, Italy and Romania. This poster presents an overview of phase one of the project which constructed the theoretical background underlying the project.

Methods: A comprehensive review of the relevant literature and policies from the perspective of the four countries was undertaken. The review focused on distinguishing the different definitions and typologies of elder abuse have been adopted within the four countries and how these inform policy responses. An exploration of a range of theoretical approaches along with the risk factors associated with elder abuse were also explored.

Results: Emerging theories in explaining elder abuse within individual relationships suggested one needs to encounter the other. At the centre of generational intelligence theory is the belief that by recognising differences between generations, there is greater empathy amongst carers. Sociodrama as a medium for building empathy is explored. By coming to know the older person as an individual they therefore, not only provide care to the person, but also care about them.

Conclusions: Using generational intelligence to underpin elder abuse prevention has the potential to revolutionise current approaches to elder abuse prevention. It can provide a new perspective and understanding through which staff and organisations view their role, advancing residents’ social identity, enhancing reciprocal relationships and challenges against assumptions. It is envisaged that the model will lay the groundwork for further research and educational training models beyond the work of the current project.

HIGH BURDEN OF FRAILTY AMONG PATIENTS AGED OVER 65 YEARS IN A TERTIARY REFERRAL HOSPITAL

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Background: Frailty as a concept is associated with key clinical syndromes including falls, polypharmacy and worsening mobility. Screening and measurement of frailty is recommended as part of comprehensive geriatric assessment of older patients. However, there is no clear consensus on its definition and measurement.

Methods: Assessment of frailty was retrospectively performed on all medical patients over 65 years admitted to University Hospital Limerick in a 1 week period. The 9 point Edmonton Frailty Score in app version (Doctot) was utilised as it has been validated for acute medical unit patients. The predicted length of stay of each patient was correlated to the obtained frailty score. Frailty as a concept is associated with key clinical syndromes including falls, polypharmacy and worsening mobility. Screening and measurement of frailty is recommended as part of comprehensive geriatric assessment of older patients. However, there is no clear consensus on its definition and measurement.

Results: Over 7 consecutive days, there were 226 medical admissions in UHL; 118 were over 65 years. Of the 51 patients screened, 21% patients were assessed as mild frailty, 13% moderate frailty, and 27% were deemed severely frail.50.9% were male. Median age was 75.6 years. Predicted length of stay for patients scoring mild frailty percentages was 7.4 shorter. Mortality at follow up of 24.4% moderate scores had hospital LOS 9.9 days with mortality 2.9% and severe scores had hospital LOS 15.6 days and 12.9% mortality at follow up.

Conclusions: A key tenet of the ED Taskforce Report 2015 is the immediate creation of rapid access elderly assessment and treatment services for elderly patients in all acute hospitals. In this regard, rapid mobile assessment tools of frailty can augment national care policies to identify vulnerable patients. There is a high burden of frailty in acute medical wards and utilizing predictive length of stay can aid more efficient discharge planning.
Background: Ischemic Stroke is among the leading causes of severe disability and death, however, the cause remains unexplained in approximately 20–40% of cases resulting in the classification of Cryptogenic Stroke. Antial fibrillation (AF) is a well recognised cause of ischaemic stroke, with the risk of further stroke being reduced by two thirds with anticoagulants. Implantable loop recorders (ILRs) allow continuous cardiac monitoring for up to 3 years in the detection of AF.

Methodology: In selected stroke patients (n=894) admitted to our University Hospital, an ILR device was inserted when no cause for their stroke had been found. This study analyses the differences between those patients who were discovered to have AF during follow up.

Results: 54 ILRs were inserted over an 18 month period. AF (> 30 seconds) was detected in 23 (42.5%) patients. Of those with AF, the mean age was 69.5yrs (Range 49– 85) and 57% were female. The mean time to detection of AF was 3 months (range 1 day to 10 months). Comparing risk factors of those with AF to non AF, hypertension (ischaemic heart disease, diabetes and previous stroke), the most significant finding was diabetes (17%) in the AF group compared to (6.4%) in the non AF cohort.

Conclusion: In this select group of Cryptogenic Strokes, AF was detected by ILRs in 42.5% resulting in a greater use of anticoagulants. Complication rate was low and ILRs may have a central role in the investigation of embolic stroke of uncertain source. Further studies are required to determine which patients will derive the most clinical benefit from ILRs as well as the cost effectiveness of this approach.

A RARE CASE OF A THALAMIC INFARCTION PRESENTING WITH A VERTICAL GAZE PALSY

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Background: To present a rare case of thalamic stroke presenting with a vertical gaze palsy.

Method: We present a case of a 40 year old lady who presented with vertical diplopia, slurred speech and left facial droop. The patient had a background history of Non Hodgkin Lymphoma cycle 2 day of RCHOP. Her symptoms gradually improved with only vertical diplopia remaining after 6 hours. Initial CT Brain showed no acute infarct or haemorrhage. She presented seven days later with symptoms of arterial compromise affecting her right hand.

Results: MRA Brain on day 7 showed acute right thalamic infarct, MRA revealed thrombosis in the right innominate artery hence identifying the likely mechanism of her thalamic infarct. The patient was anti-coagulated and her symptoms of arterial compromise subsided. Her symptoms of diplopia improved with the use of prisms. Acute onset of vertical diplopia in the setting of infarction is most often associated with midbrain infarcts. We present a case report of a thalamic infarct presenting as vertical diplopia with no midbrain involvement due to thrombosis of the right innominate artery. Our literature review identified only three previous cases of vertical diplopia as a consequence of thalamic infarct with no midbrain involvement. The presumptive mechanism in these cases was interruption of the supranuclear inputs.

Conclusion: Acute onset vertical diplopia can rarely present secondary to thalamic infarction. We believe this is the fourth reported case of this nature and the first to be the consequence of thrombosis of the innominate artery.

THE FIRST KNOWN CASE OF SPLENIAL HAEMORRHAGE PRESENTING WITH ACUTE AMNESIA

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Background: Isolated splenial haemorrhage is rare. There are several reports of retro-splenial haemorrhage presenting with amnesia, however there are no previous case reports of isolated splenial haemorrhage with this presentation. We report the first known case of splenial haemorrhage presenting with amnesia.

Methods: We reviewed the clinical and radiological findings of a 66 year-old man who presented with retrograde and anterograde amnesia of 6-hours duration. A literature review was carried out over previous reports of splenial lesions, in particular splenial haemorrhage, and their presentations.

Results: The patient was admitted with a working diagnosis of transient global amnesia (TGA). His past medical history was unremarkable. Neurological examination and initial CT brain were normal. MOCA revealed isolated impairments in visuospatial function. MRI brain revealed a small focus of haemorrhage in the left splenium. Our literature review demonstrated one case report of an isolated splenial lesion presenting with acute amnesia secondary to ingestion of herbicide, but none secondary to haemorrhage.

Conclusion: The diagnosis of acute amnestic syndromes remains challenging. Isolated splenial lesions as a cause of acute amnesia are very rare. This case highlights the importance of performing appropriate neurologica investigations in patients presenting with acute amnesia as TGA remains a diagnosis of exclusion.

DOES HE LIKE FAIRY CAKES? EXPLORING COMMUNICATION IMPAIRMENT, MARGINALISATION AND PERSON-CENTRED CARE

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Background: Person-centred care is increasingly a primary objective for persons with dementia in residential settings but, in practice, is challenging for residents, staff and family. While conducting a grant supported project in the area of eating, drinking and swallowing in a dementia specific unit, where residents’ food and drinks preferences and dislikes (FDPD) were reviewed from multiple perspectives, an issue emerged which prompted the reviewer to ask if we are aware of the extent of these challenges.

Method: A 70-probe questionnaire based on the menu cycle was administered to staff (SQ) and family (FQ). Following this, selected residents were interviewed re FDPD using a supported conversation approach that uses a pictorial system called Talking Mats™ (TM).

Results: While conducting the TM. FDPD interview with a non-verbal resident, the reviewer spotted an item of variance. SQ and FQ reported that he liked fairy cakes but he indicated that he disliked them in TM. FDPD. The reviewer asked the question again in a different section and he reiterated that he disliked fairy cakes. The story unfolded. While conducting a TM which explored broader eating, drinking and swallowing issues, the resident revealed that he had experienced changes in the way things tasted to himself.

Conclusions: The reviewer poses 4 possible explanations for what occurred, which includes the possibility that he dislikes fairy cakes, but that he eats them because there is little choice and he feels powerless to do anything about it. We need to challenge our assumptions about the extent that we really are listening to residents, including non-verbal behaviour. The issues raised here were only revealed because the reviewer probed; otherwise they would have remained invisible and unheard. Is he (and other non-verbal people) unwittingly marginalised because of his communication impairment? If so, what do we want to do about it?


BLOOD PRESSURE CONTROL IN OLDER PEOPLE AND ITS ASSOCIATION WITH CARDIOVASCULAR EVENTS: A SUBGROUP ANALYSIS FROM THE ASCOT STUDY

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Background: Ambulatory Blood Pressure Monitoring (ABPM), mostly measured in studies at baseline has been shown to be a more potent predictor of cardiovascular risk than that measured in the clinic. Less prognostic information is available following initiation of therapy, especially in the elderly. The aims of our study were to evaluate the prognostic value of ABPM in those ≥65 years on treatment on cardiovascular events and whether blood pressure can be lowered safely in view of recent studies with lower BP targets.

Method: We looked at those ≥65 years old from the Anglo-Scandinavian Cardiac Outcomes Trial (ASCOT). All patients had at least three other cardiovascular risk factors, but no previous history of coronary heart disease. They were randomised using a prospective, randomised, open, blinded end-point design. Repeated ABPMs were performed over a median follow-up period of 5.3 years. We adjusted for baseline variables (age, sex, lipid profile, BMI, and diabetes), treatment and clinic systolic BP.

Results: During the follow-up period 719 patients were evaluated, average age was 70.4 (+/-3.7) and 26% were female. Their ambulatory systolic blood pressure (SBP) was 132.79 mmHg (SD = 11.7), 134.45 mmHg (SD = 11.48) and 126.23 mmHg (SD = 14.71) for 24 hour, daytime and nighttime respectively. There were 84 cardiac events. An increase of 10 mmHg in daytime, nighttime and 24 hour systolic BP increased the possibility of a cardiovascular event giving the respective hazard ratios of 1.29 (1.04 to 1.59) and 1.26 (1.18 to 1.34). These results were similar for systolic blood pressure and with diabetes.

Conclusions: The majority of elderly hypertensive patients on treatment additional prognostic information regarding cardiovascular risk can be gained from repeated ABPM measurements. However, tight control of nighttime SBP might result in an increased risk.
THE ABBREVIATED MENTAL TEST SCORE: THE 1916 QUESTION

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Background: The Abbreviated Mental Test (AMT) is a 10-item mental test used to screen for dementia. It assesses long-term memory by asking “What year did World War I (WWI) begin?”; a question that is culturally specific. The aim of this study was to examine if asking the year of the Easter Rising for long-term memory would be valid in an Irish cohort.

Methods: Patients aged ≥65 years were recruited from the day-hospital service of an urban teaching hospital. Following patient assent, demographics were recorded and the AMT was administered with the additional question “What year did the Easter Rising occur?” The Mini-Mental State Examination (MMSE) was administered as a reference standard.

Results: Forty-nine patients were recruited, 73.5% female (n = 36), mean age 81.14 years (SD = 6.798). There were significant positive correlations between AMT-standard and AMT-Irish scores (r = 0.706, p < 0.001), AMT-standard and MMSE scores (r = 0.531, p < 0.01) and AMT-Irish and MMSE scores (r = 0.464, p < 0.01). Forty-two patients correctly answered the Easter Rising question (ERQ) while 17 correctly answered the WWI question (WWIQ) (p < 0.001). All those who correctly answered the WWIQ, answered the ERQ correctly. No patient correctly answered the WWIQ alone. However, in this sample, this difference did not lead to a significantly greater number being classed as normal/abnormal. Receiver Operator Curve analysis showed that higher cut-offs for the AMT-Irish were more sensitive and specific than the AMT-standard. Receiver Operator Curve analysis showed that higher cut-offs for the AMT-Irish were more sensitive and specific than the AMT-standard. Further work is needed to validate AMT-Irish vs. AMT-standard as there appears to be a significant difference in the level of knowledge between the long-term memory aspects of each version.

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Background: One-year mortality is up to 33% for elderly hip fracture patients. There is an integrated care pathway (ICP) for these patients in our hospital. We also collect data for the Irish Hip Fracture Database (HIHF), in particular 6 key performance indicators (KPIs): Admission to orthopaedic ward within 4h; surgery within 48h; pressure ulcer assessment; orthogeriatric support; osteoporosis review; falls assessment. Aim: We examined if our hospital meets IHF standard, and if standards improved from 2014 to 2015.

Methods: We interrogated our hospital’s IHF 2014-2015 entries for patients ≥65 years, comparing them with standards above.

Results: Data for 159 patients recorded in 2014. Representative sample from 2015 of 41 patients analysed for comparison. In 2014 62% were admitted to orthopaedic ward; 18% had surgery within 48h. In 2015 63% had surgery within 48h, 97% in 2015. In 2014 96% had pressure ulcer assessment, and 97% in 2015, with 6.4% having an ulcer on assessment. In 2014 77% had a bone health review recorded; 90% in 2015. Orthogeriatric review recorded for 78% in 2014; 100% in 2015. Falls assessment rose from 22% in 2014 to 94% in 2015. Median length of stay in 2014 and 17d in 2015, with more patients being discharged home 2015.

Conclusion: There is continuing improvement in hip fracture care in our hospital. Ongoing delays in admission time to wards is reflective of a national beds shortage. Our day hospital aims to enable patients to remain living safely and independently at home for as long as possible with the appropriate supports in place. We discuss options available with regard to accessing community supports via the public health nurse. We also initiate discussions around future care plans if a patient can no longer remain at home.

METHODS: A retrospective review of the 2014 database of patients supported with their Nursing Home Support Scheme (NHSS) application from the day hospital was completed.

Results: In total 122 patients were supported with a NHSS application from the day hospital, 52 female, 30 male, average age 86. 76 patients had a diagnosis of dementia, 9 had Parkinson’s disease and 37 were frail. 68 patients lived at home alone, 44 lived with family and 10 had moved to LTC prior to day hospital assessment. 107 patients were in receipt of a home care package, 28 attended local day centres and 16 had regular respite. Of the 122 patients, 56 were more stroke victims and 46 patients who moved to LTC. 21 have passed away, 10 in the care of their nursing home and 11 in the acute hospital. 23 patients remained living at home with community and family support. 13 of these passed away at home and 10 continue to attend for regular review. These 10 patients have seen an increase in home supports including additional home care package hours, day centre attendance and respite. It is unknown if the remaining 43 patients completed the NHSS application as they had no further attendances to this hospital.

Conclusion: A supportive family/social network and accessing appropriate levels of care in the community enables older people to remain living in their own homes for longer.
RECOGNITION OF DELIRIUM IN AN IRISH EMERGENCY DEPARTMENT

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Background: Delirium is currently a major cause of morbidity and mortality. Prevalence of delirium in older patients is approximately 10% in the Emergency Department (ED). It is under-recognised by emergency physicians. The Royal College of Emergency Medicine (RCEM) and British Geriatric Society (BGS) recommends that delirium screening is a key quality indicator for geriatric emergency care. Our aim is to determine rates of delirium recognition in the Emergency Department of an Irish University Teaching Hospital and review if formal assessments were being made and documented for same.

Method: Records were reviewed on all patients discharged with a diagnosis of delirium from January to March 2016. All those who had been seen by an emergency doctor pre-ceeding admission had an ED note review for diagnosis of delirium or a synonym, in addition to the documentation of the use of a structured assessment tool such as the Confusion Assessment Method. All patients wherein delirium was not diagnosed in ED had a medical note review to determine whether it was diagnosed on admission, or subsequently developed as an inpatient.

Results: 54 patients discharged with a diagnosis of delirium were suitable for review. The median (range) age was 85 (75-98); 59% were female; 83% had been admitted under a Medical Speciality, the remainder under a Surgical Speciality. In 18 patients, delirium developed following admission (33% post operatively). Of the 36 patients that were delirious on admission, 25 (69%) had been diagnosed in ED. No patient had a structured assessment for delirium documented in their ED notes.

Conclusion: Recognition of delirium in an Irish ED is sub-optimal. Education on structured assessment tools for all emergency staff could help raise detection of delirium in this environment, leading to an overall improvement in geriatric emergency care. Further study following the introduction of this tool is warranted.

RETROSPECTIVE ANALYSIS OF ANTICOAGULANT PRESCRIBING FOR ATRIAL FIBRILLATION IN A DUBLIN GERIATRIC OUTPATIENTS CLINIC

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Background: Atrial fibrillation is the most common cardiac arrhythmia worldwide and is a major risk factor for ischemic stroke. Anticoagulant medications are proven to reduce stroke risk. However, given the advent of non-vitamin K antagonist oral anticoagulants (NOAC), is Warfarin still the predominant anticoagulant prescribed for patients with atrial fibrillation? Our study aimed to evaluate anticoagulant prescribing trends and practices for patients with atrial fibrillation in a geriatric outpatient setting (OPD).

Methods: We retrospectively reviewed the clinic notes of all patients who attended the geriatric OPD between January 2014 and September 2015. Only patients with a documented history of atrial fibrillation in their medical notes were included. It was noted if patients were on anticoagulant, antplatelet treatments or neither. Adverse events such as haemorrhage were also noted.

Results: 257 patients were identified with a history of atrial fibrillation. 48.25% (n = 124/257) were on Warfarin, 18.29% (n = 47/257) were on a NOAC, 26.46% (n = 62/257) were on an antplatelet alone but no anticoagulant therapy and 0.78% (n = 2/257) had no medication listed documented. Therefore, 66.54% (171/257) of patients attending the clinic with documented atrial fibrillation were on some form of anticoagulation.

82.98% (n = 39/47) patients on NOAC therapy had a renal function check in the 6 months prior to the clinic review. Of note, 3.3% (n = 9/257) of patients had their anticoagulant medication changed in the clinic – 66.66% (n = 6/9) of these were changed from Warfarin to a NOAC, 22.22% (n = 2/9) from Aspirin to a NOAC and 11.11% (n = 1/9) from no antplatelet/anticoagulant to Warfarin therapy. 4.68% (n = 8/171) of patients on anticoagulation had a major haemorrhage requiring blood transfusion/hospitalisation.

Conclusions: Our results reflect recent trends of increased prescribing of NOACs for atrial fibrillation. However, the majority of patients are still maintained on Warfarin therapy and it will be interesting to observe how these trends evolve into the future.

BENZODIAZEPINE AND Z-DRUG PRESCRIBING FOR OLDER PEOPLE IN A DUBLIN HOSPITAL: A COMPLETED MULTIDISCIPLINARY AUDIT CYCLE

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Background: Altered pharmacokinetics places older people at risk of adverse effects of benzodiazepine and Z-drugs including falls, fractures and psychomotor impairment. We aimed to assess the prescribing of these drugs in those > 65 years in a Dublin hospital against ICD-10 criteria, NICE guidelines and Royal College of Physicians recommendations and to assess the impact of a multidisciplinary educational intervention.

Methods: We carried out a cross sectional audit on medical notes, nursing notes and medication prescriptions of all inpatients > 65 years on our two specialist geriatric medicine wards (SGW) and three mixed medical/surgical wards. We subsequently issued new sleep guidelines, delivered two educational sessions to NCHDs and gave pharmacists deprescribing rights. The audit cycle was completed by a re-audit nine months from original study using identical methods.

Results: There was a high prevalence of hypnotic drugs being prescribed 23/101(23%) in the initial audit. This reduced to 20/99 (20%) post intervention. Comparing pre and post intervention there was a prescribing prevalence rate on the SGW of 14% vs 5% (p = 0.0606) and non SGW of 29% vs 24.5% (p = 0.616). Post intervention an improvement was noted in the choice of drugs being prescribed in accordance with the guidelines (100% vs 90%, p = 0.0041) and in discontinuation rates with a reduction from 63% to 29% (p = 0.029) in the prevalence of patients staying on the drug for more than 4 weeks.

Conclusion: A multidisciplinary polypharmacy approach to improving night sedation prescribing practices has resulted in evidence based prescribing and increased deprescribing rates. However it has not improved the overall number of prescriptions. Ongoing educational strategies with regular audit within the hospital setting are pertinent to further improve prescribing practice.

A SNAPSHOT OF BLOOD PRESSURE MEASUREMENTS IN HOSPITALISED PATIENTS: ARE WE PAYING ATTENTION?

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Background: Recent evidence shows midlife hypertension is a risk factor for the development of dementia, vascular disease and heart disease in later life. In contrast, older adults are at risk of over treatment of blood pressure (BP) leading to orthostatic hypotension. In this study we sought to identify hospitalised patients with: i) uncontrolled hypertension in midlife ii) hypotension in older age in 70 s with the aim of identifying an opportunity for screening and reviewing medications.

Methods: Prospective study conducted on a one day period on all inpatients in Tullamore Regional Hospital. Beside observations and medical charts were used to obtain age, sex, weight, BP (mean of last 3 readings), previous history of hypertension and drug treatment. Hypertension was defined as a BP above 140/90 mmHg and hypotension a systolic BP below 120 mmHg. The age groups were subdivided into midlife (age 30-69) and older (age 70 and above).

Results: A total of 80 patients were reviewed with an average BP of 128/72 mmHg (+/-17/10). Of these 80 patients reviewed 40% (n = 32) were known to have hypertension. 21% (n = 17) of these patients had a BP above 140/90. 30% (n = 5) were in the 30-49 age group and only one patient was on an antihypertensive. 70% (n = 12) were over 70. 15% (n = 7) of patients over 70 had a systolic BP>120 mmHg and were on an antihypertensive.

Conclusions: Over a third of patients included demonstrated sub optimal control of their blood pressure as measured by beside observations. Although there were a number of middle age adults with uncontrolled blood pressure, this was not acted on. Similarly older adults with low blood pressure did not have action taken to review their medications. Bedside BP measurements represent a unique opportunity for intervention. Further work is required to see if redesigning BP charts with prompts to consider changing medications would benefit patients in the long term.

BLOOD PRESSURE VARIABILITY IS INCREASED IN OLDER IRISH ADULTS

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Background: Hypertension is one of the most common chronic medical conditions and is a major risk factor for cardiac and vascular diseases. Ambulatory blood pressure (ABP) provides an average systolic blood pressure value (SBP) which gives superior risk stratification compared to that measure at the clinic setting. Blood pressure variability (BPV) may also be an important therapeutic target and is easily gained from ABP. Aim: The aim of this study is to look at the relative BPV in the community among younger and older adults.

Methods: BP was measured using an ABPM (SpaceLabs device) at baseline before the initiation of therapy; Ethics approval for the study was attained. Results: There were 17160 of patients included in this study. 10886 (56.5% female, average age 51) were under 65 years of age and 6286 (49.5% female, average age 73) greater than 65 years. Average daytime SBP were 138.3 mmHg, 118.7 mmHg and 132.0 mmHg at night respectively in the younger population while 139.8 mmHg, 126 mmHg and 133.7 mmHg in those older than 65 years old. The co-efficient of variation (CoV) which adjusts for mean SBP was greater in older subjects, 9.6303 vs 10.0541 for daytime and 9.4609 vs 9.8495, p = 0.001 for nightime.

Conclusion: This study showed that the elderly population has a greater BPV compared to a younger population. Certain antihypertensives also reduce BPV and may offer advantages when used in an older population.
ASSOCIATION BETWEEN FRAILITY, LENGTH OF STAY AND DISCHARGE DESTINATION IN THE ACUTE MEDICAL UNIT

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Background: Improving the acute care of the frail older person is a key recommendation of the National Programme and the National Programme for Older People. With a view to developing optimal care pathways in our Acute Medical Unit (AMU), we measured the frailty profile of older patients and assessed the association between frailty, length of stay (LOS) and discharge destination.

Methods: We recorded the Clinical Frailty Scale (CFS) of unselected medical patients aged ≥ 65 years admitted to the AMU over a 10 week period. The CFS was scored within 2 hours of admission from the history, examination and collateral history where necessary.

We divided the level of frailty into 3 groups: 1-3 not frail, 4-6 mild/moderately frail and ≥ 7 very frail. The outcome variables were LOS and discharge destination for Older patients.

Results: We recorded the CFS of 113 patients (68 (60%) female). The overall mean age was 79.8 years and LOS was 6.43 days. 28 (25%) were not frail, 69 (61%) were mild or moderately frail and 16 (14%) patients were severely frail. The mean LOS in CFS 4-6 was 6.44 days. 20 (28.9%) required off site rehabilitation or convalescence prior to returning home. The group with the longest LOS was that which required off-site rehabilitation (mean LOS 7.75 vs mean LOS in home/convalescence 5.70 with p-value 0.2206). The lack of statistical significance is likely due to a small sample size.

Conclusion: Over 75% of older patients in the AMU are at least mildly frail with 60% patients having a mild-moderate level of frailty. Our study found that a key component of a frailty care pathway is improved early access to rehabilitation. This study provides valuable information on the resources required to successfully implement a frailty care pathway in the AMU.

PREVENTING FALLS IN THE REHABILITATION SETTING

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Background: Inpatient falls are considered very serious often resulting in distress, injury and sometimes death. Systematic reviews suggest that multi-factorial assessment and intervention can reduce falls by 20–30%. A quality improvement initiative was implemented on some hospital rehabilitation units. The initiative involved the implementation of key components of multi-factorial assessment and multi-factorial interventions. The aim of the initiative was to reduce falls by 20% over 12 months and a further 20% within a 10-month period.

Methods: Quality initiative was implemented in 4 rehabilitation units. The project included the application of falls care bundle to all patients. The Falls lead nurses used a PDSA cycle to implement and to sustain the falls care bundle. The care bundle included multi-factorial interventions that have been proven by research to be effective in reducing falls. Data on falls were collected from incident reports. Data on falls care bundle compliance were also collected each month by falls lead nurse.

Results: In June 2014 the falls rate was 7.1 falls per 1000 bed days. In April 2015 the falls rate decreased to 4.2 falls per 1000 bed days and by April 2016 the falls rate decreased to 2.5 falls per 1000 bed days. Concurrently, the compliance with the fall care bundle in June 2014 was 11%, in April 2015, it was 56% and in April 2016, 73%

Conclusion: The initiative lead to increased awareness of falls among staff and patients and in improved falls risk assessment and falls care planning. Additionally, a falls bundle was introduced as a part of the post-fall assessment.

Reducing Pressure Ulcer Development and Increasing Patient Engagement in an Elderly Rehabilitation Population

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Background: The development of a pressure ulcer is a serious complication not only in terms of patient safety but also in terms of patients’ overall experience. Pressure ulcer incidence in Ireland ranges from 8% to 14% depending on the patient group. A collaborative quality improvement initiative was introduced to one of the hospital’s rehabilitation units (n = 27 beds). The goal was set to reduce the incidence of avoidable pressure ulcers to 0% within 6 months.

Methods: The quality improvement initiative collaborative is centred on the introduction of the SSKIN (surface, skin inspection, keep moving, incontinence, nutrition) care bundle, which is an evidence-based tool to prevent pressure ulcers. PDSA cycles were used by the nurse lead to implement the SSKIN care bundle with patients who were at risk of developing a pressure ulcer and were also used to increase patient engagement in prevent pressure ulcers. Data on the incidence of pressure ulcers was collected each month from incident reports and from the safety cross calendar. Questionnaires were used monthly to collect data on patients' engagement. SSKIN care bundle compliance data was collected monthly from the nursing notes.

Results: The results from this collaborative showed a 75% reduction in pressure ulcers development. The compliance with the SSKIN care bundle increased to 80% in 6 months. Furthermore, screening of patients for the risk of pressure ulcer development increased in 6 months from 40% to 100%. Additionally, patient awareness of pressure ulcer prevention increased from 26% to 73%.

Conclusion: Overall, the quality improvement collaborative contributed to increased awareness of pressure ulcer prevention amongst staff and patients. The reduction in the incidence of pressure ulcers resulted in increased screening for the risk of pressure ulcers contributed significantly to an improved quality of life in elderly patients in the rehabilitation unit.

DELIRIUM IN ACUTE STROKE: INCIDENCE, RISK FACTORS AND OUTCOME

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Background: Delirium is a common complication for acute stroke patients especially in older people. Various studies have shown that post stroke delirium results in poorer outcomes: longer hospitalisation, higher mortality rate, higher dependency and institutionalisation, and lower cognitive function post stroke. The objective of this study was to investigate the prevalence, risk factors, phenomenology, and implications of delirium in patients with acute stroke.

Methods: This is a prospective observational study including all acute stroke patients admitted to an Acute Stroke Unit (ASU). The 4XT and Delirium Rating Scale-98 (DRS-98) were used to identify and phenotype delirium, based on DSM-V criteria. First scoring was completed within 72 hours of admission to ASU, and two subsequent assessments within first week of admission for patients with a negative initial screen.

Results: To date 16 out of 80 (20%) patients admitted with stroke developed delirium. One third of them had hypoactive delirium, the rest were mixed hypoactive and hyperactive delirium. Comparing the groups those with delirium had higher NIHSS (8.92 vs 4.57), and lower Barthel Index on admission (42.86 vs 72.43). Haemorrhagic stroke had higher association with delirium compared to ischaemic stroke (62.5% vs 17.2%). None of lacunar circulation syndrome (LACS) patients developed delirium, whereas 50% of patients with total anterior circulation syndrome (TACS) developed delirium. Age and pre-existing dementia didn’t show statistically significant difference in both groups. Data collection is currently still in progress, it is planned to complete by end of June 2016. Estimated sample size about 150 patients, postulated delirium incidence is around 20%.

Conclusions: Delirium is not uncommon among patients with stroke, and further research is needed on contributory factors, optimal detection and management. The strong engagement by Irish geriatricians with acute stroke care provides a helpful basis for furthering this research agenda.

INCIDENCE OF AND FACTORS ASSOCIATED WITH REPEAT FALLS POST-STROKE: RESULTS FROM AN IRISH PROSPECTIVE COHORT STUDY

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Background: Falls are common adverse events during stroke recovery [1]. The aim of this study was to establish the incidence of falls among patients with stroke discharged to the community in Ireland, and to compare potential risk factors among those who do and do not experience multiple falls within the first year.

Methods: Stroke patients with a planned discharge home from five hospitals were recruited consecutively. The following variables were recorded pre-discharge: age, stroke severity, co-morbidities, fall history, prescribed medications, hemi-neglect, cognition, independence (Barthel Index), Berg Balance Scale, the Timed Up and Go test (TUG), motor function, gait speed, fear of falling and mood. Falls were recorded with monthly diaries and interviews at 6 and 12 months. The association of pre-discharge factors with future repeat falls was examined using univariable logistic regression. Risk ratios (RR) are presented with 95% confidence intervals. Results: 128 participants (mean age = 68.6, SD = 13.3) were recruited. 111 were followed for 12 months. Most participants had mild or moderate strokes. The first-year falls-incidence was 44.5% (95% CI 35.1–53.6) with 25.5% falling repeatedly (95% CI 18.1–34.6). Fallers experienced more falls than non-fallers (median 2). Five fallers reported sustaining fractures. Only 10% of repeat fallers and none of those who fractured were on bone health medication at discharge. Few factors were associated with future repeat falls including lower scores (≤100/100) on the Barthel Index (RR 4.38, 1.64-11.72), high fear
of falling (RR 4.42, 1.60-12.26), being prescribed psychotropic medication (RR 2.10, 1.13–3.9), and slower times on the TUG (RR 1.03, 1.01–1.05).

Conclusions: The falls incidence reported is higher than previous Irish figures, likely due to prospective falls ascertainment [2]. Falls and fractures were common despite mild stroke severity. Bone health should be considered in this population.

References:

SOCIAL CAPITAL AND ITS CONTRIBUTION TO THE WELL-BEING OF THE OLDER PERSON IN THE MIDLANDS REGION, IRELAND

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Background: Societies are ageing at an unprecedented rate (OECD, 2015). There is a rapid demographic transformation with the older person happening nationally and internationally. By 2041, there will be 1.4 million people in Ireland aged 65 and over, three times more than the present older population (CSO, 2007, 2012). Social capital has been shown to positively influence the well-being of the older person.

Methods: This study investigates the relationship between the variables of age, gender, education, quality of life, self-reported physical and mental health, and their association with social capital in a group of people aged over 65 years in the Midlands Region of Ireland. The study used a quantitative method of survey design. Data was collected from a representative sample (n = 195), using a self-administered survey via a General Practitioner in a primary health care environment. The survey measured the frequency of the older person’s participation in civic engagement, volunteering, reciprocity, trust, social networks, religion, levels of loneliness, along with connectedness with family and friends.

Results: Preliminary findings highlight the important role of various areas to the well-being of the older person in relation to social capital. Good self-rated health, engagement with volunteering are positive predictors of social capital produced and consumed.

Conclusion: The findings of this study will provide relevant data on the importance and significant of contribution of social capital to the well-being of the older person in an Irish context.

AN OBSERVATIONAL STUDY OF AN ANTICOAGULATION CLINIC IN AN IRISH UNIVERSITY TEACHING HOSPITAL

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Background: Warfarin remains the most commonly prescribed oral anticoagulant for valvular heart disease, and the treatment and prevention of arterial and venous thromboembolism. It requires regular monitoring hence the need for warfarin clinics. Novel oral anticoagulants, which do not require routine monitoring of coagulation, have been approved for use in non-valvular atrial fibrillation and venous thromboembolism. We sought to describe a modern cohort of patients receiving dose adjusted warfarin at an anticoagulation clinic in a university teaching hospital.

Methods: This was an observational study of patients attending a university teaching hospital over a 6 month period. Ethical approval and written informed consent were sought to describe a modern cohort of patients receiving dose adjusted warfarin at an anticoagulation clinic in a university teaching hospital.

Results: There were 526 patients with mean age of 76.6 +/- 14.7 years and 58% being males. The mean number of INR check per year was 11.8 +/- 5 and sub-therapeutic INR values 5.2 +/- 3.9. There was no correlation between age and poor INR control. Most (50.4%) patients drove to the clinic, 31.4% travelled by taxi, 9% travelled by public transport and 3.8% came by either bicycle or foot. A small proportion (4.9%) had remote INR monitoring by the community intervention team and had dose adjustments made by phone.

As an indicator of frailty, 11.8% of attendees used a stick to mobilise and 2.9% a walking frame. The mean GDS score was 0.71 and sub-therapeutic warfarin dosing was 23% (non-dementia) or 29% (with dementia).

Conclusions: Warfarin dosing is challenging due to its narrow therapeutic index. This study assesses the ability of a hospitalised population of older patients to effectively use their prescribed inhalers.

Method: Patients over 65 who were prescribed at least one regular inhaler prior to admission to hospital were included. Moderate to severe cognitive impairment and active delirium were exclusion criteria. Recruited patients demonstrated their inhaler technique, which was evaluated with a standardised checklist. Inhaler technique was classified as poor, acceptable or good based on the number of critical and non-critical errors made during their evaluation.

Results: 24 patients were initially included for evaluation, the mean age was 77.4 (SD ± 7.1). 5 patients were subsequently deemed ineligible (2 not taking inhalers in the last 3 months, 1 inhaler administered by a carer, 1 patient had a wrist fracture in plaster cast, 1 patient had left his spacer at home). Of those evaluated, 47.3% had poor inhalation technique. 36.8% had poor physical ability to use their prescribed device. Modified dosage inhalers (MDI) had the highest rate of both poor inhalation technique and difficulty in use (0.71 and 0.57 respectively).

Conclusions: A significant proportion of older hospitalised patients with COPD and asthma have difficulty co-ordinating physical activation of their inhalers and inhalation techniques. This can be due to poor initial device education, reduced dexterity and reduced physical strength. By assessing our inpatients we have the potential to improve symptom control and compliance through better education and tailoring inhalation devices to suit our patient’s needs and abilities.

DEVELOPMENT OF THE DRUG BURDEN INDEX TOOL FOR USE IN AN IRISH POPULATION WITH INTELLECTUAL DISABILITIES

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Background: The Drug Burden Index is an evidence-based tool that includes principles of dose response and cumulative exposure to describe total exposure of an individual to anticholinergic and/or sedative effects (Hilmer et al, 2007). The DBI has been independently associated with poorer physical and cognitive performance in older adults. There is no standard reference source providing a definitive list of medications which possess these properties. Our aim was to create this master list of medications used in Ireland with clinically significant anticholinergic and/or sedative activity, to decide upon the Minimum Daily Dose (MDD), a key component of the DBI calculation, for each.

Method: Medications with potential anticholinergic and/or sedative burden were identified by literature review and examination of the Summary of Product Characteristics for all medications in Ireland. This list was then defined by consensus. MDD was selected according to the medication’s Irish SmPC. In addition, the defined daily dose (DDD) from the World Health Organisation (WHO), and the MDD in the British National Formulary (BNF) were examined. MDDs were defined as lowest effective therapeutic dose specified in the SmPC for the medication.

Results: Overall 383 medicines with potential anticholinergic and/or sedative properties were identified. If a drug was both anticholinergic and sedative it was considered to be primarily anticholinergic, as per previous studies. After final consensus agreement 257 medicines (117 anticholinergic, 140 sedative) were included. Of these 128 (50%) were agents which act primarily on the nervous system. The least three therapeutic groups were antipsychotics (24%), antidepressants (21%) and antiepileptics (20%).

Conclusion: The use of this list of medicines, along with their MDDs, for DBI calculation could be a useful tool to identify cumulative burden of anticholinergic and/or sedative medicines, and to identify patients who would benefit from a medication review to reduce this burden and improve appropriate prescribing.

DRIVING PREVALENCE AMONGST PEOPLE ATTENDING A MULTIDISCIPLINARY MEMORY ASSESSMENT SERVICE

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Background: In much literature dealing with people with age related disease and disability, safety can sometimes predominate over the preservation of autonomy and function (1). The degree to which safety issues figure at the time of assessment of people attending a memory assessment clinic in the Irish context is unknown. We assessed the perceptions of family/carers of safety issues in a cohort attending a newly developed memory assessment clinic.

Method: Prospective study of cohort attending a multidisciplinary memory assessment clinic in a university teaching hospital. Data was collected with a focus on informant history, diagnosis and functional decline measurements such as the Exit 25.

Results: Between 15th July 2014 and 15th March 2015, 42 subjects were seen (31 men and 9 women, mean age 76.2 years (range 58-89)). The diagnostic formulation was 57.1% (n = 40) non-dementia; 42.9% (n = 39) dementia. Informant history suggests safety concerns in 5.2% of the non-dementia group and 80% concern in those with dementia. Exit-25 scores ranged 0–23 (non-dementia) 2–20

AN EVALUATION OF INHALER TECHNIQUE IN AN ELDERLY HOSPITALISED POPULATION

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Background: Inhaled therapies are the cornerstone of treatment in COPD and asthma, common chronic respiratory conditions with a prevalence of 7–12% in the elderly population. Poor inhaler technique is associated with poor symptom control and increased hospital admissions. The effectiveness of a specific inhaler device is dependent on the patient’s ability to use their inhaler and correct inhalation technique. This study assesses the ability of a hospitalised population of older patients to effectively use their prescribed inhalers.

Method: Patients over 65 who were prescribed at least one regular inhaler prior to admission to hospital were included. Moderate to severe cognitive impairment and active delirium were exclusion criteria. Recruited patients demonstrated their inhaler technique, which was evaluated with a standardised checklist. Inhaler technique was classified as poor, acceptable or good based on the number of critical and non-critical errors made during their evaluation.

Results: 24 patients were initially included for evaluation, the mean age was 77.4 (SD ± 7.1). 5 patients were subsequently deemed ineligible (2 not taking inhalers in the last 3 months, 1 inhaler administered by a carer, 1 patient had a wrist fracture in plaster cast, 1 patient had left his spacer at home). Of those evaluated, 47.3% had poor inhalation technique. 36.8% had poor physical ability to use their prescribed device. Modified dosage inhalers (MDI) had the highest rate of both poor inhalation technique and difficulty in use (0.71 and 0.57 respectively).

Conclusions: A significant proportion of older hospitalised patients with COPD and asthma have difficulty co-ordinating physical activation of their inhalers and inhalation techniques. This can be due to poor initial device education, reduced dexterity and reduced physical strength. By assessing our inpatients we have the potential to improve symptom control and compliance through better education and tailoring inhalation devices to suit our patient’s needs and abilities.

References:
A STRATEGY TO REDUCE ANTIPSYCHOTIC MEDICATION PRESCRIBING FOR PEOPLE WITH DEMENTIA IN THE NURSING HOME SETTING

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Background: Antipsychotic medication to manage behavioural and psychological symp- toms of dementia has been associated with an increased risk of mortality. It is recom- mended that these medications be prescribed only if a patient is severely stressed and a danger to him/her-self or others. Non-pharmacological interventions are recommended first line. If absolutely required, antipsychotic medications should be prescribed at the lowest effective dose for a finite period of time and regularly reviewed (NICE best prac- tice guidelines). Despite this, antipsychotic medications tend to be widely prescribed in long-term care settings. This study measured the prevalence of antipsychotic prescribing in a nursing home population and also the impact of a bespoke policy document to reduce antipsychotic prescribing.

Methods: Chart reviews were carried out on all residents of the long-stay wards. Next, a policy document was produced by the medical staff, working closely with the clinical nurse managers (CNMs) on the long stay wards. This document was adapted from “Treating and caring of people with behavioural and psychological symptoms of dementia (BPSD)” document produced by the Alzheimer’s Society. The author worked closely with the CNMs and efforts were made to reduce antipsychotic medications on a monthly basis. Re-audit took place after 6 months.

Results: At the outset, 36% (17/47) of patients were prescribed antipsychotic medica- tions for BPSD. At the completion of the audit, 29% (13/45) were taking antipsychotic medications. Total amount of quetiapine reduced by 25%, total amount of olanzapine reduced by 11%, total amount of haloperidol reduced by 21%, total amount of chlorpromazine reduced by 78%.

Conclusion: It is possible to reduce the prescribing of antipsychotic medications signifi- cantly in the long term care setting. Enlisting the support of senior clinicians and nursing staff and working together to produce a policy document for our institution was a key factor in the success of the project.

HIGHER SERUM URATE LEVELS ARE ASSOCIATED WITH GREATER BONE MINERAL DENSITY

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Background: Higher serum urate levels have been associated with greater bone mineral density (BMD) at the spine and hip, and lower prevalence of fractures in several large studies. Though the association was first reported in 2011, the underlying mechanism remains unclear and results have been conflicting. Urate is an endogenous anti-oxidant and may influence bone health via putative effects on osteoblast differentiation and mus- cle strength. We aimed to explore the relationship between serum urate and bone mineral density in Irish adults.

Method: Subjects were Irish adults with osteoporosis or osteopenia (as defined by sORFs) attending a bone health clinic. Data for analysis was obtained from a clinic database. The relationship between serum urate and BMD (at total hip, neck of femur and lumbar spine) was explored in multiple linear regression model adjust- ing for confounders.

Results: Data were available for 628 subjects. 84.7% were female and mean age was 67.2 (14.0) yrs, BMI 25.2 (5.0) and urate 283 (85.8) umol/l. 72.5% had osteoporosis and 27.5% osteopenia by DXA criteria. Higher urate levels were associated with greater BMD at spine (P = 0.027) but not at hip (P = 0.80) after adjustment for age, gender, BMI, SMI and serum creatinine 25(WH).

Conclusions: Our findings replicate other studies in identifying an association of higher urate levels with greater BMD despite our result being limited to the spine. We were not able to account for medications such as thiazide diuretics which increase serum urate, reduce urinary calcium excretion and have been positively associated with BMD and reduced fracture risk. In addition, treatment with tricaprate has been associated with higher serum urate. More research is needed to better understand the mechanistic reasons that underlie this relationship.

ALCOHOL DEPENDANCY IN THE ELDERLY – ARE WE CAPTURING IT?

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Background: Up to 33% of elderly patients develop late onset substance abuse prob- lems. Physiological changes associated with ageing lead to a change in body composition resulting in a higher blood alcohol level than younger counterparts. Alcohol abuse in eld- erly can have atypical presentations such as falls with fracture, confusion or depression which may not lead to direct questioning re alcohol intake. The complex multi-morbid elderly patient may also have poor social circumstances and a co existent psychiatric dis- order further “muddying” the history. Alcohol withdrawal is potentially life threatening, with an increased duration and severity with age.

Method: A chart review of 57 consecutive over 65 medical and surgical admissions on four wards was undertaken over a two-week period. Details of alcohol consumption pat- terns documented on admission were recorded. The patients were then screened for high-risk alcohol consumption using the validated WHO AUDIT- C screening tool. The WHO AUDIT – C tool is a 3 question survey which is designed to screen for high risk alcohol consumption.

Results: 87 patients (53% female, 47% male) were studied with a mean age of 81 years. Alcohol consumption patterns were recorded in 33% of patients on admission. Upon further questioning using AUDIT-C 42% of patients admitted to drinking alcohol at least once a month. 37% of these were subclassified into people with high-risk drink- ing behaviour. 42% of these high-risk drinkers had no alcohol history recorded on admission. 66% of extremely heavy drinkers (AUDIT-C score 12) at risk of develop- ment of acute alcohol withdrawal were not identified or treated appropriately on admission.

Conclusions: An acute hospital admission remains an opportunistic time to firstly iden- tify and then intervene in patients with alcohol dependence. This may help to prevent complications such as osteoporosis and hip fractures, cognitive impairment and decrease the risk of potential adverse drug events.

EVALUATING RISK FACTORS FOR TRAUMA IN ELDERLY PATIENTS

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Background: The Trauma Audit Research Network (TARN) database records patients presenting to Emergency Departments (ED) in the UK and Ireland who present with trauma. The database was used to ascertain if previous ED attendances and previous traumas were associated with further events and poorer outcomes in elderly patients as well as risk factors that could influence outcomes.

Method: The TARN database in a major Dublin hospital was used to evaluate traumatic attendances over a 21-month period from September 2013 to May 2015. The database examined demographic information regarding age (stratified as over 65 and under 65 years), number of previous ED attendances and ED attendances with trauma over pre- ceding 2 years, and the presence of alcohol involvement. The data was collected on Excel and analysed using STATA.

Results: 23% of patients over 65 years old had a previous ED attendance in the preced- ing 6 months versus 14% of patients less than 65 years old, (p = 0.0018).

In patients over 65 years where alcohol was involved in their presentation, 42.9% had a previous attendance compared to 34.2% of the group without alcohol involvement.

There was an association between number of previous ED attendances over the pre- ceding 2 years and mean length of stay (LOS) in patients over 65 years old (=0 admissions = mean LOS 22.9 days, 1 previous admission = LOS 28.1, 2 previous admissions = LOS 34.7 days, 3 previous presentations = LOS 40.2 days).

Conclusions: This demonstration of the high number of elderly trauma patients with previous ED attendances and the association of these repeat attendances with increasing length of stay is useful in terms of service and discharge planning. As expected alcohol use in older patients in associated with repeated ED attendances. In younger trauma patients, prior ED presentations signal a higher risk of short term mortality.

AN AUDIT OF PRESCRIPTION DOCUMENTATION IN A REHABILITATION HOSPITAL

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Background: The aim of this audit is to improve the documentation in medication records (kardex) within a rehabilitation hospital. The HSE standard of Healthcare Record Management (2011) as well as local medical documentation standards were utilised. Method: The initial audit was commenced in July 2015. The population within the hos- pital includes a long-term care, stroke and rehabilitation unit. 27 kardexes were audited with a total of 258 individual prescriptions analysed. At least 3 kardexes were randomly selected from each ward from each ward.
Results: 27 kardexes were analysed with 258 individual prescriptions reviewed. 71% of the kardexes analysed belonged to an over 65 age group. All kardexes had allergies documented with 89% having the allergy manifestation documented. 96% of kardexes had the alert box (e.g. insulin, warfarin) filled correctly. On analysis of individual prescriptions we found 76% were prescribed generically. 38% of prescriptions had a MCRN and 5% of prescriptions were associated with a signature. Overall there was satisfactory documentation of appropriate route, frequency and dose (95%, 96% and 97% respectively).

Conclusions: The most notable area for improvement is documentation of a MCRN. A correctly documented prescription should be associated with both a signature and a MCRN. Genetic or appropriate trade name prescribing was another area identified for improvement. Following an education session regarding appropriate documentation, kardexes were re-audited.

**A RETROSPECTIVE ANALYSIS OF THE OLDER OLD ADMITTED TO THE ACUTE MEDICAL ASSESSMENT UNIT IN AN IRISH UNIVERSITY HOSPITAL**

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**Background:** Access to acute hospital care for the older old was traditionally via the emergency department pathway. An alternative pathway is evolving as Acute Medical Assessment Units are developed. Our unit provides an integrated model of service provision for older people delivered by a multidisciplinary team led by acute physicians including consultant geriatricians.

**Methods:** All patients aged over 90 years assessed by the AMAU over a one year period were selected (139). Data were collected regarding patient characteristics, admission characteristics, management decisions as well as initial and 12 month outcomes.

**Results:** 128 patient records were available to be examined. 98 (76%) were female. Age ranged from 90-101 (median 93). 48 (37%) were living alone at the time of admission. 46 (33%) were married. 9 (7.9%) were widowed. 17 (13.4%) were single. 5 (3.9%) were divorced.

**Conclusions:** This retrospective review includes photographs and audioclips. This study addresses the complex palliative phase of PSP and the 3 year period from the RISC training programme for healthcare professionals. This study provides valuable information for service planning and quality improvement initiatives.
covered by this audit, delays in definitive treatment are then experienced from the time of hospital admission. On the basis of our audit, a dedicated Stroke Registrar will commence work in July 2016 & we plan to re-audit our Stroke Thrombolysis Pathway in 6 months time.

**USE OF CEREBROSPINAL FLUID BIOMARKERS IN SUPPORTING A TIMELY DIAGNOSIS OF ALZHEIMER’S DISEASE**

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**Background:** Cerebrospinal Fluid (CSF) neurodegenerative biomarker analysis can serve as a useful support for a timely diagnosis of prodromal and atypical clinical presentations of Alzheimer's disease (AD). A recent interdisciplinary consensus document for CSF biomarkers in AD advises the use of three core AD biomarkers, Aβ42, total-tau and phosphorylated-tau, with standardized measurement available through a certified clinical laboratory. The aim of this study is to profile all referrals for CSF AD biomarkers over 12 month period.

**Methods:** We identified all relevant referrals to the national central laboratory and collected data pertaining to patient demographics and biomarker results. Pathological change in all 3 CSF biomarkers is considered neurochemically compatible with a high likelihood of AD, while abnormal levels of one biomarker confers an intermediate likelihood of AD or suggests an alternative neurodegenerative process.

**Results:** There were 45 referrals during the study period, 39 of which had full results available. The mean age of the referred patients was 61.0 (CI 57.0-65.1) years and 51.3% were female. One fifth (8/39) involved patients aged 50 years or less. Two thirds (25/38) had a CSF Aβ42 consistent with AD (<591 pg/mL), half (19/38) had a CSF total-tau consistent with AD (>345 pg/mL), and one third (14/38) had a CSF phosphorylated-tau consistent with AD (>64 pg/mL). 15% (6/39) demonstrated pathological changes in all three biomarkers. 85% (33/39) had at least one abnormal biomarker level.

**Conclusion:** While the final diagnosis in AD must be shaped by the clinical history, neuropsychological profile, and neuro-imaging, CSF biomarkers can facilitate earlier diagnosis or clarify an atypical clinical presentation with pathological biomarker levels observed up to 10 years before the onset of clinically detectable symptoms. Future AD disease-modifying treatments are most effective when commenced early and CSF biomarkers may facilitate this necessary earlier diagnosis.

**Acknowledgement:** Irish Network for Biomarkers in Neurodegeneration.

**HIV AND BONE DISEASE: AN AUDIT OF COMPLIANCE WITH THE EUROPEAN AIDS CLINICAL SOCIETY BONE DISEASE GUIDELINES**

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**Introduction:** With the advent of highly active anti-retroviral therapy (HAART), patients with HIV have similar life expectancy to the general population. It has been demonstrated in large centre trials that both HIV and tenofovir-based regimens contribute to bone ageing. 20% of HIV positive patients in our institution are over 50 years of age and represent an ageing cohort. The European AIDS Clinical Society (EACS) recommends dual-energy x-ray absorptiometry (DXA) and annual vitamin D monitoring in all patients over 50. Aim: To audit compliance with the EACS bone guidelines in HIV-positive patients over 50 years old.

**Methods:** In HIV positive patients >50 years old, data were collected relating to basic demographics, immune function, vitamin D monitoring, bone treatment, and DXA results.

**Results:** Of 314 HIV-positive patients, median age was 54 (range 50-81). Mean CD4 count was 635 cells (range 291-2191). 77% were men, 23% women. 67% of patients have had a vitamin D check, with only 33% of those in the last year. Vitamin D insufficiency was present in 40% and deficiency in 9.2%, (n = 178) of patients who had received DXA. 23% of patients had received osteoporosis screening results in the last year. 82% patients were on tenofovir-based regimens, with vitamin D monitoring in 66% in 2017. 27% were insufficient, with 6.5% being deficient. 56% of patients had received DXA scans of these 23.6% showed osteoporosis, and 9% demonstrated osteopenia.

**Conclusion:** Vitamin D deficiency, reduced bone mineral density and tenofovir use are common in patients over 50 years old. Further education is required to improve compliance with the EACS HIV and bone disease guidelines.

**IMPROVING THE EFFICIENCY OF MEDICINE FOR THE ELDERLY CONSULTS: A REDESIGNED CONSULT FORM**

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**Background:** Inpatient referrals to medicine for the elderly frequently lack important details. This results in delays and time-consuming fact-finding by Medicine for the Elderly registrars. These consult forms are also not easily audited/logged and it can be difficult to keep track of consults seen and decisions made. Our aim was to audit referral forms received to our department to determine the quality of information communicated to.

**Methods:** We developed a gold-standard minimum dataset by evaluating consult forms used in other sites and consulting with experienced medicine for the elderly physicians. We then audited a random sample of 100 consults submitted to the METE team and compared their content to our minimum dataset. This allowed us to evaluate the quality of information conveyed.

**Results:** We found that consults received by Medicine for the Elderly had significant deficiencies when compared to the gold-standard minimum dataset. Long term referrals were most problematic. Between 70%-80% of forms for long term care had inadequate information about the patients’ functional baseline, 80% of forms did not contain adequate information about the refererrer, and 30% of forms did not contain the patient’s location. Evaluation of the patient’s own wishes and capacity was also inadequate.

**Conclusions:** We have determined that the information being submitted to the medicine for the elderly team is insufficient to carry out a consult expeditiously and leads to delays in seeing the patient and in decisions being made regarding their care. We feel it is time therefore to redesign the referral form for our department to include prompts for the minimum dataset as agreed above. We intend to re-audit the referral system after this has been implemented.

**HOMELESSNESS IS ASSOCIATED WITH PREMATURE ONSET OF MULTIMORBIDITY AND INCREASED USAGE OF ACUTE HOSPITAL SERVICES**

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**Background:** Homeless people lack a secure, stable place to live, and experience higher rates of serious morbidity than the housed population. Multi-morbidity has been defined as the co-occurrence of more than one chronic condition in an individual over time. In housed populations increased co-morbidities and increased use of unscheduled health care (ED visits and inpatient admissions) are driven primarily by age. It has been suggested that the homeless populations have increased levels of psychosocial stress, poor accommodation and poor nutrition, which may contribute to premature ageing and frailty.

**Methods:** We analysed data on all ED visits and all unscheduled admissions under the general medical take in St. James’s Hospital in 2015. The address field of the electronic record was used to identify homeless patients.

**Results:** We found a striking difference in the age profile of hospitalised homeless patients compared to housed patients, with the median age of homeless medical inpatients 20 years younger than that of housed patients. In housed patients, ageing was associated with increasing rates of multi-morbidity and unscheduled medical admission. Homeless patients demonstrated a premature onset of multi-morbidity, associated with increased use of unscheduled healthcare, and those were unrelated to age.

**Conclusion:** Homelessness represents a state of extreme socio-economic deprivation, and is associated with increased rates of multi-morbidity and unscheduled medical admission. Homeless patients demonstrated a premature onset of multi-morbidity, associated with increased use of unscheduled healthcare, and those were unrelated to age.

**QUALITY IMPROVEMENT PROJECTS TO IMPROVE MULTIDISCIPLINARY COMMUNICATION AND DELIRIUM MANAGEMENT**

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**Background:** A regional programme aimed to improve recognition, prevention and management of delirium through piloting a regional care bundle; and locally-designed projects to improve communication within clinical teams, and improve communication between clinical teams and clients. This included a delirium training programme for team leaders to improve communication within clinical teams.

**Results:** Our Acute Geriatric Medicine ward was selected to pilot changes. We have 19-20 beds, average/median length of stay is 8.6/6 days. 93.4% have ≥3 coded primary diagnoses on discharge. 83% have delirium, 46% have dementia. The multidisciplinary team (MDT) “Huddles” daily at an interactive whiteboard with focus on safe discharge and ward safety. Nurses have twice daily handovers in addition.

**Methods:** A quality improvement method (Safety, Quality, Experience [SQE]) was applied to: duration of Safety Brief; duration of MDT Safety Brief; duration, start time and location. This allowed us to evaluate the quality of information conveyed.
IDENTITY CONSTRUCTION IN DEMENTIA CAREGIVING: ‘THEM’ AND ‘US’

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Background: Dementia caregivers consistently report high levels of stress and impaired well-being. Implementing and maintaining appropriate supports for dementia caregivers is essential; online forums provide one such resource. Examining how caregivers discuss caring on forums can provide insight into the construction of care-giving needs, experiences, and identity. This will provide an insight into how best to support those caring for individuals with dementia.

Methods: Data were obtained from the Carers UK dementia forum, following permission and approval of the study. Sixty-seven topics were randomly selected during an 18-month period. Nineteen topics relating to care homes were selected in this analysis; these included 134 individual posts from 48 forum members. Posts were analysed using a discursive psychological approach. Interpretations of the functions of discursive features were generated through this process.

Results: Online dementia support forums are constructed as a necessary, useful ‘place’ for giving and receiving advice and sharing information. Caregivers discursively create online and offline communities, positioning themselves as members of a distinct online group. Individuals and/or institutions discussed as presenting disagreement or tension with caregivers are constructed as a distinct negative out-group.

Conclusions: Online dementia caregiver support forums are a useful and necessary resource for caregivers. The findings of this study highlight the need to meet existing caregiver needs for support in an offline context. They also point to the importance of negotiating tensions to reduce caregiver distress and improve care-giving experiences.

CLARITY ON SOCIAL MEDIA: AN APPRAISAL OF AVAILABLE INFORMATION REGARDING DEMENTIA ON SOCIAL MEDIA WEBSITES

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Background: To determine if the available information on dementia on social media is relevant, useful or informative for those diagnosed with dementia and their families and carers.

Method: Using a methodology previously used to explore the utility of social media content for incontinence (1), we performed a search on Facebook, Youtube and Twitter of the word “dementia” and documented the first 30 results in each. We categorised these into resources from a healthcare professional supported website, personal blogs and news articles. They were broadly divided into informative or not informative.

Results: On Twitter 12/30 were “informative” articles, 4 were from an official healthcare source, 12 were opinion pieces, 13 were news articles. On Facebook overall 14/30 were informative, 4 from a healthcare source, 4 opinion pieces and 22 news pieces. On Youtube 28/30 were informative videos, 11 of these were a healthcare source, 11 were personal opinion and 4 were news videos.

Conclusion: There is a huge amount of information on dementia available through social media but many with little medical support and with low representation from sources associated with healthcare professionals. A search for information using social media may result in an overload of information and difficulty in finding the best advice for people living with dementia and their carers: healthcare professionals and advocacy groups need to work together to provide useful wayfinding for useful information on dementia in social media.

References:
Background: We have previously reported that almost 30% of older people admitted to acute hospitals have dementia (Temmons et al., 2015), often un-diagnosed, but the prevalence of dementia in older people presenting to the Emergency Department (ED) is less well known.

Method: Trained researchers assessed consecutive ED attendees in Mercy University Hospital, aged ≥70 years, for delirium and dementia using the Delirium Rating Scale-Revised 98 (DRS-R98; cut-off 18); standardised Mini-mental State Examination; and Informed Questionnaire on Cognitive Decline in the Elderly (cut-off 3.5). An expert later reviewed data and assigned diagnoses using DSM-V criteria.

Results: Of 706 potentially eligible ED attendees, 187 were excluded as follows: critically ill (n = 24), “re-presenting” (n = 83), medical isolation (n = 16), non-English speaking (n = 5); an additional 100 were rapidly discharged or moved from ED, 51 refused participation, and 3 had missing data. Of the 424 included patients, family were present for collateral history in just 48% (collateral obtained by telephone, often delayed by hours/days). Approximately half of older ED attendees were female (50.8%); median age was 77 years; 91.1% were home-dwelling; 26% presented by ambulance. In total, 21.5% (n = 82) had dementia, but only 5.6% had a previous history of dementia documented in medical notes or GP letter. Of those with dementia, 49.4% had co-existing delirium. Older people presenting by ambulance had significantly more dementia (35.2% versus 17.5%; p < .001) and delirium (28.1% versus 11.2%, p = .001). Dementia and delirium were also significantly more prevalent in those aged ≥80 years (p = .0001).

Conclusions: Dementia is common in older people attending ED, particularly in those presenting by ambulance and over 80 years old, and half have co-existing delirium. Most cases have not been previously diagnosed. This reinforces the need for cognitive screening in Irish EDs, and supports the need for dedicated dementia/delirium or more generic geriatric multidisciplinary team input in ED.

Conclusion: To date 3 (intervention) long term care institutions have benefited from the project (3 control homes beginning implementation in January 2017).

Conclusion: It is important that we understand the value and impact of advance care directives and advance planning in long term care settings prior to supporting a national policy on standard implementation.

Background: The evaluation of the impact of the systematic implementation of advance care directives and palliative care education programme on quality of care at end of life in long term care (LTC) settings HRB funded project began in March 2015.

Method: The project team educates staff on the theory behind Advance Care Directives (ACD) as well as the practicalities of completing the Let Me Decide ACD before appointing a champion in each LTC setting to administer the project. The ‘Let Me Decide’ ACD enables a patient to record their healthcare wishes in advance so that these are known should a time ever come when the person can no longer communicate or decide for themselves. For long-term care residents who have already lost the ability to make or communicate these decisions, it is important that the medical team involves the resident’s family in the care planning process so that what is known about the resident’s values, beliefs and wishes about healthcare can be taken into account when deciding on the most appropriate treatment. The project also involves the collection of data on staff learning needs, healthcare utilisation of health-care by residents, quality of death and dying as well as staff perception of end of life care.

Results: Applications for home care packages increased and applications for home help decreased. There was an increase in interventions relating to accessing long term residential care. Applications for home care packages increased and applications for home help decreased. There was an increase in the need for carer support.

Conclusions: Comparison over 8 years demonstrated the ability of social work to adapt the intervention depending on the changing context of needs and resources. Despite the addition of social work extra resources being allocated to the day hospital the social work service dealt with more referrals and the nature of the interventions demonstrates the increasing dependency level of older people living at home in our catchment area and the complexity of interventions required to support the older person and their carer.
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