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Age and Ageing, Volume 41, 2012
Age and Ageing, Volume 40, 2011
Age and Ageing, Volume 39, 2010
Age and Ageing, Volume 38, 2009
Age and Ageing, Volume 37, 2008
Age and Ageing, Volume 36, 2007
Age and Ageing, Volume 35, 2006
Age and Ageing, Volume 34, 2005
Age and Ageing, Volume 33, 2004
Age and Ageing, Volume 32, 2003
Age and Ageing, Volume 31, 2002
Age and Ageing, Volume 30, 2001
Age and Ageing, Volume 29, 2000
Age and Ageing, Volume 28, 1999
Age and Ageing, Volume 27, 1998
Age and Ageing, Volume 26, 1997
Age and Ageing, Volume 25, 1996
Age and Ageing, Volume 24, 1995
Age and Ageing, Volume 23, 1994
Age and Ageing, Volume 22, 1993
Age and Ageing, Volume 21, 1992
Age and Ageing, Volume 20, 1991
Age and Ageing, Volume 19, 1990
Age and Ageing, Volume 18, 1989
Age and Ageing, Volume 17, 1988
Age and Ageing, Volume 16, 1987
Age and Ageing, Volume 15, 1986
Age and Ageing, Volume 14, 1985
Age and Ageing, Volume 13, 1984
Age and Ageing, Volume 12, 1983
Age and Ageing, Volume 11, 1982
Age and Ageing, Volume 10, 1981
Age and Ageing, Volume 9, 1980
Age and Ageing, Volume 8, 1979
Age and Ageing, Volume 7, 1978
Age and Ageing, Volume 6, 1977
Age and Ageing, Volume 5, 1976
Age and Ageing, Volume 4, 1975
Age and Ageing, Volume 3, 1974
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Evaluating Frail People’s Use and Experience of the Irish Healthcare System: A Mixed Methods Study

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Background: Frail older people are vulnerable to adverse outcomes and require a multi-modal, integrated package of healthcare services. Planning such care requires robust evidence about the frail population and their current patterns of service utilisation in order to identify the nature and scale of problems in the current model of care. This study describes the community-living frail older Irish population and examines their patterns of service utilisation and their experiences seeking, securing and managing services.

Methods: A sequential explanatory mixed methods design was operationalised. Data was obtained from wave one of the Irish Longitudinal Study on Ageing (TILDA) for those aged ≥65 years (n = 3,507). Multivariate regression techniques examined the impact of frailty, measured by the Frailty Index, on utilisation of hospital and community services adjusting for need, predisposing and enabling factors. Latent class analysis identified profiles of service use among frail TILDA participants (n = 745). Data from semi-structured interviews with a qualitative sample of frail older people (n = 12) explored why service-use patterns occur.

Results: 24% (95%CI: 23–26) of the Irish older population were classified as frail. In adjusted models, frailty remained a significant predictor of utilisation across many types of services. Four diverse patterns of service use were identified among frail older people. Misaligned referral routes, hospital consultant waiting lists and inadequate budgeting all contributed to impeding access to services. However, the Public Health Nurse Service enabled navigation and referral to community services.

Discussion: The findings indicate a supply-constrained, hospital-centric healthcare system which fails to proactively manage the needs of the majority of the frail older population. Receiving community services is a rarity rather than the norm, and these are utilised mainly by the very-frail (FI > 0.40, p < 0.01).

Conclusions: Since the frail older population comprises a diverse set of service users, new models of care should be designed to reflect that diversity.
ENLARGED PERIVASCULAR SPACES OF SUBJECTS WITH SILENT LACUNAR INFARCTION FROM A NATIONAL LONGITUDINAL STUDY ON AGEING

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Background: Silent lacunar stroke is common in older people. We are increasingly aware of the relevance of enlarged perivascular spaces (EVPs) as an indication of underlying vascular disease. We analysed a subset of community-dwelling participants over the age of 65 years from a nationwide study to determine differences between subjects with and without lacunes.

Methods: 440 participants over the age of 65 years were randomly chosen from a nationwide dataset of over 8,000 individuals who were recruited nationally on the basis of socio-economic and geographical proportional stratification.

All participants underwent 1T MR brain scans were reviewed and scored for background cerebrovascular disease, including EVPs, lacunar infarcts and subcortical hyperintensities. Diffusion Weighted Imaging (DWI) and Apparent Diffusion Coefficient (ADC) maps were reviewed to identify acute parenchymal insults. Reviewers were blinded to the participants’ medical history.

EVP score was attributed by counting the number of unique spaces on the MR slice with the most spaces as follows: <10 = 1, <20 = 2, 20–40 = 3, >40 = 4. Anatomical location and number of lacunes was noted, while Scheltens’ scale was applied to rate subcortical hyperintensities.

The cohort was then separated into those with and those without radiological evidence of lacunar infarction, and analysed.

Results: The mean age of the entire cohort was 71.9 years, 227 (51.6%) participants were female. 46 (10.5%) subjects had lacunes.

Subjects with lacunes were older (73.5 vs. 71.6, p = 0.035). EVP score was significantly higher in subjects with lacunes (2.6 vs. 2.2, p = 0.001). Scheltens’ score was very significantly higher in subjects with lacunes (13.8 vs 9.3, p = 0.001).

Conclusion: Subjects with silent lacunar strokes had evidence of more EVPs, which may indicate a relationship.

Prevalence of Potentially Inappropriate Medications (PIMs) According to STOPP/FRail in an Older Frailer Cohort with Limited Life Expectancy

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Background: STOPP/FRail is an explicit tool, developed by Delphi technique, to assist physicians with de-prescribing medications in older frailer patients with limited life expectancy. The objective of this research was to identify potentially inappropriate medications (PIMs) according to STOPP/FRail in a representative population.

Methods: Comprehensive multi-disciplinary applications for nursing home placement, between January and June 2016, were retrospectively reviewed. Each application comprised detailed data regarding diagnosis, medication use, function and cognition. STOPP/FRail criteria were applied where appropriate.

Results: 464 assessments were analysed. 38 were excluded because of incomplete information. STOPP/FRail was applied to 274 (64.3%) patients; 152 patients did not meet STOPP/FRail inclusion criteria. The STOPP/FRail group were older 84 (SD7) vs 77 (SD13) years, p < 0.001, had 1 more comorbidity (7 (SD2) vs 6 (SD2), p < 0.001, were more dependent Barthel (8 (SD4) vs 12(SD5), p < 0.001 and more likely to have
DECOMPRESSIVE CRANIECTOMY FOR MALIGNANT MIDDLE CEREBRAL ARTERY SYNDROME: THE IRISH EXPERIENCE

Background: Malignant middle cerebral artery (MCA) syndrome is a complication of ischaemic stroke. Untreated, mortality is up to 80%. A meta-analysis showed that decompressive craniectomy (DC) improves survival (OR 0.19, 95% CI 0.1–0.37) but functional outcomes vary [1]. This case series aims to examine the Irish experience of DC for malignant MCA syndrome.

Methods: This series reviewed cases in an Irish neurosurgical referral centre. It receives nationwide referrals and represents a significant proportion of DC performed in Ireland. Operating theatre logbooks for the years 2009–2014 were reviewed. Patients who underwent DC for the treatment of malignant MCA syndrome were included. Medical records were reviewed to assess 6 month mortality rates. Functional outcome was measured by modified Rankin Scale (mRS) at 1 and 6 months post-operatively.

Results: 23 patients were included with a mean age of 58.9 ± 11.8 years (range = 23–240). The mRS score at 6 months was 0.6 (range = 0–4). Complete data on functional recovery was available for 21 patients. The mean mRS 1 month post-procedure was 5.0 (SD = 1.0). The mean mRS 6 months post-stroke was 4.4 ± 0.2 (n = 21). 56% (13 of 23) of patients were living at home 6 months post-stroke.

Conclusions: DC reduces mortality in malignant MCA syndrome and has been available in Ireland for many years. Our results show that patients who underwent surgery had low mortality rates but significant disability as measured by the mRS.

Reference:

EXPERIENCES AND PERCEPTIONS OF SELF-MANAGEMENT FOR OLDER ADULTS WITH MULTIMORBIDITY: A MULTI-STAKEHOLDER STUDY

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Background: For persons with multimorbidity (PwMs), self-management is a complex process that involves integration of knowledge and tasks for multiple, and often interacting, chronic diseases [1]. Patients are frequently required to prioritise conditions, and to reconcile conflicting information and clinical advice [2]. The current study aimed to understand experiences related to self-management of multimorbidity for older patients (aged over 65), and for key stakeholders in their care network. The data presented was collected as part of an extensive requirements gathering exercise to inform the design of a digital health ecosystem that aims to support self-management and improve integration of care for older PwMs.

Methods: Semi-structured qualitative interviews and focus groups were conducted with 19 older PwMs, 7 informal carers, 16 formal care workers, 6 general practitioners, 4 pharmacists, and 15 other healthcare professionals. Interviews and focus groups were transcribed and analysed using thematic analysis.

Results: A number of themes associated with self-management of multimorbidity emerged during the interviews and focus groups, including “symptom recognition”, “symptom monitoring”, “appointments”, “information for self-management”, “motivators for self-management” and “barriers to self-management”.

Conclusion: The findings from this rich, multi-stakeholder dataset highlight a number of key motivating factors and barriers to effective self-management for older PwMs in Ireland. This study highlights the importance of providing sufficient information, education and support to empower older PwMs to play a more active role in the management of their conditions.

References:
Methods: We conducted 12 case studies with people with dementia (late and young onset dementia) and their families. We used quantitative (questionnaires) and qualitative (interviews) data to explore their palliative care needs, and potential benefit of palliative care input.

Results: Caring for a loved one with dementia is very difficult; carers experienced high levels of anxiety, depression, and caregiving burden. Many experienced anticipatory grief. There was little stigma about the term “palliative care”. Carers wanted more emotional support, and acknowledgement of their needs, and felt that sometimes they were not included in the unit of care. Carers found it difficult coping with transitions of care, especially the move into long term care. One child contrasted the experience of a parent dying of cancer, directing their own care to the end, compared to the other parent dying from dementia where the child felt a large burden of decision making, and felt conflicted about “forcing the person to eat” when they no longer recognised food. In cases of young onset dementia (<65 years), the carers experienced more existential issues and were sometimes caring across three levels (parents, spouse and children).

Conclusions: People with dementia and their families could be greatly supported through a palliative care approach. Carers value formal psychological and emotional support, and assistance with daily activities, particularly taking care of their loved one’s care needs. Carers of people with Young Onset Dementia are particularly vulnerable and may need individualised support.

**076** “AGING WELL GROUPS” – DEVELOPMENT AND EFFECTIVENESS OF 8 WEEK COMMUNITY BASED HEALTH PROMOTION GROUPS

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Background: As part of one of the strands of the local Integrated Falls service there was a need to develop community opportunities to stay healthy and well as one ages. Three 8 week community groups were advertised and delivered in 2016/2017. The groups were entitled “Aging Well” and material used was obtained from both the Web Falls Elderly Study [Jackson et al, (1998)] and Lifestyle Matters [Craig & Morgan, 2007].

Methods: The 8 week groups were developed and delivered to community dwelling people, aged 50+. The groups were delivered in a local library and community centre in the area (male and female) from the city and suburbs signed up to attend the groups. The 8 week group content included links with activity and health/wellbeing, falls prevention, energy conservation, overcoming loneliness, social interaction and a planned outing to a local museum. The groups were delivered by two Occupational Therapists. Client satisfaction was measured through the use of pre and post questionnaires regarding location, group facilitation and what clients actually achieved in the participant’s locality.

Results: Participants reported an increase in their knowledge and confidence with regards to their physical and mental health in their own community at the end of the 8 week groups. They also noted that their confidence engaging in community activities had increased as a result of attending the 8 week course.

Conclusion: Loneliness is a common theme that emerged from the groups and there is a need to factor this into the development of other community groups in the future. Occupational Therapists have traditionally looked at individual client centred practice rather than taking a population based health and wellbeing approach. We have demonstrated that the principles of linking activity and health/well-being can be successfully applied in a community setting with well adults to encourage health promotion.

**079** ENVIRONMENTAL APPROACHES TO COGNITIVE AGING: AN INVESTIGATION OF THE ROLE OF POPULATION DENSITY AND DISABILITY

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Background: Understanding how increasing urbanisation affects health inequalities with ageing has gained growing interest [1], but the synergistic influence of environmental and individual factors on cognitive ageing is yet unclear [2]. The present study investigated the impact on cognitive health of living in more or less densely populated areas and having or not a disability.

Methods: Using data from a large cohort study and the Census, we explored cross-sectional variations in global cognition, memory, and executive functions for 4,127 Irish people aged 50+ based on the level of population density of the electoral division of residence (approximately 20km2) and the presence of disabilities (ADL and/or IADL). Regression models controlled for socio-demographic, health and lifestyle covariates.

Results: Overall higher cognitive scores were found in more rather than less populated electoral divisions (10+ vs. <10 persons per hectare) after controlling for covariates. However, participants with disabilities living in the most densely populated areas had the poorest performance in terms of MoCA (p = 0.005), immediate recall (p = 0.002) and executive functions (p = 0.009). Demographic or lifestyle circumstances did not affect these results.

Conclusions: While highly populated areas present more opportunities for mental stimulation which can benefit cognitive health, having a disability may increase the individual’s susceptibility to environmental stressors (e.g. crowding), with a negative impact on cognition. The findings highlight the importance of considering how the lived environment for its individual resources or limitations to better understand geographical variations in cognitive ageing.

References
2. Cassarino M, Setti A. Complexity As Key to Designing Cognitive-Friendly Environments for Older People. Front Psychol 2016; 7: 1329.

**080** SOUTHERN TRUST ACUTE CARE AT HOME SERVICE FOR OLDER PEOPLE

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Background: The population is ageing. Acute Care at Home (A@H) is a Consultant led multidisciplinary team, providing Comprehensive Geriatric Assessment and acute non-critical care to our older population, preventing hospital admissions and promoting a better quality of life for our older population, supporting them to live independently for longer.

Methods: Quantitative, a retrospective analysis of length of stays, admissions avoided, discharges facilitated, acute bed days saved and changes to care requirements.

Results: From 01/04/2016 to 31/03/2017 Average length of stay was 4.9 days compared to 6.8 days in hospital, 719 admissions were avoided, 148 early discharges were facilitated, 5,896 estimated acute bed days saved. 79% of patients did not need changes to their existing care requirements, 4% required a new or increase to their existing package.

Conclusions: The Acute Care at Home model is successfully treating older people at home reducing the burden on the Emergency Department and Acute services in hospital. It also maximises independence, improves quality of life, and decreases the dependency on on-going social support for our older population.

**081** ECONOMIC ANALYSIS OF A PHYSICIAN-IMPLEMENTED, MEDICATION SCREENING TOOL IN OLDER IRISH HOSPITALISED PATIENTS

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Background: In 2011/2012, a single-blind, cluster randomised controlled trial (RCT) was conducted in a tertiary, referral Irish hospital to evaluate the screening tool of older person’s prescriptions (STOPP) and screening tool to alert right treatment (START) criteria compared to usual hospital care [1]. This intervention demonstrated positive outcomes in terms of reduction of adverse drug reactions (ADRs). The aim of this study is to evaluate the cost-effectiveness of the physician-implemented STOPP/START criteria to unsolicited, older hospitalised patients applying the most currently available (2015) healthcare costs (CAHC).

Methods: Cost-effectiveness analysis (CE) alongside conventional outcome analysis in a cluster RCT. The screening tool was applied to medicines of intervention arm patients (n = 360); control arm patients (n = 372) received usual care from the hospital medical team. Incremental cost-effectiveness was examined in terms of costs to the Irish healthcare system in 2015 and an outcome measure of ADRs during inpatient hospital stay in 2011/2012. Uncertainty in the analysis was explored using a cost-effectiveness acceptability curve (CEAC).

Results: On average, the intervention arm was more costly but was also more effective. The associated incremental cost-effectiveness ratio (ICER) per ADR averted was €5,469. The probability of the intervention being cost-effective using CAHC at threshold values of €0, €1,000, €5,000, €10,000 and €20,000 was 0.236, 0.274, 0.450, 0.672 and 0.921 respectively.

Conclusions: Physician-led implementation of the STOPP/START screening tool is more costly relative to routine hospital care. However, this tool is proven to be more effective in reducing ADRs in older hospitalised patients. Such ADRs can have a significant cost burden on the healthcare payer’s budget. Therefore, any medication screening tool that reduces ADR prevalence should be considered by healthcare decision makers for adoption in routine clinical use.

Reference
Background: Unplanned readmissions within 30 days of a previous (index) admission are common (10%-30%) and significantly impact healthcare costs [1]. Policy makers are using readmissions as a quality indicator and penalising Trusts. We suggest that readmissions are complex and involve multiple factors other than quality of care.

Methods: All medical readmissions within 30 days of index admission were captured prospectively over a 3 month period (2016). Data was collected using electronic patient records and chart reviews. The CURIO@S questionnaire created by the Safer@home research group was used as a data collection template. Ethics approval was granted.

Results: The readmission rate was 11.4% (n = 204). Median age was 70 years. Males accounted for 53.7%. A Clinical Frailty score of ≥5 was found in 37.8%. At least one fall in the previous 6 months occurred in 35.4%. Almost 60% of patients were on ≥2 medications. Respiratory infections (17%), falls (8.7%), cardiac failure (8.7%) and urinary tract infection (6.8%) were the principle diagnoses. The most frequent living situations at readmission were: 23% at home with partner/family and no external help, and 19.6% living alone.

Conclusions: This study suggests that readmitted patients have a high proportion of complicating Patient and Disease Factors including frailty, falls, polypharmacy, living with partner/family (and no external help), and living alone. These factors stand apart from hospital care and indicate that readmissions are complex and multifactorial. We recommend policy makers consider Patient and Disease Factors when defining readmissions as a hospital quality indicator.

References

THE EFFECTS OF DISCRIMINATION AND PERCEPTIONS OF AGEISM ON COMMUNITY PARTICIPATION AMONG OLDER ADULTS

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Background: At present, the majority of research and policies surrounding combating ageism have focused on paid employment and the labour market. It is well established that ageism can have detrimental effects on older people’s quality of life and result in self-isolated lifestyles. Studies also highlight the potential to affect an individual’s self-esteem and overall health. However, ageism as a barrier to community engagement is largely overlooked. The current study aims to explore experiences of ageism and perceived ageism within a social inclusion framework focusing on community participation.

Method: Data is from the Healthy and Positive Ageing Initiative (HaPAI) survey, a population-representative cross-sectional survey of community-dwelling adults aged 55+ in 21 local authority areas in Ireland (n = 10,540). A mixed-effects logistic model (to account for county-level clustering) was used to investigate the association between ageism (both experienced and perceived) on community engagement, including participation in sports or social clubs, church connected groups, self-help or charitable bodies, other community groups or day centres.

Results: Experiences of discrimination were significantly associated with higher levels of participating less than monthly or not at all in community events. Perceptions of ageism were significantly associated with lower rates of participating weekly in community events and higher rates of participating less than monthly or not at all in community events.

Conclusion: The current study highlights how experiences and perceptions of ageism can negatively affect community participation. The study also demonstrates how other factors such as locality, self-rated health status, occupational status and education may indirectly affect social inclusion thus offering valuable insights for policy makers interested in promoting and enhancing positive ageing in Ireland.

HOW DO PEOPLE PERCEIVE HOME-CARE ROBOTS? A QUESTIONNAIRE STUDY WITH OLDER PEOPLE, FAMILY CAREGIVERS, AND CARE PROFESSIONALS IN JAPAN

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Background: Japan is at the sharp edge of population ageing. Accordingly, assistive technologies such as home monitoring robots to support care for older people are being developed. However, to develop a home-care robot, it is necessary to respond to the needs of the older person. This study aims to understand the perceptions of older people who receive home-care, family caregivers and home-care professionals towards the development of such robots.

Methods: A self-administered questionnaire was devised and sent to 4,445 people. The participants included older people who receive home-care, as well as family caregivers and home-care professionals in one prefecture in Japan. The questionnaire was designed to understand their perception of a home-care robot and its usefulness, and the participants’ willingness to take part in empirical research to develop such robots.

Results: 577 people participated in the study: 76.4% were home-care professionals (n = 441), while older people accounted for 14.2% (n = 82) and family caregivers for 9.4% (n = 54). 33.4% of the professionals surveyed showed a willingness to participate in the research, compared with only 40% of the older people and their family caregivers. 63.0% of the older people who receive home-care demonstrated a negative perception towards the use of robots while they are still being tested, and similarly, the negative response from professionals and family caregivers exceeded 50%. Where safety and convenience were confirmed by research, 56.8% of the older people, 66.7% of family caregivers and 83.7% of professionals indicated their willingness to use such robots.

Conclusions: This study shows that the older people and those involved in providing care generally have negative perceptions towards home-care robots. Therefore, a research ethics system needs to be developed rather urgently around research and development of home-care robots if such technologies are to be effectively utilised.

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EARLY MDT INTERVENTION AND IMPROVED CARE PATHWAYS FOR THE FRAGILE OLDER PERSON IN A REHABILITATION HOSPITAL

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Background: The National Clinical Programme for Older People stipulates that frailty screening is a critical component of the Comprehensive Geriatric Assessment. To ensure best practice, new care pathways were introduced to facilitate timely and effective management of adults (≥65 years) admitted to Clonlara Hospital for rehabilitation. We aimed
to assess frailty, length of stay (LOS) and discharge outcome; and determine if early MDT identification of frail patients facilitates efficient discharge planning.

Methods: A prospective study was conducted from August 2016 to March 2017 inclusive. Data was collected from two rehabilitation wards that received patients (>65 years) from two acute teaching hospitals. A frailty screen proforma, combining the Clinical Frailty Scale (Rockwood) and Fried’s Frailty Phenotype model, was designed and used by physiotherapists at initial patient assessment. Data on patient demographics, living arrangements, LOS, pre-admission home supports, discharge outcome/destination were collected. From December 2016 to March 2017, a new frailty pathway was introduced whereby patients with a score of ≥3 on the proforma were referred immediately to other MDT services.

Results: 262 patients were included, mean age at 81 years (range 65–98 years). Females predominated at 78.6% (n = 206), 67% (n = 176) were classified as ‘Frail’, 31% (n = 81) as ‘Pre-Frail’ and 2% (n = 5) as ‘Not Frail’. 49% (n = 128) lived alone. 46% (n = 37) of the ‘Frail’ group required either a new or increased home supports on discharge compared to 23% (n = 20) of the ‘Pre-Frail’/‘Not Frail’ group. Average LOS pre/post-implementa- tion of the frailty care pathway was 44 and 31 days respectively (p = 0.0005). Discharge destination: 80% (n = 210) home, 15% (n = 40) returned to parent hospitals (acute medical issues) and 3.1% (n = 8) for long term care.

Conclusions: Early identification of frail patients and comprehensive MDT intervention facilitated more structured and planned discharges and statistically significant reduction in patient LOS.

139 INFLUENCES ON APPROPRIATE ANTIPSYCHOTIC PRESCRIBING IN RESIDENTS WITH DEMENTIA: A QUALITATIVE EXPLORATION USING THE THEORETICAL FRAMEWORK

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Background: Antipsychotics are often inappropriately prescribed to nursing home resi- dents with dementia despite evidence of increased risks and limited effectiveness, but can be effective when used for correct indications. The Theoretical Framework Domain Framework (TDF) is a theory-based approach to understanding key aspects of healthcare profes- sionals’ behaviours and developing improvement interventions to target those behaviours. This study aimed to explore the influences on appropriate antipsychotic prescribing in residents with dementia using the TDF.

Methods: Twenty-seven semi-structured qualitative interviews were conducted with a purposive sample of participants involved in the care of residents with dementia (four consultants, five general practitioners, eight nurses, two pharmacists, two healthcare assis- tants (HCAs) and three family members). An interview topic guide was developed using findings from our previous systematic review. Participants provided written informed consent. Interviews were audio-recorded and transcribed verbatim. A qualitative frame- work analysis informed by the TDF, involving two coders, was conducted to identify the relevant barriers and facilitators.

Results: Eight TDF domains were identified as relevant to antipsychotic prescribing behaviour: social/professional role and identity, social influences, beliefs about conse- quences, environmental context and resources, knowledge, behavioural regulation, beliefs about capabilities and emotion. Barriers to appropriate prescribing included inadequate resources and education, pressure to prescribe, an expectation that behaviours can be “cured”, reliance on antipsychotics to reduce nursing demands, and the belief that resi- dents are suffering because of their behaviours. Facilitators included specialist care units, advocacy and leadership by staff, knowledge of cardiovascular risks, and inclusive decision-making. There were conflicting views as to the influence of national regulatory bodies on prescribing; some believed they have enabled a blanket “anti-antipsychotic” climate.

Conclusions: This detailed qualitative analysis demonstrates that appropriate anti- psychotic prescribing is a complex behaviour influenced by several domains. Our study has generated much needed evidence to inform improvement efforts in this field.

136 DOES AN INTERACTIVE, TELECONFERENCE-DELIVERED, PALLIATIVE CARE LECTURE SERIES EMPOWER NURSING HOME STAFF TO MANAGE PATIENTS MORE AUTONOMOUSLY?

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Background: ECHO (Extension for Community Healthcare Outcomes) is a form of online interactive teaching, which has gained international traction. Teleconferencing tech- nology is used to allow experts at a “Hub” to audio visually teach and interact with many different front-line Healthcare Providers at “Spoke” centres. Emphasis is on stakeholder directed interaction and encouragement of spoke-spoke engagement. This project evalu- ates the effectiveness of the first such pilot for the Republic of Ireland, which is occurring in the south Dublin region. It consists of specialist topics over 10 sessions around Palliative Care. Our aim is to measure project success by quantifying gains in staff confi- dence at managing such issues.

Methods: A subgroup of nursing homes was randomly selected for assessment. The contact person in each nursing home provided staff with Likert-style questionnaires to assess confidence before the lecture (pre-questionnaire), directly after (post-questionnaire) and six weeks after. The first two lectures of the series have been completed: advance care planning (ACP) and nutrition and hydration (N&H).

Results: We present the data from the first two lectures in the series. 22 nursing homes and 130 staff participated in the sessions. Of 6 randomly selected nursing homes and 39 staff, their pre-lecture questionnaire confidence in managing ACP was 6.2/10 (SD 1.8) while their post-lecture confidence score was 7.7/10 (SD 1.4) (25% increase), p < 0.0005. Pre-lecture questionnaire confidence score in managing N&H was 6.8/10 (SD 2.4) and post-lecture score was 8.6/10 (SD 1) (27% increase), p < 0.0005. All staff groups (nurs- ing vs. non-nursing) exhibited equal confidence gains (p = 0.4) and years spent in the role was not a predictor of confidence change (p = 0.75).

Conclusions: The first two lectures of this interactive, novel, ten-lecture series signi- ficantly improved nursing home staff confidence in managing palliative care situations. Six- week participant follow up is planned to identify sustained benefit.

138 IS ORTHOSTATIC HYPOTENSION AT BASELINE ASSOCIATED WITH A DECREASE IN COGNITIVE FUNCTION AT FOUR YEAR FOLLOW-UP?

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Background: Orthostatic hypotension (OH) is a reduction in systolic blood pressure (BP) ≥20 mmHg and/or diastolic BP ≥10 mmHg within three minutes of standing. It is thought OH may increase the risk of cognitive impairment (CI) due to cerebral hypoperfusion (CH). It is unclear whether OH and CI coexist due to underlying neurodege- nerative, or whether OH increases the risk of CI through CH. This study aims to assess whether baseline OH is associated with cognitive decline.

Methods: Data from waves 1 and 3 (4 year interval) of The Irish Longitudinal Study on Ageing (TILDA), a prospective cohort study comprising of community dwelling people ≥50, were used. Participants who attended for health assessment (HA) at both waves were included. Individuals with diagnosed dementia, stroke or Parkinson’s at baseline, or...
Age and Ageing
who had received diagnosis of stroke or Parkinson's at follow-up, were excluded. Beat-to-beat heart rate variability (BHF) lasting 110 seconds was measured using a Finometer. OH110 was defined as OH sustained up to 110 seconds post stand. A composite error score for MOCA and MMSE was used to assess cognition (log(60-MMSE + MOCA)) – 3)).

Results: 3,115 participants who had HA at both waves and adequate AS data at wave 1 were included. 127 (4.08%) of these had OH110. Using Mixed effects analysis, OH110 was associated with an increase in the cognitive error score at follow-up (0.12, p-value 0.001), with adjustment for confounders. Based on adjusted mean margin, cognition improved between wave 1 and 3 in participants with OH110 (2.02±1.54, p<0.001).

Conclusions: TILDa offers a unique opportunity to assess implications of OH on cognition, using beat-to-beat BP measurement. In this study, OH110 was associated with cognitive decline in community dwelling adults over the age of 50 at 4 year follow-up.

162 KEY STAKEHOLDERS’ EXPERIENCES OF RESPITE SERVICES FOR PEOPLE WITH DEMENTIA AND THEIR PERSPECTIVES ON SERVICE DEVELOPMENT: A SYSTEMATIC REVIEW AND META-ETHNOGRAPHY

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Background: It is important to understand how we can develop health and social care services, which can support people with dementia (PwD) to age in place, in a way that is acceptable to clients, and feasible as regards implementation. Therefore, this study aims to understand key stakeholders’ experiences of respite services for PwD, and their perspectives on service development.

Method: A systematic search was conducted of the Pubmed/MedLine, Embase, Cinahl, Psycinfo, Scopus, Web of Science, and Cochrane databases (1980–2016, English) with fixed search terms relating to ‘respite’ and ‘dementia’, following PRISMA guidelines. Nobil and Hare’s meta-ethnography was employed. Key concepts were identified, reciprocal and re-framing translation techniques were applied to primary studies, and findings were synthesised into third order interpretations, leading to a ‘line-of-argument’.

Results: In total 23 papers were reviewed, which described 20 independent samples across 12 countries. The views of 889 participants were synthesised (13 PwD, 690 carers, 186 other perspectives on service development).

Conclusions: This study provides evidence on the feasibility and potential impact of a digital LSB across different contexts.

163 IMPLEMENTING DIGITAL LIFE STORY WORK FOR PEOPLE WITH DEMENTIA: THE RELEVANCE OF CONTEXT TO USER EXPERIENCE

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Background: Digital Life Story Work is fast becoming a major trend in reminiscence work for people with dementia. Now, the life storybook (LSB) can be created digitally, using the LSB helped them reconnect with their past. In the group context, family caregivers felt the social setting was the most valuable part, both for themselves and the person with dementia. In the one-to-one context, family caregivers valued the facilitator's presence and enjoyed bonding over memories. For care staff, the LSB facilitated meaningful interaction and fostered relationships with residents and families. They also used the app for some unanticipated but positive purposes. All participants enjoyed the intervention, found it useful, and valued the digital LSB’s capacity to host multimedia materials. Limited IT skills was the most frequently cited barrier.

Conclusions: This study provides evidence on the feasibility and potential impact of a digital LSB across different contexts.

164 WHAT DOES COMMUNITY LIVING MEAN FOR OLDER PEOPLE EXPERIENCING DISABILITY?

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Background: Community living encompasses the elements of living independently and being included in the community. Community living is also firmly rooted in the notion of interdependence, of which social interaction is a central component. Older people experiencing disability are susceptible to compounded challenges in maintaining meaningful community living in the face of changing needs and circumstances. Policy responses must be cognizant of what community living actually means, thereby enhancing the dignity and independence of the person in order to maximise their wellbeing and social interaction.

Methods: In order to gain a better understanding of what community living means at the intersection of ageing and disability, qualitative interviews were conducted with twenty older people living in the community with a physical or cognitive disability. The interviews followed a narrative style so as to allow the participants’ voice to lead the discussion. This paper presents results of analysis of these interviews.

Results: The participants conceptualised community living as refracted through their lived experiences of ageing with a disability. The narratives that emerged from the interviews revealed participants who were deeply grounded in a sense of identity derived from their community and their perceived role within that community. A strong thread of resilience linked the individual experiences. The importance of social interaction to overall wellbeing must be recognised and fostered in the future.

Conclusions: Policy discourse in ageing and disability increasingly focuses on supporting both cohorts to live independently and be included in the community. To be successful, policies must address the individual realities and particular needs of the people for whom they are enacted. In developing and delivering effective community living initiatives, it is important to understand what exactly community living means for older people living with disabilities. This is particularly important in light of a growing older population, many of whom will come to experience disability.

165 A REALIST EVALUATION OF INTENSIVE HOME CARE PACKAGES FOR PEOPLE WITH DEMENTIA

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Background: Intensive Home Care Packages (IHCPs) were introduced to provide personalised and high levels of support for people with dementia (PwD) to remain at home or to be discharged home from hospital. A study evaluating the effectiveness of IHCPs was commissioned to inform future development and resourcing of home care for PwD. Realist evaluation [1], increasingly used in the evaluation of complex interventions, addresses real world questions of relevance about what works, for whom, in what contexts.

Methods: A mixed methods, multi-participant study was designed within a realist evaluation conceptual framework. The process evaluation involves semi-structured interviews with health service staff, analysed using thematic analysis. Data collection tools for PwD/carer dyad include quality of life, caregiver burden, resource utilisation, and dementia severity. Each dyad also participates in a semi-structured interview. Process consent is used so that PwD can participate as fully as possible.

Results: To date 17 PwD/carer dyads have been interviewed with high levels of need identified. 40% of PwD have severe dementia; 25% of carers report a moderate burden. Qualitative interviews reveal how IHCPs support PwD with unique needs and circumstances. Resource utilisation is complex; the IHCP complements high levels of family care and out-of-pocket payments. Themes emerging from interviews with 53 health service staff include the task-oriented nature of current home care; the complexity of implementing personalised IHCPs; and communication. Data collection is ongoing.

Conclusions: This realist evaluation is identifying an appetite for personalised home care supports and the challenges of implementation. It is providing important evidence on how home care services might be organised and resourced in the future to achieve the best outcomes, taking into account not only costs but also outcomes and the social value of supports for PwD.

Reference
Background: The Alzheimer’s Questionnaire (AQ) is a validated informant-based questionnaire designed to quickly and accurately detect cognitive impairment in general practice and geriatric service-users [1]. Our Memory Clinic sees approximately 550 patients a year and has included the AQ in its screening protocol since 2013. This retrospective review aimed to establish the optimal AQ cut-points to aid diagnosis in our Memory Clinic population.

Methods: Patients attending the Memory Clinic with AQ score documented were included. Chart Review captured the following data: AQ Score (0–27), Age, Consensus Diagnosis, Gender, Education, MMSE and CAMCOG scores. Diagnoses were categorised into 4 groups: Subjective Memory Concerns (SMC), Mild Cognitive Impairment (MCI), Alzheimer’s Disease (AD) and Other. Area Under the Curve analysis was used to compare AQ score and consensus diagnosis. The Youden Index was used to determine the cut-points with maximum sensitivity and specificity for each diagnosis.

Results: Of the 367 males, 476 females, Mean age = 68.8 categorised into: SMC = 105, MCI = 413, AD = 217, Other = 108. In our population, the following AQ cut-points are optimal to suggest diagnosis: ≥ 21 to distinguish AD from MCI (SMC: AUC = 0.773), ≥ 7 to distinguish MCI from SMC (AUC = 0.740), ≥ 28.5 (ie 9) to differentiate AD from SMC (AUC = 0.697) and ≥ 21 to differentiate from AD from MCI (AUC = 0.741).

Conclusions: In our population we can conclude that an AQ score of ≥ 21 is suggestive of SMC, 7–19 of MCI and ≥ 21 of AD. A score of less than 9 is a good predictor of SMC over AD. The cut-points are notably different from those recommended by previous studies [1]. This review and analysis demonstrates that different cut-points are necessary in a Memory Clinic population.

Reference:

176 OLDER WOMEN’S EXPERIENCES OF AGEING AND HEALTH RELATED ISSUES

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Background: Both globally and nationally women live longer than men (UN, 2013). It is important to continue to develop health and social care services and supports for older women that are responsive to their views and needs. This study explored older Irish women’s experiences of ageing and health related issues. To date there is little published from the ‘perspective of this cohort.

Methods: Interpretive phenomenology, specifically the ‘Vanouver School of Doing Phenomenology’ (Halldórsdottir, 2008) guided the research design. Purposive and snowball sampling were used. Data was collected through individual in-depth interviews with co-researchers (women aged over 65 years, n = 23). Data analysis included a meta-synthesis of individual case constructions.

Results: Older women’s experiences are more than the sum of the different aspects of their experiences and the findings provide a holistic view of the meaning of these.

‘Memory: a disconnection: a process of adaptation and continued engagement’ describes the essential meaning of the women’s experiences. Four themes were identified: ‘Being in control: Balancing needs and supports’; ‘Navigating a changing world’; ‘Being connected and involved’; ‘Trying to stay well’. The findings demonstrate that autonomy, adaptation and continued engagement are crucial factors to consider in planning and developing services for older women in Ireland.

Conclusions: This study focused on the intersection between and impact of health, ageing and gender on older Irish women’s experiences. This interconnectedness shaped their experiences. Recommendations are provided for health and social care delivery; health care professional education and policy development.

References

183 ARE WE FAST ENOUGH: FIVE YEAR STROKE INTRAVENOUS THROMBOLYSIS DATA FROM A GENERAL HOSPITAL

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Background: Intravenous thrombolysis remains the cornerstone of acute ischaemic stroke treatment despite the addition of intra-arterial thrombectomy to treatment options. Current guidelines from the American Heart Association specify that all patients should have Door to Needle Time (DNT) of 60 minutes. Over the last five years, changes and efficiencies have been instigated in the hospital to try to achieve this target.

Methods: We performed a retrospective analysis of 2012 to 2016 data from our internal stroke register.

Results: Overall thrombolysis rates are unchanged over 2012–2016 (22%, 18%, 14%, 2013 to 2016). However, the percentage of patients who get treated on target (within 60 minutes) has risen from 32% in 2012 to 61% in 2016. The median DNT has also improved from 66 minutes (2012) to 45 minutes (2016). This achievement was largely achieved by improving “In-Hours” (0900–1700, Monday to Friday) DNT. In 2012 57% achieved target and in 2016 85% achieved In-Hours DNT improvement. Median “In-Hours” DNT improved from 24 minutes (2012) to 36 minutes (2016); “Out-of-Hours” (outside 0900–1700, Monday to Friday) DNT target slightly increased from 22% (2012) to 30% (2016). “Out-of-Hours” median DNT worsened from 82 minutes (2012) to 99 minutes (2016). Median Door to CT time improved from 33 minutes (2012) to 21 minutes (2016) and median CT to Needle time improved from 34 minutes (2012) to 28 minutes (2016). Median stroke onset to needle time was unchanged from 179 minutes (2012) to 183 minutes (2016).

Conclusions: Substantial improvements have been made in treating patients who present “In-Hours” with an acute ischaemic stroke within 60 minutes. The emphasis will now be to improve “Out-of-Hours” treatment times.

208 AGEING IN DIVERSE URBAN NEIGHBOURHOODS: SOCIAL EXCLUSION AND LIFE-COURSE RELATIONSHIPS WITH PLACE

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Background: Dominant urban settlement patterns meant that questions about enhancing multidimensional social inclusion across the life course need to be embedded in the context of urban neighbourhoods. There is a growing body of evidence that place of residence impacts on participation in a range of different areas of life, and subsequently on different forms of health and well-being. Less, however, is known about how placed-based mechanisms either protect against or intensify experiences of exclusion. Further, an understanding of how these mechanisms interact with key events in people’s lives is largely unknown, as is what this interaction might mean for people at different life stages and different social locations. In this paper, we investigate how characteristics of urban settings combine with life-course experiences and positions to construct inclusion and exclusion for children and youth, older people and people with disabilities.

Methods: This paper draws on data from the 3-Cities Project which used an explorative participatory approach and focused on six different kinds of neighbourhoods across Dublin, Galway and Limerick. Analysis is based on life-course and co-along interviews with children and youth, older people and people with disabilities.

Results: Life-course transitions are embedded in, and influenced by, the neighbourhoods in which people live. As such, changes in neighbourhoods, such as demographic, social and economic shifts, and changes in the lives of children and youth, older people and people with disabilities combine to shape group and cross-group needs. Findings point to different mechanisms within neighbourhoods that can determine the degree to which experiences/transitions impact on the lives of children and youth, older people and people with disabilities.

Conclusions: A holistic idea of participation and a fuller assessment of how people live their lives within their neighbourhoods and cities needs to be embraced for children and youth, older people and people with disabilities.

210 A SYSTEMATIC REVIEW OF THE CAUSES AND MANAGEMENT OF NON-THROMBOTIC STROKE CAUSED BY TISSUE EMBOLI

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Background: Various bodily tissues have been reported to enter the arterial circulation and embolise to the brain resulting in ischaemic stroke. Most frequently non-thrombotic, embolic stroke (NTES) of tissue origin is iatrogenic or related to an underlying disease process. With the increase in elective surgery and interventional procedures, NTES may increase in prevalence.

Aim: To compile a summary of the Background, incidence, presentation and treatment of NTES of tissue origin, by conducting a systematic review of the current literature.

Summary of Review: We searched EMBASE and MEDLINE for articles on NTES of tissue origin published in English with no restriction on publication date (search date March 2016). 787 articles were identified and screened and 150 articles were ultimately reviewed in full text and included in qualitative analysis. Articles deemed relevant were assessed by a second reviewer to confirm compatibility with the inclusion criteria. References of included articles were reviewed for relevant publications. We categorised the pathology of the emboli into the following groups: amniotic fluid (2 reports), tumour (43 reports), fat (49 reports), cholesterol (12 reports) and intravascular debris. We then summarised the available literature within each tissue category.

Conclusions: NTES of tissue origin is an uncommon but important diagnosis to consider particularly in younger stroke patients and in certain clinical settings. Treatment for NTES is currently anecdotal and based on small case series. Embolocytomy may emerge as the therapy of choice due to the longer treatment timeframe and heterogeneity of the emboli.
THROMBOLYSIS FOR STROKE IN IRELAND: INCREASING ACCESS AND MAINTAINING SAFETY IN A CHALLENGING ENVIRONMENT

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Background: In the setting of a national audit of acute stroke services, we examined the delivery of thrombolytic therapy for ischaemic stroke, and whether current practice was achieving safe outcomes and consistent delivery for patients.

Methods: Data obtained from the recent national stroke audit was compared against previous Irish audit, the most recent SSNAP UK stroke audit and the SSFTS-MOST study.

Results: Thrombolysis was provided in 27 acute hospitals throughout Ireland during the period assessed with 82% (22/27) providing 24/7 access, the remaining sites using direct policies. Decision to thrombolise was made by stroke trained consultants in 63% (17/27) units, with general physicians and emergency medicine consultants convening the others. Thrombolysis rate for non-haemorrhagic stroke was 11% (n = 80/742, CI 95% ± 2.25) versus a 1% rate in the 2008 audit. Sites receiving patients through direct policy had the highest thrombolysis rate, average 24%. Nearly 30% of cases were thrombolysed on the weekend.

83% of cases were managed in a stroke unit at some time during admission versus 54% of the national total cases. 37% of patients were ≥80 years. The mortality rate was 11.3% versus the national mortality rate for nonthrombolysed ischaemic strokes of 10% (p > 0.5) and this is comparable to SSFTS-MOST 2007 study 3-month mortality rate of 11.3% (p > 0.5).

Conclusion: Stroke thrombolysis is being effectively and safely provided in acute stroke services in Ireland despite regular involvement of non-specialist staff. There is still potential to improve thrombolysis rate.

SCREENING FRAILTY IN THE EMERGENCY DEPARTMENT: THE UTILITY OF THE SHARE-FI IN PREDICTING OUTCOMES IN A COHORT OF OLDER PATIENTS

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Background: Greater numbers of older patients are accessing hospital services. Specialist geriatric input at presentation may improve outcomes for high risk patients. The Survey of Health, Ageing and Retirement in Europe Frailty Instrument (SHARE-FI) [1] was developed for use in the community but has been shown to be useful in the emergency department (ED).

Objective: To measure frailty, review its prevalence in older patients presenting to ED and compare characteristics and outcomes of frail patients with their non-frail counterparts.

Methods: Prospective cohort study was carried out with pre-specified convenience sampling of those aged ≥70 years presenting to ED on a 24/7 basis, from January-August 2014. Patient characteristics were recorded using the symphony electronic data system; SHARE-FI assessed frailty, Cognition, delirium and six and twelve month outcomes were reviewed. Binary logistic regression was used to estimate odds ratios for covariates.

Results: Age predicted mortality (OR2.34, 95% CI1.30–4.21, p = 0.004) and the composite outcome of “alive and at home” at 12 months (OR0.49, 95% CI0.23–0.83, p = 0.069). Dementia (OR0.24, p = 0.005) and polypharmacy (OR0.37, 95% CI0.16–0.87, p = 0.022) were predictive of being alive and at home at twelve months. Frailty was not associated with a significant difference in mortality rates (OR0.89, 95% CI0.58–1.38, p = 0.614) or being alive or at home at 12 months (OR1.07, 95% CI0.52–1.57, p = 0.745).

Conclusions: This study suggests SHARE-FI was an inappropriate screening instrument for use in the ED. It may be of greater use to treat all older patients as being at risk of adverse outcomes. New screening tools to assess older patients presenting to hospital are required.

FLIP (FRAIL AGEING IN PLACE) AS A NEW QUALITY MARKER

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Background: Frailty is associated with increased hospital Length of Stay (LOS), readmission rates, and complexity in discharge planning. Targeting lower LOS times may however, reduce the quality of care and diminish patient outcomes.

Older people living with frailty should be facilitated to remain in their own homes and ‘age in place’. However, this has not yet been measured as a key performance indicator. We would like to introduce the concept of Length of Ageing in Place (LAP) time.

Methods: We retrospectively analysed all patients under the Frailty Service who received Comprehensive Geriatric Assessment over 6 months. We calculated the LAP time as the difference between current admission and previous discharge date i.e. length of time at home.

Results: We analysed 136 consecutive admissions (47.8% female). The mean PRISMA-7 score was 5.35. The six-month readmission rate was 27% with 10.8% having ≥3 admissions. The mean Clinical Frailty Score for readmitted patients was 6.72. The mean LAP time was 36.16 days (median 19.5) at home. Those readmitted spent less time in hospital, mean LOS was 10.35 days (median 7 days) compared to 13.64 days (median 8 days) for patients not readmitted. Most patients were discharged home (78%).

Conclusion: Older adults living with frailty are significant users of health care yet their preferences are under-represented in research, health care decision making, and health policy formulation. Limitations of this study are that the LAP time only being calculated when a patient is readmitted and readmissions are not classified as avoidable/ unavoidable. We are currently collecting data for a survival analysis of readmission and LAP with one year of follow-up.
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 multifactorial 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 multifactorial assessment and multifactorial interventions. The aim of the initiative was to reduce falls by 20% over 12 months and a further 20% within a 24 months period.

Methods: Quality initiative was implemented on four 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 multifactorial interventions that have been proven by research to be effective in reducing falls. Data on falls was collected from incident reports. Data on falls care bundle compliance was also collected each month by falls lead nurses.

Results: In June 2014 the falls rate was 7.1 falls per 1,000 bed days. In April 2015 the falls rate decreased to 4.2 falls per 1,000 bed days and by April 2016 the falls rate decreased to 2.5 falls per 1,000 bed days. Concurrently, the compliance with the fall care bundle in June 2014 was 11%, in April 2015, it was 50% and in April 2016, 73%. Overall, the initiative lead to increased awareness of falls among staff and patients in addition to improved falls risk assessment and falls care planning. Additionally, a Falls Huddle was introduced as a part of the post fall assessment.

Conclusion: Introducing evidence-based care bundles of multifactorial assessment and intervention using a quality improvement approach resulted in improved delivery of multifactorial assessment and intervention and a significant reduction in the fall rate.

USE OF PRE-STROKE ANTICOAGULATION TO ASSESS CHANGES IN ANTICOAGULATION PRESCRIBING FOR STROKE PREVENTION IN AF, SINCE THE INTRODUCTION OF DOACS

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Background: The prevalence of atrial fibrillation (AF) in ischaemic stroke is estimated at approximately 30%. Proportion of patients with ischaemic stroke and known AF who are prescribed anticoagulation is an accepted quality metric (NHS) for anticoagulation in the community. We aimed to quantify changes in the proportion of anticoagulated patients and those prescribed DOACs who presented with ischaemic stroke and previously known AF to our institution between 2013 and 2016.

Methods: The National Stroke Register was used to identify all patients admitted to our institution between 2013 and 2016 with ischaemic stroke and AF. For each year, the proportion of patients on anticoagulation (overall) and DOACs was calculated. Primary endpoint was the change in proportion of patients prescribed anticoagulation prior to stroke. The secondary endpoint was proportion of ischaemic strokes attributable to AF. We performed a Chi Square test to assess statistical significance.

Results: A total of 522 patients presented to our institution with ischaemic stroke, of which 22% were known to have AF. The proportion of patients prescribed DOACs increased from 8% in 2013 to 58% (p = 0.0069). There was a downward trend in proportion of AF patients prescribed anticoagulation which has led to an overall increase in the proportion of people with AF being anticoagulated. It may also be associated with a decrease in the proportion of ischaemic strokes attributable to AF which requires a larger sample to adequately test. In our opinion, the case of anticoagulation with DOACs, along with the associated increased risk of a bad outcome post stroke.

Conclusion: The audit quantifies the paradigm shift in OAC prescribing since the introduction of DOACs which has led to an overall increase in the proportion of people with AF being anticoagulated. It may also be associated with a decrease in the proportion of ischaemic strokes attributable to AF which requires a larger sample to adequately test. In our opinion, the case of anticoagulation with DOACs, along with the associated increased risk of a bad outcome post stroke.

END OF LIFE CARE IN TWO ACADEMIC ADULT HOSPITALS. CARE EXPERIENCES FROM THE PERSPECTIVE OF BEREAVED RELATIVES - VOICES THAT MATTER

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Background: Four in ten (43%) of all deaths in Ireland occur in acute hospitals (HFI, 2014). A considerable body of evidence suggests however there are wide variations in the quality and standards of end-of-life care (EOLC). Two large acute teaching hospitals and their academic partners undertook a collaborative research project to assess the quality of EOLC from the perspective of bereaved relatives.

Methods: A quantitative descriptive retrospective survey of bereaved relatives of patients who died in both hospitals between August 2014 and January 2015 was carried out. A 39-item questionnaire was developed and distributed to 781 bereaved relatives. 356 valid questionnaires were returned (Hospital A, n = 167; Hospital B, n = 189), giving an overall response rate of 46%. Data was analysed using SPSS and NVivo software.

Results: 80% (n = 178) of deceased persons reported on were over the age of 80 and 35% (n = 126) between the age of 60 and 80. Seven key themes emerged which related to quality of care, meeting care needs, dignity and respect, communication, hospital environment, support for relatives and benefits of surveying bereaved relatives. One in 8 (12% n = 41) respondents rated care as fair or poor. 79% of relatives indicated pain was relieved and 73% indicated personal care was provided to a high standard. 95% were satisfied with their end of life care. 60% of patients died in a single room and relatives viewed care in a single room as key in the provision of good care at end of life.

Conclusions: EOLC in our hospitals is good by international standards. Asking bereaved people for subjective descriptors of their experience of EOLC can provide powerful insights and recommendations for improvements.

INDICATORS ON HOME BASED CARE FOR PEOPLE WITH DEMENTIA: A TOOL FOR INFORMING POLICY IMPLEMENTATION AND PLANNING

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Background: A priority action of the National Dementia Strategy (2014) is to provide integrated services and home support for people with dementia (PwD). Intensive home care packages (IHCPs) for PwD were introduced on a test basis in late 2014 to provide a high level of flexible and personalised support to enable discharge home from acute hospital or to support the person to remain at home.

Methods: International literature informed the development of a suite of indicators to monitor the quality and delivery of dementia IHCPs. A common, evolving quantitative dataset, collected from four sites, includes administrative data on the content and cost of IHCPs, and socio-demographic characteristics of recipients. Outcomes data is collected as part of the IHCP review process.
STAFF PERCEPTION OF END OF LIFE EXPERIENCE OF SUPERIOR RISK STRATIFICATION IS OBTAINED FROM abstracts

Results: Data to the end of February 2017 show that, 200 PwD had received an IHCP, 106 of which were still active. The characteristics of respondents were: female 57%; mean age 83 years; married 55%; living with spouse/partner 50%; living alone 31%; high/maximum dependency (Barthel Index) 80%; discharged from acute hospital 65%. A weekly average of 41.4 support hours was provided; mean weekly marginal cost was €600 and mean cost 36 weeks. Of those asked if the IHCP met their needs, 91% of PwD who responded stated that it did. A lower proportion (75%) of family members stated that the IHCP met the needs of the PwD.

Conclusion: This is a unique dataset for Ireland and is critical for informing implementation and future planning of personalised home care services for PwD. It provides evidence for the feasibility of discharging PwD with high needs home from acute hospital and supporting PwD to remain at home. IHCPs seem to be effective at targeting those at highest risk of admission to long-stay residential care, but not necessarily less costly.

STAFF PERCEPTION OF END OF LIFE EXPERIENCE OF SUPERIOR RISK STRATIFICATION IS OBTAINED FROM abstracts

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Background: Older people have an increased risk for cardiovascular disease such as Stroke). The prevalence of hypertension is very significant in this population. Hypertension-lowering medications reduce the risk for such events. However, routine clinic blood pressure reading (CBPM) can be inaccurate and misleading in diagnosing hypertension. Therefore, the use of these medications can be detrimental in the older population who do not need them. We reviewed the data of a subgroup of patients over the age of 65 from the ABPM Population Study Ireland (ABPM STUDY) who had Ambulatory blood pressure monitoring (ABPM) in the primary care setting.

Methods: ABPM recordings performed in the primary care clinic setting between January 1999 and June 2012 for the indication of raised CBPM were examined using the data8 ABPM primary care module. Ethical approval was obtained from the local hospital ethics board and all data were anonymised.

Results: Twenty-seven thousand, seven hundred and sixty-seven (27,767) patients over the age of 65 had valid day-time and night-time blood pressure (BP) readings and were included in the review. Average age was 75.4 (SD 9.8), and 56.3% were females. Fifty-two point six percent (SD 15.3) of the population had sustained hypertension and 28.1% have white coat hypertension. When the data was analysed for dippiings, 18% (SD 17.4) had reversed-dipping, 32.6% (SD 15.7) were non-dippers and about 14.7% (SD 15.2) were extreme dippers.

Conclusion: ABPM is becoming indispensable in the risk stratification of some complex older adults. It allows for greater individualisation of therapy. As identified above, some people with white coat hypertension do not need BP lowering medications while those with elevated night-time BP need better 24 hour control. None of this will be evident if our management is based merely on clinic blood pressure readings.

SUPERIOR RISK STRATIFICATION IS OBTAINED FROM ABMUTATORY BLOOD PRESSURE MONITORING IN OLD IRISH ADULTS

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Background: Frailty, an increased state of vulnerability results in lower social engagement and quality of life, increased dependency, higher rates of morbidity, health service utilisation, hospital readmission and mortality. While it is poorly understood and not yet well articulated in the literature is the frequency of common frailty syndromes among frail older Irish people admitted acutely to hospital.

Methods: This observational analysis included consecutive patients aged ≥75 years, screened for identifying frailty with the PRISMA-7. One of four care pathways was assigned to each patient: (1) Frailty pathway (PRISMA-7 ≥ 3, direct access to Comprehensive Geriatric Assessment (CGA) with take-over of care by specialised Frailty Service), (2) Non-frail (PRISMA-7 score < 3), (3) Medically unsuitable (too unwell for CGA) or (4) Consultation if required (unable to take-over due to service capacity).

Results: 566 cases were analysed over a six-month period. Most were female (51.9%) and aged between 75–84 (61.8%), with 38.2% aged ≥85 years. In all 156 (27.5%) were taken on the Frailty Service pathway; 91 (16%) were diverted to the non-frail pathway, 231 (40.7%) were too medically unsuitable and 90 (15.8%) were not taken due to lack of service capacity. For those taken on the Frailty Service Pathway the most common geriatric syndromes systematically identified and targeted by CGA were: falls and immobility 92.8%, polypharmacy 69.5%, incontinence 51.8%, malnutrition 32.1% and acute delirium 24.3%.

Conclusion: Our experience suggests that older adults presenting for medical admission have complex geriatric syndromes requiring CGA. This should be met with an acute frailty pathway early in the course of admission to identify common frailty syndromes, which are highly prevalent in this population and require specialist interdisciplinary management. Further research with larger samples measured over prolonged periods is required to purposefully measure outcomes in this cohort.

MEDIATION BURDEN IN THE LAST YEAR OF LIFE

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Background: Aging is an important principle of patient-centred care is to match interventions and medications to a patient’s overall condition and goals of care. STOPPfrail is a validated list of medications that are potentially inappropriate in older people with high morbidity and poor one year survival prognosis. An acute hospital admission is an opportunity to optimise prescribing. The aim of this study was to determine the prevalence of STOPPfrail potentially inappropriate medications (PIMs) amongst patients discharged from hospital in the last year of life. In addition, we aimed to measure the total number of medications consumed by patients while in hospital in the last year of life. Methods: A retrospective chart review was conducted on 222 older patients hospitalised with acute medical illnesses for at least 2 days in the year prior to death. Patients who died during a single hospital admission were excluded. For one hospitalisation (chosen at random if the patient was hospitalised more than once) the prevalence of STOPPfrail PIMs at the time of hospital discharge was measured.

Results: The mean age of patients was 82. The median number of hospital bed days was 24 days (IQR 12–42). Medication exposure was high with 41% of patients consuming more than 25 different medications and 14% consuming more than 35 medications during hospitalisation in the last year of life. STOPPfrail medications were highly prevalent with 77% of decedents prescribed at least 1 PIM and 27% at least 3 PIMs. For patients prescribed 5 or more regular medications at the time of hospital discharge (n = 188), implementation of STOPPfrail rules would have resulted in a 22.3% mean percentage reduction in regular medications.

Conclusions: For many patients, the last year of life is a period of profound medication burden. The majority of these patients are exposed to PIMs according to explicit STOPPfrail criteria.

FRAILTY IN AN ACUTE HOSPITAL: POINT PREVALENCE AND CHANGE IN BASELINE STATUS DURING HOSPITALISATION

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Background: Frailty is common among older hospital inpatients. While data is available on the prevalence of frailty in acute hospitals, it is usually based on retrospective
Utilising a Hybrid Model of Medical Management in Age and Ageing

Vitamin D Deficiency and Cognition Function: A Case Control Study

Results: Our 18 bed TCU opened in September 2016. Over 300 patients have been admitted from the acute hospital to date. The average TCU patient is aged 75 years old. 81% of patients were discharged home and 13% transferred back to the acute hospital. Feedback from MDT staff and patients regarding the model of care has been very positive. The TCU has impacted significantly on patient flow in the acute hospital.

Conclusion: The TCU is operational and is achieving its goals. The hybrid model of medical care has been successful and could be replicated elsewhere. Integrated, multidisciplinary solutions such as this can be instrumental in moving care closer to home and achieving better, patient-centred care for older persons.

Methods: Frailty was found throughout but was highest on general internal medicine and orthopaedic wards. Of those screened, a smaller number were pre-frail, 12% (48/398), and this was similar at baseline and review. Age had a stronger correlation with baseline (r = 0.60) than current CFS scores (r = 0.54). Frailty was found throughout but was highest on general internal medicine and orthopaedic wards. Of those screened, a smaller number were pre-frail, 12% (48/398), and this was similar at baseline and review.

Conclusion: Frailty is highly prevalent in hospital inpatients with one-third of all adult inpatients frail at baseline. Frailty status as measured by a global frailty measure (CFS) appears to worsen significantly during admission likely reflecting acute illness and may not represent a patient’s true frailty status.

Background: Emergency Departments in Ireland have faced increased numbers of emergency department admissions in recent years. Over half of bed days in acute hospitals are accounted for by patients aged over 65. If we are to treat these patients more quickly and avoid emergency overcrowding, allowing patients to flow freely through the acute hospital is essential. Innovative, patient-centred solutions are required to improve patient care and achieve safe, timely discharge.

Methods: We planned and commissioned an off-site transitional care unit (TCU). The TCU patient cohort comprise those who no longer need acute hospital services but are not yet ready for discharge home. The model of care is a hybrid whereby medical cover is provided by local GPs supported by consultant geriatricians. MDT staff are part of the acute hospital team.

We analysed TCU activity to date. Admission numbers, basic demographic, and diagnostic information were collated. Impact on readmission rates was assessed and 30 day readmission rates for the TCU cohort were compared to those of the general hospital population. Qualitative interviews were conducted with MDT staff.

Results: A total of 59 participants (44%) attended for repeat assessment. At baseline cases had mean 25(OH)D levels of 18.6 nmol/L compared with controls, 98.1 nmol/L. Cases (participants with Vitamin D levels <25 nmol/L) were randomly selected and compared with age and sex matched controls with Vitamin D levels >75 nmol/L. All participants were invited to attend for a further assessment after a mean of 5.3 years and underwent repeat cognitive assessment with Repeatable Battery for the Assessment of Neuropsychological Status (RBANS) and Vitamin D testing.

Background: The effects of Vitamin D on bone health and osteoporosis are well documented and its effects beyond bone are recognised. Increasing evidence supports a role for 25-hydroxyvitamin D (25(OH)D) in cognitive function, though results from studies have been inconsistent. The aim of this study is to prospectively evaluate if association between serum 25(OH)D and cognitive function exists.

Methods: This nested case control study included 134 participants from the TUDA study with Mini Mental State Examination (MMSE) >26/30 at baseline. Cases (participants with Vitamin D levels <25 nmol/L) were randomly selected and compared with age and sex matched controls with Vitamin D levels >75 nmol/L. All participants were invited to attend for a further assessment after a mean of 5.3 years and underwent repeat cognitive assessment with Repeatable Battery for the Assessment of Neuropsychological Status (RBANS) and Vitamin D testing.
EXAMINING THE NEED AND EFFECTIVENESS OF REMINISCENCE GROUP THERAPY WITHIN AN ACUTE HOSPITAL ENVIRONMENT: A PILOT STUDY

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Background: Dementia and reduced cognition is an increasingly prevalent condition. A retrospective study found that 39% of individuals open to occupational therapy on an acute Care of the Older Person’s ward in 2016 had a diagnosed Dementia/cognitive decline. A point prevalence of one particular day in May 2017 confirmed that 71.4% (n = 20) of patients, on this same ward, had a diagnosed Dementia/cognitive decline. Mental health difficulties and reduced quality-of-life are prevalent amongst individuals with cognitive difficulties, yet few services consider this. Reminiscence group therapy (RGT) has been found to improve quality-of-life, wellbeing and mood for institutionalised older people with dementia [1].

This study intended to explore self-reported quality-of-life, anxiety and depression amongst hospitalised individuals with dementia/cognitive decline, and the impact of RGT aimed at improving quality-of-life and mood.

Methods: Mixed methods were used. Quantitative measures were completed with 65% (n = 13) of those identified with a documented dementia/cognitive decline through the point prevalence in May 2017. Qualitative data were collected through individual interviews, focusing on engagement in RGT.

Results: Pre-test quantitative measures found that 76.9% scored <84 on the Dementia Diagnosis of Life, with 59% reporting ‘poor’ or ‘fair’ overall quality-of-life. Additionally, 46% exceed the ‘normal’ depression range, and 31% exceeded the ‘normal’ anxiety range on the Hospital Anxiety and Depression Scale. To date, five individuals have partaken in RGT. Qualitative findings include improved mood and well-being, and reduced anxiety.

Conclusion: Although quantitative post-treatment measures are unavailable to date, qualitative findings indicate that RGT is a promising intervention for improving levels of depression, anxiety and quality-of-life for hospitalised people with dementia/cognitive decline. It would be beneficial for further studies to include a randomised controlled approach.

Reference

KNOLEDGE AND PREFERENCES OF OLDER PATIENTS REGARDING CARDIOPULMONARY RESUSCITATION IN AN ACUTE HOSPITAL IN IRELAND

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Background: Cardiopulmonary Resuscitation (CPR) is an important first aid tool. The survival rates after out of hospital CPR is relatively low for older patients at approximately 4% [1]. We investigated the knowledge and preferences of older patients regarding CPR and assessed whether improved CPR knowledge influenced their preferences.

Methods: A cross-sectional administered survey was distributed by physicians to a sample of 35 patients over 65 years of age without dementia and/or depression. A 10 question survey tool was used to collect basic demographic data and data on CPR knowledge. We also asked preferences before and after discussion on CPR. Poisson regression with robust error variance was used to assess association between demographic characteristics and preference for CPR.

Results: The mean age of patients that took part in the study was 78 (SD 7.4), 51% of the patients were male. Only one patient had previously been given any information on CPR by a physician. When asked about CPR, 57% of patients had adequate knowledge of CPR with 74% of patients expressing a desire to be resuscitated. There was no association found between age, gender and desire for resuscitation. After patients were provided with information on CPR, the percentage of patients who wanted CPR fell to 58%. No association was found between age and desire for resuscitation. However, female patients were less likely to want CPR compared with men after provision of information on CPR (OR: 0.76, 95% CI: 0.66–0.89).

Conclusion: Patients preference for CPR changed after provision of information by physicians. Hence, there should be adequate discussions regarding CPR with older patients in hospital.

Reference

THE INFORMANT HISTORY IN THE COGNITIVE ASSESSMENT OF OLDER ADULTS IN GENERAL PRACTICE

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Background: Despite recognition of the utility and importance of a suitable informant history in the assessment of those with a memory problem, the vast majority of GP’s report having never received training in obtaining a suitable informant history and do not use structured tools to guide their interview. Further emphasis on the informant history as a distinct clinical entity on medical curricula, as well as increasing emphasis on the ready availability of structured informant tools, is warranted.

References

DEMENTIA DIAGNOSIS AND REFERRAL IN GENERAL PRACTICE: A REPRESENTATIVE SURVEY OF IRLISH GPS

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Background: Many patients with a memory problem or concern over cognition present to their General Practitioner (GP) in the first instance. Despite this, the current diagnostic and referral patterns of Irish GPs remains unclear.

Methods: An online survey on dementia diagnosis and referral practices distributed to three separate cohorts of GPs (n = 600) followed by a reminder one month later.

Results: Ninety-Five responded (14%), 52.2% male who were representative of Irish GPs in terms of gender (χ² = 0.77 p = 0.38), urban/rural/mixed location (χ² = 2.5 p = 0.29) and practice size (χ² = 7.3 p < 0.12). Most personally diagnose either 1–3 (68.5%), 4–6 (21%; 20/95) patients with dementia per year. The majority routinely use the MMSE as their screening tool of choice (82.1%; 78/95). Two-thirds (62.1%; 59/95) refer >80% of those with possible dementia for further assessment/support, most commonly to support/carry a diagnosis (70.5%; 67/95). Referral is most frequently to a geriatrician (79%; 75/95). In half of cases (50.5%; 48/95), GPs report referring to a professional working as part of an established memory clinic. One-fifth of GPs referred receiving dementia-specific postgraduate training (18.9%; 18/95) and over four-fifths (82.1%; 78/95) would welcome further training.

Conclusion: Most GPs personally diagnose the three or less cases of dementia per year and refer the majority of patients with concern over cognition for further support (most often to a geriatrician). Further attention to the ongoing establishment of dedicated memory clinic services and referral pathways is warranted.

Poster presentations
DEEP VENOUS THROMBOSIS IN IRISH OLDER ADULTS ATTENDING AN ACUTE MEDICAL ASSESSMENT UNIT

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Background: Irish patients demonstrate a high prevalence of risk for venous thromboembolism. This risk increases with age. The aim of this study was to evaluate our management protocol for older adults presenting on clinical suspicion of deep vein thrombosis, its prevalence in this age group and current treatment used in our setting.

Methods: Retrospective data was obtained from older adults who attended the AMAU on clinical suspicion of DVT from September 2015 to May 2016. Information collated included risk factors, Wells score, D-dimer assay, duplex ultrasonography results and treatment. Patients risk for DVT was scored as either high or low.

Results: 95 older adults were included in the study period; mean age was 76.2 ± 6.7 years (range 65–94 years). 69.5% were female. The risk for DVT was high in 81.3% patients however, DVT was diagnosed in 18.9% patients. Median D-Dimer was 3.81 mg/ml in patients with DVT while median D-Dimer was 0.98 mg/ml in patients without DVT. Median Wells score was 4 in patients with DVT compared to median Wells score of 2 in those without DVT. 61.1% patients were treated with novel oral anticoagulants (NOACs) compared to 11.1% patients who were treated with warfarin. None of the patients in the low-risk group with normal D-dimer concentrations (50-500 mcg/ml) had DVT.

Conclusion: DVT was diagnosed in 18.9% of older adults assessed for clinical suspicion of DVT in our AMAU. Higher D-dimer concentrations and Wells score tended towards a positive diagnosis for DVT. Our practice shows the previously documented reluctance of DVT in our AMAU. Higher D-dimer concentrations and Wells score tended towards a positive diagnosis for DVT. Our practice shows the previously documented reluctance of DVT in our AMAU.

TILT TABLE TEST OUTCOME IN THE DIAGNOSIS AND PREVALENCE OF SYNCOPE IN PATIENTS WITH VITAMIN D AND VITAMIN B12 DEFICIENCY

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Background: Syncope is a clinical syndrome in which transient loss of consciousness is caused by abrupt drop of systemic blood pressure for a brief duration (8 to 10 seconds) and is spontaneously self-limited.

Tilt testing is recommended where a cardiac cause of syncope has been outruled. Reproduction of symptoms here is diagnostic.

Vitamin B12 and vitamin D deficiencies are implicated in causing syncope due to auto-nomic dysfunction and hence an important cause to rule out when assessing a patient with orthostatic hypotension and syncopeal symptoms.

Methods: This is a retrospective analysis of haemodynamic changes in response to tilt table testing that were recorded by a non-invasive volume clamp technique (finometer).

The following diagnoses were made: Orthostatic Hypotension (OH), Carotid Sinus Syndrome (CSS), Neuro-cardiogenic Syncope (NCS) and Postural Tachycardia Syndrome (POTS). Blood levels of vitamin D and vitamin B12 were checked.

Results: 181 patients underwent investigation from 1st October 2015 to 30th September 2016. Mean age was 72 years. The male to female ratio was 11:9. 100 patients out of 181 had positive tilt table test. 46% (n = 46) met the criteria of OH. 40% (n = 40) patients were diagnosed CSS, 77% (n = 31) of these being vasodepressor and 23% (n = 13) being cardioinhibitory. 13% (n = 13) got the diagnosis of POTS.

1 patient had NCS.

Out of these 100 patients 71 had vitamin B12 or vitamin D deficiency. Hence only 29 patients had normal vitamin levels.

23% (n = 23) of patients with syncope were vitamin B12 deficient. However 56% (n = 56) of patients with syncope had vitamin D deficiency.

9 patients had deficiency of both vitamin D and vitamin B12.

Conclusions: 1-The tilt table test is a useful tool in the diagnosis of syncope.

2-Vitamin D and vitamin B12 deficiencies have significant association with syncope and should be ruled out in all patients with syncope as a potential cause.

MEASURING IMPACTS OF INTRODUCING COMMUNICATIVE ROBOTS WITH INFRA-RED RADIATION MONITORING SYSTEM ON WORKLOAD OF NIGHT SHIFTS IN NURSING CARE FACILITIES

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Background: The impacts of using robots and ICT in care settings have not been sufficiently evaluated, particularly in relation to workers’ workload, despite much attention being paid to public expenses and harsh working environment, leading to a shortage of staff. The purpose of this paper is to evaluate quantitatively the effects of introducing communicative robots on night shift duties of nursing facility workers.

Methods: The subjects are five staff members in charge of late-night work, looking after older people (17 female and 3 male, aged 87.1 +/- 5.8 yrs) in an environment where a communicative robot with an infra-red radiation monitoring system was introduced. We quantitatively investigated psychological stress, such as feelings of tension, depression, anger, alertness, fatigue and confusion, using POMS-VAS. We also examined feelings of sleepiness, anxiety, discomfort, vagueness, and total stress level, using the “method for checking subjective symptoms”.

Results: During the fourth week, compared with the pre-introduction phase, the total fatigue level measured by the “method for checking subjective symptoms” was significantly improved before nap (p < 0.05), after nap (p < 0.05), and the end of the night shift (p < 0.001). In particular, improvement in feelings of anxiety, discomfort and lethargy were remarkable. Along with this improvement, the accidents in nursing home, especially the trauma accidents decreased.

Conclusion: The introduction of a communicative robot with an infra-red radiation monitoring system significantly improved the subjective psychological burden of late night nursing care workers, and alleviated the night-time work workload.
BONE HEALTH CHECKLIST WITH PHARMACY SUPPORT IMPROVES THE MANAGEMENT OF LOW TRAUMA FRACTURES: A QUALITY IMPROVEMENT PROJECT

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Background: The rehabilitation of older people with acute low trauma fractures is increasingly occurring in an intermediate care setting. A component of management should involve bone health review. Our Trust has a 29 bedded community rehabilitation unit with a Consultant led service. We performed a retrospective review of discharge letters to General Practitioners which demonstrated suboptimal documentation of bone health review (57%) as well as inconsistent vitamin D level testing of patients (56%). This led to the development of a bone health checklist which was to be completed by the pharmacist with the aim of improving bone health review and information sharing with primary care.

Methods: Following the introduction of the above changes a further retrospective audit of all discharge letters over a 3 month period was performed and results compared with the previous audit.

Results: Seven discharge letters were reviewed following implementation of the checklist. Documentation of bone health on discharge letters improved significantly; 89% vs 57%. Vitamin D levels were checked in 89% of patients compared to 56% prior to its introduction. Dietary Calcium intake was also assessed in 86% of patients.

Conclusions: The introduction of a bone health checklist with pharmacy support improved management of older patients with low trauma fractures significantly, facilitating tailored medicines optimisation. Inclusion on the discharge letter ensures effective communication to the primary care physician. The role of the unit pharmacist in facilitating completion of the assessment was invaluable.

STRUCTURING DIABETES MELLITUS CARE IN LONG TERM NURSING HOME RESIDENTS

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Background: Nursing home residents have more complex care needs with higher levels of comorbidity, disability and cognitive impairment. It is estimated that 1 in 4 nursing home residents has diabetes mellitus. These patients are particularly vulnerable and require special attention.

Methods: We compared current practice in the 44 long term residents in Peamount Hospital with the standards recommended in the Diabetes UK “Good Clinical Practice Guidelines for Care Home Residents with Diabetes”.

Results: Of 44 residents, 10 were diabetic. Only one resident was screened for diabetes on admission. Residents did not have specific diabetic care plans. There were no algorithms for the management of hypoglycaemia, hyperglycaemia or diabetic complications. 70% of diabetic residents had a HbA1c checked in the last year, but there was no formal schedule of HbA1c monitoring. There was no protocol for screening for diabetic retinopathy, foot disease or nephropathy. In house access to dietetics and chiropody was provided.

Conclusions: This audit demonstrated some elements of good practice and hypoglycaemia was a rare occurrence. However, there was no formal screening for diabetes on admission. Diabetic care was delivered on an ad hoc basis without individualised care plans, documented gluco-meters or scheduled monitoring for complications. National and local policy to guide management of diabetes mellitus in long term care residents should be developed. In the interim, the Diabetes UK guidelines should be followed. All residents should be screened for diabetes. There should be individualised diabetic care plans and clear policies for management of hypoglycaemia, hyperglycaemia and long term diabetic complications.

AN AUDIT OF EMERGENCY DEPARTMENT PRESENTATIONS OF NURSING HOME RESIDENTS

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Background: Due to the nature and complexity of age and co-morbidity, the burden of care presented by the geriatric population is higher than for other cohorts of the community. With Ireland’s ageing population, increasing demands are continually being placed on acute hospital services.

The objective of this audit was to examine nursing home referrals in the acute setting. We examined how many were medically assessed prior to admission, how many were admitted and what proportion could be better treated in the community setting.

Methods: This was a retrospective study using data taken from ED presentations of nursing home residents from January – March 2016 in an Irish secondary care facility. Patient demographics, presenting complaints, admission status, length of stay and discharge diagnosis were recorded in Microsoft Excel.

Results: In the 12-week period, 90 nursing home residents were presented to ED. Their mean patient age was 83 years (SD 7.4 yrs). 59% of patients (n = 53) had seen a GP before presenting; 37% (n = 33) had not. 73% of patients (n = 66) were admitted; 27% (n = 24) were discharged same day. 10% of patients (n = 9) died during admission; 2% (n = 2) were discharged to End-of-Life care.

Conclusions: This study shows that most nursing home residents need hospital admission, which reflects their level of frailty and co-morbid illness. Up to 27% were discharged from ED on the day of assessment, suggesting they would have been better managed in the community by GP or geriatrician review. Additionally, with the presence of community geriatricians or a frailty team locally a further 7% would have been discharged earlier were the service available.

A PLAN FOR EVERY PATIENT: ACHIEVING EXCELLENCE IN COMMUNICATION AND INTERDISCIPLINARY WORKING ON A SPECIALIST GERIATRIC WARD

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Background: Beaumont Hospital catchment area has a 20% higher proportion of over 65% and over 85% than the national average. The clinical needs of older patients are complex as they frequently present with multiple co-morbidities accompanied by functional decline, cognitive deterioration and complex social care needs. Older patients should have access to Comprehensive Geriatric Assessment and appropriate treatment without unnecessary delay. In 2015 the Beaumont improved care performance plan was developed to deliver the objectives of the National Clinical Programme for Older People (2012).

Aims and objectives: To enhance communication processes and reduce potential delays via prompt referral to MDT for Comprehensive Geriatric Assessment and collaborative interdisciplinary decision making regarding patient needs, goals, and predicted dates of discharge.

Methodology: Quality improvement methodology was adopted. Multiple driver diagrams and plan-do-study-act cycles were completed. Regular data was collected to measure the impact of the implemented changes. Monthly clinical sub-group meetings provided a structured forum, accountability for staff and a formal way to identify gaps in the service.

Results and Discussion: A daily Plan for Every Patient board meeting has been established on Hardwicke ward, led by a Clinical Nurse Manager and lasting approximately 20 minutes. It is attended by the full MDT including Consultants and/or Senior Registrars, and a representative from the hospital’s delayed discharge team. It facilitates prompt identification of new patients, sources of delay and potential discharges that day, as well as immediate referral to the MDT. MDT referral response times have been minimised to within 24 hours during the core working week.

Conclusion: Daily board meetings have been embedded into practice. An ethos of daily decision making, communication and planning for discharge from admission has been established on the ward. The emphasis is now on sustaining the improvements to date on Hardwicke ward, as well as sharing the learning with other MDTs.

USING CLINICAL AUDIT TO IMPROVE HIP FRACTURE CARE IN IRELAND: THE IRISH HIP FRACTURE DATABASE

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In 2016, 3,610 patients over the age of 55 were hospitalised with a hip fracture in Ireland. The acute hospital care costs are in excess of €45 million and growing. This doesn’t include the long term costs of rehabilitation, convalescence, community care and long term care.

The IHFD is a clinically led, web based audit of hip fracture casemix, care and outcomes. It is supported by the Irish Gerontological Society (IGS) and the Irish Institute of Trauma and Orthopaedics (IITOS) and the National Office of Clinical Audit (NOCA) provides governance and operational support for the IHFD. All sixteen eligible hospitals in the Republic of Ireland are included.

The most recent IHFD report 2015 published in 2016 is comprised of data from 2,962 hip fracture cases from 16 hospitals. The coverage of the data for 2015 was 81%. The mean length of stay was 20 days and the median length of stay was 13 days in 2015. The 2016 report will be published later this year. Preliminary data for 2016 shows the coverage has increased to 86.5%.

In the 2015 National report published in 2016 70% hip fractures were female, 83% patients were admitted from home and 48% were independently mobile, 37% fractures were intra-capsular displaced, 36% of arthroplasties were cemented and 80% patients were discharged directly home. Thirty-nine percent (39%) of patients were reviewed by a geriatrician at any time during their admission. The proportion of patients being reviewed pre-operatively is 15%.

In 2017, the focus continues to be on improving data quality and increasing coverage nationally to 100% for all sites. To ensure all suspected hip fracture patients should be brought directly to the trauma operating hospital. Each hospital should establish a hip fracture working group to review and utilise the IHFD data locally to improve patient care.
Background:
A diagnosis of delirium among older inpatients is associated with increased length of stay, morbidity and mortality. Recognition of delirium in hospitals is poor leading to undertreatment and mismanagement. The National Clinical Programme for the Older Person (NCPOP) has published a pathway for the assessment and management of delirium in older people. Our objective was to assess the point-prevalence of delirium in all ≥70 years old inpatients with a hip fracture in our institution on the 27/07/2016.

Parallel to this we assessed if patients were managed according to NCPOP guidelines.

Methods:
All inpatients ≥70 with a diagnosis of hip fracture were screened for delirium using the 4XT and the AMTS (Abreviated-Mental-Test-Score). Medical notes were reviewed to assess if delirium management was according to guidelines.

Results:
16 inpatients were included, mean age 82.94 yrs. 50% screened positive for delirium. 9 patients had an underlying diagnosis of dementia. The mean score of the 4AT 3.31, 3 patients scored 0, 6 patients scored 2+ suggestive of delirium. The mean score of the AMTS was 2.63. 9 patients had a score ≤5, indicating evidence of possible cognitive impairment or early phase delirium. 6 received pharmacological intervention: quetiapine as first line (4 patients), haloperidol (1 patient), and haloperidol & quetiapine (1 patient). 7 patients also received non-pharmacological therapies; relocation to a single room (2 patients), healthcare assistant supervision (2 patients), falls alarm (3 patients). 4 inpatients were managed according to NCPOP guidelines.

Conclusion: The point prevalence of delirium in our cohort was high. Patients were being screened for delirium; however, screening tools employed were not documented. First line medications used were not according to guidelines. Delirium care is therefore suboptimal. Going forward, the NCPOP pathway has been deployed on the orthopaedic ward and formal education about the guideline given to HCPs. After 6 months we will re-audit.
cognitive decline and are a potential reversible cause of cognitive impairment. However the frequency of PIMS use in the memory clinic setting at the point of referral is not well studied.

Methods: A database of all patients referred to our memory clinic from January 2013–April 2017 was created. Demographic data, medications, cognitive assessments, and diagnosis for all patients were recorded retrospectively. The presence of polypharmacy (5–9 medications), hyper-polypharmacy (>9 medications), Anticholinergic Burden (ACB) Score and PIMS for cognition as defined by Beers and STOPP criteria was recorded for all patients with a formal cognitive diagnosis. Patients with no evidence of cognitive impairment were excluded.

Results: 277 patients with a formal cognitive diagnosis were identified (50.9% female, mean age 77.0 (IQR 73–82)). The mean Addenbrooke’s Cognitive Examination, Mini- Mental State Exam, and Fronto Assessment Battery scores were 67.6 (IQR 59–78), 23.3 (IQR 20–27) and 12.8 (IQR 10–16) respectively. 31.5% (n = 90) of patients were diagnosed with mild cognitive impairment and 67.5% (n = 187) with dementia. Polypharmacy was present in 47.7% (n = 132) and 17.0% (n = 47) had hyperpolypharmacy. 15.2% (n = 42) of patients had a clinically significant ACB score of ≥3. 20.7% (n = 57) of patients had ≥1 PIM as defined by STOPP criteria. 27.4% (n = 76) had ≥1 PIM as defined by Beers criteria. The most commonly prescribed PIMS were non-benzodiazepine hypnotics (n = 26), benzodiazepines (n = 23) and blader antimuscarinics (n = 29).

Conclusion: We identified a high prevalence of polypharmacy, PIMS, and anticholinergic medication burden in patients with a formal cognitive diagnosis at the point of referral to a specialist memory clinic. Our results highlight the importance of addressing inappropriate prescribing in patients with cognitive disorders.

EXPLORE THE IMPACT A TRAINING PROGRAMME HAS ON ACUTE HEALTHCARE PROFESSIONALS’ ATTITUDES AND UNDERSTANDING OF DEMENTIA

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Background: Acute healthcare professionals lack education and training in dementia care. This results in people with dementia having poorer outcomes when admitted to the acute healthcare setting. An overarching aim of The National Dementia Strategy (2014) is the provision of optimal care for people with dementia in all healthcare and community settings. In response to this, Dementia Elevator a national inter-professional suite of educational programmes were developed to help individuals, communities and health systems engage positively with people with dementia. This study aimed to evaluate a training programme on acute healthcare professionals’ attitudes and understanding of dementia.

Methodology: A mixed methods research methodology was employed to answer the research questions. The first phase of this study employed a quantitative approach (n = 42) using questionnaires, and the second phase employed a qualitative approach (n = 9) using interviews.

Results: The findings from this study indicate that participants’ attitudes to dementia were high and were enhanced as a result of the training programme. There was a statistical significant difference in attitudes post the educational intervention illustrating health-care professionals’ optimism towards the abilities and future of individuals with dementia. Participants adopted a range of discourses when constructing people with dementia including: competency to care, emotional challenges and organisational culture. Furthermore, wider discourses were drawn upon by participants that constructed identities of people with dementia.

Conclusion: Healthcare professionals strive to deliver person-centred care but were impeded owing to the task focused culture within the acute setting and emotional challenges. Acute healthcare settings must become more dementia-friendly for individuals with dementia owing to the findings of this study with a focus on environment, staff competency and the overall organisational culture of these settings. Healthcare professionals require further education and training in the area of dementia and the promotion of a person-centred approach to care.

REDUCING THE USE OF PSYCHOTROPIC MEDICATION IN NURSING HOME RESIDENTS: A MULTIDISCIPLINARY INTERVENTION

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Background: The reduction in psychotropic drugs in older people with dementia is becoming a key national recommendation. HIQA recommends a regular medication review to ensure this. Systematic reviews of medications show that psychotropic drugs are a key factor for falls (Harlakainen et al, 2007) and antipsychotic medications increase the risk of stroke 3-fold and risk the of death by one and a half times (Shekelle et al, 2007, Schneider et al, 2005).

Aims and Objectives: The aim was to determine the use of psychotropic medication in two nursing home units with a view to reducing same.

Methods: We carried out a multidisciplinary (MDT) (medical, nursing, OT, HCA and pharmacy staff) medication review every 3-5 weeks between March and May 2017. We collected the data via a chart review before and after the intervention.

Results: There were 49 residents living in the two units. 59% were female and the median age was 86 (range 72–107). 26 (54%) had a documented history of dementia, 2 (4%) a history of recent delirium and 8 (17%) a history of psychiatric disorder. The use of psychotropic medications was high 20(50%), 16 (33%) were on an anticholinec,17 (35%) were on a hypnotic and 17 (35%) were on an oral antipsychotic. After almost three months of regular medication reviews we have stopped or have achieved a dose reduction in psychotropic medications for 23% of our residents. The proportion of residents taking antipsychotics have dropped from 16(33%) to 11(22%),(p = 0.025)

Conclusion: Through our regular MDT medication reviews we have successfully stopped the use of psychotropic medications in 36% of residents and reduced them in a further 13%. These are preliminary results and we are hopeful that we will further limit psychotropic medication use by continuing this intervention.

HOW WELL DO MEASURES OF TONGUE STRENGTH CORRELATE WITH OROPHARYNGEAL DYSPHAGIA IN OLDER PERSONS?

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Background: Tongue strength is a key component of an efficient and safe swallow but has been shown to decline with age. Acutely unwell older adults often exhibit difficulty swallowing leading to aspiration pneumonia, malnutrition, dehydration and increased mortality. We hypothesised that acutely unwell older adults may experience further decreased tongue muscle strength contributing to the increased levels of dysphagia seen in older inpatients. This pilot study sought to determine the correlation between tongue strength and oropharyngeal dysphagia in older adults presenting to an acute hospital.

Methods: A retrospective study was completed to analyse 3 months of clinical data from suitable inpatients referred to Speech and Language Therapy (SLT) for a swallow assessment. A clinical swallow evaluation, EAT-10 dysphagia questionnaire and lingual strength & endurance, as measured using the Iowa Oral Performance Instrument System (IOPI), were completed. The relationship between these measures were analysed to determine whether reduced tongue strength was a reliable indicator of oropharyngeal dysphagia and/or the severity of same in older hospitalised patients.

Results: Data from 15 older adults had been analysed. Initial results suggest that reduced tongue strength and endurance are highly predictive of the presence of an oropharyngeal dysphagia. Further analysis is required to determine if tongue strength correlates with severity of the dysphagia and its sequelae.

Conclusions: Reduction in tongue strength correlates with the presence of dysphagia and measures of these parameters may prove a useful addition to dysphagia assessment. Further work is ongoing to determine if strength correlates with severity of dysphagia and if specific therapeutic interventions directed at increasing tongue strength may reduce dysphagia associated morbidity.

ADVANCE CARE PLANS – A MISSED OPPORTUNITY?

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Background: Nearly half of all deaths in Ireland occur in hospital [1]. We aimed to review the deaths under our service, and evaluate the use of Do Not Attempt Cardiopulmonary Resuscitation (DNA/ACPR) forms and the presence of absence of Advance Care Plans (ACP).

Methods: This was a retrospective chart review of patients admitted on unscheduled take over a 12 month period.

Results: Of 679 patients admitted, there were 73 deaths. Data were available on 71/73, median age 80yrs old. 83% (59/71) were admitted from home, and 15% (11/71) were admitted from nursing homes (NH). 62% of those who died (44/71) had a life-limiting illness, dementia being the most common (27/44). 37/71 patients had an ACP. 7/11 NH patients had no documentation of resuscitation status in their transfer letter. DNA/ACPR decisions occurred in 68/71 prior to death. The median time from completion of the form until death was 7.5 days. The DNA/ACPR decision was discussed with only 1/68 patients. The decision was discussed with family in 54/68, and there was no discussion with either the patient or family in 7/68.

Conclusions: Death is common, with almost one in ten patients dying during their admission. There is also a high burden of multimorbidity, but despite this, uptake of ACPs was low; especially in the frail NH population. It is challenging to involve the patient themselves during the acute phase of their illness and indeed may add to their distress. Consideration should be given to the timing of these decisions and the expanding role of ACPs. A wider societal discussion and public education programme around DNA/ACPRs and ACPs are essential components in improving these important and challenging discussions.

Reference
THE PATIENT WITH PARKINSON’S DISEASE IN EXTENDED CARE

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Background: In 2016 the Irish Palliative Care in Parkinson’s Disease Group issued guidelines on assessment and management of palliative care needs in Parkinson’s disease and related disorders (PD/RD). We carried out a review of patients with PD/RD in our extended nursing care unit (ECU, 88 beds) to ascertain their number, comorbidity, physical and cognitive function, and use of medications, specifically antiparkinsonian, analgesic, psychotropic and antimicrobial drugs.

Methods: Patients were included if PD/RD had been diagnosed by a specialist. Comorbidity, physical and cognitive function were recorded. Medication use over a week (12–18 December 2016) and antimicrobial prescriptions over six months for clinically diagnosed LRTIs were ascertained.

Results: 18 patients with PD/RD were identified, 3 were excluded (2DIP1 actively dying) leaving 15 (13PD, 2MSA).

PD patients were older (mean age PD 81 yr, MSA 78 yr) and had a longer disease duration from diagnosis compared to the 2 patients with MSA (PD 16.2 yr, MSA 4.5 yr).

Barthel Index was 5 or less in 13(12/16%) patients, whilst 10/13(77%) patients had severe cognitive impairment. 77% of PD patients (10/13) had 4–8 comorbidities, the most common being hypertension, dementia, stroke and osteoporosis.

All patients except one were receiving Levodopa. Most patients 67% (10/15) were on antiparkinsonians whilst 53% (8/15) were receiving antidepressants, mainly quetiapine, with 6 (40%) patients receiving benzodiazepines. 10/15 (67%) patients were receiving analgesics. 10/15 patients (67%) were receiving antidepressants, antipsychotics and analgesics are commonly prescribed reflecting the prevalence of depression, agitation/psychosis and pain. The majority of patients had dysphagia with some requiring repeated courses of antibiotics for aspiration pneumonia.

HOSPITALISATION AND SURGERY: IS EXPOSURE ASSOCIATED WITH INCREASED SUBSEQUENT DEPRESSIVE SYMPTOMS? EVIDENCE FROM THE IRISH LONGITUDINAL STUDY ON AGEING (TILDA)

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Background: Increasing numbers of older people are undergoing hospitalisation and surgical procedures. While necessary, these exposures may lead to an increase in depressive symptoms. Our objective was to determine whether hospitalisation or hospitalisation with surgery under general anaesthesia is associated with an increase in depressive symptoms in adults over the age of 50.

Methods: Depressive symptoms were assessed using the Centre for Epidemiologic Studies Depression Scale (CES-D) in 8,036 individuals at waves 1 and 2 of The Irish Longitudinal Study on Ageing (TILDA), two years apart. Mixed-effects models were used to investigate the hypothesis after adjustment for risk factors for depression and potential confounders.

Results: During the 12 months preceding wave 1, 459 participants were hospitalised (mean age 67A, 55.3% female) and a further 548 participants (mean age 66.6, 51.8% female) were hospitalised and underwent surgery with general anaesthesia; 6,891 (mean age 63.5, 54.3% female) were not hospitalised. There was a 7% increased adjusted incidence rate of depressive symptoms (IRR [95%CI] = 1.04 [1.00, 1.08]) in the CES-D in the hospitalisation group and a 4% increased adjusted incidence rate of depressive symptoms (IRR [95%CI] = 1.04 [1.00, 1.08]) in the surgery group compared to those with no hospitalisation.

Conclusion: Hospitalisation and surgery are associated with increased depressive symptoms. This is the first time a longitudinal population-representative study has demonstrated this relationship for both exposures simultaneously.

THE EFFECTIVENESS OF STROKE REHABILITATION IN OLDER OLD PATIENTS COMPARED TO A GROUP OF YOUNGER STROKE PATIENTS

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Background: Stroke rehabilitation can be as effective in older people as in younger people. Age should not be a barrier to access rehabilitation and selection criteria should be the same as their younger counterparts.

Method: All patients admitted to a specialist inpatient rehabilitation hospital post stroke between 2010–2016 were included. Patients were assessed for rehabilitation potential prior to transfer and received an individualised interdisciplinary rehabilitation programme. Admission and discharge Barthel scores were recorded. We analysed the change in Barthel index (BI) and length of stay (LOS) by age group.

Results: 185 patients were included, 10 of these were excluded due to death, becoming unwell and self-discharge. Patients (47% men, mean age 77.8, 83% ischemic strokes) were generally previously independent (81% modified Rankin 0–4). 32.6% of patients admitted for rehabilitation showed no evidence of cognitive impairment, 20.1% had mild cognitive impairment, 22.9% moderate cognitive impairment and 11.4% severe cognitive impairment. Mean increase in Barthel did not differ across the age groups and there was no significant difference in LOS. For all age groups, the mean BI on admission was 13 (4.7 SD), 15.6 on discharge (4.34 SD) with a mean LOS of 82 days. In the under 65s (n = 13), the mean BI on admission was 13.8 (6.1 SD), 16.1 (4.9 SD) on discharge with a mean LOS of 78 days (70 SD). Over 85 (n = 35), mean BI on admission 11(4.2SD), 15.3 (5.7 SD) on discharge, LOS was 2.9 for the 76–85 group and 2.3 for other age groups. p values for BI change and LOS trends across age groups were non-significant. 81% of patients were discharged home.

Conclusion: Stroke rehabilitation can be as effective in older old people as in younger people. Further work is needed to improve diagnostic accuracy of TIA.

TIA OR NOT TIA? THAT IS THE QUESTION. A REVIEW OF DIAGNOSES SEEN IN A RAPID ACCESS TIA CLINIC

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Background: Transient ischaemic attacks (TIA) are a medical emergency which requires prompt investigations to avoid a subsequent stroke. Our hospital provides a rapid access TIA clinic where patients with suspected TIA can be referred for review by a stroke specialist the following day to avoid unnecessary admission. Basic investigations include bloods, fasting risk factors, carotid Doppler and electrocardiogram. Other tests are organised as necessary. We aimed to examine the final diagnosis of patients referred to our rapid access TIA clinic, highlighting patients who required an unscheduled admission.

Methods: Retrospective study including all patients seen in a rapid access TIA clinic from January 2015–December 2016 in an Irish University Hospital. We examined patients who had a formal diagnosis of TIA, stroke or alternative diagnosis.

Results: 279 patients included, mean age 62 (+/−16 SD), 53% female. 98.2% of patients (n = 274) were assessed and discharged the same day. 3 patients (1.1%) were admitted for two days and 2 patients were admitted for 3 days for further investigations. Reasons included high risk TIA, optic neuritis and seizure.

Overall, 38% of patients (n = 106) had a confirmed diagnosis of TIA. 47.2% of TIAs presented with amaurosis fugax, 11.1% of patients (n = 31) had a confirmed stroke either by examination, CT or MRI brain. The most common ‘TIA Mimic’ was migraine (16.1% of presentations, n = 45). Other common mimics included pseudoseizure/sycope (4.7%), syncope (4%), dizziness (3.2%), other established ophthalmic diagnosis (2.9%), demyelination disorder (2.9%), new cognitive impairment or delirium (2.2%), seizure (1.8%), musculoskeletal disorder (1.8%) and other medical diagnosis (1.8%). 5.7% (n = 16) of presentations remained unexplained.

Conclusions: The use of a rapid access TIA clinic avoids unnecessary admissions and reduces LOS. However, a very high proportion of patients seen are not TIA. Further work is needed to improve diagnostic accuracy of TIA. Factors predicting TIA have been studied in the past with low diagnostic usefulness. Should the gold standard remain assessment by a stroke specialist?

SELF-MANAGEMENT: A PATIENT-CENTRED OPTION FOR MANAGING DAILY CHALLENGES POST-STROKE

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Background: Self-management programmes are increasingly regarded as an appropriate way to support people with long-term chronic conditions. Limited research has examined the effectiveness of self-management post-stroke. Although stroke occurs as an acute event, it is then a chronic condition for the stroke survivor and a leading cause of long-term disability (Begg et al., 2007). While different from other chronic conditions, similarities in the care required for self-management may be used to design an effective method for individuals to confidently self-manage their symptoms. UK national stroke guidelines recommend offering all patients training in self-management skills. This study investigated the impact of a self-management programme aimed at managing stroke-related symptoms and improving engagement and performance in activities of daily living for individuals post-stroke.

Method: A previously developed self-management programme which had positive impacts on activity performance, fatigue, pain, mood, self-efficacy and quality-of-life for...
individuals with rheumatic diseases was adapted and run with individuals in an acute stroke rehab setting.

A qualitative approach was used to collect data through individual non-structured interviews following completion of the self-management programme. Thematic analysis confirmed reoccurring patterns and themes were derived.

Results: Three individuals with mixed stroke diagnoses completed an occupational ther-apy self-management programme between March and May 2017. Patients reported an improved understanding of fatigue and a greater ability to manage both stress and fatigue. They also identified a change in attitude following the programme and highlighted self-management strategies they utilised daily.

Conclusion: Although positive, these results are preliminary. Further research should include pre-test and post-test quantitative measures of fatigue, pain, mood and self-efficacy. This could potentially assist the development of a stroke self-management model of care.

Reference

IS FEAR OF FALLING ASSOCIATED WITH DECLINE IN GLOBAL COGNITIVE FUNCTIONING IN OLDER ADULTS: FINDINGS FROM THE TILDA STUDY

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Background: Fear of falling (FoF) is present in 23% of Irish adults over 50 and may be an early marker of decline in cognitive functioning. However, previous studies examining the association between FoF and cognitive functioning were cross-sectional in design, included small samples and the measurement of cognitive functioning was limited to memory. We aimed to test the hypothesis that FoF is associated with decline in global cognitive functioning (GCF) in adults aged 50 and older.

Methods: Data were from 4960 participants (aged 50–98, 54.3% female) in The Irish Longitudinal Study on Ageing, a representative population-based observational study. FoF was based on self-report in 2010. GCF was measured with the MoCA and MMSE in 2010 to 2014. The cross-sectional association between FoF and GCF measured in 2010 was examined using linear regression. The prospective association between FoF measured in 2010 and the risk of >1SD decline in GCF was examined using logistic regression. Models were run unadjusted and after adjustment for demographic and health factors. Interaction with age and mediation by social participation and physical activity were examined.

Results: In 2010, the prevalence of FoF ranged from 15% in 50–55 year olds to 41% in 85+ year olds. In the unadjusted cross-sectional models, those with FoF had lower scores on the MoCA (B = −0.94, 95% confidence interval [CI] = −1.17,617) and MMSE (B = −0.41, CI = −0.55,27). In the unadjusted prospective models, FoF was asso-
ciated with a greater risk of decline in MoCA (odds ratio [OR] = 1.51, CI = 1.21,189) and MMSE (OR = 1.47, CI = 1.16,183). However, all associations attenuated and were no longer statistically significant after adjustment for confounders. No statistically signifi-
cant interaction with age was found (p > 0.26). Additional adjustment for social participa-
tion and physical activity did not change the results.

Conclusions: The association between FoF and GCF is fully explained by demographic and health factors.

THE IMPACT OF AGE ON THE INCIDENCE OF ADVERSE DRUGS EVENT (ADEs) CAUSING HOSPITALISATION IN PATIENTS WITH CANCER

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Background: Over 60% of all cancers are diagnosed in patients’ 65 years. The aim of this study was to ascertain the incidence of adverse drug events (ADEs) causing hospitalisation in older patients with cancer and identify if it differs to that of the general acute age group.

Methods: This prospective observational study was conducted over a 12-month period. ADEs were neutropenia with associated infection in 23%, nausea/vomiting in 18.9% and major complication in 17.6%.

Conclusions: Approximately 1 in 4 acute admissions in adult patients with cancer are ADE related. ADEs are caused by non-cancer drugs as frequently as cancer specific treatments in both older and younger adults. Older cancer patients experience ADEs at similar frequency to their younger counterparts. The ADE rates reported here for older cancer patients are higher than those previously reported for the general acute population.

LAMP IN ACTION: THE FEASIBILITY OF SOCIAL PRESCRIBING IN THE MEDICINE FOR THE ELDERLY OUTPATIENTS

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Background: Social determinants of health include loneliness, social isolation and phys-
ical inactivity and are more common in older populations. Social prescribing is a means for health professionals to refer patients to community resources that will address these determinants.

Methods: We determined the prevalence of loneliness, social isolation and physical inactivity in the general geriatric outpatients and sought patients’ opinions of the useful-
ess of the social prescription. Consecutive non-demented patients attending outpatient were approached to complete a standardised questionnaire comprising the De Jong Gie rveld Loneliness Scale, Duke Social Supports Inventory (DSI), a Modified Physical Activity Questionnaire and information on health service utilisation in the previous 12 months. A social prescription was generated using LAMPS’s website tool for each patient with the LAMP catchment area and the community assets returned for each were recorded. Ethical approval was obtained.

Results: Forty-four patients participated; 20 were male. Most (93%) were aged 70–89 and 45% lived alone. 59% had three or more chronic diseases. 75% endorsed loneliness, 11% anxiety and loneliness. Mean DSSI score was 23 (range 17–28) indicating moderate per-
cieved social supports. Healthcare utilisation included 257 GP visits, 170 outpatient visits, and 357 inpatient bed-days in the preceding 12 months. They reported an average of 357 minutes sitting each day. The majority of respondents felt that the social prescription was beneficial and useful. There were 30 patients living within the LAMP catchment area. Each had access to a mean of 4.2 social engagement, 2.8 physical activity and 2.1 nutri-
tion community assets.

Conclusion: Social prescribing is a novel tool that is currently not widely used in clinical settings in Ireland. Our study suggests that social prescribing in the geriatric outpatient is potentially beneficial and feasible. LAMP’s website resource adds a holistic and non-
pharmacological therapeutic tool to the armamentarium of health care professionals working in medical gerontology.

POINT PREVALENCE OF MALIGNANCY IN A GERIATRIC MEDICINE INPATIENT COHORT

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Background: With Ireland’s ageing demographics and increasing risk factor prevalence, the incidence of cancer is expected to double by 2040 [1]. This will lead to a fourfold increase in its prevalence, presenting an important challenge for the provision of optimal cancer care to older persons. We set out to evaluate the point prevalence of current and prior diagnosis of malignancy in a specialised geriatric medicine inpatient population of an acute hospital.

Methods: Data was extracted by reviewing the electronic patient record and paper chart of each patient under the care of the geriatric medicine service on a single week day. Information regarding demographics, current and prior cancer diagnosis and treatment was recorded.

Results: On the day of data collection, there were 154 inpatients under the care of our geriatric service. The median age was 83 years; 71 (46.1%) were male. The prevalence of current diagnosis of cancers excluding non-melanoma skin cancer was 12.34% while the prevalence of previous cancer diagnosis was 16.25%. The commonest current cancer diagnoses were that of female breast (n = 3), lung (n = 2), colorectal (n = 2), mouth & pharynx (n = 2), multiple myeloma (n = 2) and others (n = 2). Twelve had had surgery or were undergoing treatment during this hospitalisation. Six were being managed conserva-
tively. Of those that received treatment, 4 were treated with surgery alone and 3 were on hormonal therapy.

Conclusion: Geriatric oncology is an increasingly recognised and evolving subspecialty. Our findings highlight the prevalence of current and prior malignancy in a geriatric medi-
cine inpatient cohort and support the need for further interdisciplinarily training, opportu-
nities for shared learning and the potential for increased integration of clinical services in the future.

Reference
INVESTIGATING THE RELATIONSHIP BETWEEN SUBCORTEXICAL HYPERINTENSITIES ON 3T MRI BRAIN AND FAILURE OF STABILISATION OF BP IN AN AGEING POPULATION

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Background: We wished to investigate whether there is a relationship between burden of subcortical hyperintensities on MRI brain and failure of stabilisation of blood pressure on active stand test, and so test the hypothesis that repeated episodes of transient hypoperfusion contribute to development of such hyperintensities.

Methods: 440 community-dwelling participants ≥65 were randomly chosen from a nationwide dataset of >8,000 individuals. All participants underwent 3T MR brain. Scans were scored for subcortical hyperintensities according to Scheltens’ scale. Cohen’s kappa coefficient determined inter-rater agreement.

Results: A standing orthostatic test (active stand) was performed on same individuals. Beat-to-beat blood pressure was measured non-invasively using digital photoplethysmography (Finometer®) for 2 minutes post-stand.

Conclusions: In this population of community-dwelling participants, there is no discernible significant relationship between burden of subcortical hyperintensities and (previously uninvestigated) failure of stabilisation on active stand test.

ORTHOSTATIC HYPOTENSION: HEALTHCARE PROVIDERS’ KNOWLEDGE ON ITS IDENTIFICATION AND MEASUREMENT

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Background: Orthostatic hypotension (OH) is defined as a sustained drop in systolic and diastolic blood pressure (BP) within 3 minutes of standing of at least 20 mm Hg systolic and 10 mm Hg diastolic BP respectively. Recurrent falls, dizziness and syncopal related to OH are common reasons for hospitalisation. Early identification and management of OH is an important step to prevent adverse outcomes and improve patient’s overall function.

Aim: To assess healthcare providers’ knowledge in evaluating for OH.

Methods: Questionnaires were distributed to the doctors and nurses at a Dublin based teaching hospital. The questionnaire included 13 questions regarding basic knowledge of OH and its measurement. Questions were based on international guidelines on the appropriate measurement and assessment of OH.

Results: 72 questionnaires were collected from both medical and nursing staff. Only 22% (n = 16) of the participants answered correctly on both the systolic and the diastolic definition of OH. Only 22% (n = 16) were able to name 3 OH symptoms. 24% were aware that the patient should be lying down for at least 5 minutes before BP measurement. Subsequent standing BP measurements that should be taken at 1 and 3 minute intervals after standing was only correctly identified by 28% (n = 20) and 14% (n = 10) of respondents respectively. Finally, only 4% (n = 3) of all respondents reported that they had received formal training in the evaluation of OH.

Conclusion: This study revealed significant lack of knowledge on OH across multiple levels of the healthcare hierarchy. Education programmes directed at both doctors and the nursing staff are needed to ensure proper screening and evaluation of OH in the hospital.

Reference

Rehabilitation in older people can be a challenge in terms of its impact on their over-all health, nursing home (NH) admission, hospital readmissions and mortality. This study aims to evaluate the rehabilitation outcome for older patients admitted in a rehabilitation unit in Munster.

Methods: Retrospective study of patients admitted for rehabilitation from 01 January 2014 to 31 December 2014. Data were collected from minutes of MDT meetings, www. rippled-telephone.com, and phone conversation with patients/family, as approved by the local ethics committee. Patients were categorised into 60–79 years and ≥80 years age group.

Results: 154 patients were admitted, 102 were female (66%), mean age 80.9 years (SD ± 7.5), 59% (n = 91) were ≥80 years. Overall median length of stay (LOS) was 18 days (IQR 12,27). Most patients had the shortest LOS (18 days) and stroke patients, the longest (22.5 days). Hospital was the main source of admission (85%, n = 131). On admission, median MMSE and mean Barthel Index (BI) were higher in ≥80 years than ≥79 years and 1.980 years, 28 (QR 22.29,24) vs 24 (QR 18.28,26) (p = 0.002) and 11.5 (SD ± 4.3) vs 10.5 (SD ± 3.3) (p = 0.124), respectively, while mean FRASE was higher in ≥80 years 12.3 (SD ± 2.6) vs 10.8 (SD ± 3.4), (p = 0.004). Immediately after rehabilitation, 82% (n = 126) went home, 10% (n = 15) were transferred to NH, and 8% (n = 13) to hospital. After twenty-seven months, 77% (n = 84) of the living cohort remain at home. 54 (64%) mobilized independently. 4% (n = 2) of ≥60–79 years in long-term care.

Conclusion: In this cohort, rehabilitation has had beneficial impact on older people’s discharge destination, mobility and mortality. Further study comparing MMSE, BI, FRASE and frailty index on admission, immediately after and 2 years following discharge from the rehabilitation unit is recommended, the result of which may serve as basis in considering increase of rehabilitation beds in the unit.

FRAILTY IN THE ACUTE HOSPITAL SETTING: AN ANALYSIS OF PATIENT DATA

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Background: Our Care of the Elderly (COE) Department consists of 78 beds within the acute hospital. The current patient journey model is for admission to the Medical Assessment Unit (MAU) from the Emergency Department (ED) prior to triaging to the relevant medical specialty. As part of a review into the case for (or against) an Acute Frailty Unit we reviewed the characteristics of our current patient cohort.

Methods: Data for patients admitted to one of our acute COE wards was contemporaneously entered into an anonymised database cataloguing information including frailty, length of stay (LOS) and rates of dementia and delirium. Frailty was defined by the use of a frailty screening tool which was agreed by the clinicians within the COE department.

Results: Data for 423 patients was analysed. Mean age of patient was 83 years. 78.2% were identified as frail. A large number of patients came directly from ED rather than through MAU (70.8%). The LOS for frail patients was longer than non frail (mean 12.3 vs 8 days). The mean LOS for those frail patients admitted directly from ED was shorter than those frail patients who came indirectly to the ward (11.1 vs 14.8 days). The same trend was seen in the non frail (6.7 vs 15.2 days). 56.4% of patients were identified as having delirium. 43% of patients had a diagnosis of dementia.

Conclusions: Whilst currently not designated as an Acute Frailty Unit we are already caring for a large number of frail older patients. Notably the LOS for both frail and non frail was shorter when patients were admitted directly to our department. This may be because the sickest patients would be prioritised for a MAU bed with telemetry (which our unit cannot provide), or early Comprehensive Geriatric Assessment decreases LOS.

ACCURACY OF DEATH CERTIFICATION IN A UNIVERSITY TEACHING HOSPITAL: POOR DOCUMENTATION OF COMORBIDITIES IS COMMON

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Background: Death certificates are frequently used as the source for epidemiological data on the prevalence of diseases. Previous studies suggest that demographic details are often inaccurate in death certificates. We postulated that comorbidities may be under-documented in assessment unit (MAU) patients, particularly in older patients with multiple coexisting conditions.

Methods: Death certificates completed during a six-month period in a university teaching hospital were investigated for accuracy, with specific emphasis on accurate documentation of common comorbidities. 183 death certificates were divided into those relating to patients aged over and under 75 years. Death certificates were examined for accuracy and documentation of comorbidities and these were compared with the actual diagnoses documented in the patients’ casetones. The rate of omissions were compared between the two population groups.

Results: The cause of death was accurately documented in all death certificates. Overall, comorbidities were more commonly omitted and omissions were more frequent in the older group compared with the younger cohort, with at least one comorbidity omitted in 71% of death certificates in the older cohort versus 56% in the younger group (p = 0.0481). For individual diagnoses, under-documentation rates were similar in both age-groups.

Conclusions: While the actual number of death certificates reviewed in this audit, the majority of certificates omitted one or more important comorbidity, with the rate of omissions of individual diagnoses being similar for individual conditions in both age-groups. This result may be due to an over-emphasis in training
on accurate documentation of the correct cause of death. Appropriate education is recommended to increase the accuracy and utility of death certificates.

DEVELOPMENT OF AN INTERDISCIPLINARY SINGLE ASSESSMENT FORM FOR USE IN INTEGRATED CARE SETTING

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Background: A multidisciplinary integrated care service commenced in January 2017, consisting of a geriatrician, two clinical case managers, social worker, an occupational therapist, a physiotherapist. The objective is to support older persons care across the healthcare continuum, from acute hospital to community; anticipating and meeting complex care needs as they arise. An essential piece in achieving this goal was to develop a standardised interdisciplinary Comprehensive Geriatric Assessment form which all members of the team were competent completing.

Methods: Mixed methods Delphi process was used. Weekly team meetings were held to identify relevant specialty priorities for inclusion. Review of commonly used assessment forms and screening tools for older persons was then carried out by the team. Through a number of additional meetings this information was amalgamated to compile a user friendly, patient centred assessment form based on current best practices. Each team member educated their colleagues on how to complete their discipline specific section of the form. The form was piloted for 4 months and then reviewed by the team.

Results: The form was largely based on the InterRai single assessment tool (SAT). This multi-domain SAT has been recognised as a comprehensive screening tool for older persons and through extensive research was found to be most fit for purpose for Ireland (HSE). Key sections included detailed demographics, home environment and supports, medications, and measures of cognitive, physical, and functional wellbeing. Additional aspects not present in SAT but were considered of importance, such as the AD8 dementia screening instrument, were included.

Conclusions: Feedback from team members reported that the form was user friendly, identified key issues and guided onward referral and actions. The form has also developed new areas of competency for each member of the team which in turn resulted in an improved service for older persons.

DEVELOPING A CARE COMMITTEE FOR DEMENTIA PATIENTS IN A REHABILITATION SETTING

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Background: The traditional patient profile in Clontarf Hospital is changing. There is an increase in geriatric rehabilitation patients and therefore an increase in comorbidities associated with older age, cognitive impairment. These patients have specific needs and it is important that these needs are addressed from a hospital wide perspective.

Methods: A Dementia Care Committee has been established in order to improve the care of patients with cognitive impairment through; staff education, development of care pathways and service improvement. An invite to attend the group was extended to all staff and disciplines. The committee has monthly meetings to provide guidance on the care of the patient with cognitive impairment and to increase awareness at an organisational level of cognitive impairment and its’ impact on function.

Results: Areas of intervention/improvement have been identified and sub groups have been formed to address same. These include:

- Staff Education –development of a Dementia Awareness Training Programme. There is poor awareness of the types of dementia and its’ impact on functional abilities and rehabilitation potential in the hospital.
- Improving the Physical Environment. The hospital was not designed for this patient population and would benefit from becoming more “dementia friendly”.
- Signposting – sourcing information regarding dementia supports in the locality and directing patients to same.
- Developing a memory rehabilitation group in conjunction with the OT department.

Conclusions: The Dementia Care Committee has been well received and is well attended by a diverse range of staff disciplines. Areas of service delivery that need improvement have been highlighted by front line staff and working groups have been set up to address these issues. The Committee has encouraged dialogue regarding dementia within the hospital which has encouraged staff to provide appropriate and high quality care for cognitively impaired patients within a rehabilitation setting.

CONCORDANCE OF FDG-PET IMAGING WITH NEUROPSYCHOLOGICAL ASSESSMENT IN PATIENTS PRESENTING WITH COGNITIVE IMPAIRMENT WITH ATYPICAL FEATURES

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Background: The use of antipsychotic medication for the management of challenging behaviours in the healthcare setting remains commonplace. This is both within the specific licence of the control of persistent aggression in patients with moderate to severe Alzheimer’s dementia and in the setting of delirium. We sought to review the prevalence of such prescribing practices in patients over 65 years across a range of specialty wards of a large teaching hospital.

Methods: We undertook a point-prevalence review of six inpatient wards (two specialist geriatric wards, two general medical wards and two surgical wards, one general surgery, one orthopaedic). Admission prescriptions, current prescriptions and pharmacy notes were reviewed to identify changes since admission. Medical notes were reviewed for a background on the patient service of a large teaching hospital.

Background: Diagnosis of dementia remains primarily a clinical one and can be challenging in clinical cases. Advances in functional neuroimaging and increased availability have meant that updated guidelines from the National Institute of Ageing and Alzheimer’s Association (NIAA/AA) and the revised Diagnostic and Statistical Manual of Mental Disorders 5th Edition (DSM-5) include the use of such modalities as supportive examinations in atypical cases. We sought to compare the concordance of findings of fluorodeoxyglucose positron emission tomography (FDG-PET) with neuropsychological assessment in a convenience sampling of patients attending the Geriatric Medicine out-patient service of a large teaching hospital.

Methods: We identified 11 patients with FDG-PET imaging that had also undergone neuropsychological assessment from a retrospective analysis of attendees to our outpatient clinic. Detailed interrater reports were available for all FDG-PET studies. Neuropsychological assessments were reviewed and deficits identified, with scores greater than two standard deviations below the mean both when compared with normative data from age-matched peers and with the patient’s own estimated pre-morbid IQ) considered abnormal.

Results: On neuropsychological assessment, 8 out of 11 had abnormalities detected in at least one cognitive domain. Of these, 7 out of 8 had abnormalities on functional imaging. Of those with normal neuropsychological findings, 2 out of 3 had abnormalities on imaging, giving an overall concordance rate of 73%.

Conclusion: Concordance between abnormalities identified on FDG-PET imaging and neuropsychological assessment was high but not absolute, as evidenced by patients with normal neuropsychological findings and abnormal imaging and vice versa. Current functional imaging techniques, while useful, remain only one part of a multifaceted approach to the evaluation of suspected cognitive impairment.

KNOWLEDGE OF ACUTE STROKE GUIDELINES AMONGST GENERAL MEDICAL AND EMERGENCY MEDICINE PHYSICIANS IN A COMPREHENSIVE STROKE CENTRE; A RE-AUDIT

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Background: Acute stroke care continues to advance, with the expansion of services for providing endovascular thrombectomy in addition to intravenous thrombolysis. A previous study in this comprehensive stroke centre showed sub-optimal awareness of internationally recommended guidelines regarding time frames for delivery of these therapies. In response to these findings our centre undertook a variety of interventions to improve guideline awareness including education of relevant NCHDs.

Methods: We repeated a survey regarding usual practice, knowledge of local and international guidelines and NIHSS certification using a previously developed anonymous standardised questionnaire. These were distributed to NCHDs of registrar and SHO level across the general medical and emergency medicine departments.

Results: 39 completed questionnaire were returned (Medical n = 26, ED n = 13). Awareness of time window for pFA < 4.5hrs improved from 78% to 100% and 83% to 92% for Medical and ED doctors respectively. Awareness of target door-to-CT time of <25 mins improved from 22% and 31% to 23% to 31 % . However, awareness of target door-to-needle of <60 mins time for IV pFA declined from 33% to 15% and 61% to 38%. NIHSS certification increased from 43% to 54% and 13% to 15%. Reports from ED doctors of ambulance pre-alert (17% to 38%) and immediate stroke registrar contact (31% to 85%) also improved consistently.

Conclusion: Although modest in places, there was an almost uniform improvement in awareness of guideline recommendations. The utilisation of best practice approaches, such as ambulance pre-alert and immediate stroke registrar contact was also reported to have increased across the board. This was in the setting of provision of dedicated education sessions on a background of a comprehensive reorganisation of the hyperacute stroke treatment pathway. It can reasonably be suggested that this increased awareness and adherence to best practice will translate into more effective service delivery and better patient outcomes.
formal diagnosis of dementia, psychiatric history and identification of delirium. Those with a prior history of psychotic illness were excluded.

Results: 149 patients were included, F:M ratio 42:58, average age 81 (range 65 to 100), average length of stay 30.3 days (range 1 to 458). On admission, 11.4% were prescribed antipsychotics regularly and 16.5% at the time of review, a rise of 1.8 fold and 12.4 fold respectively. Surprisingly, prevalence on admission was higher in those patients admitted to the specialist geriatric wards (17.9% and 1.5%) and those with a documented history of dementia (25.5% and 3.9%). Of those without a documented history of dementia started on an antipsychotic, 80% had documented delirium.

Conclusion: Our findings are broadly in line with previously published national and international studies on antipsychotic prescribing rates in older patients (both with and without dementia) on admission to hospital. However, the degree of escalation in prevalence across admission is dramatic, reflecting a possible over-reliance on pharmacological measures for the management of challenging behaviours in this setting.

Conclusion: Our findings are broadly in line with previously published national and international studies on antipsychotic prescribing rates in older patients (both with and without dementia) on admission to hospital. However, the degree of escalation in prevalence across admission is dramatic, reflecting a possible over-reliance on pharmacological measures for the management of challenging behaviours in this setting.

Background: In Ireland, recruiting nurses to work in residential care settings for older people is a challenge. Evidence suggests that nurses employed in this space feel devalued and undervalued. Nurses have been compared to their colleagues employed in the acute sector. Furthermore, nurse graduates describe it as a less attractive career choice. Such negative constructions can directly impact on the recruitment and retention of such vital members of the healthcare team. How nurses construct their identities influences their behaviour, how they engage with policy and ultimately it affects the care patients receive. This study examined the professional identity of nurses employed in residential settings for older people.

Methods: With a focus on language, this study employed a discourse based method-ology. Identity is viewed as ever changing, constructed and reconstructed through inter-action. Data is currently being collected through semi-structured interviews that utilises a narrative approach with nurses and other healthcare professionals. The influence discourses have on the construction and reconstruction of identities of nurses employed in residential care settings for older persons has yet to be explored from a national or inter-national perspective.

Results: Preliminary findings suggest that multiple identities and discourses exist and are influenced by wider social and historical norms. Through exploration and discovery, it is hoped this study will enhance the professional identity of nurses working in this field and recognise the invaluable contribution they make to older person care in Ireland.

Conclusion: The study of nursing identity is significant as it offers insight into how the profession perceives itself and is perceived by others. Nursing identities develop in the working environment, thus influencing certain behaviours in inter-professional working, and clinical decision-making. The outcomes of this study have the potential to influence policy and marketing developments in this specific area of nursing practice and ultimately improve patient care.

Background: An Alzheimer’s Café (AC) is a monthly support and education service in the form of a café for patients with dementia and typically set up by community volunteers.

Our project was to evaluate the impact of setting up an AC using an integrated hos-pital - community care model. The emphasis was on creating a relaxed space where peo-ple with dementia (PwD) their families/carers could come together for socialisation, education and support under a person-centred ethos.

Methods: Three Health & Social Care Professionals from our Hospital attended training on ACs. Key stakeholders from acute, community and local government formed a steer-ing committee. They worked to instigate change in care delivery in dementia, encompassing the ethos of the AC movement, and the targets of the National Dementia Strategy 2014, of reducing stigma, encouraging early diagnosis and providing intervention and support. Quantitative analysis in the form of a participant audit was used to inform quali-tative discussions around patient-centred themes. Participants were asked questions relating to the educational topics and the impact attending the AC had on them and their families.

Results: The first AC was held in April 2016 and continues monthly for two hours, 25 PwD, the carers and 8 volunteers on average attend per month. 20 have returned to at least 4 out of 5 ACs. 100% of the people who attended and provided feedback rated the AC as a ‘very posi-tive experience’ with a ‘warm, easy atmosphere’. They felt education sessions were rele vant and informative and were more likely to attend as the person recommending the AC

Conclusion: An AN exploratory study examining an innovation to delivering person-centred care. The emphasis was on creating a relaxed space where people lived with dementia admitted to acute hospitals, which have no infrastructures to meet their specific care needs. This leads to greater risk of patient falls and deterioration in functional/cognitive capacity. The patient/family experience can be frightening and stressful.

Methods: Two Dementia Companions were appointed to care of the older peoples’ wards. Following refinement, a further test spread of four Dementia Companions across five acute medical wards and the Emergency Department were introduced. A bespoke training programme was developed for the companions in line with tiers 1–2 of The Dementia Learning and Development Framework (Public Health Agency PHA 2016). Regular reflective learning sessions were held, facilitating peer support and an opportunity to inform practice. Quantitative measurements analysed were; falls rates and episodes of distressing/challenging behaviour. Qualitative data on patient/carer feedback, staff experiences and Dementia Companion reflections was collected in the form of semi-structured interviews, focus groups and the recording of personal journals.

Results: Falls activity indicates a decrease of 71% falls (approximately 7% reduction in the total number for one year). A reduction of 40–50% episodes of distressing/challenging behaviour was observed. Themes emerging from qualitative data from patient/carers and staff were reassurance on patient safety, promoting adequate nutrition and hydration, a calm environment and releasing professionals’ time to deliver effective acute clinical care. Significant information from the companions’ reflective journals suggests that the companion role promotes and facilitates ‘personhood’, fundamental to person-centred dementia care (Kinswood 1997).

Conclusions: This innovation demonstrates improved outcomes for patients. Cost bene-fits to healthcare include: reduced patient falls and episodes of distressing/challenging behaviours. The evaluation validates this as a service delivery model which encompasses addressing the clinical need whilst contemporaneously preserving the identity and dignity of the patient and improving their acute care experience.

Background: In advanced disease, people with Parkinson’s disease (PD) experience many disabling symptoms such as inability to perform activities of daily living, reduced speech/interaction, hallucinations, and poor sleeping, which in addition to the effects on the person, often impact greatly on their family carer. Caring for someone with a long-term progressive illness may cause anticipatory grief, i.e. grief experienced before a bereavement. This has been widely studied in illnesses such as dementia and cancer, but less so in relation to PD. The study aims were: 1) To demon-strate the occurrence of anticipatory grief as experienced by carers of people with PD; 2) To explore how this grief relates to caregiver burden and caregiver depression.

Methods: Family carers of people with moderate to advanced PD (Hoehn & Yahr stages 3–5) were invited to complete a survey, including demographic questions about the per-son with PD and themselves, and three questionnaires: Zautar burden Interview (ZBI); 15- item Geriatric Depression Scale (GDS); and Anticipatory Grief Scale (AGS).

Results: Features of anticipatory grief were universally experienced by carers of people with PD. Carers experiencing higher anticipatory grief scores tended to be caring for a person with PD and themselves, and three questionnaires: Zautar burden Interview (ZBI); 15- item Geriatric Depression Scale (GDS); and Anticipatory Grief Scale (AGS). Compared to the results of the GDS, carers under-reported depression when asked directly. Results of the ZBI showed the majority of carers had a high care burden index. However, many positive aspects to caring were also apparent.

Conclusion: Carers of people with advanced PD experienced anticipatory grief, as well as depression and a high caring burden. To improve bereavement symptoms, focus should include the period both before and after the death of a loved one. Healthcare pro-viders should always pay attention to PD carers’ psychological wellbeing as carers may under report their depression.
Atrial Fibrillation and Stroke Prevention: An Audit of Anticoagulation Use and Monitoring
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Background: Prevalence of atrial fibrillation (AF) increases with age and almost 10% of people over 65 are affected. It is one of the most significant risk factors for ischaemic stroke; however, proper treatment reduces this risk by up to two thirds. Our aim is to determine whether anticoagulation prescribing in patients presenting to our hospital with a known diagnosis of AF is in line with the NICE guidelines and whether these patients are receiving appropriate follow up.

Methods: 50 inpatients with a documented history of AF were selected randomly for inclusion in the audit. Patients newly diagnosed with AF on admission were excluded. Their CHA2DSVASc & HASBLED scores were calculated. Anticoagulation (OAC) on admission was recorded. Recorded INR values were reviewed for INRs, time in therapeutic range (TTR) and U&E monitoring was checked using the hospital lab system.

Results: The mean age was 81.6. Mean CHA2DSVASc was 4 (range 2 – 6) and HASBLED was 2 (range 1 – 4). 32% of patients were on aspirin, despite all having CHA2DSVASc scores of 2 or above. High falls risk was the most common reason cited for a patient not to be on OAC (43.75%). 40% of patients were anticoagulated with warfarin and 28% were on a direct oral anticoagulant (DOAC). TTR for those attending the warfarin clinic was 62% as compared to 38% for those attending their GP. 64% of patients on a DOAC did not have a U&E check in the last 6 months, and 43% of these were dosed inappropriately given the patients renal function.

Conclusions: Despite clear guidelines, a large number of patients remain under anticoagulated or on improper doses of OACs. Following this audit, we intend to survey GPs on their prescribing practices, provide educational sessions, and outline a clear follow up pathway for patients on OACs upon hospital discharge.

Community-Based Approaches to Looking After Older People in Tokyo
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Background: Population ageing is a global phenomenon, and community-based approaches have been promoted by many stakeholders in order to provide the structures and services to support residents’ wellbeing and productivity. As one of the world’s largest urban areas, Tokyo is faced with a great challenge to maximise the health, functional capacity and participation of older people. The recent census shows that the population of older people in Tokyo surpassed 3 million for the first time. This paper addresses some of those challenges, and shows a few examples of local communities’ initiatives in Tokyo to help older persons stay in their private homes and communities.

Methods: This is a scoping study collating information from local communities in Japan’s urban areas where unique initiatives were adopted and pursued by local councils, healthcare professionals, social workers and carers. A case study method, combined with document analysis and interviews, was adopted to illustrate similarities and differences among local communities’ approaches to looking after older people.

Results: Different models (initiatives and approaches) were found across Tokyo, each reflecting its distinct local history and profile (e.g. industry, local politics). Out of these, two municipalities were identified to compare and contrast. It is found that community-based approaches to looking after older people in Tokyo have been often driven by national government, and developed in response to matters such as the lack of affordable housing and increasing care needs. However, proactive measures were also taken to make towns livable and inclusive, and to maximize the quality of life for residents.

Conclusions: To address the same issue of a super-ageing society, local solutions were sought depending on who became the main drivers for change, and the resources available. Further study needs to be carried out to measure the effectiveness of these models, and also compare them with other initiatives such as the Global Age-Friendly Cities project.

Developing a Questionnaire to Understand Perceptions Towards Home-Care Robots among Older People Who Receive Home-Care, Family Caregivers, and Home-Care Professionals
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Background: As a country with one of the fastest ageing populations, Japan takes seriously the development and implementation of home-care robots that meet user needs, which would enable ageing in place. This study aims to develop a questionnaire to understand perceptions towards home-care robots among older people who receive home-care, their families, and home-care professionals.

Methods: 1) Literature review: Databases (e.g. Ichushi Web) were used to search for relevant papers published between 2000 and 2016. The keywords used were “living alone,” “elderly,” and “difficulties.” The needs of the community-dwelling older people and the difficulties faced by home-care professionals were extracted from 44 examples in the literature. Surveys on home-care robots conducted in Japan and Europe were also referenced. 2) Abstract/Questionnaire design: A research team whose members’ backgrounds range from nursing science and robotics to health policy created components and items for the questionnaire until consensus was reached. 3) Pretest: A pretest was conducted with 18 individuals to refine the questionnaire.

Results: A questionnaire with a 4-point Likert scale was developed with 2 items concerning the willingness to use home-care robots: 6 items on past experience with robots; 29 items on topics such as direct involvement with robots, risks of using robots, participation in robot development/research, and protection of privacy associated with using robots; and 52 items on the level of support expected from home-care robots.

Conclusions: The questionnaire was created by an interdisciplinary research team based on the current development of home-care robots and needs of home-care professionals and older people. Further refinement and roll-out of the questionnaire in other countries and/or worldwide in Japan will usefully illuminate different perspectives (e.g. social and cultural differences) on home-care robots.

Attitude and Perceptions of Self-Management and Health Monitoring of Community-Dwelling Older-Adults Participating in Residential Activities in Japan
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Background: In Japan, for a super ageing society, a community-based integrated care system is being promoted. In the care system, social active participation is being promoted. It gives them joy and leads to prolonged years of healthy life. So they should be developing self-management skills and health monitoring in order to maintain their activities. The aim of this study is to investigate attitude and perceptions of self-management and health monitoring of community-dwelling older-adults participating in residential activities.

Methods: A self-administered questionnaire was conducted and data collected from participants of a residential group’s seminar on October 25th, 2016 in Chiba City.
questionnaire consisted of items mainly on attitude and perceptions of self-management and health monitoring.

Results: Participants’ (n = 60) mean age was 74.86 years SD (5.24); 51% were male and 55% were over 75 years, 58% were couples. Subjective health that was very good and good showed 81.0%, but participants who felt depressed during the month was 28.3%. All participants except 8 people had diseases. 56 (93.3%) kept records of medical health check ups, 51 (85%) had a health check up every year, 45 (75%) took notes of the types of their medications and 28 (46.7%) noted their blood pressure data. Only 7 (11.2%) took notes if they had bowel movements. More than half of the participants, especially males indicated willingness to use a health monitoring system, which can access medical examination data at any time.

Conclusions: Many participants perceived their health as good, even though they had diseases. The results showed the implementation of appropriate self-management and health monitoring among older adults who participated in residential activities. As they indicated willingness to use health monitoring systems, health professionals should engage in the community and discuss how to utilise health monitoring systems to advance self-management.

Are we seeing the bigger picture? Older adults with low vision – the role of the occupational therapist

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Background: Age related eye conditions lead to significant functional implications for older adults. With an ageing population, we should expect a marked increase in the number of older adults with a vision impairment and low vision.

Guidelines recommend that occupational therapists (OT) should be assessing vision’s impact on daily functioning and offering education to improve and maintain independent living and a visual screen should be completed for older adults with a falls history. A clinical audit was completed to check whether the OT in the Medicine for the Older Person outpatient day hospital are screening vision and adhering to best practice guidelines.

Methods: A retrospective audit of Comprehensive Geriatric Assessment (CGA) forms was completed using a paper count method. Data including age, sex, low vision (LV) diagnosis, vision screening, falls history, referral to low vision services (NCBI) and community OT referral was collected.

Results: 64 outpatient CGA forms reviewed, (16 male; 49 female).
No patients had a visual screen. 81% wore glasses (n=52); 45% had a recent fall and nearly half of the population had a LV diagnosis: 38% (n=24); 46% of those with a diagnosis had a recent fall.
OT referred 30% (n=7) of those with a LV diagnosis to NCBI (without a visual screen being completed) and only 40% of those with LV were referred to community OT.
There was no record of clients with LV receiving educational information.

Conclusions: The OT’s in our day hospital are not assessing vision’s impact on function. Patients are not being offered education about self-management strategies and are not consistently being referred to NCBI and community OT’s for environmental assessment. A visual pathway has been developed and is being piloted and audited with a view to improve practice and patient outcomes in the day hospital.

An examination of the factors associated with influenza vaccination uptake among older people

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Background: Influenza immunisation is a primary preventative health intervention which is recommended for high-risk groups including older people, however, the uptake rate in Ireland fails to reach the WHO and European Commission annual target uptake rate of over 75%. The aim of this study is to examine the prevalence of influenza vaccination among people aged 65 and over and the demographic, socio-economic and health predictors of influenza vaccination uptake in 21 Irish Local Authority areas.

Methods: The Healthy and Positive Ageing Initiative (HaPAI) survey data was used (n = 10,549) which is a random-sample, population representative survey of people aged 55 and older, living in 21 Local Authority areas in Ireland (2015–2016). Stata 14 was used to carry out descriptive statistics and a mixed-effects logistic regression. Seasonality was also adjusted for in the model.

Results: Of the 6,548 eligible participants, 65% received the influenza vaccination (ranging from 46%–79% across the 21 Local Authority areas). Uptake of the influenza vaccination was significantly associated with being male, age, marital status, household composition and occupational status. In terms of health, the likelihood of getting the flu vaccination was significantly higher among respondents who need assistance with mobility, have fair/poor self-rated health, have two or more chronic conditions and are past smokers. Compared to respondents with no health cover, uptake was significantly higher among respondents with dual health cover (medical card and health insurance), followed by respondents with a full medical card, private health insurance and a GP-only card.

Conclusion: The prevalence of influenza vaccination remains below the WHO and EU Commission target level. Understanding the factors that influence influenza vaccination uptake among older people will inform future community public health plans to increase immunisation rates among older people. These local uptake rates may inform localised, targeted efforts to improve coverage.

Perceptions and use of technology to support self-management for older adults living with multiple health conditions within a care ecosystem

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Background: There are few empirical investigations exploring older people’s experience and perceptions of health technologies. While older adults generally have positive opinions and attitudes towards trying and using new technologies (Miznner et al., 2010), health status itself is a moderating factor for computer use and digital literacy (Heart and Kalderon, 2013).

In this study we have explored what technologies older people with multimorbidity (PwM) are currently using and how they, and their networks of care, perceive technology to support their health conditions. The results presented here are part of an extensive requirements gathering exercise to inform the design of a digital health ecosystem that aims to support self-management and improve integration of care for older PwMs.

Methods: Semi-structured qualitative interviews and focus groups were conducted with 19 older PwMs, 7 informal carers, 16 formal care workers, 6 general practitioners, 4 pharmacists, and 15 other healthcare professionals. Interviews and focus groups were transcribed and analysed using thematic analysis.

Results: Older adults with multimorbidity perceive technology as a mechanism to sustain living independently in their own home but have concerns around accessibility and ease of use. Healthcare professionals were more cautious in their perception of the role of new technology to support PwMs, primarily due to privacy and security concerns. Both PwMs and GPs highlighted the potential for digital monitoring to create additional anxiety about health conditions.

Conclusion: This empirical investigation has highlighted barriers and drivers for the design of new technology to support people living with multimorbidity.

References

Pressure ulceration in long term care: lessons from a four year health service evaluation

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Background: Pressure ulcers cause pain, discomfort and reduced quality of life to the individual and are costly to the healthcare provider. Frail older adults are at increased risk of pressure ulcer development. Monitoring and evaluation of pressure ulceration is necessary to guide improvements in service and quality of care. The development of pressure ulcers can increase the length of stay in health care settings and the cost of treating pressure ulcers is estimated to range from £45 to £430 per day depending on the severity of the pressure ulcer.

Methods: This is a four year (2013–2016) retrospective health service evaluation of pressure ulceration data at a large long term care facility in Ireland. The aim of the study was to describe trends in total person time exposed to pressure ulceration over four years and to examine differences in pressure ulceration in persons admitted with a pressure ulcer compared to residents who acquired a pressure ulcer.

Results: 105 patients experienced pressure ulceration with 133 pressure ulcers identified over four years. Half of all new cases of pressure ulceration were acquired while resident and half were acquired prior to admission. A downward trend in total person days spent with pressure ulceration was observed from 2014 (n = 3051 days) to 2016 (n = 1803 days). A higher proportion of those admitted with pressure ulceration experienced sacral and heel ulceration and grade three and four ulcers compared to residents.

Conclusions: These findings provide evidence to support further development of clinical practice and education by the tissue viability clinical nurse specialist at this facility. The location of pressure ulceration in “non–traditional” sites in residents has implications for nursing and equipment at the facility whilst the “traditional” locations found in those admitted with pressure ulceration will inform educational content for informal carers and formal home care staff.
SUPPORTING OLDER PEOPLE WITH MULTIMORBIDITY: EXPERIENCES OF CAREGIVER BURDEN AMONG PAID CARE WORKERS IN IRELAND

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Background: As the number of older people living with multiple chronic health conditions increases, there is a growing recognition of the burden associated with management of these conditions, for both the person with multimorbidity (PuM) and their caregivers. Care support networks for older PuMs increasingly include paid care assistants, yet there has been little examination of the challenges experienced by such care workers in supporting their clients. The current study aimed to explore the experience of care workers in Ireland, who support community dwelling older people with multiple conditions. The data presented were collected as part of a wider requirements gathering study to inform the design of ProACT, a digital health ecosystem that aims to improve integration of care for older PuMs.

Methods: Semi-structured focus groups were conducted with experienced care workers and informal-carers (n = 16; 100% = female) providing home care support for PuMs in two counties in Ireland. Data from the focus groups were transcribed and analysed using an iterative thematic analysis approach.

Results: A range of challenges are experienced by paid care workers who support older PuMs in a home care context. These include a lack of information needed to support clients, poor communication across the care network, insufficient time to provide care, inadequate training and work-related psychological stress.

Conclusion: The like the term ‘treatment burden’, the concept of a ‘burden of care’ may be both relevant and under-recognised in paid caregivers. Additional research is needed to further explore the burden of care experienced by paid care workers and to inform potential strategies and responses to reduce such burden for this critical cohort of care providers.

GET RID OF THE LID: REDUCING THE USE OF LIDDED BEAKERS ON A CARE OF THE ELDERLY WARD

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Background: Drinking from a lidded beaker increases the risk of aspiration as it encourages a head back position where the neck is extended, opening the airway. Carrión et al. (2015) reported that 47.4% of Frail Older Persons admitted to an acute geriatric unit presented with oropharyngeal dysphagia, therefore limiting aspiration risk is an important consideration. It was subjectively observed by ward staff that lidded beakers were commonly being used for patients. This project aimed to investigate and reduce the use of lidded beakers on a care of the elderly wards.

Methods: A quality improvement methodology was employed. Quantitative and qualitative methods were used to identify use of lidded beakers on a care of the elderly ward. Discussion groups and questionnaires were used to investigate staff perceptions and knowledge, to inform the intervention. Weekly education sessions were provided to ward staff and weekly auditing was completed to measure the use of lidded beakers throughout the intervention. Descriptive statistics were used to illustrate data collected.

Results: The initial audit showed that 80% of patients on a care of the elderly ward received their tea in a lidded beaker. The intervention resulted in a steady decline in the use of lidded beakers over a 7 week period, with only 6% of patients receiving their tea in a lidded beaker by week 7.

Conclusions: An education focused quality improvement intervention was successful in reducing the use of lidded beakers on a care of the elderly ward, which is an important consideration in reducing aspiration risk.

STAFF, VOLUNTEER AND FAMILY EXPERIENCES OF LIFE STORY WORK WITH RESIDENTS WHO HAVE MODERATE TO SEVERE COGNITIVE IMPAIRMENT

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Background: There is some evidence to suggest that life story work is an effective intervention with people with dementia however, there is a paucity of research exploring its potential benefits from a staff and family perspective in the Republic of Ireland. The aim of this study is to explore the experience of staff, volunteers and family members of residents involved in life story work. Additionally, the study aims to gather data that will inform the future approach to life story work in the residential care service and support the continuation of the life story books as part of usual care.

Methods: The research was conducted following recent implementation of life story books for people with moderate to severe cognitive impairment in a residential care setting in Ireland. A qualitative research design was employed using a constructivist approach. Focus groups were the primary data collection tool.

Results: Separate focus groups were completed with three groups of participants: staff across four wards (N = 24; 4 focus groups), volunteers (N = 5) and family members (N = 5). All groups perceived benefits to life story work. Consistent themes emerged: remembering the person (humanising the person); knowing the person better; communication and engagement (more meaningful conversations); enjoyable to share the moment; demonstrating that staff cared and observed resident responses (“face lights up”); calming effect. Participants also gave feedback that will inform the approach in practice, such as updating books to promote resident interest.

Conclusion: This qualitative study contributes to the evolving literature on life story work for people with dementia and should support the continuation of life story work in this setting. Although it is difficult to generalise these findings, this research study suggests that life story work could be beneficial for similar populations in residential care. Further research is required to explore the resident perspective.

FEASIBILITY OF THE 4-AT RAPID ASSESSMENT TOOL FOR DELIRIUM SCREENING IN THE OLDER PATIENT IN THE EMERGENCY DEPARTMENT

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Background: The 4-AT is a test indicated for the rapid screening of delirium in hospitalised elderly patients. The objective of this study is to evaluate the feasibility of use of the 4-AT among clinical staff in the Emergency Department.

Methods: Prospective time and motion study of a cohort of elderly patients (>65 years) attending the Mater Misericordiae University Hospital Emergency Department over a three day period. Ten assessors (ED CNM, ED nurse, Medical Student) of varying grades and experience performed the 4-AT in the ED. Time taken to carry out the 4-AT was recorded by a third party. Upon completion of the test each assessor recorded the following: 1) Performer Level 2) Formal geriatric experience 3) Formal 4AT training 4) Number of previous assessments carried out 5) Ease of use of 1–5 6) 4-AT score. The main outcome measure was the time taken to carry out the 4-AT and ease of use.

Results: A total of 32 patients were assessed using the 4-AT screening tool. Mean age was 79 years (SD ± 6); majority were male (56.2%). Mean 4-AT score [0–14] was 1.75 [SD ± 1.9]. Of the 10 assessors, 4 had formal geriatric experience and one had formal training with the 4-AT. Median time taken to carry out 4-AT was 58 seconds. All assessors reported an ease of use of 1 (scale 1–5). In addition to assessing feasibility of 4-AT, the study also revealed a relationship between patient characteristics and time taken to carry out 4-AT.

Conclusions: The 4-AT is a feasible screening tool for delirium in the ED. This is on account of its brevity, no special training is required and is easy to perform by any healthcare professional at first contact with the patient.

LEAN THINKING IN IMPROVING THROMBOLYSIS PROVISION. A UNIVERSITY TEACHING HOSPITAL EXPERIENCE

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Background: Lean thinking aims to streamline organisational processes to improve quality and patient safety through waste reduction and increased efficiency. Shortening the door to needle time is an indicator of quality improvement in acute stroke.

Methods: Key areas for process improvement and streamlining were identified in the thrombolysis pathway. These included the pre-alert hospital system, the pre-alert for emergency CT, and the acute stroke management protocol. A review of the existing process was conducted and compared with outcomes after implementation of the changes. Outcomes in a standard 9 to 5 working day were also compared with ‘on-call’ hours.

Results: A total number of 9 patients received thrombolysis in the six months prior to implementation of the lean project. The absolute numbers of patients receiving thrombolysis improved by 60% in the six months after implementation, to 15 patients. A total number of 27 post implementation thrombolysis cases were reviewed.

The door to imaging time improved from an average of 38 minutes, to 23 minutes. In hours this improved from 28 minutes to 13 minutes. Out of hours this improved from 44 minutes to 30 minutes.

The average door to needle time was 73 minutes beforehand with an improvement to 49 minutes after 9 to 5 pm door to needle time improved from an average of 56 minutes to 34 minutes. Out of hours average door to needle time improved from 93 minutes to 63 minutes.

The redesigned stroke protocol encouraged swifter communication and clerking which was proven upon re-audit.
Conclusion: Lean process implementation streamlined the steps in the thrombolysis pathway. The door to needle time improved to under one hour, which is an international benchmark target. The success of this new strategy needs to embed the culture of the hyperacute management of stroke, and to strive for continual improvement.

CAN SOCIAL ROBOTS HELP TO REDUCE LONELINESS AND SOCIAL ISOLATION IN PEOPLE WITH DEMENTIA? A DELPHI SURVEY
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Background: People with dementia (PWD) commonly report feelings of loneliness and social isolation. Social robots may be a means of supporting connections with friends and family and with the person’s environment. This study aimed to establish consensus amongst experts regarding the role of social robots in reducing loneliness and isolation in PWD.

Methods: Experts in dementia and/or robotics were invited to participate in a three round online Delphi survey. Following an extensive literature review thirteen statements were developed and piloted to establish validity and clarity. In Round 1, panellists (n = 31) rated their level of agreement with these statements using a 5-point Likert scale. In Round 2, panellists (n = 24) re-rated their agreement while viewing their score in comparison with the rest of the panel (median and interquartile ranges). Key areas of disagreement which emerged in Round 2 were explored further in Round 3 (n = 17).

Results: There was high consensus agreement that social robots could reduce loneliness and isolation in PWD. Panellists agreed that social robots may be most useful where PWD live at home alone, or in residential care settings to support staff. Key principles when designing a robot include the consideration of a personalised and individualised robot which offers choice to the PWD. For effective implementation, the PWD should be actively engaged throughout the development process and the family/caregivers should be included during early stage implementation. Music and reminiscence interventions were considered feasible and important interventions delivered by a robot.

Conclusion: Experts in the field agreed that social robots may have a role in reducing loneliness and social isolation in PWD. However, the robot should be developed to interact with each person at an individualised level. Future research should examine the level of consensus amongst PWD with regard to the role they feel social robots may have in their lives.

A RETROSPECTIVE AUDIT OF TEMPORAL ARTERITIS TREATMENT BASED ON CLINICAL DIAGNOSIS AND TEMPORAL ARTERY BIOPSY
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Background: Early diagnosis and treatment is critical to prevent irreversible ischaemic complications, such as visual loss in Temporal Arteritis (TA). We aimed to audit cases against a standard guideline.

Methods: We performed a retrospective audit of TA cases in a 6-year period from 2011 to 2016 in Mayo University Hospital and applied criteria against the British Society of Rheumatology and British Health Professional Rheumatologist guideline on TA.

Results: In this period, a total of 39 Temporal Artery Biopsies (TAB) were performed. The mean age was 70 yrs + 14 (19 males and 20 females). Twenty (51%) were commenced immediately on steroid treatment for their clinical presentation. The most frequent documented clinical symptoms were; unilateral headache in 32(82%), headache of recent documented clinical symptoms were; unilateral headache in 32(82%), headache of

Conclusion: There was high consensus agreement that social robots could reduce loneliness and isolation in PWD. Panellists agreed that social robots may be most useful where PWD live at home alone, or in residential care settings to support staff. Key principles when designing a robot include the consideration of a personalised and individualised robot which offers choice to the PWD. For effective implementation, the PWD should be actively engaged throughout the development process and the family/caregivers should be included during early stage implementation. Music and reminiscence interventions were considered feasible and important interventions delivered by a robot.

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Conclusion: Experts in the field agreed that social robots may have a role in reducing loneliness and social isolation in PWD. However, the robot should be developed to interact with each person at an individualised level. Future research should examine the level of consensus amongst PWD with regard to the role they feel social robots may have in their lives.

POTENTIALLY INAPPROPRIATE PRESCRIBING OF PROTON PUMP INHIBITORS – A QUALITATIVE STUDY
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Background: Proton pump inhibitors (PPIs) are indicated for many gastric disorders, but reports of potentially inappropriate prescribing are widespread. Serious adverse effects of long term PPI therapy, including increased risk of fracture, Clostridium difficile infection and hypomagnesaemia continue to cause concern, particularly in older persons. The aim of this study was to explore possible reasons for potentially inappropriate prescribing (PIP) of PPIs.

Methods: This was a qualitative study; 23 doctors were issued an online survey, exploring topics such as: familiarity with licensed PPI indications and associated doses/duration of treatment, potential adverse effects and current PPI prescribing practices.

Results: Survey response rate was 52% (12 respondents). Long term PPI therapy was selected for inappropriate indications, such as Los Angeles Grade A oesophagitis. The adverse effects most recognised were: hypomagnesaemia (83%), Clostridium difficile infection (67%) and increased fracture risk (58%). Knowledge of potential drug-drug interactions was low; except for clopidogrel (92%). Only 33% of the opportunities for prescription review were selected, with admission cited as the optimum time for review. Documentation of indication for newly prescribed PPIs on discharge was low (25%), but duration of therapy was higher (58%), particularly if noted on oesophago-gastro-duodenoscopy (OGD) reports.

Conclusions: PPIs were perceived as safe, but knowledge of recommended treatment durations, awareness of potential adverse effects and drug-drug interactions was low. Review of PPI prescriptions was infrequent. Documentation of indication for newly prescribed PPIs on discharge was low, but documentation of PPI duration was higher. Education initiatives and modification of OGD reports to capture additional prescribing information are possible interventions.


A QUESTIONNAIRE TO DETERMINE KNOWLEDGE OF DELIRIUM RECOGNITION IN THE EMERGENCY DEPARTMENT
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Background: Delirium frequently complicates hospital admissions resulting in increased morbidity and mortality. Despite this, literature search and previous departmental audit suggest that staff often goes unrecognized by both nursing and medical emergency department (ED) staff. Following on from our departmental audit on delirium recognition, we wanted to assess staff knowledge of delirium, and screening tools to detect it, prior to implementation of an educational programme.

Methods: This was a cross-sectional survey: An anonymised questionnaire of closed-ended questions was created and made available to medical and nursing staff in the ED, both on paper and online.

Results: 25 responses were received from 8 doctors and 17 nurses. 36% (n=9) were answering for more screening tools for delirium, and 32% (n=8) had used one of these tools in the past. All respondents were aware that delirium is usually an indicator of a serious underlying illness, and 96% (n=24) were aware that it carries adverse outcomes. The prevalence of delirium in patients >65 presenting to the ED was...
overestimated, with 58.3% (n = 14/24) estimating this at 20–30%, while most literature quotes this at 10%.

Conclusion: Knowledge of delirium screening tools is limited and screening tools are not widely used within this urban Irish university hospital ED. Despite participants overestimating the prevalence of delirium in the over 65s attending the emergency department, it is under-diagnosed in acute presentations. We hope that educational tools will help improve awareness and use of screening tools. Further study following implementation of these is warranted.

INAPPROPRIATE USE OF ASPIRIN AMONG OVER 65-YEAR OLD ADMISSIONS TO A REHABILITATION HOSPITAL

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Background: There is strong evidence supporting the use of aspirin for secondary prevention of cardiovascular (CV) events such as myocardial infarction (MI) or stroke. However, more recent significant evidence shows the risk of major extracranial or gastrointestinal bleeds counterbalances any benefit in primary prevention. We assessed inappropriate aspirin use by over 65-year-olds admitted to a rehabilitation hospital.

Methods: We recorded admission demographics, aspirin use, anti coagulant use, previous MI or stroke and other CV risk factors on an anonymous, ‘opt-in’ basis, over a prospective thirty-day period. We interviewed patients, reviewed medication documentation and phoned GPs.

Aspirin use was defined as appropriate for patients with previous MI, stroke, or at high risk (i.e. having a 10-year CV mortality risk > 10% or two risk factors from: hypertension, hyperlipidaemia, atrial fibrillation, diabetes, smoker, unstable angina).

Results: A total of 55 over 65-year-old admissions, 35 female(29), 20 male(M) with an average age of 81. 56% (17 F, 14 M) were taking aspirin. 36% (10 F, 1 M) of these were taking aspirin inappropriately. The majority of patients did not know why they had been prescribed aspirin. Some had been taking aspirin for over twenty years. One patient had a previous perforated gastric ulcer and one suffered regular nose bleeds. We discussed the risks and benefits of aspirin. 73% taking it inappropriately did not want to change their medication routine.

The 36% rate of inappropriate use in our over-65 group compares with 19% in two Irish 2013 assessments of 619 all-age patients taking aspirin in the community.

Conclusions: More than a third of over-65s admitted for rehabilitation taking aspirin were using it inappropriately, increasing potentially fatal bleeding risks and achieving no mortality benefit. In light of this, a new algorithm for aspirin use, based on evidence and guidelines, was developed by the medical team to help rationalise medications and improve outcomes.

INTRODUCING THE SSKIN BUNDLE IN A REHABILITATION SETTING: A PILOT PROJECT

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Background: The prevalence rate of pressure ulcers in Ireland is consistent with international figures, 12–38% (HSE 2009). It is essential that all healthcare professionals understand the importance in determining all those who are at risk, so that effective prevention methods can be implemented.

Methods: The SSKIN bundle is designed as a resource pack to aid in the assessment and care planning for people at risk of pressure ulcers. 28 SSKIN Bundles were completed on an older person and orthopaedic ward over a two month period in Clonard Hospital. Inclusion criteria were patients with a Waterlow score of 10 or above or deemed by clinical judgement for example reduced mobility and incontinence issues. Exclusion criteria were patients with less than a Waterlow score of 10, independent with mobility and continence. OT and nursing staff completed SSKIN bundles weekly and provided and used on client specific interventions.

Results: 64% of patients were considered “at risk” of pressure ulcers development. Identified risk factors were reduced mobility, fragile skin integrity, incontinence and low body mass index. Interventions included all patients were encouraged to weight shift or mobilise every 30 minutes. An activity chart was put in place for two patients who mobilised with assistance. 78% of patients were provided with pressure cushions and 29% were provided with static air/air alternating pressure relief mattresses. 21% of patients were provided with static air/air alternating pressure relief mattresses.

Background: For older people to remain living at home, access to GP services outside office hours is essential. Consultation with older residents in two counties in Ireland, highlighted the out-of-hours GP service as an area of concern for those hoping to stay living in their own home for longer. Against a background of active multi-stakeholder engagement in supporting age-friendly communities, this research examines the barriers to accessing and using GP Out-of-Hours for older people.

Method: A mixed method approach was used in the research, including questionnaires, focus groups with older people, over sixty-five, (n = 48) and examination of call data (n = 771 calls) from the GP Out-Of-Hours provider. The aim was to identify the issues arising for older people should they become sick outside office hours and how these impact access to and use of the service.

Results: The findings of this research are that multiple interlinked challenges face older people in the community which mitigate against their ability to use GP Out-Of-Hours. The main priority for older people is speed of access to care but barriers encountered include a lack of information, location of treatment centres, the admission process, transport, availability of a social network to support access and concerns about being treated dismissively. Providers also face challenges with limited resources, GP shortages and service fragmentation to meet cost efficiencies.

Conclusion: It is concluded that addressing the challenges of access and use for older people will require sensitivity to the challenges of provision and will necessitate a comprehensive approach involving all the community stakeholders engaged in supporting the regional and national age-friendly agenda.

SEVEN DEMENTIA PALLIATIVE CARE GUIDANCE DOCUMENTS

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Background: There has been growing recognition of the complexities involved in providing palliative and end-of-life care for people with dementia. However there is a notable void of practice guidelines to support health and social care staff to do so.

Aim: To develop a suite of guidance documents for health and social care staff working in all care settings to assist them in the delivery of palliative and end-of-life care with people with dementia.

Method: A desk top review of Irish literature on dementia and palliative care was completed and compared against an Irish review of the educational needs of staff working with people with dementia. Following a process of consultation and feedback seven care domains were agreed upon as focus for the documents. An expert advisory group (EAG) was convened for the development of each document and a project advisory group was in place to oversee their overall development. Literature reviews were carried out and consensus within each EAG was achieved. Key themes from the literature informed key considerations and guidance.

Result: Seven guidance documents with accompanying factsheets, listed below, were developed.

1. Facilitating discussions on future and end of life care with a person with dementia
2. Advance care planning and advance healthcare directives with a person with dementia
3. Loss and grief in dementia
4. Management of hydration and nutrition
5. Pain assessment and management
6. Ethical decision making in end of life care for the person with dementia
7. Medication and dementia: Palliative assessment and management

Conclusion: The documents are available for use and require translation into practice so that people with dementia can be assured that their palliative care needs are appropriately addressed.

BARRIERS TO ACCESS AND UTILISATION OF GP OUT-OF-HOURS FOR OLDER PEOPLE

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Background: For older people to remain living at home, access to GP services outside office hours is essential. Consultation with older residents in two counties in Ireland, highlighted the out-of-hours GP service as an area of concern for those hoping to stay living in their own home for longer. Against a background of active multi-stakeholder engagement in supporting age-friendly communities, this research examines the barriers to accessing and using GP Out-of-Hours for older people.

Method: A mixed method approach was used in the research, including questionnaires, focus groups with older people, over sixty-five, (n = 48) and examination of call data (n = 771 calls) from the GP Out-Of-Hours provider. The aim was to identify the issues arising for older people should they become sick outside office hours and how these impact access to and use of the service.

Results: The findings of this research are that multiple interlinked challenges face older people in the community which mitigate against their ability to use GP Out-Of-Hours. The main priority for older people is speed of access to care but barriers encountered include a lack of information, location of treatment centres, the admission process, transport, availability of a social network to support access and concerns about being treated dismissively. Providers also face challenges with limited resources, GP shortages and service fragmentation to meet cost efficiencies.

Conclusion: It is concluded that addressing the challenges of access and use for older people will require sensitivity to the challenges of provision and will necessitate a comprehensive approach involving all the community stakeholders engaged in supporting the regional and national age-friendly agenda.

DEMOnographics of a Dublin Nursing Home: RATES of INCONTINENCE, COGNITIVE DISOrIENTATION, IMPAIRED MOBILITY and FRaILTY

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Background: Mobility, incontinence and levels of cognition and disorientation vary among nursing home residents. Their presence can impact on areas such as skin integrity, falls and the potential spread of multi-drug resistant organisms (MDRO).

Objective: To establish the prevalence of incontinence, mobility, cognition disorientation in residents at a Dublin nursing home.

Methods: A point prevalence study was performed, over one week in February 2017.

Results: The major prevalence rates were (n = 86/98) of residents consented and were included in this study. The mean age of residents was 84 years (range 69 – 94 years), with an average Barthel score of 6 and a median Waterlow score of 15.Two-thirds, 68% (n = 58/86), were incontinent (urinary, faecal or doubly incontinent). Of ambulatory residents, 39% (n = 12/31) were incontinent, contrasting to wheelchair bound (85%); n = 39/46) and bed-bound (87%); n = 7/8) residents. Residents with reduced mobility 87% (n = 54/86) had
cognitive issues, which was comparable to ambulatory residents (78%; n = 31/86). The average age of carers was 56. 79% were female. 57% were caring for a par- ticular of daily living. It ranges from 0 (more disability) to 20. The average burden) to 88 (frequently burdened), the average was 42.2 (s.d. = 1.5). There was a strong negative correlation between these variables (g = −0.58, p < .01). The Zarit instrument measures the burden experienced by carers. On a scale of 0 (no burden) to 88 (frequently burdened), the average was 42.2 (s.d. = 1.4). The Zarit instru- ment was positively associated with the EQ-5D scores but not associated with self- reported health state. The Barthel index measures the difficulty a person with dementia experiences in per- forming activities of daily living. It ranges from 0 (more disability) to 28. The average score was 10.5 (s.d. = 5.3). We found no correlation between the Barthel and the Zarit indexes. We found no correlation between Zarit and the age of the carer and no differ- ence in the average Zarit score of people who did paid work and those who didn’t. Conclusions: The average contribution by informal carers is very high. The burden of care was not related to demographic variables, carer’s health or the disability of the per- son being cared for.

Methods: Statistical analysis of key variables measuring socio demographic variables, carer’s health and burden. Non parametric tests were used.

Results: The average age of carers was 56. 79% were female. 57% were caring for a par- ticular of daily living. It ranges from 0 (more disability) to 20. The average burden) to 88 (frequently burdened), the average was 42.2 (s.d. = 1.5). There was a strong negative correlation between these variables (g = −0.58, p < .01). The Zarit instrument measures the burden experienced by carers. On a scale of 0 (no burden) to 88 (frequently burdened), the average was 42.2 (s.d. = 1.4). The Zarit instru- ment was positively associated with the EQ-5D scores but not associated with self- reported health state. The Barthel index measures the difficulty a person with dementia experiences in per- forming activities of daily living. It ranges from 0 (more disability) to 28. The average score was 10.5 (s.d. = 5.3). We found no correlation between the Barthel and the Zarit indexes. We found no correlation between Zarit and the age of the carer and no differ- ence in the average Zarit score of people who did paid work and those who didn’t. Conclusions: The average contribution by informal carers is very high. The burden of care was not related to demographic variables, carer’s health or the disability of the per- son being cared for.

Background: While there is evidence to suggest the positive effect of deprescribing on clinical outcomes in older people, the best way to engage prescribers in deprescribing interventions remains unclear. This systematic review aimed to examine the characteristics and effects of deprescribing interventions on medication use. This current study reports on the preliminary findings in a narrative synthesis.

Methods: A systematic search of the literature to identify studies examining the effects of deprescribing interventions, and a narrative synthesis of the evidence. Randomised controlled studies were included if they reported on interventions in people aged ≥25 years to encourage the discontinuation of existing drug prescriptions, reduction of dosages, or targeting prescribing appropriate prescribing. Study selection, data extraction and risk of bias assessment was done by at least two researchers independently. This review was conducted according to the PRISMA guidelines for systematic reviews and meta- analyses.

Changing Behaviours: A Systematic Literature Review of Deprescribing Interventions in Older People

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Background: The prevalence of atrial fibrillation (AF)-associated stroke is expected to rise substantially in the coming decades. This literature has established the benefit in long- term outcome for vitamin K-antagonist anticoagulation in atrial fibrillation-associated stroke. This study’s aim was to incorporate the use of newer anticoagulants and deter- mine their association with functional outcomes and mortality.

Methods: Quantitative: retrospective cohort study, at a 600 bed university teaching hos- pital. Patients were recruited from November 2014 - December 2015. 256 patients with ischaemic and haemorrhagic stroke were included. Patient characteristics at index presen- tation and outcomes were recorded through review of electronic patient records.

Results: 220 patients with ischaemic stroke, 116 anticoagulated for atrial fibrillation, 32 patients with intracranial haemorrhage, 6 with subarachnoid haemorrhage, none of whom were anticoagulated. Types of therapy included Warfarin (21.5%), Apixaban (30.2%), Rivaroxaban (13.8%), Dabigatran (10.6%), Aspirin (16.4%) and Clopidogrel (6.03%). Mean length of stay for those anticoagulated for AF-associated ischaemic stroke was 34.5 days. For those not anticoagulated, 0.07% had MRS 6 scores on discharge, 0.03% MRS 5, 16% MRS 3, 26% MRS 2, 20% MRS 1, 17% MRS 0. For those not anticoagulated, 43% had MRS 6, 21% MRS 5, 14% MRS 3, 21% MRS 0 scores at time of discharge. Improved functional status as defined by MRS was associated with anticoagulation at stroke onset. There was no difference in length of stay between those anticoagulated and those not.

Conclusions: Anticoagulant therapy for atrial fibrillation-associated stroke is correlated with improved functional outcomes and mortality as defined by the MRS. There was no difference in length of stay, however prolonged waiting times for placement in a rehabili- tation facility may be contributory. This study demonstrates the beneficial influence asso- ciated with newer oral anticoagulants, in addition to their established use in stroke prevention.
and communication. We plan to integrate further workshops biannually into our post-graduate medical training programme.

**NON-CONSULTANT HOSPITAL DOCTORS’ ATTITUDES AND KNOWLEDGE TOWARDS SEDATIVE PRESCRIPTION IN AN ACUTE HOSPITAL**

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**Background:** Consumption of sedative medications is an independent risk factor for falls. These medications are known risk factors for the development of delirium and are known to reduce the alertness and concentration of older patients.

Older patients are more vulnerable to adverse effects associated with these medications due to changes in pharmacokinetics and pharmacodynamics associated with ageing.

**Methods:** We aimed to explore attitudes and knowledge of sedative prescriptions among doctors in a tertiary Irish hospital. A structured online questionnaire was distributed to 100 non consultant hospital doctors (NCHDs) including medical registrars, senior house officers and interns.

**Results:** The overall response rate was 40% (n = 40). A total of 38 (95%) of respondents reported prescribing sedatives due to same medications recorded on community prescriptions of patients. 30 doctors (75%) selected that they prescribed these agents due to direct patient request with 32 (82%) citing pressure from patients and 9 (23%) pressure from nursing staff as an influencing factor in increased prescription of sedatives. Of those who took part, 5 (12%) admitted that they never assess background history of drug or alcohol dependency prior to prescribing. NCHDs accurately identified the adverse effects associated with benzodiazepines but one third were unsure regarding common adverse effects with Z drugs. The majority of participants (87.5%) were in favour of an educational session on non-pharmacologic approaches towards sleep hygiene.

**Conclusions:** This survey reflects pressure to prescribe sedatives and hypnics in the acute hospital setting with many not feeling adequately equipped to educate and encourage non-pharmacologic approaches towards sleep hygiene. A multidisciplinary educational module is currently in development and will be integrated into the postgraduate education curriculum.

**THE PREVALENCE OF ATRIAL FIBRILLATION (AFIB) IN ISCHAEMIC STROKE IN A RURAL POPULATION: A REVIEW**

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**Background:** A fibrillation is associated with a five-fold increased risk of ischaemic stroke resulting in more severe disability and higher mortality rates. We defined known as a fibrillation as a patient having a documented note in the medical file or ECG record of atrial fibrillation. A previous study of 218 older stroke patients showed a prevalence of atrial fibrillation over 40% with a preponderance of females at 56% versus males 44%.

**Methods:** We reviewed data from our stroke register database on 486 acute stroke patients diagnosed with stroke from January 2015 to April 2017 in Mayo University Hospital. Patient’s age, gender, a fibrillation status and type were analysed using Statistical Package for Social Sciences (SPSS). Ethical approval was granted for this study.

**Results:** Ischaemic stroke was evident in 445 (92%) while haemorrhagic in 41 (8%). The mean age of stroke patients was 75 years (±12) with an average age of stroke patients with an a fibrillation of 80 (±9). A fibrillation was identified in 153 (34%) patients, 82 (53%) males and 71 (46%) females. On this cohort, 113 (74%) patients had previously known a fibrillation, 36 (31%) of whom were not on anti-coagulation therapy, 20 (55%) males and 16 (44%) females. There was a total of 51 (11%) deaths, 27 (53%) had a fibrillation while 24 (47%) did not.

**Conclusion:** Our study has not confirmed the higher prevalence of older females in our initial study. However there is a high prevalence of a fibrillation (34%) in our older rural population with a higher mortality rate. Prevention programmes for atrial fibrillation detection need to target this older rural population.

**IMPACT OF FRAILTY ON HEALTHCARE OUTCOMES AFTER ISCHAEMIC STROKE IN PATIENTS WITH ATRIAL FIBRILLATION**

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**Background:** Frailty is associated with increased mortality and institutionalisation among stroke patients, however, little is known about the impact of frailty on other important healthcare outcomes post-stroke. One of the most common stroke mechanisms for older adults with frailty is atrial fibrillation (AF). We examined the impact of frailty on hospital length of stay (LOS) and 30-day mortality post stroke with AF.

**Methods:** Data was collected using an existing database of stroke patients presenting consecutively to a large university hospital from August 2014-July 2016. A retrospective chart review was performed to assess pre-admission frailty, using the Clinical Frailty Scale (CFS), cut-off of ≥5 for established frailty. Baseline function was measured with the Modified Rankin Scale (mRS) score.

**Result:** In total, 113 patients were identified with ischaemic stroke and AF; median age 80 years (range 54–101 years) and 60% male. Frail patients were significantly older, p = 0.008. Median pre-admission CFS score was 3 (+/−3) and 26.5% scored ≥5, indicating most were mildly to severely frail. Median pre-admission mRS was 1 (+/−2) increasing to 3 (+/−2) at discharge. Frail patients had significantly worse scores at baseline & discharge, p = 0.001. Frail patients (CFS ≥ 5) had statistically significantly longer acute hospital LOS, median 22 days vs. 15 for non-frail patients, p = 0.04. In all, 10% of non-frail but no frail patients were suitable/acceptable to avail of early supported discharge, p = 0.001.
Background: Alien Hand Syndrome (AHS) was first described in the literature in 1908 and is characterised by complex, goal-directed activity in one hand that is not voluntarily under the patient’s control. AHS is associated with a variety of underlying neurological and medical conditions. The functional impact of this disorder was very profound; the affected hand pulled out numerous nasal-gastric tubes necessitating the fitting of a bridle, she persistently pulled her own head, heart failure with reduced ejection fraction, and moderate mitral stenosis. Following routine investigations, PPM interrogation and repeat echocardiography, a tilt table test was performed. During the passive stand, her usual prodrome of paleness, dizziness, and sweating was noted over a 2-minute course. 103 patients had Vitamin D levels checked. 41 (40%) were male. 62 (60%) were female. The age range was from 70 years of age to 99 years of age. 44 (42.7%) were deficient in Vitamin D (level <30 nmol/L). Of this cohort 36 (81.8%) were not on Vitamin D supplementation prior to admission. 67.5% of patients with deficient Vitamin D levels were discharged on Vitamin D supplementation. 39 (57.5%) of patients had levels >50 nmol/L. In this group 86.4% of patients were on Vitamin D supplementation. Though numbers were small, likely under-powering the study, these data suggest an association between frailty and increased LOS in older patients with ischaemic stroke and aortic stenosis that poor baseline functional status has a significant impact on outcome. Frailty measures could be added to be thrombosis criteria to enhance decision-making.

**BARRIERS TO WALKING DURING AN ACUTE MEDICAL ADMISSION: PERSPECTIVES OF OLDER PATIENTS AND STAFF**

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**Background:** Hospital Acquired Deconditioning is increasingly recognised as a major cause of functional decline, falls, frailty, institutionalisation and mortality. Immobility due to illness can be exacerbated due to practices and structures within hospitals. The aim of this study was to explore the barriers to walking, as perceived by patients and nursing and Health Care Assistant (HCA) staff on acute medical wards.

**Methods:** Questionnaire based interviews were conducted with 20 current medical inpatients, 20 former medical inpatients (>70 years) and 20 Nursing/HCA staff, to gain a subjective account of perceived barriers to walking during a medical admission. Qualitative data was obtained and thematic analysis was undertaken.

**Results:** All staff identified falls risk as a barrier to patients walking, they expressed concern regarding the consequences of falling for both the patient and staff. In contrast, only a quarter of the patients expressed concern regarding falling. Staff were also more likely than patients to perceive clinical factors or symptoms as a barrier.

**Time constraints was a dominant theme across all groups. Staff reported that they were too busy, while patients were reluctant to ask busy staff to help them to walk and were unsure whose role it was. Environmental factors including cluttered and crowded wards and corridors, shiny floors, unsuitable toilet areas were seen as a deterrent among all groups. Most patients expressed that they were motivated to walk but they reported a lack of encouragement from staff. Some also expressed the need to conform to expected behaviours and were therefore unsure if they were allowed to walk.

**Conclusion:** This study identified that patients and staff perceive some similar barriers to walking while in hospital. However there were conflicting perspectives on issues such as falls risk, clinical status and behaviour. This highlights areas where current practice may be contributing to deconditioning.

**LADY VS HAND: A RARE CASE ALIEN HAND SYNDROME**

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**Background:** Alien Hand Syndrome (AHS) is defined as involuntary and purposeless, stereotyped movements of an affected hand in the absence of voluntary control. Alien Hand Syndrome (AHS) was first described in the literature in 1908 and is characterised by complex, goal-directed activity in one hand that is not voluntarily under the patient’s control. AHS is associated with a variety of underlying neurological and medical conditions. The functional impact of this disorder was very profound; the affected hand pulled out numerous nasal-gastric tubes necessitating the fitting of a bridle, she persistently pulled her own head, heart failure with reduced ejection fraction, and moderate mitral stenosis. Following routine investigations, PPM interrogation and repeat echocardiography, a tilt table test was performed. During the passive stand, her usual prodrome of paleness, dizziness, and sweating was noted over a 2-minute course. 103 patients had Vitamin D levels checked. 41 (40%) were male. 62 (60%) were female. The age range was from 70 years of age to 99 years of age. 44 (42.7%) were deficient in Vitamin D (level <30 nmol/L). Of this cohort 36 (81.8%) were not on Vitamin D supplementation prior to admission. 67.5% of patients with deficient Vitamin D levels were discharged on Vitamin D supplementation. 39 (57.5%) of patients had levels >50 nmol/L. In this group 86.4% of patients were on Vitamin D supplementation prior to admission.

**Conclusion:** This study highlighted that Vitamin D deficiency is common in a frail older population. There were missed opportunities to supplement Vitamin D levels in patients who were deficient. Supplementation appears to be an effective way to overcome Vitamin D deficiency. As Vitamin D deficiency is common in a frail older population all patients should be considered for blood tests inclusive of Vitamin D levels and appropriate action should be undertaken to appropriately supplement those deficient.

**DEFINING STRESSORS LEADING TO ACUTE HOSPITALISATION IN FRAIL OLDER ADULTS**

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**Background:** Frailty is a clinical syndrome which is characterised by an age-related deterioration of various physiological functions resulting in decreased ability to cope with acute stressors and is a well-established risk factor for increased morbidity and poorer health outcomes. With the introduction of acute care models for specialised geriatric care, hospitals are increasingly implementing pathways to identify vulnerable patients and then providing a specialist interdisciplinary evaluation and management in a co-horted ward/clinical area. Our aim was to categorise clinical syndromes of frail older adults admitted to a newly introduced specialist geriatric ward (SGW), in order to better understand the stressors precipitating an acute medical presentation.

**Methods:** Retrospective review of hospital-recorded discharge data gathered on all patients admitted to a newly established SGW via a frailty pathway protocol over a six month period (June to November 2016). Exclusion criteria: stroke as primary reason for admission; age < 70.

**Results:** Total, n = 219. The principal causes for admission were found to be infection (including sepsis) n = 77 (35.2%); syncpe/dizziness n = 27 (12.3%); cardiac diagnoses n = 23 (10.5%); falls/trauma/fracture n = 22 (10.1%); delirium or dementia, n = 11 (5.0%); pain n = 10 (4.6%); malignancies n = 7 (3.2%); endocrine n = 3 (1.4%) and other n = 39 (17.8%).

**Conclusion:** Infection, probably the most well recognised acute stressor of the frailty syndrome, was diagnosed in one-third of patients in this group. However, nearly two-thirds of these patients, including the “other” category (diagnoses made in <1% cases) illustrate the marked heterogenous nature of acute stressors resulting in cognitive; cardiac; sarcopenic or malignancy-related frailty. We expect that the ongoing observation of frailty stressor trends will serve as a guide to planning future management protocols and further refinement of specialised care for older patients in the acute setting.

**A STUDY OF VITAMIN D LEVELS IN A SCREENED FRAIL OLDER POPULATION**

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**Background:** Frailty is a state of increased vulnerability to poor resolution of homeostasis after a stressor event. Vitamin D levels in a screened frail older population in Ireland have not been clearly delineated.

**Methods:** Database of frailty patients was reviewed retrospectively to identify Vitamin D deficient patients. A frailty clinical nurse specialist screened an older inpatient population using the CHSA clinical frailty scale. All patients identified as frail who had a Vitamin D level checked during their inpatient stay were included for analysis. A level of <30 nmol/L was deemed inadequate. A level greater than 50 nmol/L was deemed adequate.

**Results:** 189 patients were identified over a five-month course. 103 patients had Vitamin D levels checked. 41 (40%) were male. 62 (60%) were female. The age range was from 70 years of age to 99 years of age. 44 (42.7%) were deficient in Vitamin D (level <30 nmol/L). Of this cohort 36 (81.8%) were not on Vitamin D supplementation prior to admission. 67.5% of patients with deficient Vitamin D levels were discharged on Vitamin D supplementation. 39 (57.5%) of patients had levels >50 nmol/L. In this group 86.4% of patients were on Vitamin D supplementation prior to admission. Of the patients identified on Vitamin D supplementation prior to admission only 9.8% of these patients had a Vitamin D level <30 nmol/L.

**Conclusion:** This study highlighted that Vitamin D deficiency is common in a frail older population. There were missed opportunities to supplement Vitamin D levels in patients who were deficient. Supplementation appears to be an effective way to overcome Vitamin D deficiency. As Vitamin D deficiency is common in a frail older population all patients should be considered for blood tests inclusive of Vitamin D levels and appropriate action should be undertaken to appropriately supplement those deficient.

**TRANSIENT LOSS OF CONSCIOUSNESS - A DIAGNOSTIC CHALLENGE**

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**Background:** Transient loss of consciousness (T-LOC) is a common presenting complaint in older adults, with a broad differential. Often un-witnessed, it is a major diagnostic challenge.

**Methods:** We present a retrospective review of the case of a 90 year old lady who presented with six months of increasingly frequent episodes of T-LOC.

**Results:** MD typically experienced T-LOC for 2 to 5 minutes without tongue biting or urinary incontinence. She reported a short prodrome of light-headedness. This was on a background of similar episodes since childhood. She was diagnosed with epilepsy in her teenage years and commenced on several anti-epileptic drugs. She developed Mobitz II heart block in 2004 for which a permanent pacemaker (PPM) was inserted. The frequency of T-LOC appeared to reduce for a number of years. Her recent history is also notable for atrial flutter, heart failure with reduced ejection fraction, and moderate mitral stenosis. Following routine investigations, PPM interrogation and repeat echocardiography, a thallium test was performed. During the passive stand, her usual prodrome developed and a blood pressure drop of 55/19 mmHg (to 115/54 mmHg) was followed by a loss of consciousness, consistent with vasodepressor neurally mediated syncope. Sodium valproate and anti-convulsants were discontinued and midodrine was titrated up.
She has reported a reduction in the frequency of syncopal episodes (2 in the last six months).

Conclusion: Epilepsy is not uncommonly confused with neurocardiogenic syncope. This case demonstrates the need to re-evaluate the diagnosis in the setting of refractory symptoms. The presence of a permanent pacemaker adds to the complexity as pacemaker settings and function need to be considered. Head up tilt is a useful provocational test in the investigation of unexplained syncope, even in the oldest old.

Reference:

A MULTIMODAL INTERVENTION TO REDUCE THE SOONER THE BETTER: DOES EARLY SPEECH AND LANGUAGE THERAPY INVOLVEMENT IN STROKE MANAGEMENT RESULT IN BETTER DYSPHAGIA OUTCOMES?

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Background: Dysphagia is present in approximately two-thirds of patients within the first three days of onset of stroke. Early detection of dysphagia reduces pulmonary complications, length of stay and healthcare costs. National Clinical Guidelines recommend that patients are seen by Speech and Language Therapists (SLTs) for initial assessment within 48 hours of admission. The objective of this audit was to ascertain if stroke patients admitted to the acute hospital were assessed by SLT within 48 hours of admission, and whether those patients had improved dysphagia outcomes compared with those patients admitted to the acute hospital were assessed by SLT within 48 hours of admission.

Methods: Retrospective database review of all stroke admissions from January to December 2016. Descriptive analysis carried out using Microsoft Excel and quantitative analysis carried out using GraphPad Software – Prism 7. TOMs is a 6-point scale for dysphagia (0 = Severe, 5 = No Dysphagia).

Results: SLT received referrals for 70% (n = 137) of all stroke presentations (N = 195). Of patients referred: 66% referred within 48 hours, with 98% seen by SLT within 48 hours of receipt of referral. Day of admission impacted average length of time awaiting referral to SLT, which was significant (p = 0.0015). 64% of patients were seen within 48 hours of admission (Group A) and 36% were seen after 48 hours (Group B). Group A showed greater improvement in TOMs scores (p = 1.6) compared to Group B (p = 0.6), had significantly fewer LRTIs prior to SLT involvement (13%) than group B (27% (p = 0.0424) and had a lower rate of readmissions with LRTIs (17% versus 21%).

Conclusion: Patients who are seen by SLT within National Guidelines timeframe have better dysphagia outcomes. This audit highlights the need for early recognition of dysphagia in the acute stroke setting.
USING A COLLATERAL QUESTIONNAIRE TO IMPROVE THE QUALITY AND TIMELINESS OF OBTAINING A FUNCTIONAL HISTORY

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Background: The timeliness and quality of functional history taking is variable, especially if a patient has cognitive impairment. Patients and relatives can also be frustrated with repetitive history taking by different members of the multidisciplinary team. We felt there was an opportunity to obtain a thorough and timely functional history using a collateral questionnaire, which all MDT members would have access to.

Methods: We designed a questionnaire which was handed promptly to the person most knowledgeable about the patient i.e. friend/relative after their admission. This questionnaire explored pre-admission mobility, activities of daily living (ADLs), home circumstances, continence, nutrition, driving, falls, cognition and mood. There was also the opportunity for free text.

Results: A pre-intervention audit was performed in May 2016 which ascertained what aspects of and how timely the functional history was documented. The same audit was repeated after introduction of the questionnaire in October 2016. The post-intervention audit included 22 patients with an average age of 84 years and an average AMT score of 6/10. There was an 82% completion rate of the questionnaire (n = 18). 89% of these questionnaires were fully completed (n = 16). Post-intervention, there was an improvement in timeliness of gathering a complete functional history from an average of 6 days to 3 days. There was widespread improvement in the quality of all aspects of functional history obtained, especially regarding falls, ADLs, nutrition, driving and cognition. Informal feedback from members of the multidisciplinary team who used the questionnaire was positive.

Conclusion: This collateral questionnaire resulted in a more detailed and timely functional history. It is not only useful for patients who are cognitively impaired, as it provides a detailed collateral history on all aspects of functional history, especially falls, ADLs, nutrition, driving and cognition. The whole MDT were able to access the results and found it useful.

DEVELOPING THE PHYSIOTHERAPIST’S ROLE ON AN INTEGRATED CARE TEAM FOR OLDER PERSONS

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Background: An Integrated Care Team (ICT) commenced in January 2017 as a pioneer site of an integrated multidisciplinary team (geriatrician, a social worker, two clinical case managers, an occupational therapist and a physiotherapist). The role of the physiotherapist on a specialised Older Person’s ICT is a novel concept and needed to be appropriately developed.

Methods: Meetings were held with physiotherapy managers across various sites, representing local primary, secondary and tertiary organisations to ascertain available physiotherapy resources, waiting lists and referral pathways, and to determine the needs of the older people accessing physiotherapy. A communication link was established between these areas to ensure seamless transition for the older person from one to another. Local voluntary organisations were visited in order to utilise existing community resources as viable exercise locations for older people; and to identify locations for health promotion in the community. The clinical role of the physiotherapist was developed for urgent assessment of mobility, falls and balance for people accessing the ICT. An education role was incorporated for educating ICT colleagues in completing and interpreting evidence based mobility and falls screening tools as part of the initial comprehensive assessment. Reflective practice is continuously implemented to assess progress and to further develop the role.

Results: Diagnoses of Parkinson’s Disease and dementia have been identified as the highest need for physiotherapy in ICT to date. One third of people referred to ICT have been assessed by the physiotherapist and linked to appropriate services, and three health promotion talks have been delivered in the community.

Conclusions: The physiotherapist on the ICT is a bridge between primary, secondary and tertiary organisations. There has been positive feedback to date. New service developments have been identified and will continue to inform the physiotherapist’s evolving role.

Reference
Health Service Executive (HSE), available online at http://www.hse.ie/eng/services/list/4/olderpeople/sat/ Accessed on 05/05/17.

THE GREAT ESCAPE: VIRTUAL REALITY AS A COMPLEMENTARY THERAPY IN THE ELDERLY IN RESIDENTIAL SETTINGS, A PILOT STUDY

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Background: Virtual reality (VR) is an immersive artificial environment experienced through audiovisual stimuli generated using interactive technology. Numerous medical fields use VR, including pain management1 and rehabilitation2. Some VR studies have examined cognitive assessment and diagnosis, there is little evidence in its use regarding mood or quality-of-life. This prospective pilot study aimed to examine the effect of bespoke VR software on the mood of residents with and without cognitive impairment in a Long Term Care (LTC) setting.

Methods: Participants were recruited from LTC. Inclusion criteria included an MMSE of >15. Written informed consent was obtained from all subjects or proxy with patient consent. Each participant completed Likert questionnaires before and after the VR session. Nursing staff answered a validated questionnaire (QUALIDEM) measuring subjects’ QoL. The 1 week after the VR environment was administered via Oculus VR headset. Participants had a choice of any/all of 4 separate scenes. Exposure time was limited at 30 minutes.

Results: 23 participants were recruited; 7 Males, and 16 Females. Mean age 80.87 (SD 6.45), and MMSE 21.38(SD 5.423). 95.7% of patients enjoyed the experience, 73.9% wanted further sessions. Nurse reported Qualidem on 14 patients improved across all positive domains (Mean 82.2–88.6, SD 21.19 – 19.20, p = .4759).

Conclusion: Patient experience was almost uniformly positive. Subjectively patients reported improved mood, and many desired further sessions in VR. Nursing staff reported improved mood and QOL in subjects. Further prospective studies with repeated exposures to VR environments are warranted, with ongoing assessment of mood and behaviour.

References

PALLIATIVE CARE IN NURSING HOME RESIDENTS: ARE WE DOING ENOUGH?

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Background: Nursing home residents (NHRs) have poor survival outcomes following hospitalisation. Palliative care interventions can improve quality of healthcare in this frail population. Our study aimed to examine the provision of palliative care for NHRs during the last 6 months of their life.

Methods: Retrospective analysis of NHRs with unscheduled admissions to a tertiary teaching hospital, over a 12-month period in 2016.

Results: 567 NHRs had unscheduled admissions over this period. 31% (n = 176) died within 6 months of admission. 55% of deaths (n = 96) occurred in hospital. Of those who died in hospital, their mean time from admission to death was 9 days (1–93 days), with one third died within 48 hours of admission. 80 residents died in nursing homes within 6 months of admission. Their mean time from discharge to death was 61 days (1–173 days), with just over 40% died within the first month.

Overall, 26.7% (n = 47) of deceased residents were seen by palliative care team (PCT). The majority (85%) of assessments occurred in hospital. Of those who died in hospital, 25% (n = 24) had palliative care interventions. They were referred an average of 3.6 days (0–17 days) prior to their death. 17% (n = 4) were referred on day of death. Of those who died in nursing homes, 20% (n = 16) were referred by PCT in hospital and the mean time from referral to death was 20 days (1–68 days). All bar one referrals were seen by PCT on the same day of referral.

16% (n = 13) of those who died in nursing homes had community palliative care interventions following discharge. 7 were referred directly by their GP, with the remaining referred by hospital based PCT. 39% (n = 24) had advance care planning documented in their transfer letters on discharge.

Conclusion: Uptake of palliative care service among NHRs is poor with only 1 in 4 referred during the last 6 months of life. Interventions focusing on improved education and enhanced communication are required to address this deficiency of care in NHRs.

THE FIRST 6 HOURS IN A STROKE PATIENT’S JOURNEY

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Background: Hyperacute treatments using acute reperfusion therapy (ART) are now standard practice in stroke. The benefits of these treatments are time dependent, hence the primary focus of management is the rapid diagnosis and delivery of a reperfusion therapy to an appropriate patient. Our audit aimed to examine the standard of care received by patients who presented with neurological symptoms within 6 hours of onset, using the RCP London 2016 guidelines.

Methods: Retrospective analysis of stroke patients presenting within 6 hours of stroke symptoms. The clinical assessment and radiological imaging were reviewed and the clinical decision making for or not for ART was examined.

Results: 97 new stroke patients were admitted during a 5-month period (March–July 2016). Average age was 79 years with equal male: female ratio. 47.4% (n = 46) presented within 6 hours of symptoms onset. Of these,15 (32.6%) received ART in forms of intra-arterial thrombolysis (n = 8) or thrombectomy (n = 4). 3 patients had both treatment. Our thrombolysis rate was 11%. Median time from symptoms onset to emergency department (ED) triage was 105 mins (30–280 mins) and median time from triage to CT brain was 40 mins (10–950 mins). Our average door to needle time was 66.5 mins.
20–127 mins). Those who received ART, were younger (mean age 77 years vs 79.6 years), more independent (80% with pre-stroke mRS 0–1 vs 48.4%) and presented earlier to ED (median time from symptoms onset to ED triage 90 mins vs 127 mins). 31 patients received no ART. Most common reasons for not offering treatment included: minor stroke (22%), intracranial haemorrhage (16%), and rapid resolution of symptoms (9%). 35% had no clear documentation of contraindications to treatment.

**Conclusion:** Our thrombolysis rate of 11% is in line with national average. There is good compliance with guidelines in brain imaging, appropriate candidate selection and prompt delivery of treatment. However, documentation of clinical decisions in those who received no ART remains poor.

**Background:** Research demonstrates that delays in the Emergency Department (ED) are detrimental for patients. We aimed to assess whether older people who experience delay in the ED are at greater risk of functional decline.

**Methods:** Data was collected on all patients over 70 years old, admitted through the ED of a Dublin hospital, on 10 separate days, randomly chosen over a 2 year period.

Four validated scales (Barthel Index (BI), Mini Mental State Exam (MMSE), Modified Rankin Scale, and Elderly Mobility Scale (EMS)) assessed functional status on presentation, day 3, 10 and 60 day discharge.

Changes in assessment scales were analysed from admission to day 3, from admission to discharge and were correlated with time spent in ED awaiting ward admission.

**Results:** Eighty-two patients completed assessments (42 (51.2%) female). Mean age (SD) was 84 years (range 71 – 93). Thirty-seven per cent of patients spent more than 24 hours in the ED awaiting inpatient admission. Of note, male patients experienced significantly longer time in the ED awaiting a bed following admission (p = 0.02).

A significantly greater deterioration in BI at day 3 and at discharge (p = 0.043, p = 0.041) was noted for those who waited longest for admission. Furthermore, four patients who waited over 48 hours in ED (n = 15), significantly more experienced a deterioration in Rankin at day 3 (11 vs 4 (p = 0.04)). By discharge the trend remained but was non-significant (9 vs 6, (p = 0.3)). Interestingly, no correlation was found between the duration of ED delay and deterioration in MMSE: or the EMS (p = 0.97) on day 3 or at discharge (p = 0.869).

**Conclusions:** Our study demonstrates a significant correlation between hours waiting in ED and functional deterioration in admitted older people. It highlights the complex needs of older patients in this setting and reveals a gender bias in patient prioritisation for admission.

**Background:** The Irish National Dementia strategy of 2014 highlighted a number of priority actions including timely diagnosis, timely intervention with integrated services and support. With this in mind through collaboration with people with dementia and their carers we identified gaps within our existing services. Following this a key priority action was the development of a memory assessment and support clinic. An essential element of the memory assessment and support clinic is cultivating key partnerships between the acute hospital and community partners to enhance the provision of support and care to persons with dementia and their carers.

**Methods:** Data was collected on all patients referred to the Memory assessment and support clinic (MAS) clinic from November 2015 to November 2016.

**Results:** A total of 181 patients were reviewed in the MAS clinic. The mean age was 76 years. Of these, 140 were new patient assessments. Referral sources were: 38% from GP, 22% from inpatient services, 21% crisis or admission avoidance referrals and 19% from other services such as psychiatry of old age. There were 80 urgent referrals to the clinic. The clinical findings of these urgent referrals included 37 with a new medical diagnosis, 28 with carer crisis, 44 with social crisis, 40 with previous diagnosis of dementia and 59 with a delirium at the time of referral. The outcomes for this cohort were as follows: 16 referred to community liaison or care manager (Dublin only), 8 referred to the Community Intervention Team, 12 for acute hospital admission, 12 for GP or other professional advice, 8 for admission to emergency respite and 70 had a medication change.

**Conclusions:** Our experience in the development and evolution of the integrated MAS clinic highlights the necessity of an organisational culture and ethos change towards a more patient centred approach to supporting persons with dementia and their families.

**Background:** Deep vein thrombosis (DVT) is common in patients admitted to hospital with an acute stroke and may result in pulmonary emboli (PE). It is estimated that approximately 20% of immobile stroke patients will develop a DVT and 10% a PE. Following the CLOTS 3 Trial, IPCs should be considered for venous thromboembolism prophylaxis for acute stroke patients according to the RCP National Clinical Guidelines for Stroke (2016)(1).

**Methods:** All patients admitted with an acute stroke from January to December 2016 were included in this audit. The guidelines (2016) advocate the use of IPC stockings within 5 days of admission to hospital and should be continuous for 30 days or until the patient is mobile or discharged. We particularly advocated the use of IPC in haemorrhagic immobile patients where antplatelet therapy is contraindicated.

**Results:** 383 patients (mean age 74) were admitted with stroke in 2016 of which 64 (17%) were haemorrhagic, 319 (83%) were ischemic. 50 patients admitted to the stroke unit were prescribed IPC stockings of which 35 patients (70%) tolerated well. 7 patients (14%) did not tolerate and a decision was made to remove the IPC stockings on a further 6 patients (12%) due to palliation. Of the 383 patients, 3 DVT’s (0.8%) and 2 PE’s (0.5%) were confirmed through ultrasound and CT imaging.

**Conclusion:** While the numbers in this audit were small and revealed a low prevalence of DVT and PE, this data could be interpreted, that IPC stockings combined with early mobilisation, adequate hydration and antplatelet therapy are as effective in preventing DVT’s and PE’s in ischaemic strokes or perhaps there is a large proportion of patients that are being missed due to the severity of their stroke and die before a diagnosis is made. More research is needed and we will continue to monitor this data and re-audit in the future.
85.2% for the physicians. Attitudes about the physician’s shared role mean total score for the nursing group was 22.68%, and 62.7% for physicians with a statistically significant difference. Secondly, the Team Skills Scale mean score for all respondents was 73%. Thirdly, Inter-professional collaboration scales overall mean score for communication was 74.2% and the mean score for accommodation of the team was 78%. Interviews revealed positive responses to videoconference technology, inter-professional collaboration learned and perceived improved clinical outcomes.

Conclusions: These results show the perceived outcomes of learned inter-professional collaborative knowledge and skills resulted in behaviours recognised by the participants as ensuring effective case based discussions of complex patients within the nursing homes. Initiatives such as the tele-mentoring IPE initiative enables an integrated care service between acute and community services.

SLURRED SPEECH – AN UNUSUAL CAUSE
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Background: Hypertrophic Olivary Degeneration is a rare type of trans-synaptic degeneration. It occurs secondary to lesions which disrupt any tract within the dentatorubro-olivary pathway which is made up of a triangle including the dentate nucleus, red nucleus and inferior olivary body.

Methods: We reviewed the clinical and radiological findings of a 62-year-old man who presented with ataxia, slurred speech and dizziness. A literature review was carried out of previous reports of Hypertrophic Olivary Degeneration, in particular previous cerebral haemorrhages, and their presentations.

Results: Initially the patient presented with an episode of collapse associated with loss of consciousness. Relevant past medical history included ischaemic heart disease, previous percutaneous coronary intervention, hypertension and hypercholesterolaemia. Of note he was on aspirin. Clinical examination revealed ataxia and slurred speech. CT and MRI Brain imaging revealed a right cerebellar haemorrhage. Aspirin was restarted following repeat MRI brain at a one month confirming resolution of the haemorrhage. The MRI brain noted a lesion of high signal on T2/FLAIR, and was associated with enlargement of the left side of the medulla oblongata. Given its location and the time interval between this study and the previous MRI it was thought most likely to represent Hypertrophic Olivary Degeneration.

Eight months after the original presentation the patient represented with increased ataxia, slurred speech and dizziness. Neurological examination was positive for palatal myoclonus. MRI confirmed progression of the Hypertrophic Olivary Degeneration with no acute stroke disease.

CONCLUSION: This case highlights palatal myoclonus which is one of the rare clinical manifestations of Hypertrophic Olivary Degeneration. The case also maps MRI brain changes to the associated clinical manifestations over the proposed timeline reported in the literature. Hypertrophic olivary degeneration, although rare, remains an important condition for clinicians to be aware of due to its classical presentation and findings on imaging.

WHY DO NURSING HOME PATIENTS NEED ACUTE HOSPITAL ADMISSION?
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Background: Nursing Home (NH) residents are frail, functionally dependent and have a high prevalence of dementia. NH residents who attended the Emergency Department have more advanced and severe disease and are more likely to require admission. The reasons for admission and the clinical outcome of NH residents in hospital may help with the design of alternate treatment pathways for them.

The aim of the study was to describe the NH residents who required hospitalisation over a 12-month period by their discharge diagnoses, length of stay (LOS) and inpatient mortality.

Methods: NH residents from the North Dublin City who were admitted into an urban teaching hospital were identified over a 12-month period. Using the electronic patient record of the hospital, the demographics, frequency of admission, discharge diagnosis, LOS and inpatient mortality were recorded.

Results: 140 men and 216 (61%) women from NH had 498 hospital admissions over a 12-month period. The common reasons for admissions were infection (n = 197, 40%), falls and fractures (n = 96, 19%), cardiac causes (n = 42, 8%), gastrointestinal complaints (n = 37, 7%) and stroke or transient ischaemic attack (n = 26, 5%). Infection-related diagnoses accounted for one-third of the total bed-days and falls and fractures-related diagnoses accounted for another third of bed days. 43 (12.1%) NH residents who were admitted died as inpatients and the median hospital LOS to death was 6 days (range 1–90).

Discussion: Infection, in particular respiratory infection, and falls were the two most common reasons for hospitalisation in NH residents. A clear pathway including vaccination, management of infection in the nursing home and alternative care pathway, such as access to a community hospital may reduce acute hospital attendance. In severely frail residents, a clear advanced health care directive and skilled educated nursing staff in the NH may allow terminally ill patients to die in their NH.

A REVIEW OF CEREBROSPINAL FLUID SAMPLES SENT FOR XANTHOCHROMIA – A NECESSARY TEST IN THE DIAGNOSIS OF SUBARACHNOID HEMORRHAGE?
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Background: In diagnosing subarachnoid haemorrhage (SAH), a non-contrast CT brain within 6 hours of symptom onset can yield a diagnostic sensitivity of up to 100% [1]. Cerebrospinal fluid samples can be analysed for xanthochromia if the diagnosis remains in doubt. We studied whether the test for xanthochromia was useful and cost effective in diagnosing SAH in our hospital, given that it is processed in another institution with significant associated costs.

Methods: A retrospective analysis was done of all xanthochromia tests done from January 2014 to October 2016. Further data was collected from medical records of patients with ambiguous test results. Patients: 206 requested tests for xanthochromia over 34 months with 178 results received. 167 (93.8%) results were negative, 10 (5.6%) ambiguous (e.g. SAH not excluded) and 1 (0.6%) was positive, leading to a diagnosis of SAH. None of those with ambiguous results were ultimately diagnosed with SAH.

Conclusions: Xanthochromia is still a relevant test to diagnose SAH, but in a very small number of cases in our hospital. Given the proportion of positive tests (0.6%), we need to be more stringent about selecting patients who require this investigation.

Xanthochromia is processed off site and costs a minimum of €106.50 per test (€89.98 per year). We are in the process of identifying cases where the test did not add to the diagnostic process. In view of the high cost and low yield, better patient selection based on thorough history taking, decision rules such as the Ottawa Subarachnoid Haemorrhage rule, as well as timely CT scanning would cut down on unnecessary testing and result in significant savings.


OBSTRUCTIVE SLEEP APNOEA: SHOULD WE SCREEN FOR THIS IN STROKE?
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Background: Sleep-disordered breathing is an emerging phenomenon in stroke. Obstructive sleep apnoea shares many risk factors with stroke, and likely has independent association. Current stroke guidelines do not routinely address this issue.

Methods: Case Study. A 43 year old female presented to the Emergency Department, following an acute onset of headache while playing football. She described an attack lasting 10/10, lasting two hours. She had no past medical/surgical history and took no regular medications. She was a non-smoker and seldom drank alcohol.

Examination revealed a raised BMI (28) and papill oedema; right pupil 3mm, left pupil 4mm. NIHSS 5. A CT brain was negative for acute haemorrhage; an MRI demonstrated a right lacunar infarct.

ECHOCARDIography, carotid dopplers and telemetry were all normal. Ambulatory blood pressure monitoring revealed average daytime readings of 125/80 with absence of nocturnal dip. A Holter screen demonstrated LDD: 3:1, HLD 1:8, triglycerides: 1:0. Other bloods were normal. On review of history she reported daytime somnolence, nocturnal apnea and a history of significant snoring. Epsworth score 13:24. Sleep studies were performed.

Results: While the study was negative, there was significant snoring and upper airways resistance syndrome. Given her lack of nocturnal blood pressure dipping, and absence of other major stroke risk factors, a therapeutic trial of CPAP has been instigated. We will repeat her sleep studies and blood pressure monitor and assess for response in terms of symptoms and blood pressure.

Conclusion: There is strong evidence of the association between OSA and stroke with a high prevalence among stroke survivors. Considering the possible benefits and minimal risk of therapy, identification of OSA and its treatment in this cohort seems reasonable.


RAPIDLY-PROGRESSIVE CEREBRAL AMYLOID ANGIOPATHY: A BLEEDING CATASTROPHOE
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Background: Cerebral amyloid angiopathy (CAA) is increasingly recognised as a cause of intracerebral haemorrhage and dementia in older patients. The deposition of amyloid beta peptide leads to a series of destructive alterations in vascular architecture, predisposing to haemorrhage. The presence of CAA leads to a substantial risk of recurrent haemorrhage, with one cohort of 71 survivors of intracerebral haemorrhage having a 2-year
cumulative recurrence rate of 21% (Greenberg and Willerden, 2013). Recurrent haemorrhages are associated with a high mortality rate.

Methods: This is a qualitative report of 3 patients with recurrent intracerebral haemorrhages at short intervals, with all fulfilling Boston Criteria for probable CAA. All patients came under the care of the Stroke Service at Hospital X, with 2 receiving ongoing care for haemorrhages.

Results: The first patient, a 75-year-old female, had 3 lobar intracerebral haemorrhages within 4 weeks, and died as a consequence of these. The second patient, a 66-year-old female, presented with right occipital and left parietal lobe haemorrhages, and went on to have 2 further haemorrhages within the following 6 months. Interestingly, there were no microhaemorrhages evident on gradient-echo MRI imaging; however, cerebrospinal fluid analysis demonstrated decreased beta amyloid, and high total and phosphorylated Tau, supporting the diagnosis of CAA. The final patient, a 71-year-old female, presented with a frontal lobar haemorrhage, and had 2 further lobar haemorrhages over the next month.

Conclusions: There is a subgroup of patients in whom the intervals between intracerebral haemorrhages secondary to CAA are short. The factors responsible for this are not well-understood. Further investigation is required to establish the pathophysiology of these cases, with a view to instigating therapeutic interventions.

Reference

Background: In 2016, a survey was completed (n = 320) of a busy Model 4 Irish hospital to ascertain the knowledge and attitudes of staff prior to the introduction of a dementia training programme. This ‘Butterfly Scheme’ programme would help staff to more readily identify those with dementia and provide some basic training. The Irish National Dementia Strategy suggests that any training should lead to a change in practice and attitudes, adding weight to the need for this current study.

Methods: This was a non-experimental descriptive study using an online cross-sectional survey with a response of 320. Ethical approval was granted by the hospitals ethics committee. There were some standardised elements to the questionnaire but for this poster the free text answers of some questions about training needs will be analysed. Primary cycle 1 was completed followed by secondary cycle coding to determine themes and issues.

Results: Demographics will be presented in terms of job type, educational attainment and age. The response rate of 320 gave a confidence level of 95% with an approximate 5% margin of error. The main theme raised (with a frequency of 25%) was further education on communicating with a person with dementia, followed by education on the disease (16%); caring for the person in the acute hospital context (14%); management of agitation and wanting more knowledge on community resources available.

Conclusion: There continue to be ongoing needs in relation to training for hospital staff in communicating with and treating persons with dementia. Any training provided should address the issues raised in this survey.

OLDER PEOPLE AND HOMECARE: “AND ONE WEEK NOBODY CAME AT ALL..... IT WAS REALLY UPSETTING, I WAS WATCHING THE DOOR”

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Background: Older people in Ireland are living longer and largely wish to remain in their own homes for as long as possible. Consequently, homecare provision is expected to increase by 100% by 2021. Yet this discretionary service remains unregulated, contributing to considerable variations in service provision and allocation of hours. This paper aims to identify the strengths and limitations of the existing services based on the experiences of older people in receipt of homecare.

Methods: A qualitative methodology was employed in an effort to gain an in-depth insight into the experiences of older people. Fifteen semi structured interviews were undertaken with older people in receipt of homecare. Two focus groups with active retirement groups (total thirteen participants) were undertaken to assess the perceptions towards homecare provision of older people who are not in receipt of such a service.

Results: Older people are largely satisfied with the homecare they receive. Yet greater choice and consistency were found to be desired. The key findings suggest that the older person's relationship with the homecare worker directly influences their level of satisfaction with their homecare. Regular social contact and knowing someone would be visiting them on an agreed day was found to be important. Having multiple different homecare workers was cited as being problematic for some older people in addition to having too short a timeframe for the homecare visit.

Conclusion: Having a regular homecare worker and building a meaningful relationship is particularly significant for older people in receipt of homecare. Older people require sufficient time within which to have their homecare needs met. Further research pertaining to homecare organisations is necessary to explore the organisational structures and culture which shape the provision of this vital service.

HEALTHCARE PROFESSIONALS’ ATTITUDES, PRACTICE AND INFLUENCING FACTORS WITH REGARD TO CONSIDERING OLDER PERSONS’ SPIRITUALITY DURING REHABILITATION: A MIXED-METHODS STUDY

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Background: Healthcare has grown from a narrow, disease perspective to a wider notion of well-being. Interest in ageing and spirituality has increased due to research evidencing supporting the health benefits of religious participation and spirituality; spirituality is linked to positive psychological functioning in older adults and higher life-satisfaction. However, older adults’ spiritual and religious needs are often overlooked. Healthcare...
ADHERENCE AND PERSISTENCE TO TERIPARATIDE TREATMENT

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Background: Osteoporosis increases the risk of fracture and associated morbidity and mortality. Efficacy of anti-osteoporotic treatment is based on drug potency and adherence and persistence. Teriparatide (TPTD) is the first anabolic agent developed for the treatment of osteoporosis and can significantly reduce the incidence of vertebral fractures. We evaluated adherence and persistence to TPTD treatment in patients with severe osteoporosis in a specialised Bone Health Service.

Methods: A cross-sectional and retrospective longitudinal study was performed of all patients in our clinic with severe osteoporosis treated with TPTD from 2004 to 2016.

Results: 597 patients commenced TPTD from 2004 to 2016: 90% female, mean age 70 years (range 30–99); 225 (38%) had vertebral fractures; 136 (23%) had Colles fractures; and 75 (13%) had a hip fracture. 106 patients (18%) are currently on treatment. 491 patients in our clinic with severe osteoporosis treated with TPTD from 2004 to 2016.

Conclusions: Adherence and persistence with TPTD was higher than that reported with oral antiresorptive treatments. The major factor that reduced adherence and persistence was tolerability. These findings are important, as high adherence and persistence with therapy is necessary to ensure an optimal therapeutic outcome.

CHANGE IN RELIGIOUS AFFILIATION IN MIDDLE AGED AND OLDER ADULTS IN IRELAND. WHAT ARE THE IMPLICATIONS FOR HEALTH?

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Background: The 2016 Irish census reported that the Catholic population has declined in the past five years, with a corresponding increase in the number of non-religious. Older populations are more likely to be religious and some evidence suggests that religious involvement can provide resources conducive to health and wellbeing. This study aimed to determine if changes in religious affiliation affected health and wellbeing in the older population in Ireland.

Methods: We analysed data from Wave 3 of The Irish Longitudinal Study on Ageing (TILDA), a stratified probability cohort of adults over 50 resident in Ireland (n = 6,566).

Change in religious affiliation was estimated using a recall measure of religious affiliation 20 years previous to interview. Multivariate models were used to determine whether religious affiliation change was associated with depressive symptoms and self-reported health, adjusting for sex, age, health, education and marital status.

Results: Overall, the majority of the population identified as Catholic, with little change in the last five years. Of the 6,566 respondents, 63% identified with oral antiresorptive treatments. The major factor that reduced adherence and persistence was tolerability. These findings are important, as high adherence and persistence with therapy is necessary to ensure an optimal therapeutic outcome.

iiii36
Results: We screened 2562 papers. 33 papers, published between 1996 and 2016, were included. The study with estimates of the prevalence of OPD in the NH population ranging from 12% to 88%. OPD estimates varied with the investigative methodology used with qualitative questionnaires revealing lower estimates to those obtained from objective measures. Referral to SLT was reported in just two papers.

Conclusions: The wide range of prevalence estimates found in this systematic review reflects the lack of standardisation in defining, investigating, and managing OPD internationally. There is a need for larger local and international studies of the prevalence of OPD in NH residents with the aim of creating a systematic approach to OPD screening and management in this vulnerable population.

OVERCOMING FRAILTY: EVALUATING THE ROLE OF AN OCCUPATIONAL THERAPIST ON A FRAIL ELDERLY TEAM

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Background: Occupational Therapists can significantly reduce hospital admissions and ensure timely, appropriate and safe discharges home in older adults with frailty (COT, 2016). A Frail Elderly Team was established in an acute hospital in January 2016 to effectively meet the needs of older people with complex needs. The Occupational Therapist, as part of the interdisciplinary team, places an immediate focus on the person’s meaningful occupations, enabling participation in daily activities and maximising quality of life.

Methods: A quantitative study was conducted in order to evaluate the efficacy of the Occupational Therapy role on the Frail Elderly Team. Data was collected on all patients referred to the Occupational Therapist from January to December 2016. A review of assessment outcomes, treatment methods, discharge recommendations and day hospital input was carried out using Microsoft Excel. A detailed analysis of the data collected was completed to evaluate the role of the Occupational Therapist.

Results: The Occupational Therapist received 487 referrals between January and December 2016. Following assessment, 24% of patients were discharged home from the Emergency Department. Of those admitted, 48% continued to be reviewed by the Frail Elderly Team Occupational Therapist until their discharge home. Cognitive screens were administered with 383 patients; assessments of personal and domestic activities of daily living were completed with 308 patients and 40 patients were issued with adaptive equipment. The new interdisciplinary clinic in the day hospital generated 47 referrals for Occupational Therapy. Further input from the Community Occupational Therapist was indicated for 113 patients.

Conclusions: The role of the Occupational Therapist has been evaluated, demonstrating a commitment to effectively meeting the needs of older people with frailty and promoting independent living.

Reference

FINDING THE FRAIL IN THE EMERGENCY DEPARTMENT - A RETROSPECTIVE REVIEW

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Background: The clinical syndrome of frailty is one of the most challenging consequences of the ageing population (Clegg et al, 2013). A frail older person will often present to the emergency department (ED) with nonspecific complaints. The BGS (2012) recommended that on presentation to the ED that screening for frailty should be completed with a more detailed assessment initiated if components of frailty are identified.

Methods: A retrospective review of patient case notes of patients assessed in the ED has enabled identification of frail older people, their impairments and has resulted in earlier HSCP referrals. The main concerns identified by FITT were functional status (47%), cognition (22%) and/or social environment (10%). No concerns were identified for only one in three patients (35%).

Conclusions: The implementation of FITT in Beaumont Hospital’s ED has enabled earlier identification of frail older people, their impairments and has resulted in earlier HSCP referrals. This is the initial step in the development of a modern, whole system pathway for frail older people to ensure that patients are managed assertively and their length of stay is kept to a minimum.
ASSOCIATION OF DRUG BURDEN INDEX WITH PHYSICAL FUNCTION IN IRISH OLDER ADULTS WITH INTELLECTUAL DISABILITY

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Background: The Drug Burden Index (DBI) is a tool which quantitatively evaluates the burden from anticholinergic and sedative medications. DBI scores have been associated with poorer physical performance in older adults without intellectual disability. This study aimed to evaluate the association between DBI scores and two physical function measures - Barthel Index (BI) activities of daily living (lower scores indicate greater dependence) and Functional Comorbidity Index (FCI) in older adults with ID.

Methods: Data from Wave 2 of the Intellectual Disability Supplement to the Irish Longitudinal Study on Ageing (IDS-TILDA) were analysed. Analysis of Covariance (ANCOVA) was used to compare adjusted means of two physical function measures – BI and FCI. Means for BI were adjusted for gender, age, level of ID, and history of falls. Means for FCI were also adjusted for comorbidities.

Results: Of the 677 with medication data, 24.4% (n = 165) had a DBI score ≤ 0.1, 54.2% (n = 367) had a DBI score of 1+. After adjusting for confounders, DBI 1+ was associated with higher dependence in BI activities of daily living (p = 0.002). Both DBI 0–1 and DBI 1+ were associated with higher FCI scores (p = 0.018 and p < 0.001, respectively).

Conclusions: Higher Drug Burden Index was significantly associated with poorer physical function and less independence in older adults with ID. This tool could be useful to trigger medication review and optimising use of anticholinergic and sedative medications in older adults with ID, potentially improving quality of life.

SCREENING TOOL PERFORMED BY INFORMAL CARERS, THE QUICK MEMORY CHECK, CORRELATES WITH QUICK SCREEN FOR MILD COGNITIVE IMPAIRMENT

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Background: Many patients may have to wait for substantial periods of time before they can receive cognitive assessment by specialist professionals. The Quick Memory Check (QMC) is a short valid screen for use in the community by informal carers of patients with the potential to improve the efficiency of clinic appointments and scope for cost-effective assessment at multiple timepoints.

Methods: Informal carers of patients administered the QMC at home prior to attending a memory clinic at St Finbarr’s Hospital, Cork, where the Quick Mild Cognitive Impairment (Qmci) screen and the Standardised Mini Mental State Exam (SMMSE) were administered by trained nurses. Of 220 patients who completed cognitive assessment in clinic, 150 had the QMC completed by their informal carer. The average measures intra-class correlation was calculated with SPSS version 20, using an absolute agreement, two-way mixed effects model.

Results: The QMC (Section B) showed strong agreement with the Qmci screen, with an intra-class correlation of 0.78, and a 95% confidence interval of 0.71–0.84.

Conclusions: The QMC represents a reliable means for patients to be screened for cognitive impairment at home by family members. Special training is not required, the assessment can be performed by following the simple instructions provided with the QMC. Future research may help to further refine instructions for carers on completing the QMC.
WHAT IS THE PREVALENCE OF UNTREATED DEPRESSION AND DEATH IDEAION IN OLDER PEOPLE? DATA FROM TILDA

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Background: While later life is generally characterised by happiness and emotional well-being, late life depression (LLD) affects a significant proportion of older people and is a risk factor for death by suicide. Despite this, it is well recognised that LLD often goes undetected or untreated. Little research has quantified the burden of untreated LLD at a population level to date however.

Methods: This is a cross-sectional study in a large nationally representative sample of older adults aged ≥50 years, examining the prevalence of untreated LLD and death ideation (DI).

Depression was defined either as scoring ≥16 on the Centre for Epidemiological Studies Depression Scale or a Composite International Diagnostic Interview indicative of major depression. Participants not prescribed antidepressants or antidepressants were defined as untreated.

To define DI, participants were also asked ‘In the last month, have you felt like you would rather be dead?’

Results: 12% (839/7,055) met criteria for depression and one third (241/839) of these were on appropriate medical therapy.

Compared to the treated group, those with untreated depression were no less likely to have visited their general practitioner (GP) in the last year. Those with untreated depression were less likely to endorse symptoms of persistent low mood or worthlessness however.

Over 3% (227/7,055) of participants had DI. Less than one third (68/227) had visited their GP within the last 12 months and two thirds met criteria for depression (146/223).

Conclusion: This study demonstrates that two thirds of older people with LLD are not prescribed appropriate medical therapy, and that depression is closely associated with DI.

It is important therefore to raise awareness of depression among older people themselves, as well as their families and healthcare professionals, with particular focus on the fact that LLD is not an inevitable consequence of ageing and that effective treatment is necessary for successful practice change.

PREVALENCE OF BOWEL COLONISATION WITH CLINICALLY SIGNIFICANT BACTERIA AMONG HIGHLY DEPENDENT RESIDENTS IN A PRIVATE LONG TERM CARE FACILITY (LTCF)

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Background: Due to the high levels of antibiotic usage in nursing homes, they are a potential reservoir for multi-drug resistant bacteria and a point of entry into acute healthcare facilities. The aim of this study was to examine the prevalence of bowel colonisation with clinically significant bacteria and analyse the characteristics of the tested cohort in a 140 bedded LTCF.

Methods: A quantitative point prevalence study was carried out over a ten day period in February 2017. Faeces specimens from consenting residents were collected and cultured for Clostridium difficile (C.difficile) Vancomycin Resistant Enterococci (VRE) and Extended Spectrum Beta-Lactamases (ESBL) producing Enterobacteriaceae using standard laboratory processes. Residents’ age, level of cognition, continence, mobility, use of indwelling devices and accommodation status was analysed.

Results: The mean age of the population studied was 77 years. The majority (77%) of residents were disorientated, 63% wheelchair dependent, 92% incontinent, 27% had urinary catheters, 58% lived in single rooms and 42% in double rooms. Laboratory data (n = 77 residents). None of the 77 residents that provided a sample were positive for VRE. Three residents were colonised with different rhotypes of C. difficile, of which only one was toxigenic. Eleven residents, from five separate wards, were colonised with ESBL-producing Enterobacteriaceae.

Conclusions: It was established 18.1% of the cohort studied were colonised with clinically significant bacteria in their bowel, which contradicts previous findings of 50% prevalence in LTCF. Despite the high dependency levels and low level of functional ability, the expected high level of colonisation was not detected.

References

A NOVEL PATHWAY TO IMPROVE DEMENTIA CARE IN ACUTE HOSPITALS MAY REQUIRE SPECIALIST NURSE SUPPORT TO ACHIEVE PRACTICE CHANGE

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Background: Almost 30% of older people admitted to acute hospitals in Ireland have dementia. We introduced a novel dementia pathway in an acute hospital as follows: all older people (≥70 years) screened for cognitive vulnerability (dementia, dementia, or delirium on dementia) in ED; patients with dementia received daily delirium screening and a dementia care bundle; enhanced communication with community at time of discharge. The pathway was supported by an extensive pan-hospital education drive and a new dementia nurse specialist (DNS) post. We aimed to assess the compliance with the pathway and explore the effects of the pathway on practice.

Methods: Three “spot” audits were performed at intervals on wards that had implemented the pathway. Twenty case-notes for a person with dementia (any type, any age) discharged between Jan 9th and Feb 20th 2017 were reviewed using the Irish National Audit of Dementia chart review tool; data was compared to 2012 (INAD) and 2014 (baseline) data.

Results: Compliance with the pathway was excellent; daily delirium screening and using a patient passport proved most challenging to staff. Practice significantly improved across most INAD parameters. Delirium screening increased from 16% to >90%; recording collateral history of the dementia course increased from 50% to >90%. Assessment for mood, pain, malnutrition all improved. The documentation of dementia stage and delirium occurrence at the time of discharge also dramatically improved. However, much of the improved performance was due to the DNS performing the relevant assessments rather than other staff. Improvements also occurred in wards without the new pathway, again suggesting that the improved care is not solely due to the pathway.

Conclusion: A novel pathway for dementia care, supported by a dementia nurse specialist, improves the care of a person with dementia in hospital, but both elements may be necessary for successful practice change.

COULD THIS HIP FRACTURE HAVE BEEN PREVENTED?

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Background: The FRAX® is a validated tool that predicts ten-year probability of hip fracture and major osteoporotic fracture with or without the addition of femoral neck bone mineral density (BMD). The aim of this study was to use the FRAX® score to determine if those presenting to our service with a hip fracture were on bone protection treatment pre hip fracture according to recommended guidelines.

Methods: Demographics, DXA history, and osteoporosis medications were collected on hip fracture patients consecutively admitted to an orthogeriatric rehabilitation unit over a 3 month period (February to April 2017). The FRAX® score was calculated (without the inclusion of BMD measurement) following the completion of a comprehensive questionnaire.

Results: 56 patients were reviewed. 72% (26/36) were female. The average age was 81 years (range 66–97), 50% (18/36) had a previous fragility fracture. 17% (6/36) had a previous contralateral hip fracture, 2 had a prior vertebral fracture and the remainder were wrist, humeral and pelvic fractures. 17% (6/36) had a DXA, 39% (14/36) had been taking supplemental calcium and/or vitamin D. 33% (12/36) were on or had previously been on bone protection. Of the 24 patients not on treatment the range for pre-fracture FRAX score for 10 year probability of hip fracture was 4.1–50.1%. In line with the new UK NOGG guidelines 25% (6/24) should have been treated and 58% (14/24) should have had DYA (BMD measurement). In the group of 8 patients who had a prior hip or vertebral fracture 38% (3/8) had not been treated.

Conclusions: Our study highlights underutilisation of BMD measurement and bone protection medications in older patients with identifiable risk factors which may have reduced their hip fracture risk.
Background: Polypharmacy is common in Nursing Home (NH) patients, with up to 50% of NH patients taking ≥9 medications. There are also high prescribing rates of potentially inappropriate medications (PIMs), including benzodiazepines, proton pump inhibitors (PPIs), NSAIDs and aspirin. It is important to note, however, that a large degree of inter-centre variability has been demonstrated in relation to prescribing in NH patients. We set out to describe prescribing practices in a single NH centre, primarily managed by a geriatrician.

Method: Pharmacy prescriptions were reviewed for all NH patients aged ≥65 in a single centre. These were cross referenced against medication administration records. Data was collected on all oral and transdermal medications prescribed regularly, in addition to any required medications that had been administered in preceding months.

Results: 43 patients were included. The average age was 82.6 (SD = 9), and 65% (n = 28) were female. 29.5% of patients (n = 13) were taking ≥9 medications. The average prescription per patient was 7.4 (SD = 2.8). All patients were taking at least one medication. The 8 most commonly prescribed medication groups included laxatives (84%), paracetamol (53%), PPIs (49%), antidepressants (47%), antiepileptics (42%), antihypertensives (40%), calcium/vitamin D supplements (40%) and antibiotics (35%). In relation to other medications of note, 23% were prescribed atypical antipsychotics, 21% prescribed hypnotics, 14% prescribed benzodiazepines and 9% prescribed NSAIDs. 39% of patients were taking strong opioid analgesics, all of whom were co-prescribed laxatives. No patients were prescribed diuretics, typical antipsychotics or dual antithrombotics. One patient was taking both aspirin and a NSAID.

Conclusion: Specialist geriatric management, in addition to frequent interdisciplinary pharmacy meetings, may have impacted prescribing practices in this centre. The anti-psychotic and PPI prescription rate had decreased since previous review, however, pre-scription rates of benzodiazepines was unchanged, with hypnotics increased. Further work is needed to optimise medication management in this centre.

Background: Self-neglect is defined as the inability or unwillingness to provide oneself with necessary resources to maintain safety and health. Severe alcohol abuse is classified as alcohol use disorder (AUD) under DSM-5. Self-neglect and alcohol use disorder are growing problems worldwide that are often unrecognized and unreported. They are linked to significant public health issues, including psychological distress, chronic disease, and death. These will put increased pressure on health and social care services as population's age.

Methods: A comprehensive literature search was conducted using ERIC/BMED, Embase, Medline PsychINFO and CINAHL, to identify articles on alcohol abuse and older people's self-neglect published between 2000 and 2017. Grey literature was also accessed. Reference lists of all included articles were reviewed. The key words included in the search were: self-neglect, abuse, alcohol misuse, alcohol use disorder and older people.

Results: The search yielded 38 articles. Thirteen studies were included in review. Studies were descriptive, case series, secondary data analysis mixed methods and cross-sectional. Several narrated and described struggles with alcoholism. Only three studies used measures to determine 6 MoD abusing. There was no prevalence data for alcohol-related self-neglect. Older self-neglecting adults who misused alcohol, have significantly higher depressions. Alcohol misuse is predictive of higher recidivism to Adult Protective Services (APS). Understanding self-neglect and alcohol misuse within a life course perspective (e.g. family systems, childhood trauma, social isolation and loneliness) is important. Practitioners challenged by cases where alcohol misuse had led to self-neglect.

Conclusions: Severity of self-neglect is heightened when older adults misuse alcohol and safeguarding is more complex. Alcohol misuse is a risk factor for self-neglect yet little research has measured alcohol abuse and severity of self-neglect among self-neglecting older adults. The causal connections between self-neglect, alcohol abuse and depression needs to be further explored.
reviewed to identify valid indications for PPI prescriptions in accordance with international guidance and best evidence. Prior to reaudit, recommendations were communicated at Grand Rounds, specialty meetings and by email.

Results: 181 inpatients were included in the first audit iteration and 179 in the reaudit. The mean age was 80 years in both cohorts. There was a reduction in patients prescribed a PPI, from 48% to 31% (p = 0.004). At reaudit, 83% of patients had a valid indication compared to 77.2% (p = 0.28). The most common indication was prophylaxis of NSAID-induced gastric and duodenal ulcers (54.4%). The remaining indications for PPI prescription were GORD or Barrett's Oesophagitis (16.5%), PUD (11.4%), gastritis (13.9%) and GI bleeding (1.3%).

Conclusions: Following the intervention, there were fewer patients prescribed a PPI and more of those on a PPI had an identifiable indication. More accurate PPI prescribing may result in less adverse effects and reduced hospital drug expenditure.

References

OLDER PEOPLE’S EXPERIENCES OF ATTENDING FALLS RISK ASSESSMENT CLINICS IN PRIMARY CARE
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Background: A fall can negatively affect the confidence and independence of an older person living in the community. Listening to the voices of service users can improve the implementation of services to address the needs of those who are at risk of falling. Our aim is to explore older peoples’ experiences of attending new Falls Risk Assessment Clinics (FRACs) in primary care.

Methods: A concurrent mixed methods study is underway at four clinics. Eligible clients are those living in the community aged 65+ who are at risk of falls. A quantitative survey is being administered to those who attended the clinic and analysed using descriptive statistics. Interviews are being conducted with a purposive sample of service users (n = 12) who agreed to be contacted during the survey. Thematic analysis will be performed on qualitative data.

Results: So far, 46 people have completed the survey (response rate 28%) and 7 people have taken part in the qualitative interviews (response rate 58%). Preliminary analysis suggests people were unsure about how they were referred to the clinic and who referred them. Overall, participants were satisfied with the assessment and support received. However, many felt the assessment was not enough to address their needs and they needed more follow up. There were also concerns regarding the lack of communication between the clinics and GPs. Practical obstacles to attending the clinic were identified such as insufficient parking facilities and unfamiliar clinic locations.

Conclusions: Older people who suffer a fall can be frail, vulnerable and therefore ‘hard to reach’ for research purposes. This study offers an opportunity for their voices to be heard. Their experiences will be used to inform and support ongoing implementation of the service.

SELF-NEGLIGENCE: VIEWS AND EXPERIENCES OF HEALTH AND SOCIAL CARE PROFESSIONALS
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Background: Self-neglect is characterised as cumulative self-care deficits that can include a diverse spectrum of behaviours (noncompliance with health care regimes, refusing services, anger, etc) environmental squaller and hoarding. There is no universally accepted definition of self-neglect and no one theory that can fully explain self-neglect. Self-neglect is a serious public health issue that is under-reported and largely hidden. Challenging elements relate to capacity issues and refusal or reluctance of older adults to engage with services. Self-neglect practice has many grey areas and is associated with feelings of powerlessness.

Methods: Qualitative data collected as part of a larger quantitative descriptive cross-sectional postal survey. Descriptive data that included open comments from 87 health and social care professionals on phenomenon of self-neglect were analysed using the 7 stage Framework method.

Results: All participants were well-placed to comment on self-neglect, 61% had 5-15 years of clinical experience and involvement in self-neglect cases in the previous year ranged from 0 (17%) to 25 plus (6%), with the median group having 3-5 cases (33%). Findings revealed one overarching core theme: Fine Balance and four sub-themes: complexity of self-neglect; personal response to self-neglect; challenges in managing the case; and recommendations for practice.

Conclusion: Health and social care professionals are key players in the decision making process in relation to safeguarding and protection of vulnerable adults at risk for self-neglect. In responding to self-neglect cases, participants were trying to balance their personal responses around duty of care, moral obligation and external expectations. Shared powerlessness, multidisciplinary team working, patient-centered responses, a relational approach in deciding the merits of different course of actions is important. Supervision and training for all members of the multidisciplinary team dealing with self-neglect is vital.

THE VALUE OF HEAD-UP TILT IN ADDITION TO ELECTROCARDIOGRAPH INTERPRETATION IN EVALUATING SYCNOE
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Background: European Society of Cardiology guidelines emphasise the necessity of history taking, physical examination and electrocardiograph (ECG) in syncope assessment (1). However, in clinical practice exclusion of Orthostatic Hypotension (OH) is an individual presenting with syncope is also a first line investigation.

Methods: This was a retrospective analysis of ECG and Head-up tilt (HUT) results on all inpatients, referred to the syncope laboratory, over a 3 month period. ECG tracings were obtained through a software program ‘Therefore’ in the Emergency Department (ED) and HUT results were retrieved from the syncope laboratory.

Results: 75 consecutive inpatients with a strong clinical suspicion for the presence of OH after their initial assessment in the ED were referred to the syncope laboratory. The average age was 75 years. 58/75 (77%) had ECG tracings available for review. Of these, 37(47%) had an abnormal ECG with a possible explanation for their synopal symptoms e.g. bradycardia or heart block. Those with an abnormal ECG had a higher average age than those with a normal ECG, 80.5 and 70.4 years respectively. On review of the Head-up Tilt results 14/75(19%) patients demonstrated OH. We could not retrieve an ECG on 2/14(14%) of these patients. 2/14(14%) patients had a normal ECG but 10/14(71%) patients with OH had an abnormal ECG namely atrial fibrillation, heart block and bradycardia. No acute cardiac arrhythmia or ischaemia was detected.

Conclusions: Careful ECG interpretation is required for initial syncope evaluation and to assess patients’ suitability for HUT particularly in older people who have comorbidities. However ECG abnormalities are present in almost 30% of older adults and may not be the sole explanation for an episode of presyncope/syncope (2). A possible cardiac cause should not negate the need to exclude OH particularly in frail older adults who may have dual pathology.

IMPROVING OUTCOMES IN OLDER PEOPLE WITH FRAILTY: A PROSPECTIVE STUDY OF THE GERIATRIC EMERGENCY MEDICINE SERVICE (GEMS)
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Background: Ireland is currently facing the challenge of providing quality and cost-effective health care for an increasing and ageing population. Older people with frailty are a complex cohort at high risk of adverse outcomes and high resource users. We developed a pathway in St. Luke’s General Hospital (SLGH), Kilkenny, to optimise care and outcomes for older patients with frailty. Weighted estimate of frailty in our CHO area (5) is estimated at 22.9% (Tilda, wave 1).

We launched our acute frailty service (GEMS) on 21st February 2017. The core team is based in AMAU and ED. All patients aged 75 and over who attend Acute Medical Assessment Unit (AMAU) and Emergency Department (ED) are screened on triage using a 3 question tool ‘Variable Indicative of Placement risk’ (VIP) and interdisciplinary Comprehensive Geriatric Assessment (CGA) is delivered within 72 hours to patients who are positively identified.

Methods: Data is collected on an Excel spreadsheet and we present analysis from 21/2/2017 to 27/04/2017 (65 days).

Results: 879 patients aged 75 and over and attended during the time period. 41% were identified as at risk. Average age was 85.1 years. 67% received CGA and within 1.63 days. Admission conversion rate was 56%. The average length of stay was reduced from 10.6 to 8.8 days p < 0.01 (p < 0.05) 45% were identified as ‘Vulnerable to Moderately Frail’ (4-6) on Rockwood Clinical Frailty Score (CFS) and 31% as ‘Severely frail to Terminally ill’ (7-9).

Conclusion: GEMS pathway reliably identifies older people at risk of adverse outcomes e.g. polypharmacy, malnutrition, falls etc. and reduces the average length of stay in hospital.

Critical to the success of the service is the mandatory screening on triage and the interdisciplinary culture of the team. We hope to expand our service to include an ambulatory assessment unit and an in-patient acute frailty unit.
PARTICIPANTS’ PERSPECTIVES AND PREFERENCES ON CLINICAL TRIAL RESULT DISSEMINATION: THE TRUST THYROID TRIAL EXPERIENCE

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Background: The results of clinical trials are not traditionally disseminated to clinical trial participants. While there is a growing awareness that participants should receive study results, little is known about the most appropriate methods of doing so. The Thyroid Hormone Replacement for Subclinical Hypothyroidism Trial (TRUST) was a multi-centre, double-blind, randomised, placebo-controlled trial which tested the efficacy of thyroxine replacement in subclinical hypothyroidism in older adults (≥65 years). Our aim is to use a Public and Patient Involvement (PPI) approach to identify, develop and evaluate a participant-preferred method of receiving the results of the TRUST Thyroid Trial.

Methods: Using a mixed methods approach, an intervention study was undertaken at the Irish TRUST site. The first phase of the study used PPI (focus groups and 1-1 sessions with trial participants) to develop a participant-preferred method. In the second phase, Irish TRUST participants (n = 194) were randomised into the intervention (PPI method) and comparison groups (standard method). In the third phase, participants were sent a questionnaire. The primary outcome is difference in understanding of results between the two groups.

Results: The ongoing, findings from the first phase clearly established that the preferred method of receiving results was a postal letter containing a 2-3 page summary of the trial, condition, treatment and overall results. In phase two, all randomised participants received the results of the trial. Data collection is ongoing for phase three, the current response rate for the questionnaire is 58%.

Conclusions: PPI is a relatively new concept in clinical trials and little is understood about its impact and effectiveness. This study provides empirical evidence on participants’ perspectives and preferences of clinical trial result dissemination and demonstrates to other trialists how study results should be communicated to participants aged ≥65 years.

THE AGEING OF MAJOR TRAUMA

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Background: Traditionally major trauma has been viewed as a disease of young men involved in high-energy transfer mechanisms. The aim of this study is to describe the demographics, clinical details and outcome of major trauma presenting to a tertiary urban university hospital in Ireland over a 31-month period.

Methods: An urban tertiary referral teaching hospital was one of the first institutions in Ireland to contribute to the Trauma Audit & Research Network (TARN) database and has been doing so since September 2013. A number of parameters are presented including demographics, mechanism of injury, Injury Severity Score (ISS), mortality and length of stay.

Results: 1,088 patients were included in our TARN dataset from September 1st 2013 – March 31st 2016. 50.7% (n = 551) were male. The mean age at presentation was 38.5 years (range 28–103). Over 65% (n = 382) in that cohort. The most common mechanism of injury was “fall less than 2 meters” (n = 665, 61.1%). In the over 65 years population, 81.7% (n = 367) suffered a fall less than 2 meters, 65.5% had an ISS of 1-14 and 34.4% scored >15. The median ISS was 9 (range 1–57). The mean length of stay was 21.0 days (SD 33.8). 51 patients (5.9%) died, of whom 39 were over the age of 65.

Conclusions: Our trauma database included more patients over the age of 65 years than under, and the predominant mechanism of injury was one of low energy i.e. fall from less than 2 meters. Our study demonstrated the importance of monitoring calcium levels and renal function before and during denosumab therapy in patients with multiple co-morbidities. Vigilance is required amongst physicians and GPs who initiate denosumab therapy. Our study demonstrated the importance of monitoring calcium levels and renal function before and during denosumab therapy in patients with multiple co-morbidities. Vigilance is required amongst physicians and GPs who initiate denosumab therapy.

MECHANICAL FALLS: A MISLEADING PSEUDO-DIAGNOSIS?

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Background: Falls are the commonest cause of ED attendances in older adults. Diagnosis of a “mechanical fall” infers the absence of contributing intrinsic or extrinsic factors and in our experience leads to an absence of diagnostic rigor applied to other presentations. This small study reviews the medical work up, multi-disciplinary team input and ultimate diagnosis of patients with a HIPE code “Mechanical Fall” in a Dublin teaching hospital.

Methods: Retrospective chart review of all patients with a primary HIPE diagnosis of “Mechanical Fall” between January 1st and December 31st 2015. Primary reason for referral to hospital, falls work up (i.e. history, physical exam, investigations, MDT input, discharge destination) were recorded.

Results: 66 patients were identified and case-notes obtained for 46 (70%). Mean age 78 years (range 28–97); 29/46 (63%) female. 84.7% were admitted from home, 10.9% were nursing home residents and 4.4% resided in sheltered accommodation. 45.6% patients had clear recollection of the index fall, 58% had a collateral history of the fall documented. Documented history was documented in 30% of patients. 71.2% had a neurological exam and 32% had a musculoskeletal exam documented. 72% were referred for MDT assessment. Medication review was performed in 37% of patients and bone health assessed in 65%. Following admission 64% were found to have intrinsic factors contributing to falls risk e.g. sepsis (20%), acute stroke (15%), new Parkinsonism (7%), orthostatic hypotension (7%), alcohol excess (7%), multi-factrial (8%). 74.4% admitted from home returned directly and 8.7% were referred for off-site rehabilitation. 15% required new admission to nursing home from hospital. The in-hospital mortality rate in this group was 6.5%.

Conclusions: Our study illustrates that the majority of older patients presenting with falls have an underlying medical condition requiring intervention. Use of the term mechanical fall is potentially dangerous as it oversimplifies what invariably represents a complex issue.

HYPOCALCAEMIA AND DENOSUMAB IN THE TREATMENT OF OSTEOPOROSIS: A PROSPECTIVE STUDY

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Background: Hypocalcaemia is the most common major adverse event in patients with osteoporosis receiving the bone resorption inhibitor denosumab and has been reported in patients with metastatic bone disease and stage 4 and 5 chronic kidney disease. Little is known in patients without these co-morbidities. Untreated hypocalcaemia may lead to prolonged QT, congestive cardiac failure, hypotension and seizures.

Methods: A prospective cohort study was undertaken between May 2015 and May 2017 of patients aged ≥65 years with a new diagnosis of osteoporosis. Patients were initiated on denosumab therapy and monitored to identify who developed hypocalcaemia (<2.10 mmol/l) by day 10 post first dose. Patients were initiated from an Irish acute tertiary hospital and 2 affiliated rehabilitation units in the same country. Patients with eGFR < 30 ml/min/1.73 m2 or receiving dialysis were excluded from the study, as were patients with metastatic bone disease. Baseline biochemical serological tests, including calcium, vitamin D and PTH were collected prior to initial dosing of Denosumab along with documentation of past medical history, current medications, vitamin supplements and a repeat ECG. Indicators of frailty including weight, Timed Get Up and Go (TUG) and Modified Barthel Index were recorded.

Results: Patients were re-evaluated 10 days post-Denosumab dose for hypocalcaemia with repeat serological testing.

Conclusion: Sixty patients were recruited in the study; 82% were women. Median age 80.4 years. Baseline biochemical tests were normal in all participants. Four patients (6%) developed hypocalcaemia by day 10 post Denosumab therapy initiation (range 1.83 mmol/l–2.10 mmol/l). All were asymptomatic with no ECG changes. None required hospitalisation but were treated with calcium supplementation. Median TUG score 20.9 seconds. Median Modified Barthel Index 15.7.

Conclusions: Our study demonstrated the importance of monitoring calcium levels and renal function before and during denosumab therapy in patients with multiple co-morbidities. Vigilance is required amongst physicians and GPs who initiate denosumab therapy.

CAN WE ASSESS VISUOSPATIAL FUNCTION VERBALLY IN OLDER MEDICAL INPATIENTS?

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Background: Commonly used tests of visuospatial function generally require a patient to use a pen and paper, e.g. the Clock-Drawing Test (CDT) or the Interseting Pentagons Test (IPT). These tests can be challenging for older patients, particularly those with visual impairment, upper limb impairment, or fatigue associated with acute illness. We aimed to assess if a novel verbal test would correlate with IPT and CDT and hence be a potential alternative method of measuring visuospatial function in older medical inpatients.

Methods: We developed a verbal test called the Environmental Visuospatial Questions Test (EVSEQ) which included questions pertaining to a patient’s environment (e.g. which is closer to you, the window or the door?). As part of a study of delirium in older medical inpatients, participants were assessed within 36 hours of admission using EVSEQ, CDT and IPT. Patients also underwent brief cognitive testing using the Six-Item Cognitive Impairment Test (6-CIT). Spearman’s Rho was used to calculate the correlation between EVSEQ and the visuospatial tests (CDT and IPT). We also examined correlation between each of the three tests and the 6-CIT respectively.
Results: Testing was conducted in 470 participants (median age 81 years, 50.4% female). Correlation between EVSQ and each of the visuospatial tests was weak (CDT 0.208, p < 0.001; IPT 0.136, p < 0.01). IPT and CDT had higher correlation (0.414, p < 0.001), yet it was still low. Correlation for each of the three tests was higher with 6-CIT, though remained low to moderate (IPT/6-CIT r = 0.149, p < 0.001; EVSQ/6-CIT r = 0.446, p < 0.001; CDT/6-CIT r = 0.578, p < 0.001).

Conclusions: Correlation was weak between EVSQ and the commonly used visuospatial tests, but also between the two visuospatial tests (IPT and CDT). Correlation was higher with the 6-CIT for all the tests, especially CDT. This highlights that other factors, including cognitive impairment in other domains, are likely to affect visuospatial test performance.

SAVE THE BRAIN CAMPAIGN: REDUCING DOOR TO CT TIMES FOR ACUTE STROKE

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Background: In acute ischaemic stroke rapid access to computed tomography (CT) imaging is essential to facilitate early thrombolysis or thrombectomy. International guidelines recommend door to CT in less than 25 minutes, however, door to times in this large teaching hospital exceeded this.

The aim of this quality improvement project was to reduce the median door (registration time) to CT time to less than 25 minutes for possible strokes presenting within 12 hours of symptom onset or unknown onset 8am to 5pm Monday to Friday.

Methods: The Institute for Healthcare Improvement quality improvement (QI) methodology was used. Baseline door to CT time data were collected. A comprehensive process analysis and benchmarking exercise was carried out. Successive PDSA (Plan, Do, Study, Act) cycles were used to test and implement change measures. Outcome and process measures were collected and displayed on run charts. Change ideas included early stroke team involvement through ambulance pre-alert, introduction of a single stroke alert number, streamlining CT request process, removal of unnecessary or duplicative process steps, improvement of team work and staff education. The primary outcome measure was door to first CT slice time.

Results: Baseline median door to CT time in October 2016 was 120 minutes. With implementation of the quality improvement initiative door to CT times improved over the following 4 month period with a median registration to CT of 11 minutes in February 2017, 17 minutes in March 2017 and a record door to CT time of 6 minutes.

Conclusions: This project has resulted in significant improvements in door to CT times for people presenting with possible stroke. This was achieved through QI methodologies without allocation of any additional resources or funding.
morbidities and complex care needs. The Red and Green Bed Day patient flow system developed by Dr I. Lass in the NHS has been demonstrated to reduce acute hospital inpatient length of stay.

Methods: We used the Red and Green Bed Day patient flow system, over 12 consecutive weekdays within 2 geriatric medical teams. A red-bed day was identified as a bed day where no activity had occurred to progress a patient to discharge and where patients were in receipt of care that did not require an acute hospital bed.

Results: Over the 12 days of the study, there were 110 inpatient bed days assessed with the red and green bed day protocol. On average there were 45 (range 41 to 53) patients per day under the 2 teams with a median age of 82 years (range 71 to 98). The study identified 275 (54%) red days and 235 (46%) green days. Commonest reasons for red-bed days included (n, %): awaiting long-term care (110, 40), awaiting home care package (91, 33.1), awaiting respite (65, 23.6), awaiting home care planning (11, 4), awaiting interventional procedure (10, 3.6), awaiting transfer to a hospice facility (8, 2.9) and awaiting specialist consultation (5, 1.8). Red Bed days due to community and hospital factors were 227 (82.5%) and 48 (17.5%) respectively.

Conclusions: We established that the Red and Green Bed Day patient flow system can be used in an acute geriatric medicine unit. It served as a valuable tool in objectively identifying and quantifying factors contributing to unnecessary prolongation of acute hospital stay.

200 FUTURE CARE PLANNING AMONGST PARENT AND SIBLING CARERS WITH AGEING FAMILY MEMBER WITH AN INTELLECTUAL DISABILITY

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Background: Multiple socio-economic factors are impacting on the future care for older people with an intellectual disability (ID) in contemporary Ireland, specifically a reduced reliance on institutional settings, the increased life expectancy for people with an ID, and a social policy prioritisation of the ‘family’ as the principal care context. This paper explores the extent and nature of future care planning amongst parent and sibling carers with ageing family members with an ID.

Methods: Situated within the parent study population of IDS TILDA (Intellectual Disability Supplement to the Irish Longitudinal Study 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.

Results: While sustained on a bedrock of ‘love labour’, future family caregiving capacity is perceived by family carers to be rapidly diminishing.

Future care planning is an emotive and highly stressful topic.

Family carers, older people with an ID and service providers appear collectively reluctantly to proactively engage in future care planning.

Few carers and older people with an ID have definitively formulated future care plans, and where plans do exist these are predominantly aspirational in nature.

This has the potential to create poor outcomes including crisis care management and inappropriate placement.

Conclusion: People with an ID, their families and service providers would benefit from future care planning. The development of a model and process for such planning is needed. However, the success of future care planning is premised on the existence of appropriate care options which firmly prolong and enhance family caregiving capacity, whilst also providing care options were care within the family is no longer feasible.

The overall mean Total Body Surface Area (TBSA) affected of the 1328 patients was 5.6±2.8 (mean TBSA of patients undergoing imaging was 14.8±4.8). Fourteen (2%) patients had a significant new finding on neuroimaging. Of the positive findings, 7 (12.5%) patients had acute cerebral infarctions. Mean Fazekas score was 3.59 (Range: 0 = Normal, 3 = Severe), 8 (14.3%) scans were normal (14.2%).

Both the admission to hospital (25/215 vs 31/1113 patients p = 0.0001 Chi Sq) or associated inhalation injury (17/147 vs. 39/1118. P < 0.0001) were significantly more likely to be imaged.

Conclusions: Patients admitted with burns infrequently undergo neuroimaging. Those who are imaged have a high prevalence of acute and chronic cerebrovascular disease.
A RETROSPECTIVE REVIEW – CORRELATING THE MINI-MENTAL STATE EXAMINATION RESULT AND THE DIAGNOSIS OF DEMENTIA

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Background: The Mini–Mental State Examination (MMSE) or Folstein test is a 30–point questionnaire that is used extensively in clinical and research settings to measure cognitive impairment. It is commonly used in medicine and allied health to screen for dementia. The MMSE is the most widely used cognitive test but its accuracy and clinical utility in diagnosing cognitive disorders is not fully known. (Mitchell, 2008).

The aim of this study was to evaluate whether the MMSE cut-off score of 24 accurately identifies patients with dementia attending a multidisciplinary memory assessment clinic.

Methods: Patients attending a multidisciplinary memory clinic in Tallaght Hospital were screened with a MMSE, in addition to further testing including Repeatable Battery of Neuropsychological Assessment (RBANS) and Exit 25.

Diagnosis was based on standard assessment including clinic visit, appropriate neuroimaging and a discussion at our weekly multidisciplinary meeting.

We then evaluated whether the MMSE cut-off score of 24 or less correctly identified patients diagnosed with dementia.

Results: 180 patients who were assessed using a MMSE were included in this study. 85 (47%) of this group included newly diagnosed Mild Cognitive Impairment, Alzheimer’s Dementia, Vascular Dementia, Mixed Alzheimer’s/Vascular Dementia who had an MMSE score of 25 or above. of which were diagnosed with dementia.

MCI = 52 (61%), AD = 18 (21%), VA = 5 (6%) and Mixed AD/VAD = 12 (14%) over and above 25.

Conclusion: The MMSE at a cut-off score of 24 or less failed to identify a significant proportion of patients with dementia attending a memory clinic. The MMSE is not an appropriate tool to be used in isolation and assessment should also include a focused history, including a collateral history as well as further cognitive and functional assessment.

THE INTRODUCTION OF A FALLS HUDDLE IN AN ACUTE MEDICAL ADMISSIONS UNIT

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Background: Falls Huddle: Huddles have been used for many years in many areas of industry to improve team communication. We are introducing a team huddle in relation to falls management to improve team communication on the issue and ultimately improve patient safety.

Aim and objectives: Aim: To reduce falls and injury from falls in an AMAU over 8 weeks by increasing compliance to standards and improving multidisciplinary communication in relation to falls management.

Objectives: To develop focused 5–10 minute multidisciplinary huddles (Monday, Wednesday and Fridays) at 11am in the selected ward by February 28th 2017.

To promote shared learning from all disciplines regarding prevention interventions by March 31st 2017.

To increase compliance to standards, in relation to falls management by March 31st 2017.

To highlight any specific management issues that arise in relation to falls management continuously.

Monitor incidence of falls using a safety cross to highlight impact of the huddle by March 31st 2017.

Methods: The PDSA cycle was used to prepare for and implement this project, and to make needed modification during the implementation stage.

Analysis: The safety cross was analysed to look at risk and the Nursing Metrics were analysed to determine compliance. A learning log was also kept.

Conclusion: An overall decrease in rates of falls of over 50% in the 8 week period and Nursing Metric compliance increased to 100%.

ISOLED NOCTURNAL HYPERTENSION PREDICTS FUTURE STROKE RISK

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Background: Essential and secondary hypertension are well documented major risk factors for cardiovascular and cerebrovascular events. This study explores the predictive value of isolated nocturnal hypertension for cerebrovascular deaths in a large patient cohort of referred hypertensive patients.

Methods: 7,239 patients underwent 24 hour ambulatory blood pressure monitoring (ABPM). None of these patients were on antihypertensive medications at baseline. Mean age 63 years. Using a computerised national registry of death mortality outcome was ascertained. For this study we focused on stroke death only. The cohort was divided into 4 subgroups based on their 24 hour ABPM results. Category 1 = normotensive, category 2 = isolated daytime hypertension, category 3 = isolated nocturnal hypertension, category 4 = sustained 24 hour hypertension. The hazard ratios of stroke death for categories 2, 3 and 4 were compared to category 1 (normotensive patients).

Results: Using cox multiple regression analysis after adjustment for age, sex, smoking history, body mass index, diabetes and cardiovascular history hazard ratios for stroke death in patients with isolated nocturnal hypertension was 1.91 (1.09–4.21). For isolated daytime hypertension hazard ratio is 1.38 (0.72–2.41) and for sustained hypertension 2.11 (1.12–3.94). Therefore, isolated nocturnal hypertension was an independent predictor of cerebrovascular mortality. Unsurprisingly sustained hypertension is also a predictor of cerebrovascular death.

Conclusions: Nocturnal hypertension is a predictor of stroke risk. This study highlights the importance of 24 hour ABPM to identify and detect this high risk patient group which could potentially be missed otherwise. The reason a patient may have isolated nocturnal hypertension is multi-factoral, however other underlying conditions, such as obstructive sleep apnoea need to be considered. Ultimately, from a clinician’s perspective, there needs to be increased vigilance and awareness of BP monitoring for nocturnal hypertension.

A REVIEW OF LONG TERM CARE ASSESSMENTS IN AN INNER CITY TEACHING HOSPITAL

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Background: Specialist geriatric services advocate for care in the community and recommend residential care as a last resort. Therefore they are involved in care needs assessments for the Nursing Home Support Scheme in acute hospitals. These reviews aim to avoid admissions to institutional care, maintain dignity and quality of life of the frail or dependent at home as long as possible and ultimately identify whether someone needs long term care or not.

Methods: In our large inner city teaching hospital patients who are not under the medicine for the elderly services require a consultation to them before they can be listed for long term care. We reviewed consultations and outcomes for a one year period. We also looked at survival rates for all listed.

Results: From January to December 2015 399 consultations were received for long term care listing on 262 patients. 180 of these were listed in 2015, 75 were not listed. The remaining 7 were not seen as too young (age < 65). Of the 75 not listed 34 returned home, 22 died, the rest went to convalescence or hospice beds or were listed in 2016 (n = 9).

Additionally 160 medicine for the elderly inpatients were listed giving a total of 340 listed. Reviewing discharge destination of this it was noted 56 (16.5%) died before discharge highlighting frailty and high likelihood of further medical events despite being deemed ready to go to a nursing home.

Conclusion: This study indicates a medicine for the elderly service is essential to ensure these inpatients listed in 2015 were deemed ready to go to a nursing home. The high mortality rate for elderly inpatients is highlighted in this study. Further medical events during the hospital stay highlight the importance of ‘emergency’ geriatric clinics.

ARE ORTHOPAEDIC WARDS ADEQUATELY STAFFED TO PROVIDE BEST QUALITY CARE IN OLDER PATIENTS?

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Background: International guidelines have identified a number of key recommendations in management of older fracture patients. These include management by a multidisciplinary team (MDT), and early involvement of orthopaedicians [1]. Adequate resources need to be assigned to orthopaedic wards to meet these recommendations.

Methods: All inpatients on an orthopaedic ward (n = 39) were audited at one specific time-point to capture dependence levels and frailty. Staffing levels were compared to a 35 bed specialist geriatric ward.

Results: Median age of orthopaedic patients was 77.5 years. The cohort included 18 hip fracture patients (median age 85 years). 90% of patients experienced polypharmacy. 26 (67%) of all patients and 96% of hip fracture patients were identified as FRAIL positive [2]. The average nurse dependency score was 2.7. All patients were under review by physiotherapy (PT), & 78% (n = 30) were referred to occupational therapy (OT). Medical social work (MSW) was deemed necessary in at least 54% (n = 21) of patients. Despite the frailty of these patients there was substantially less access to some elements of the MDT – 15% less PT, 34% less OT, 70% less MSW and 63% less access to a dietician.

The most striking difference was seen in access to orthogeriatric care with 95% less access to a consultant geriatrician (0.1 WTE vs input from 2 WTE) and no access to geriatric trained NHSS.

Conclusion: Orthopaedic patients display high levels of frailty and dependence, particularly hip fracture patients. To adequately care for this patient population staffing levels of both multidisciplinary teams and geriatric teams should more closely reflect that available on specialist geriatric wards.
A SNAPSHOT OF DENTAL HEALTH AMONG INPATIENTS ON A GERIATRIC WARD
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Background: Dentition is an important part of healthcare. Poor oral health can cause pain and impair speech, chewing and swallowing. Tooth loss impairs chewing efficacy. Chewing with removable dentures is 30–40% less efficient than natural teeth [1]. Dentition is associated with malnutrition in older persons [1]. The Comprehensive Geriatric Assessment tool identifies “dentition” as one of the minor criteria that should be evaluated in older persons [2]. The study examined the prevalence of poor dentition in a cohort of older inpatients and assessed whether dentition was identified and documented as a problem on admission. It also looked at whether or not dentition affected nutritional status.

Method: All inpatients on a medicine for the elderly ward were included in the study. These patients had a mouth exam and dentition was scored according to presence of periodontal disease and number of teeth. BMI was also recorded. The admission notes of each patient were reviewed to identify whether dental health was documented and if a dental plan was outlined. The involvement of dietitian was also recorded. Results: Sixty four percent of 29 patients aged 64–97 years had dentures, 22% had evidence of periodontal disease or caries. “Dentition” was not mentioned on the admission note of any patients assessed. 70% required clinical nutrition involvement, with 47% was not mentioned on the admission note of any patients assessed. 70% required clinical nutrition involvement, with 47% being either under or overweight.

Conclusion: Poor dentition and malnutrition was a common observation in older inpatients and assessed whether dentition affected nutritional status. 70% required clinical nutrition involvement, with 47% being either under or overweight.

References

DEVELOPMENT AND EVALUATION OF A DEMENTIA EDUCATION WORKSHOP FOR PRIMARY CARE TEAMS IN IRELAND
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Background: A core principle of the National Dementia Strategy is to ensure that all staff working in core primary care settings supporting people with dementia are trained appropriately. A three-hour workshop “Dementia Care in Primary Care – An Interprofessional Approach” was developed in 2017 for national roll out. This study reports on the development and early evaluation of the workshop.

Method: The content of the workshop was informed by a literature review of educational interventions in primary care and a needs analysis of allied healthcare professionals. The workshop was piloted with three primary care teams. A mixed method approach was used to evaluate the workshops. This included post workshop questionnaires for participants (n = 54) and a post workshop focus group with the programme design team (n = 8).

Results: The principles of inter-professional education and collaborative practice underpin the workshop which covers five areas: (1) Knowledge of dementia, (2) Understanding roles and responsibilities, (3) Team functioning and collaboration, (4) Inter-professional communication skills and (5) Supporting the person with dementia and their family. More than 80% of participants strongly agreed that the workshop improved their knowledge, confidence and understanding of dementia. Participants valued the inclusion of a case study and the interdisciplinary nature of the workshop. The potential for greater participation in the workshop was considered as an area for improvement.

Conclusion: The workshop is considered useful and feasible and overall evaluated positively. Feedback from the pilot has been used to refine the course further prior to national roll out to all primary care teams in Ireland from June 2017.

DIAGNOSING DEMENTIA IN THE REHABILITATION SETTING: PREVALENCE, PATIENT CHARACTERISTICS AND REHABILITATION OUTCOMES
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Background: We aimed to examine the number of patients diagnosed with dementia during rehabilitation admission. Dementia can have varying effects on a person’s participation in rehabilitation impacting on rehabilitation potential. It is important to disclose a dementia diagnosis to patients and their families to enable future planning as well as availing of support services.

Methods: We retrospectively examined all admissions to the Acute Rehabilitation Unit (ARU) over a 12 month period using the online database Bluespiers. We reviewed all patients’ records with a diagnosis of dementia. In this cohort additional data including demographics, medications, discharge destination, length of stay and Barthel index pre and post rehab were recorded.

Results: 437 patients were admitted to ARU over the study period. 91 (20.8%) had a diagnosis of dementia; 13.2% had the diagnosis prior to admission, 92% of whom were on medications. Those with dementia had a mean age (SD) of 83.69 (5.65) years. Sixty-nine (76.7%) patients had neuro-imaging at some point.

The median (IQR) Barthel Index preadmission was 11/20 (2–20), postadmission 13/20 (7–19). The mean (SD) Montreal Cognitive Assessment Score was 14.0 (4.7) with median (IQR) of 14 (6–24). 79.1% (72) of patients returned home, 0.02% (2) back to referring hospital unwell and 18.7% (17) to Long Term Care. 24% (58) of patients were on anti-dementia medications on discharge; 59.6% (53) on memantine, 11.1% (10) on donepezil, 1.1% (1) on rivastigmine and 5.5% (5) on galantamine. Only 54.9% (50) patients had dementia diagnosis documented on discharge letters to primary care.

Conclusion: 1 in 5 patients attending the ARU had a diagnosis of dementia. Rehabilitation potential was good in this population with most patients returning to their own homes. Communication of this diagnosis to patients GP in discharge letters was poor. We hope to put in place a protocol to standardise and improve how we assess and manage patients with dementia in the ARU and re-audit our practice.

INTRODUCTION OF A PHYSIOTHERAPY SERVICE TO A FALLS AND SYNCOPE UNIT
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Background: International guidelines recommend that older people at risk of falls are offered a multifactorial falls risk assessment (NICE, 2015). A recent initiative involved the introduction of a limited physiotherapy service to a Falls and Syncope Unit. The purpose of this study is to describe referree feedback on this new service and give details of the patient profile referred for physiotherapy.

Methods: This study has both qualitative and quantitative aspects. The qualitative aspect involved gaining referree feedback. An email with a link to an online survey was sent to district nurse, specialist nurses and consultants in the Falls and Syncope Unit.

Results: Qualitative Results – There was a 90% response rate to the survey. 100% (n = 9) of referrees who responded felt that the physiotherapy service was useful and 78% (n = 7) of referrees were either satisfied or very satisfied with the physiotherapy service. Quantitative Results – Forty-three patients were profiled, male 40% (n = 17), female 60% (n = 26) with mean age 75.7 years (range 25–91 years). Falls risk factors identified included history of falls 84% (n = 36), fear of falling 58% (n = 25) and difficulty with gait and balance 93% (n = 40). Mean Timed up and Go score was 13.2 seconds (range 8–28 seconds). The most common physiotherapy interventions included provision of a home exercise programme 86% (n = 37), advice or education 81% (n = 35) and onward physiotherapy referral 44% (n = 19).

Conclusion: Referree feedback indicates that a physiotherapy service in a Falls and Syncope Unit is a useful adjunct to multifactorial falls risk assessment. Physiotherapist assessment allowed for identification of and early intervention for modifiable falls risk factors.

Engagement in Community by Older People with an Intellectual Disability in Ireland
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Background: Irish policy promotes community living by people with intellectual disabilities. We aimed to move away from segregation/congregation of the past. This follows policy elsewhere and adheres to principles of the UN Convention on the Rights of People with Disabilities (CRPD), and is supported by a body of literature reporting better objective outcomes in community settings. Within this discourse, community is assumed as a spatial concept that roughly equates to one’s locality or neighbourhood. However, in sociology it has long been accepted that locality is just one aspect of community, and that community is more defined by relationships, bonding and belonging.

Methods: Data from three waves (2010–2017) of a longitudinal study in Ireland explored rates of community engagement by people with ID aged 40 years and above (n = 609). Variables representing both spatial and relational concepts of community were analysed, and associations with key demographic variables explored. Findings were contextualised with comparison from general population data.
Results: People with ID living in community settings continue to have higher rates of social and community engagement than those in institutions, though overall there has been little change between 2010 and 2017, which coincides with the introduction of deinstitutionalisation policy in 2011. Similarly, there has been little change in overall rates of engagement with family and friends. Older people with ID remains worse off than the general population on both fronts. However, new data shows older people with ID have good friendships.

Conclusions: While a move from congregate residential settings to community living has been a welcome policy development in Ireland, residence in one’s local community must be seen as a starting point for ‘community’ rather than an end point. Future efforts should be focused, therefore, on maintaining existing and developing new relationships for people with ID as they age within their local communities.

IS BONE HEALTH CONSIDERED IN STROKE PATIENTS AT INCREASED RISK OF FRACTURE?
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Background: It is widely accepted that patients with residual hemiparesis post stroke are at increased risk of fracture [1]. This is due to a number of factors including increased bone resorption. Despite the numerous treatments available for osteoporosis, these are often not prescribed in time to prevent fracture [2]. We examined our approach over a 12 month period to bone health in high risk stroke patients.

Methods: Medical records for all stroke patients admitted over a 12 month period were audited. Patients at high risk of fracture were identified based on residual deficit at discharge. Laboratory investigations including Calcium/Vitamin D levels where available were recorded. Discharge prescriptions were examined to investigate if replacement was commenced for Vitamin D deficient patients. DEXA scans carried out in the year post stroke were recorded.

Results: 47 stroke patients were identified as high risk for fracture. Vitamin D levels were obtained in 66% (n = 31) of these patients. Almost half of these patients (n = 6) were Vitamin D deficient. Only 1 Vitamin D deficient patient was commenced on replacement. 2 patients were referred for DEXA scan – one diagnosed as osteopenic and one did not attend.

Conclusions: Fracture prevention is currently not a priority in management of stroke patients. When Vitamin D deficiency was identified, this was not consistently treated. An increased emphasis must be placed on primary fracture prevention in this high risk population.

References

REVIEW ON TERIPARATIDE (FORSTEO) TREATMENT ON OLDER PATIENT ATTENDING BONE HEALTH CLINIC IN ST. JAMES’S HOSPITAL
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Background: Teriparatide (Forsteo) is an anabolic agent used in treatment of osteoporotic patients with high risk of vertebral fracture. It has been shown to reduce the risk of moderate to severe vertebral fractures by up to 80–90%. Vertebral fractures due to osteoporosis are common in older women.

Methods: We aimed to identify the characteristics of older adults receiving teriparatide therapy at our bone health service. We also aimed to evaluate the effect of treatment with teriparatide on bone mineral density (BMD) as well as persistence with therapy. Data were obtained from our bone health service for all adults aged 70 or older who were treated with teriparatide for at least 18 months. Data included age, gender, baseline BMD and T scores as well as changes same with treatment. We dichotomised patients by age (70–79) and 80+ to evaluate differences in the ‘older’ old.

Results: Data for 250 patients were initially available but 20% did not persist with therapy leaving 198 in our analysis, 98 aged between 70–79 and 100 aged 80 or older. Overall 95% of those were female and approximately 60% had vertebral fractures in both groups. Mean T scores were between −3.5 to −3.6 (spine) and −2.7 at hip. There was significant increase in BMD of spine of 15.3% for aged ≥ 80 + and 13.3% in those aged 70–79 with P value < 0.05. While BMD at hip increased by 1.9 to 2.4%.

Conclusions: Teriparatide was effective at increasing BMD of spine in both age groups (70–79) as well as (80+). Our findings support using teriparatide in older adults including the ‘older old’ who have high risk of vertebral fractures and where benefit may be greatest.

TALLAGHT INTEGRATED CARE FOR OLDER PERSONS TEAM—BRIDGING THE GAP
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Background: The Integrated Care for Older Persons’ Team commenced in January 2017 and consists of an MDT including a geriatrician, two clinical case managers, a social worker, an occupational therapist and a physiotherapist. The objective of the team is to improve the quality and outcomes of care for older persons and their carers and support persons to live well in their own homes and communities. The team acts as a communication bridge between acute and community health and social care services, employing a person centred, anticipatory, timely, well-coordinated and evaluated approach to care.

Methods: The team works with older persons with multiple health and social comorbidities. To access the team, a person is referred by their GP to the Age Related Healthcare Team in the Hospital. The geriatrician screens referrals. Each case is discussed at the team’s weekly MDT. Each service user is assigned a case manager and a keyworker. Upon referral, the team completes an interdisciplinary assessment of need, referring onwards and providing targeted therapeutic and rehab interventions where appropriate. Team members attend hospital MDTs and have daily contact with colleagues in both community and acute health and social care.

Results: To date 75 older persons have accessed the team for comprehensive interdisciplinary assessment, care planning, intervention and referral. At point of referral, 44 per cent of referrals have had a diagnosis of cognitive impairment, 12 per cent a diagnosis of Parkinson’s Disease. Thirty three accessed the team’s weekly rapid access clinic, with five receiving a diagnosis at this. The team accessed three emergency homecare packages to prevent hospital admissions.

Conclusions: Feedback from service users and carers has highlighted the team’s regular communication and support navigating the system as invaluable. Other professionals have observed service users’ improved wellbeing and presentation attributing this to the integrated care team intervention.

DEFINING THE CURRICULUM FOR MEDICAL CARE IN NURSING HOMES
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Background: The definition of standards of medical care and curricula for training of medical officers in nursing homes has been neglected until very recently. The EUGMS has taken a lead on this topic, examining both current national policies [1] and establishing the first set of standards of medical care in the biomedical literature [2]. A topic worthy of research is to define a core curriculum for competence in medical nursing home care.

Methods: Items and comparison of curricular items in a range of national and international sources, including the IAGG Handbook, Irish, Dutch and Australian curricula, and the AMDA competencies curriculum. These will then be prioritised by a Delphi process involving members of national societies in the EUGMS.

Results: Items common to all five sources included: delirium and dementia, mobility and falls, polypharmacy and medication review, palliative and end of life care and incontinence. Mood disorders, skin care, infection and management of chronic diseases were featured in four out of five sources.

Conclusions: This preliminary work lays the foundation for the development of an agreed common trunk to an EUGMS curriculum for training of doctors working in nursing homes with older people. It will also allow for the development of audit and quality indicators.

References

MIDLIFE GAIT ABNORMALITIES IN PEOPLE WITH TYPE 2 DIABETES—DATA FROM TILDA
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Background: There is a growing consensus that older people with type 2 diabetes have increased gait abnormalities that are strongly linked to falls, mobility, and the overall health outcomes of older people with type 2 diabetes.

Methods: The data from the TILDA study [4] were used to compare the gait abnormalities of older adults with type 2 diabetes with the gait abnormalities of older adults without diabetes.

Results: Older people with type 2 diabetes had a significantly higher rate of gait abnormalities than older people without diabetes.

Conclusions: Older people with type 2 diabetes have increased gait abnormalities that are strongly linked to falls, mobility, and the overall health outcomes of older people with type 2 diabetes.
Background: Type 2 (T2) diabetes is associated with an accelerated brain ageing process. Cognitive gait analysis is a complex process dependent on central nervous system input in non-demented adults. Identifying subtle functional changes in diabetic patients in midlife may precipitate earlier intervention and improve health outcomes from physical and cognitive perspective. Gait analysis may provide a quantitative method to achieve this. This paper explores the relationship between performance from The Irish Longitudinal Study on Ageing (TULSA).

Methods: Participants between 50 and 60 years who completed Timed-Up-And-Go (TUG) task were included (n = 1807, mean age: 64.17, SD: 2.82, female: 54%). Participants with suspected type-1 diabetes, MMSE score below 17 or serious memory impairment were excluded. Walking speed was considered as time taken to complete TUG (standardised and adjusted for height). Appropriate statistical tests and robust graphical methods were used to compare performance between healthy participants and participants with type-2 diabetes.

Results: The type-2 diabetic group showed significantly increased weight and medication burden in comparison to healthy participants. Significant difference between groups is identified by Mann-Whitney test (p < 0.001). Quantile analysis of walking speed demonstrated a complete negative shift (slowing effect) in T2 diabetic patients. The most significant slowing effect is seen comparing the lowest quantile of each group.

Conclusions: Type-2 diabetes status has a negative effect on walking speed as measured by TUG even in midlife. Further studies are required to characterise the performance of T2 diabetic patients on measures encompassing variability and rhythm, parameters which may be more sensitive to disorders of executive cognitive function.

USE OF A HIP FRACTURE PROTOCOL TO INCREASE PRESCRIBING OF BONE PROTECTION IN HIP FRACTURE PATIENTS

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Background: Hip fracture is associated with high morbidity, mortality and economic burden worldwide. Antiresorptive medications reduce the incidence of hip fractures however ever prescribing of these medications remains poor. The Irish Hip Fracture database 2016 has shown that only 30% of patients are discharged on antiresorptive medication post hip fracture.

Methods: The hip fracture protocol was established in July 2014. We collected data on bone protection medication for patients admitted with a hip fracture to an urban teaching tertiary referral hospital and subsequently discharged between July 2016 and April 2017.

Results: 193 patients were treated with 104 (female: 35 male) admitted with a hip fracture over the nine month period. The average age was 82 yrs. Overall 80.5%(112/139) were on no bone treatment on admission, 11.5% (16/139) were on calcium and vitamin D supplements, 1.4% (2/139) were taking vitamin D only and 1 patient taking calcium only; 21% (3/139) were taking Alendronate and 3.6% (5/139) were taking Denosumab. 19 patients gave a history of prior fracture: 73% (14/19) patients were on no treatment, 26% (5/19) were taking lactate and vitamin D supplements, 10.5% (2/19) were on Denosumab and 5% (1/19) was on Alendronate on discharge. 74 patients were prescribed Denosumab, 39 were prescribed Alendronate and 3 received Zoledronic Acid. 83.5% (116/139) were discharged on bone protection compared to the 19.5% of patients admitted.

Conclusions: The number of patients admitted with a hip fracture without bone protection was alarmingly high. By use of a hip fracture protocol and database we increased the number of patients being discharged on bone protection by 61%.

Reference
1. Irish Hip Fracture database 2016

PROCESSING SPEED IS ASSOCIATED WITH MULTIPLE INDEPENDENT DOMAINS OF GAIT UNDER DIFFERENT CONDITIONS

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Background: Quantitative gait analysis shows promise as an adjunct to routine clinical examination. However, interpretation of results from gait analysis can be complex. Various gait parameters are recorded with some characteristics of gait width, speed, stride length and noise introduced by the specific testing conditions can lead to over-fitting of interpretations and reducing the applicability of findings. Principal Component Analysis (PCA) may provide a method by which to overcome these challenges, by representing more interpretable uncorrelated measures of gait performance.

Methods: Data from the Irish Longitudinal Study on Ageing was employed to address this question. Participants completed a single task walk, two dual-task walks and a comprehensive neuropsychological assessment including processing speed, executive function, memory, global cognition and sustained attention. PCA was applied to 13 gait variables using methods outlined previously. Multivariate linear regression was employed to estimate the independent correlations between the neuropsychological test scores and each gait domain.

Results: A total of 3,359 participants were sampled (Age [mean ± SD]: 62.12 ± 8.2, Female: 54%). PCA found four gait domains: Pace, Rhythm, Variability and Asymmetry (accounting a minimum of 80% variance within the original variables). The domain of ‘Rhythm’ was associated with Processing Speed (p < 0.001) in a fully adjusted model. Asymmetry was also associated with Processing Speed and Sustained Attention (both p < 0.01). These findings were not consistent across dual-tasks; with executive function and the short-term memory demonstrating added associations under cognitive dual-task conditions.

Conclusions: Different independent gait domains, generated to reduce collinearity, are associated with different cognitive functions under different gait conditions. This analysis demonstrates that independent gait domains are similar to individual gait variables in their relationship with cognitive functions, as shown in this dataset previously. Independent gait domains possess advantages over individual variables, with added utility in diagnostic algorithms which use machine learning techniques.
57 patients had parathyroid ultrasound or isotope scans, 22 positive for adenoma; 35 negative. Scans significantly more likely to be positive in patients with high calcium compared with normal calcium (likelihood ratio 5.671; p = 0.0173, ChiSquare test). 13 positive scans were in patients with low vitamin D.

Conclusions: Patients with hyperparathyroidism were relatively older, osteoporotic and had high prevalence of fractures; low serum calcium and vitamin D was a poor negative predictor of adenoma. Although nonmucocaeal adenomas were less likely to have a radiologically-adenoma, they appeared to carry a similar risk of osteoporosis and fracture as those with high calcium/adenoma.

Background: Hip fractures are the most serious injury due to fall, resulting in lengthy hospital admissions and high cost to health service [1]. They result in loss of independence, with 50% of patients unable to walk independently again, difficulties in carrying out activities of daily living and around 28% die within a year [2].

Methods: We followed up 60 patients one year post hip surgery in virtual clinic, admisions from January to April 2016. They were assessed by Zuckerman Function Recovery Score (ZRS) and by New Mobility Score. The results were compared from admission to one year following hip surgery. Patients were also asked if they were on bone protection and if they had any falls.

Results: Total of 60 patients were assessed in a virtual clinic, 7 of which died. Of the remaining 53, 43 were female and 10 male. The mean age was 82. The mean ZRS on admission was 71 and after one year dropped to 58 indicating a decrease in the level of function. The mean New Mobility score was 5.4 and dropped to 4.8 at one year. Falls were protected in 6/53. Out of 53 patients, 31 remained on bone protection. Phone calls including dictations took an average of 15 minutes.

Conclusion: Following hip fracture patients have a decline in their function and in their mobility as our results show. 58% of reviewed were compliant with their bone protection.

References

BONE HEALTH REVIEW IN PATIENTS ATTENDING COMMUNITY REABLEMENT UNIT (CRU), HAROLD’S CROSS

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Background: Patients that attend community reablement unit to help improve gait and mobility should be screen for osteoporosis. Screening of bone health is a good opportunity to prevent and treat osteoporosis in the community.

Methods: Data was collected over 3 month’s period prospectively from Nov 2016 to January 2017.

Results: 76 patients were included in the study; 68% were females (n = 52) and 32% were male (n = 24). The average age was 80 years old with range from 62–92. Average BMI was 31 range from 18–62 and 30 patients had their Vitamin D checked. Average of Vitamin D level was 65.7 (n = 30) overall. Patients who were on calcium/vitamin D supplements have higher Vitamin D levels at 70.3 (n = 21) compared to patients not on any supplements where Vitamin D levels of 55 (n = 9) respectively. Out of 76 patients, 31 patients (40%) were not on any bone medication on coming in with 51.6% were females (n = 16) and 48.4% were males (n = 15). Average FRAX score for major osteoporotic fracture was 15.3 (3.2–80) and FRAX score hip – 5.5 (0.3–19). PTH level of 65.1 (40–86) n = 6. Only 37% patients were previously diagnosed with osteoporosis and 59% (n = 45) of the patients had no previous DXA scan.

Conclusion: 63% of the patients attending community reablement unit had never been diagnosed with osteoporosis previously. Some of the patients never attended an acute hospital for regular medical check-up, a quick bone health review while having rehabilitation is an opportunity to screen for osteoporosis. Patients who have high FRAX score indicative of high risk of fracture should have DXA scan and bone health clinic review.

CHARACTERISTICS AND REHABILITATION OUTCOMES OF OLDER PARKINSONIAN PATIENTS ATTENDING A DAY HOSPITAL

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Background: Day hospitals provide older people with ambulatory access to multidisciplinary assessment, though there is limited evidence on their effectiveness [1]. The Irish National Clinical Programme for Older People recommends developing Day Hospitals as hubs, coordinating care needs of patients with complex conditions and co-morbidities such as Parkinson’s disease (PD) [2]. This study aims to examine characteristics and rehabilitation outcomes of older patients attending a day hospital, including those with PD.

Methods: Data was collected for patients attending a Day Hospital incorporating a PD review clinic in a tertiary referral university teaching hospital from January-March 2012 and January-March 2016. Information on demographics, duration of rehabilitation and post functional scores were collected. Electronic data was reviewed for PD patients to examine subtype, medications and rehabilitation outcomes.

Results: In 2012, a total of 150 patients attended day hospital for an average of 6.9 weeks. Mean age was 79.5. 24.7% (37/150) attended PD review clinic for an average of 5.4 weeks. In 2016, 123 patients attended; for 7.3 weeks on average. Mean age was 79.3. 30.9% (38/123) attended for PD review; for an average of 6.5 weeks. Though not electronically recorded for all, mean UPDRS motor scores increased from 3.14 in 2012 to 35.5 in 2016 and timed up and go from 12 to 17.5 seconds.

Conclusion: Day hospitals are a valuable resource for older patients and review of rehabilitation outcomes is ongoing. Though fewer attended in 2016 than 2012, the increasing proportion of Parkinson’s patients and higher average scores recorded those attending may be increasingly complex.

References

RETROSPECTIVE AUDIT OF DELAYS IN CAROTID DOPPLER SERVICES FOR TIA AND MINOR STROKE IN MID-WESTERN TERTIARY HOSPITALS

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Background: Patients with stroke or transient ischaemic attack (TIA) deemed candidates for carotid intervention should have carotid dopplers (CD) performed within 24 hours (1). Decision regarding carotid endarterectomy is based on the North American Symptomatic Carotid Endarterectomy Trial (NASCET) whereby stenosis of 60–99% of the carotid artery should be referred for surgery within 7 days of symptom onset (2). Our aim is to analyse time from patient presentation to a tertiary hospital with minor stroke or TIA to having CD performed compared with standard of one day, recommended by the Royal College of Physicians Stroke Guidelines 2016. We intend to establish that a centralised referral process for patients in the Mid-Western region with symptoms of TIA be referred to the same facility, seen by a specialist stroke physician and have CD requested.

Methods: We retrospectively identified all patients (n = 41) who presented to three tertiary hospitals in the Mid-Western region with symptoms of TIA or minor stroke from 2014 to 2017 who had CD data. Data collected included time patient presented to hospital, had CD ordered, time CD request was received in the vascular laboratory, when they were performed and the reports.

Results: Mean interval from presentation to hospital and CD being performed was 91.6 days (p = 0.0001, 95% CI 43.56–141.6) compared with the standard of one day.

Conclusion: There was a significant delay between CD being requested in the tertiary hospital and being performed in University Hospital Limerick. Results included a delay of 6 weeks; CD being requested and using a courier for delivery of reports. A specialised clinic which GP’s can refer patients with suspected stroke or TIA allows access to urgent CD and review by specialist stroke physician within 24 hours. This will reduce patient’s stroke risk.

THE READABILITY OF INTERNET INFORMATION ON LEWY BODY DEMENTIA

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Background: Lewy Body Dementia is an increasingly prevalent condition, and is currently estimated to comprise a quarter of all dementias. Patients and carers commonly look to the world wide web as a source of health information, thus it is important that information provided is interpretable.

Aim: The aim of this study is to assess the readability of information on the internet regarding Lewy Body Dementia.

Methods: We searched Google, Yahoo and Bing for the term “Lewy Body Dementia”. The first 50 consecutive websites from each search engine were potentially eligible to be included in the study. The readability of information was examined using the Flesch Reading Ease Score (FRES).

Results: Of the 150 potentially eligible websites, 91 were included in the study. The mean FRES score was 42.6 (standard deviation: 12.1).

Conclusion: Internet information on Lewy Body Dementia is difficult to understand. The mean FRES score was 42.6; a score which is consistent with being readable only to
Background: Parkinson’s disease (PD) is a common neurodegenerative condition. Its prevalence is 3% in those aged ≥65. PD patients are complex and at risk of adverse outcomes in the acute hospital. This study aimed to review inpatient activity in relation to PD patients from 2010–2016.

Methods: This study was carried out in a tertiary referral university teaching hospital. Using the Irish Hospital Inpatient Enquiry Portal (HIPE), activity from 2010–2016 was reviewed and parkinsonian and non-parkinsonian groups’ demographics and outcomes compared.

Results: There were 120,454 admissions over the study period; 1.4% (1678/120454) had a diagnosis of PD or parkinsonism; a primary diagnosis in 155 and a secondary diagnosis in 1523. 80.9% (3344/41678) were aged ≥65. Patients with PD and parkinsonism accounted for 3.5% (35345/1016115) of bed days. Average length of stay (ALOS) was 30.08 days for those with a primary PD diagnosis and 22.67 days for PD patients with another primary diagnosis. This compares to 8.45 days for non-parkinsonian patients. PD patients aged ≥65 accounted for 5.6% (52356/910435) of bed days and had a longer ALOS than younger PD counterparts: 36.0 days for those with a primary PD diagnosis and 23.4 days for those in whom PD was a secondary diagnosis. Total 212 PD patients had a primary diagnosis of PD in 2010, increasing to 29 in 2016. The number of patient episodes for those with a secondary diagnosis of PD increased from 171 to 243 between 2010 and 2016.

Conclusion: PD patients, in particular those aged ≥65, are often at risk of adverse outcomes in the acute hospital. Improvement in patient management is needed to improve outcomes and to reduce admission rates and ALOS.

**THE USE OF DATA AND SIX SIGMA PRINCIPLES TO GUIDE A COMPLEX FALLS/BLACKOUT CLINIC**

Sinead Stoneman, Muhammad Saad Zaheer, Maire Rafferty, Amalia Ioana Costea, George Pope, Riona Mulcahy, John Paul Cooke

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Background: As part of the Waterford Integrated Care for Older People Project [WICOP], the Complex Falls/Blackout Clinic launched as a new pathway on April 4th 2017. We developed a database to refine the pathway in line with Six Sigma principles.

Methods: Using Filemaker Pro Advanced Version 15, we created an electronic clinical proforma, with separate interfaces for the administrative staff, geriatrician, clinical nurse specialist and physiotherapist. We designed unique interfaces to guide standardised assessments by the multidisciplinary team [MDT] whilst also avoiding duplication. Following MDT discussion, the interfaces combine to form a summary record of the patient’s assessment and recommended interventions. This summary record is sent to the general practitioner. The data captured feeds into a live searchable database of patients that is automatically updated with every clinic attendance.

Results: The database revealed most of the referrals came from general practice (22/28) so we sent formal correspondence highlighting the service to hospital departments and community occupational therapists and physiotherapists. Only 14/28 patients were high-risk fallers (unable to get up after a fall) so we changed our referral form to identify more suitable patients. Using the Fried Frailty Score, 6/25 patients were frail.

Conclusion: In line with Six Sigma, the database allows us to define, measure, analyse, improve and control the processes of the clinic in real time, thus ensuring that we are seeing predominantly pre-frail high-risk fallers who are best served by this multidisciplinary clinic. The database captures new community services recommended and therefore what onward demand we are creating for the already stretched community services. We plan that the database will be accessible by community-based healthcare professionals. We envisage similar systems for the other pathways of WICOP (frailty, memory, movement disorders) with the hope of creating a register of patients to aid transition between pathways should patients require it.

**REHABILITATING PERCEPTUAL DEFICITS IN FALL-PRONE OLDER ADULTS: IMPROVED MULTISENSORY PROCESSING FOLLOWING 3 DAY PERCEPTUAL TRAINING**

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Background: Falling older adults represents a major public health concern, with falls posing health, economic and societal issues and resulting in crippling healthcare costs for the national health service. Success in preventing and rehabilitating falls is tempered by the incomplete understanding of the aetiology. Multisensory processing efficiency was taken immediately pre- and post-training. General cognitive status, self-reported health and regular physical activity levels were controlled for across groups. All participants were cognitively healthy.

Methods: Community-dwelling older adults (aged 65+) were recruited to participate in an experimental training programme. Both fall-prone (n = 7) and healthy older adults (n = 20) were recruited, with fallers classified as those who experienced a fall in the previous year. Participants were required to complete 40 minute perceptual training sessions over 3 consecutive days. Measures of multisensory processing efficiency were taken immediately pre- and post-training: General cognitive status, self-reported health and regular physical activity levels were controlled for across groups. All participants were cognitively healthy.

Results: Parkinson’s disease (PD) is a common neurodegenerative condition. Its prevalence is 3% in those aged ≥65. PD patients are complex and at risk of adverse outcomes in the acute hospital. This study aimed to review inpatient activity in relation to PD patients from 2010–2016.

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Conclusion: In line with Six Sigma, the database allows us to define, measure, analyse, improve and control the processes of the clinic in real time, thus ensuring that we are seeing predominantly pre-frail high-risk fallers who are best served by this multidisciplinary clinic. The database captures new community services recommended and therefore what onward demand we are creating for the already stretched community services. We plan that the database will be accessible by community-based healthcare professionals. We envisage similar systems for the other pathways of WICOP (frailty, memory, movement disorders) with the hope of creating a register of patients to aid transition between pathways should patients require it.
Results: 3 days of computer-based perceptual training improved the fallers’ multisensory processing efficiency as indexed by improved performance on a multisensory illusion. Specifically, benefits in integrating and discriminating temporally asynchronous visual and auditory stimuli was improved post-training, reflecting more accurate perceptions of their surrounding environment.

Conclusions: This study provides promising evidence that multisensory processing deficits in older fallers can be modified through perceptual training. With only 3 days of training required to register such benefits, perceptual training offers a viable and cost-effective rehabilitation option for older adults at risk of falling. Further research is needed to show the impact on balance and falls.

THE PLACEMENT OF YOUNGER PEOPLE WITH DISABILITIES IN NURSING HOMES: AN ANALYSIS OF ASSESSMENT FORMS ACCOMPANYING NHSS APPLICATIONS

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Background: The UN convention on the Rights of Persons with Disabilities (2006) and key Irish policy emphasises the rights of people with disabilities to live independently in the community. There are more than 1,000 younger people (<65 years) with disabilities residing in nursing homes in Ireland, despite concerns about the appropriateness of this placement for them. Little is known about younger people with disabilities in nursing homes or the appropriateness of this placement.

Methods: Anonymous Common Summary Assessment Record (CSAR) forms for 47 younger people completed as part of the Nursing Home Support Scheme (NHSS) application process were obtained from one Local Placement Forum. Quantitative data on the forms was analysed by SPSS. Qualitative information was analysed using thematic analysis.

Results: Data shows that this sample of younger people applying for the NHSS ranged in age from 21–64 years; mean age: 53, married (24%), living alone (25%). Two-thirds were referred from hospital settings. Those applying with a wide range of health conditions/disabilities. One-third had multi-morbidity. Polypharmacy was high. Dependency levels (Bl) were high/maximum for 61%. Prior utilisation of community supports was low. Multidisciplinary Team (MDT) recommendation was recorded for 40% of applicants, all of whom were recommended for nursing home placement. Surprisingly, those with lower dependency were more likely to have a MDT recommendation recorded. Individuals with poor communication ability were less likely to have their care setting preferences discussed with them.

Conclusions: This small-scale study provides information on a sample of people under 65 years applying for support under the Nursing Home Support Scheme. The findings will be valuable to policymakers in reviewing the placement of younger people with disabilities in nursing homes, and identifying actions needed to ensure that people with disabilities can access the appropriate community-based supports needed to enable them to live in the community.

PATIENTS IN A STEP DOWN GERIATRIC REHABILITATION HOSPITAL – WHAT ARE THE REASONS FOR TRANSFER BACK TO AN ACUTE HOSPITAL?

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Background: To alleviate the bed crisis in our acute hospitals, suitable patients are being transferred to Step Down facilities for further rehabilitation. These patients are then managed by a Consultant led MDT until discharge home. Clontarf Orthopaedic Hospital hosts 80 beds dedicated to rehabilitation of patients post acute injury or illness. The patients are transferred from 2 acute Dublin Hospitals – The Mater Misericordiae, (48 beds) and Beaumont Hospital (32 beds). The gender breakdown is 2:1 Female to Male. During their stay some patients require readmission to an acute hospital. The purpose of this study is to assess the causes.

Methods: This study was a retrospective review of all patients transferred out from the Clontarf Active Rehabilitation Unit over a 4 month period. The reason for patient transfer and whether they were admitted to the acute hospital or reviewed in Accident and Emergency and returned to the rehab facility was studied.

Results: In a 4 month period there were 38 transfers in total, 8 male and 30 female patients. Of these, 32 were admitted and 6 were investigated and treated in Accident and Emergency and discharged back to rehab within 24 hours. The most common reason for transfer was for sepsis (18 Patients). There were 4 FAST calls; 4 patients were transferred for cardiac causes; 3 for anemia. Falls, fracture and head injury accounted for a further 4 cases. A further 4 patients were transferred for other causes (DKA, Asthma, GI obstruction and PR bleed).

Conclusion: The majority of patients requiring acute hospital transfer required transmission. The vast majority of transfers were for sepsis, with FAST calls for potential CVA and cardiac causes also featuring as significant cause.

SHOULD WE ASSESS AND TREAT ANTERIOR CHOROIDAL ARTERY STROKES DIFFERENTLY?

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Background: Descriptions of the neuroanatomical distribution, clinical manifestations and aetiology of infarction of the anterior choroidal artery (AChA) vary in the literature. Foss’s original syndrome identified features of contralateral hemiplegia, hemihypoaesthesia and homonymous hemianopia.

Methods: Ten consecutive patients with probable isolated AChA distribution stroke confirmed on MRI were examined. We compared clinical features found against Foss’s characteristic syndrome.

Results: Six subjects were female and six had left hemispheric infarction. Subjects were younger than an unselected stroke register derived group (300 subjects) with cerebral infarct (mean 58.7 vs.70.2 years p = 0.03, t-test). Eight initially presented with hemiplegia, 7 with sensory loss but none with visual field deficit. Nine were identified with dysphasia of motor and/or speech function during assessment. At discharge median modified Rankin score was 1.5 (range 0–3). Upper limb weakness was the most predominant persistent neurological finding (n = 7). This was characteristically more severe distally (mean MRC score 2.8 vs.3.5 p = 0.2 paired t-test). Aetiologically, 6 were cardioembolic and 4 were cryptogenic. On MRI review, only one AChA infarct involved the ipsilateral uncus and hippocampal region; the rest involved the region of the posterior internal capsule extending in an inverted cone shape into the white matter adjacent to the cella media, an area also commonly affected by M1 distribution Middle Cerebral Artery distribution infarction.

Conclusion: In this series, hemiplegia and hemihypoaesthesia were found in the majority of subjects; hemianopia appears infrequent. Dysphasia of speech and/or motor function seems to be a prominent feature and this is yet to be widely evaluated. If infarction volume is related to the degree of collateralisation within the M1 territory, then the AChA territory may be more susceptible to blood pressure variations. This may present important implications for the way these strokes are managed acutely. Rapid identification by emergent MRI may be warranted for suspected AChA strokes.

AUDIT OF THE ORTHOGERIATRIC SERVICE IN GERIATRIC PATIENTS ADMITTED WITH ACUTE HIP FRACTURE

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Background: The evidence shows that a dedicated Orthogeriatric (OG) service reduces the length of stay; medical complications, in-hospital mortality and improves long-term survival(1). The OG service was set up in a Level 3 HSE hospital as a three times a week pilot service with the aim of providing care towards geriatric patients admitted with acute hip fractures based on the six key standards of care set out in the Blue Book2). For this audit we were focused on three key standards: 1) Falls, 2) Bone protection and 3) Pre-operative Geriatric review.

Methods: We compared the data collected from the Hospital In-Patient Enquiry (HPE) portal from October 2013 till March 2014 versus October 2016 till March 2017 when the service became operational. Patients were reviewed just once in their admission.

The aim of the audit is to compare the Blue Book’s standards of care for each 6 months period that has been taken into study.

Results: There were 53 patients admitted in the Oct 2013–March 2014 period vs. 79 admitted in the Oct 2016–March 2017 period. Female admissions were 74% and 70%, respectively. There were no patients assessed by a Geriatrician for falls for the Oct 2013–March 2014 period vs. 20% for the Oct 2016–March 2017 period. 28% vs. 43% were assessed for bone protection, respectively. When it comes to being assessed pre-operatively by a Geriatrician, this was 9.4% and 35%, respectively. Discharges to other nursing home or convalescence increased by 9.3% for the Oct 2013–March 2014 period while for the Oct 2016–March 2017 period this figure increased only by 1.3%.

Conclusion: The audit showed that with even a scarce short-hour OG service, improvements were seen across all the standards of care. We plan to use the above results to develop and implement a business plan for the OG service in this hospital.

COMPUTERISED MEDICATION ANALYSIS DESIGNED TO MINIMISE INAPPROPRIATE PRESCRIBING IN OLDER HOSPITALISED PATIENTS: A SYSTEMATIC REVIEW

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Background: Prescribing medications for complex multi-morbid older patients is a challenge. Computerised interventions have been suggested as an effective strategy to improve the appropriateness of prescribing in this patient group. This systematic review examined the evidence of efficacy of computerised interventions designed to reduce potentially inappropriate prescribing (PIP) in hospitalised older adults.

Methods: A comprehensive electronic literature search of 8 databases from inception to end of March 2017. Studies were included if they were controlled trials (randomised or non-randomised) of computerised interventions which aimed to reduce PIP in hospitalised older adults (>65 years). Risk of bias was assessed using the Effective Practice and Organisation of Care (EPOC) criteria.

Results: A total of 594 records were identified after duplicates were removed. Eight studies met the inclusion criteria - two randomised controlled trials, two interrupted time series studies, and four pre/post intervention studies. Studies were mostly at a low risk of bias. The accepted rates of computer-generated recommendations ranged from 29% to 95% in the studies that assessed this outcome. The majority of studies showed either a significant reduction in the proportion of patients prescribed a potentially inappropriate medicine (PIM), or a reduction in PIMs ordered compared to control patients (p<0.05). Three of the included studies assessed clinical outcomes, but there is insufficient evidence to suggest that such computerised interventions can have a significant effect on these outcomes.

Conclusions: This systematic review concludes that computerised medication review interventions are associated with a significant reduction in PIP in hospitalised older adults. However, the majority of included studies only focused on a limited number of PIMs. Further studies are required that utilise robust validated software engines capable of targeting a wider range of PIP instances, and that can result in clinically significant improvements in patient outcomes.

259 POST-OPERATIVE GUIDELINES FOLLOWING A HIP REPLACEMENT: THE IMPACT OF A PATIENT INFORMATION BOOKLET ON PATIENT EXPERIENCE AND RECOVERY

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Background: Best practice dictates that patients should be offered verbal and written information about their treatment and care following a hip fracture (NICE, 2011). Considering these recommendations, a new patient information booklet entitled “Post-Operative Guidelines for Patients Following A Hip Replacement” was developed between the Occupational Therapy and Physiotherapy Departments in an acute hospital in 2016.

Methods: The patient information booklet was introduced in February 2017 and issued to patients following a total hip replacement or hip arthroplasty. A study was conducted to ascertain the booklet’s impact on patient experience and recovery. The qualitative aspect of the study involved patient satisfaction questionnaires and the quantitative aspect involved retrospective analysis, comparing length of stay and discharge destination from February to April in 2016 and 2017.

Results: The patient satisfaction questionnaires have had a response rate of 40% to date with 100% of patients finding the booklet content assisted recovery and provided them with a better understanding of their surgery and rehabilitation. Of patients surveyed, 67% stated that it would be beneficial to receive the booklet prior to surgery. Quantitative data indicates that while average length of stay was not significantly different between 2016 and 2017 (11.6 days in 2016 and 10.6 days in 2017), 52% of patients returned home directly from hospital in 2017 compared to 43% in 2016.

Conclusions: This patient information booklet is now established and in use within this hospital. The study indicates that it would be beneficial to implement this booklet prospectively for elective surgery and then reassess discharge destination and length of stay. Further analysis of the impact of the booklet use post-operatively and other impacting factors on the quantitative data is recommended.

Reference

260 PROFILE OF A NORTH DUBLIN COMMUNITY OUTREACH SERVICE

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Background: Irish healthcare in recent years has begun to focus on integration of specialist services throughout the Integrated Care Programmes. A Specialist Geriatric Nursing Home Outreach Service has been in place in our centre for frail older persons in long term care facilities with the aim of improved care and appropriate use of acute hospital services. We audited our activity to look at the profile of our service users and the interventions required, to evaluate performance and to identify gaps in service or direction for future care.

Methods: Data was collected on consecutive patients referred to the Specialist Geriatric Nursing Home Outreach Service between July 2015 and November 2016. The service consists of a Consultant Geriatrician, Gerontology CNS, and an Occupational Therapist.

Results: A total of 27 LTC residents were included in the study. All residents are female with median age of 84.5 years. 60% had no polypharmacy, 29.6% had polypharmacy and 10.4% had excessive polypharmacy. Following medication review, 33.3% of residents were identified to have potential adverse drug effect from polypharmacy. 66% was due to combination of multiple NSAIDs and 33% was due to antidepressants/anticoagulants therapy combination without clear indication. Second audit cycle following drug review produced similar results regarding the degree of polypharmacy, however no residents were identified to have potential adverse drug effect.

Conclusion: There is a high prevalence of polypharmacy among LTC residents. Due to the small sample size and short observation period, there was no difference in polypharmacy rate pre and post medication review with IRAP. However, the LTC residents are currently on safer drug combinations with clear indications recorded in medical charts and RAP.

Reference
Background: Metabolic record keeping is vital in ensuring optimal nursing home (NH) residents care. A HQIA report in 2015 described sub-optimal record keeping in majority of the NHs in the country. The Integrated Residential Assessment Programme (IRAP) was introduced in a selected ward in a level one NH as an effort to remedy the issue. This study aims to assess the efficacy of IRAP in improving record keeping and subsequently, patient care.

Method: A questionnaire survey with 15 items affecting record keeping and nursing care was distributed to two Nursing Staff (NS) groups. Group A was trained to use IRAP, and group B used paper based record. Results were analysed using SPSS and Excel 2016.

Results: 17 NS were recruited for this study. Age range was between 28–48 with median age of 40.5 years old. 100% of group A agreed that IRAP is less time consuming and allows extensive record keeping. Group A spent an average of 2.9 minutes per resident on record keeping compared to 11.8 minutes for group B. In a typical ward of 20 residents, NS would save 178 minutes on writing notes. 100% of group A would recommend use of IRAP, and 40% of group B were interested to try it. The remainder 60% of group B were apprehensive to use IRAP due to lack of confidence in their computer skills.

Conclusion: 100% agreed that electronic record keeping is beneficial for patient care.

Conclusion: IRAP significantly reduces time spent on writing notes, allowing extra time for patient care. This is vital especially in a level one NH facility where resident’s care needs are high and skilled nursing resources are limited. However ample computer training needs to be in place to assist change in work practice.

Reference

264 INFORMING THE DEVELOPMENT OF A NATIONAL DEMENTIA POST-DIAGNOSTIC SUPPORT PATHWAY

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Background: People can react to a diagnosis of dementia by withdrawing from social situations, experience reduced confidence and it can affect their sense of self. While pockets of good practice exist in the delivery of Post-Diagnostic Support (PDS) across Ireland, these are not part of an established standardised care pathway and are not provided equitably across the country. The Dementia Post-diagnostic Care Pathway Project, being undertaken as part of the implementation of the National Dementia Strategy, provides an evidence-base to inform the development of a PDS pathway which can be implemented nationally.

Methods: The project includes a scoping review to identify existing good practice and service gaps; a needs analysis involving both people with dementia and family carers and a review of international good and best practice in relation to post-diagnostic care and support. In addition, and to enable partnership and collaborative working, a multi-disciplinary and cross-sectoral steering group has been established which will inform the development of the project outputs.

Results: The presentation will further outline the project proposal and present preliminary findings from the needs analysis, including evidence on the psychological and emotional impact of a diagnosis for the person with dementia and family carers and provide case studies of innovative PDS programmes currently operating across Ireland.

Conclusions: It is anticipated that the project will improve the quality of life of people with dementia and family carers following a diagnosis of dementia by developing a model and approach to post-diagnostic care and support. Underpinned by a strong evidence-base and working in partnership with key stakeholders the project will enable the development of appropriate supports, planned around the person’s needs and preferences. The findings from this project will be used to influence and shape future Irish policy development in dementia.

265 DEVELOPING A THROMBECTOMY SERVICE - HOW ARE WE DOING?

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Background: Endovascular thrombectomy results in improved morbidity and mortality from acute ischaemic stroke in patients with anterior circulation strokes caused by large vessel occlusion. This study identifies the number of patients eligible for thrombectomy that presented to University Hospital Waterford in 2016.

Methods: Retrospective analysis of all acute stroke presentations to University Hospital Waterford (UHW), using the Hospital Inpatient Enquiry (HPE), between January and December 2016.

Results: 207 strokes were identified in UHW in 2016, of which 36 (17.4%) were haemorrhagic and 171 (82.6%) were ischaemic in aetiology. Of the 171 ischaemic strokes, 44 (25.7%) presented within 6 hours from onset of symptoms to arrive time in ED. Of these 44 cases, 33/5% had CT brain performed within the 6 hour time window. 1 (2.2%) patient was transferred to Beaumont Hospital for thrombectomy. Chart review was carried out in 25/44 cases identified of whom an additional 4 patients had NIHSS between 6 and 25, and a modified rankin score of less than 3 i.e. potential thrombectomy patients. Review of the non-contrast CT scans of these 4 patients identified one patient with a hyperdense MCA. CT angiogram had not been performed in any of the 4 patients. 2 of the patients were ineligible for thrombectomy due to other exclusion criteria.

Conclusion: Early reperfusion remains the mainstay of treatment in acute ischaemic stroke. Our audit identified low referral rates for thrombectomy which were multifactorial. Superseding the most significant issue was late presentation, with only 25.7% presenting within a six hour time window. However delayed door to CT time, lack of CT angiography, poor recognition of the appropriate patients and knowledge of the thrombectomy guidelines were also identified. The follow up of the audit will include stroke education sessions, as well as streamlining of our internal pathways for investigations and referral.

266 PRESCRIBING POST ISCHAEMIC STROKE AND TIA: A REVIEW OF COMPLIANCE WITH GUIDELINES

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Background: The Royal College of Physicians (RCP) published the National Clinical Guidelines for Stroke in 2016. They advise that patients who experience an ischaemic stroke or Transient Ischaemic Attack (TIA) should receive treatment with high dose statin and those that do not require anti-coagulation should be treated with long term clopidogrel. They also advise that pneumatic compression devices should be used for prophylaxis of venous thrombosis and that Low Molecular Weight Heparin (LMWH) should not be used. We aimed to assess our department’s compliance with these guidelines.

Methods: Our department’s Electronic Patient Record System (ePMS) was used to identify all patients admitted under the Department of Medicine for the Elderly who had a discharge diagnosis of ischaemic stroke or TIA. Data was analysed for patients admitted between January and April 2017. We reviewed the discharge prescription for the use of clopidogrel and high dose statin.

The medication kardex of inpatients in the acute stroke unit were also reviewed to look for the use of pneumatic compression devices or LMWH.

Results: 57 patients with acute ischaemic stroke or TIA were identified. Of these 63% were on high dose statin on discharge. 18% of patients were commenced on anti-coagulation. Of the patients who were appropriate for antiplatelet treatment 44% were discharged with a plan for long term aspirin and 66% were commenced on long term clopidogrel.

Of the inpatients in the acute stroke unit 57% were on prophylactic LMWH. No patient was prescribed a pneumatic compression device.

Conclusions: RCP guidelines are poorly complied with in acute stroke care. Patients are frequently discharged on inappropriately low doses of statin and on incorrect antiplatelet treatment. LMWH is over prescribed in the acute setting and pneumatic compression devices are not in use. Further education of acute stroke guidelines is required to ensure optimum stroke management.
A REVIEW OF MEDICATION IN INPATIENT FALLERS IN THE ACUTE HOSPITAL

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Background: Falls are among the most frequent and most significant incidents affecting inpatient safety, with medication being identified as a significant risk factor. Polypharmacy and potentially inappropriate prescribing (PIP) are areas of growing importance and concern. Medications used to treat cardiovascular conditions are the most common medications contributing to polypharmacy. The objective of this study was to identify the burden of medication in patients with falls in an acute tertiary referral hospital.

Methods: Retrospective review of falls in an Irish acute teaching hospital and tertiary referral centre. Falls in the inpatients was collected over a three-month period using incident report forms. The electronic discharge letter was reviewed. Information on demographics, length of stay, and medications prescribed on discharge was collected. Full risk medications were identified and reviewed.

Results: 273 patient records were reviewed. Mean age of 71.6 years (43 (15.8%) patients did not have a completed discharge summary (either died or not available). 25% of patients had a documented history of cognitive impairment and dementia on their discharge summary. 86.3% of patients had >5 medications prescribed at discharge. 55.8% of patients were on anti-hypertensives, and was associated with an increased risk of readmission (p = 0.2). Anti-depressants (47.8%), anti-psychothics (21.1%) and sedatives (20.4%). 33.3% of patients were on secondary bone protection at discharge. Anti-depressants (47.8%), anti-psychotics (21.1%) and sedatives (20.4%). 33.3% of patients were on secondary bone protection at discharge. Anti-depressants (47.8%), anti-psychotics (21.1%) and sedatives (20.4%).

Conclusions: Given that up to 40% of falls are preventable, it is vital to identify and address further medication errors for falls. Regular medication review for those taking five or more medications. The NICE guidelines re-iterates the importance of medication review, as part of a multifactorial approach to falls prevention. There are challenges changing or stopping medications as the clinical benefit may outweigh the risks falls to the patient.

WHAT HAPPENS TO OUR OLDEST OLD? A REVIEW ONE YEAR FOLLOWING ACUTE HOSPITAL DISCHARGE

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Background: The number of centenarians is increasing by about 5% annually in many developed countries. Given Ireland’s ageing population, a similar trend in numbers of nonagenarians and centenarians is likely to be found here. Little is known about the health care requirements of this population in Ireland but it is likely that they will contribute significantly to healthcare use in the future. We aimed to assess the current admission rate and outcome of the oldest old admitted to an acute Level Four hospital.

Methods: Our department’s Electronic Patient Record System (ePMS) was searched for all patients aged 90 or above admitted under Care of the Elderly during a 6 month period of hospital. Length of stay (LOS), in-hospital mortality, one year readmission and mortality rates were reviewed using ePMS, the hospital’s Integrated Patient Management System (IPMS) and obituary notices.

Results: 94 patients were identified. 81.9% were admitted from home. The median LOS was 3 days (n=1, max = 32, IQR = 10). 20 patients were transferred to a level Two hospital and the median combined LOS was 7 days (min = 1, max = 47, IQR = 10). The in-hospital and one year mortality rates were 10.6% and 38.1%. The median time from discharge to death was 92 days (min = 1, max = 361, IQR = 151).

Conclusions: Our population aged 90 years and over have high in-hospital and one year mortality rates. Median length of stay is similar to that found for the over 85 age group in the Activity in Acute Public Hospitals in Ireland Annual Report 2015 and is higher than that of younger populations. Future health care planning needs to take these age related changes into consideration.

SEDATIVES USAGE IN INPATIENT FALLERS IN AN ACUTE HOSPITAL

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Background: Falls are among the most frequent and most significant incidents affecting inpatient safety. These are multifactorial events and falls risk can be modified by addressing many of these factors. One of the most important of these is polypharmacy, and in particular sedatives. Medication review is a widely advocated risk reduction strategy.

Methods: Retrospective review of falls in an Irish acute teaching hospital and tertiary referral centre. Falls on the inpatients was collected over a three-month period using incident report forms. The electronic discharge letter was reviewed. Information on demographics, length of stay, and medications prescribed on discharge was collected. Full risk medications were identified and reviewed.

Results: 273 patient electronic records were reviewed, with a mean age of 71.6 years. 43 (15.8%) patients did not have a completed discharge summary (either died or not available). Overall median medication was 10. 20.4% were on benzodiazepines/-s/draugs on discharge. Amlodipressants – 47.8%, Anti-psychothics – 23.3%; Opioids – 34.4%. Usage of sedatives was more common in those over 65 (p<0.05) and those with a documented history of cognitive impairment (p<0.05), however, there was no difference in readmissions at 12 months.

Conclusion: Medication reviews focused on falls prevention involves balancing minimising medications associated with falls and effectively treating underlying health conditions. Polypharmacy is a common finding in patients being discharged from our institute. Reviewing and discontinuing fall risk medications in older people and/or substituting them with other drugs not associated with the risk of falls in the older will to a large extent prevent these accidents. This information will guide the development of future risk medicine reviews initiatives in our hospital, increasing their feasibility in the acute hospital setting.

MODIFICATION OF THE STOPP-START CRITERIA FOR IMPROVED LOCAL APPLICABILITY

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Background: The Stop-start (Version 2) criteria is a useful aid to the identification of Inappropriate Potentially Therapeutic-Omisión Prescriptions (PPOs) and of Potential Prescribing Omissions (POPs). Reports that they are cumbersome and time-consuming to apply in daily practice had been predicted in the original publication. We aimed to establish the number of criteria that were not met during the application of the STOPP-START tool with a view to improving its applicability.

Methods: An observational study of the application of the STOPP-START criteria. A sample (n = 75, mean age 80, 64% male) were selected across three facilities and the STOPP-START criteria reviewed. PIPs and PPOs were logged on an Excel worksheet. Time taken to apply the criteria to a specific cohort (n = 20) was estimated by checking time on entering the ward and again when leaving the ward at one facility.

Results: Overall 1.9% (11/580) of STOPP criteria were met (where 6075 is the product of sample size and number of STOPP criterion). No PIPs were identified with reference to 54 of 81 (67%) STOPP Criteria. 2.2% (56/2550) of START criteria were met. No PPOs were identified with reference to 13 of 34 (38%) START criteria. 3 STOPP and 3 START criteria accounted for 49% and 46% of identified PIPs and PPOs respectively. The median time taken to complete medicines review was 21 minutes.

Conclusions: We found a low incidence of PIPs and of PPOs. A low number of criteria accounted for almost 50% of potential prescribing issues while a sizeable number of criteria were not utilised. Modification should encompass a rationalisation of the currently published criteria with consideration of the data described above.


‘IT’S TRICKY’. GENERAL PRACTITIONERS’ (GPs’) EXPERIENCE OF TALKING TO PATIENTS WITH MILD COGNITIVE IMPAIRMENT ABOUT FITNESS TO DRIVE IN IRELAND

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Background: Driving contributes to quality of life and wellbeing. However, for 11.3% of adults over 50 living with cognitive impairment, there are issues regarding continuing to drive. The GP plays a key advisory role but there is limited evidence regarding GPs experience and a lack of guidance outlining how best to communicate with people living with MCI about driving. This paper, part of a larger study, addresses this gap with a focus on Irish GPs.

Methods: One-to-one, semi-structured interviews were conducted with GPs working in Ireland. Interviews included the use of stimulated chart recall and were conducted until data saturation was reached. Data was thematically coded by two researchers using NVIVO.

Results: A maximum variation sample of 12 GPs participated. Almost all considered talking about FTD in the context of MCI to be ‘tricky’. Challenges centred on a desire to preserve the doctor-patient relationship and the person’s mobility and independence whilst protecting the safety of road users. GPs outlined the negative consequences for all when a person is no longer considered fit to drive, noting that family involvement can be both positive and negative. GPs described incidents of collusion and subterfuge between them and families. Patient mobility between GPs for the purpose of sign off as ‘fit to drive’ is relatively common. Where unsure, GPs advised on referral to an independent assessor. Concern regarding the GP’s role in the process, reporting requirements and medical-legal issues were shared. Practical tips for communication and practice protocols were discussed. GPs would appreciate further training.

Age and Ageing
**VITAMIN D DEFICIENCY AND RESOURCE UTILISATION – A PROSPECTIVE ASSOCIATION**


**Background:** Hospital admissions and Emergency Department (ED) attendances are significant issues facing health services, accounting for a large proportion of healthcare costs and expenditure. They can also have significant implications for an individual with associated increased morbidity and mortality. The importance of identifying older people at risk and potentially modifiable risk factors is well recognised. The aim of this study is to prospectively evaluate the relationship between serum 25-hydroxyvitamin D (25(OH)D) and resource utilisation in older adults.

**Methods:** Older adults participating in the TUDA study were included in this analysis. Details relating to hospitalisation and ED attendance were accessed through local computerised patient record systems. Information was gathered from date of TUDA participation until June 2013 and included; length of stay (LOS) and reason for admission.

**Results:** Of the 3,093 participants, 1,577 participants attended the ED and 1,269 participants were admitted over the 3.6-year follow-up period. ED attenders were older (79.2 vs 73.7 years); less educated (11.3 vs 12.6 years); more frail; Timed Up and Go (TUG) at 17.8 vs 15.4 seconds and had lower serum 25(OH)D levels than those not admitted. Adjusted Cox proportional hazard ratios relating to 25(OH)D levels were: 0.80 (p = 0.0063) for <25nmol/L versus >25nmol/L. Those admitted were older (800 versus 74.5 years) and had lower mean Vitamin D levels at 58.4nmol/L versus 69.3nmol/L than those not admitted. Adjusted Cox proportional hazard models, with Vitamin D as a categorical variable, showed those with Vitamin D levels <25nmol/L, compared with >25nmol/L, were more likely to be admitted, HR 0.80 p = 0.0063. Similar results were found for ED attendances, those participants deficient in Vitamin D (<25nmol/L) were more likely to attend the ED, HR 0.78 p = 0.001.

**Conclusions:** Our study suggests an association between Vitamin D deficiency and poorer outcomes, including ED attendance and admission. As Vitamin D deficiency is a potentially modifiable factor, further studies including randomised controlled trials (RCTs) would be beneficial to further evaluate.

**STAFF ATTITUDES AND PERCEIVED BARRIERS TO ADVANCE CARE PLANNING IN LONG TERM CARE SETTINGS.**

A. Coffey, C. McGlade, N. Corrally, R. O’Sullivan, W. Molyneux

**Background:** Advance care planning (ACP) is defined as a continuous communication and decision-making process between patients, families and healthcare professionals addressing issues relating to end-of-life care prior to the patient requiring such care. According to Bernacki et al. (2014) early discussions about goals of care have been associated with better quality of life, reduced use of non-beneficial medical care near death, positive family outcomes and reduced costs. ACP offers opportunity to optimise care, promote autonomy and empower patients. Nevertheless, evidence suggests that the knowledge of health professionals on advance directives is low (Houban et al. 2014) and that there is considerable diversity of attitude in relation to ACP.

**Aim:** To measure Staff Attitudes and Barriers to Advance Care Planning (ACP) in long term care settings and after an educational intervention on ACP and ACD.

**Methods:** A quantitative design using the Attitudes and Barriers to ACP and ACD survey (Molyneux et al, 2014). Data was collected at baseline and post implementation from staff (n = 315) employed in three long term care sites. This study was part of a larger RCT to systematically implement the Let Me Decide ACP to Long Term Care.

**Results:** Results at baseline demonstrated that the majority (80%) of staff had inadequate training and support to complete ACP and few were confident in discussing end of life issues with residents. The provision of online education on ACP and face to face workshops on completion of the ‘Let me Decide’ ACD demonstrated significant differences in staff confidence in completing advanced care plans and in staff beliefs that ACD contributes to better care.

**Conclusion:** Education and training in ACP demonstrates benefits for staff in relation to increased confidence in completing Advanced Care Directives with residents in practice.

**CHARACTERISTICS AND ONE YEAR OUTCOMES OF OLDER PATIENTS HOSPITALISED UNDER SPECIALIST GERIATRIC CARE**

D. O’mullane, D. Curtin, D. O’Maloney

**Background:** The population over 65 in Ireland is expected to double in the next 20 years with significant implications for health service planning and delivery. Comprehensive data about health-care utilisation and experiences of older people will be needed to guide resource allocation and service provision. The aim of this study is to describe the characteristics and one-year outcomes of older patients hospitalised under specialist geriatric care.

**Method:** The Hospital In-Patient Enquiry (HIPE) system in our institution was used to generate a list of all patients admitted under the geriatric medicine service in 2014. For patients admitted to hospital more than once in 2014, one hospital admission was chosen at random as the index hospital admission. One year mortality was determined by accessing the hospital’s clinical information system, RIPac, the local Births, Deaths and Marriages Registry Office and, if required, by contacting the patient’s general practitioner.

**Results:** Overall, 831 individual patients were hospitalised under the care of the Geriatric Medicine service in our institution in 2014. The majority of patients were female (57.3%). Nursing home residents accounted for 8% of admissions. Of those admitted from home, 28.3% were frail and needed help with personal care. Diagnoses related to cerebrovascular disease accounted for 39.4% of admissions. Thirteen percent of patients died during their index hospital admission while a further 15.4% died within one year. In those who survived their index hospital admission, mortality was much lower for patients admitted with cerebrovascular disease-related diagnoses compared with those with other medical diagnoses (7.6% vs 24.5%).

**Conclusions:** Approximately one in four older patients hospitalised under geriatric medicine will die within one year of hospital admission. Risk of death after discharge from hospital is significantly greater amongst patients with non-cerebrovascular disease-related diagnoses. Care plans and services reflecting this vulnerability should be prioritised in this patient group.

**TRENDS OF SUBDURAL HAEMORRHAGES: INCIDENCE AND RELATIONSHIP WITH ANTICOAGULATION 2009–2016 INCLUSIVE**

M. Byrne, A. Farrelly, M. Cooney, S. Clarke, M. Barry, J. Cronin, R. Doyle

**Background:** There has been a 75% increase in the number of anticoagulation prescriptions rising from 33,000 in January 2010 to 58,000 in August 2016 (1). Reasons include the ageing population and introduction of direct oral anticoagulants (DOACs). More older people now receive anticoagulation especially for atrial fibrillation. Our aim was to calculate the incidence rate of subdural haemorrhage (SDH) on a background of increasing anticoagulation prescribing.

**Methods:** We used HIPE to identify patients in a catchment area of over 330,000 presenting to their local public hospitals between 2009 – 2016 with first acute SDH. Clinical information including demographics, medical co-morbidities, medications, examination, radiological severity, in-hospital outcome (mortality and disability) and discharge destination, was collected. Rates of SDH were calculated, using the age structure of the catchment area population from the 2011 Census and age-standardised using direct method and the European Standard Population.

**Results:** A total of 389 patients presented with SDH from a catchment area of 330,062 people. The age-standardised rate for SDH overall was 11.86/100,000 and 1.98/100,000 for anticoagulant-associated SDH. 25% gave no history of trauma. There was a possible non-significant trend towards increasing rates (p = 0.1) in SDHs overall; however, those excess SDHs were trauma-related and occurred in younger people. There was no indication of an increasing trend in anticoagulant-associated SDHs over the 8 years. In January 2010 DOACs accounted for 1% of anticoagulation however, in August 2016 DOACs accounted for 58% of all anticoagulation (1).

**Conclusions:** Despite the rapid increase in anticoagulation prescribing (75%) between 2010 and 2016 the expected parallel increase in SDH has not been demonstrated thus far. The shift from warfarin to DOACs provides a potential explanation for this and suggests that DOACs have a good safety profile in line with emerging evidence.

**Reference**

1. MMP and Department of Pharmacoeconomics, Dublin.

**DURATION OF SYMPTOMS PRIOR TO ATTENDING A MULTIDISCIPLINARY MEMORY SERVICE.**


**Background:** Timely access to a multidisciplinary memory service is important due to the increasing number of referrals and the expected increase in referrals in the coming years. However, the duration of symptoms preceding referral to a multidisciplinary memory service has not been previously studied. The aim of the current study was to describe the duration of symptoms prior to referral to a multidisciplinary memory service in patients presenting for a memory assessment.

**Methods:** A retrospective, observational study of all patients referred to a multidisciplinary memory service was performed.

**Results:** Of 156 patients referred, 105 (67.4%) were classified as having probable AD. Of the 105 patients, 62 (59%) had experienced memory problems for greater than 12 months prior to referral. Mean duration of symptoms prior to referral was 1.8 years and was significantly longer for probable AD compared to early onset dementia (p = 0.001).

**Conclusions:** The duration of symptoms prior to referral to a multidisciplinary memory service has a significant impact on the pathway to diagnosis. We recommend that when patients experience memory problems for more than 12 months they are referred earlier to a multidisciplinary memory service to optimise their quality of life and that of their caregivers.

**Reference**

1. Department of Geriatric Medicine, Trinity College Dublin, Dublin, Ireland
Background: Timely diagnosis of dementia is supported by clinical guidelines, strategies and a large body of literature worldwide. We assessed duration of symptoms prior to receiving diagnosis in cohort of patients attending a memory service.

Methods: Prospective study of cohort attending a memory service in a university teaching hospital. Data included time to presentation, age, gender, diagnosis category and marital status.

Results: The study sample consisted of 183 people. MCI = 78, AD = 50, VaD = 20, Mixed AD/VaD = 35. Mean age 75.6 (74.7 – 76.5) years. No gender differences (females 49.8%, males 50.2%). Mean time to presentation was 11.2 (10.6 – 11.9) months from start of symptoms. There was no difference in time to presentation when stratified by diagnosis category: (Standard deviation 4.7) months; AD: 11.2 (SD 4.9); VaD 11.8 (SD 5.7); Mixed AD/VaD 11.4 (SD 4.2). (p = 0.0037). Patients over 80 years had a similar time to presentation with 11.5 (10.7–12.3) months found in under 80% compared to 10.7 (9.3 – 12.0) in over 80s, (p = 0.2855). Marital status had no influence: married 11.4 (SD 4.8); separated 11.4 (SD 3.0); widowed 10.4 (5.2); single 13.5 (4.2) (p = 0.3564). Positive family history had no influence on delayed presentation.

Conclusion: Patients with symptoms of dementia took an average of a year to present regardless of age, gender, marital status and dementia type. Reasons for the delay are likely to be complex and multifactorial. We must further examine the phenomenology of delayed presentation in order to clarify the extent to which it satisfactorily represents a timely access to care for people with dementia. Encouraging timely presentation is currently important for clarity of diagnosis, emotional support and education, drug treatment and planning, research trials and in future may be critical where effective early stage treatments are available.

ACUTE SERVICES UTILIZATION AMONGST OLDER PEOPLE IN THE LAST YEAR OF LIFE

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Background: The proportion of older, frailter people in Ireland is expanding. With this demographic change comes an increasing demand for health services at the end of life. To plan and provide these services, comprehensive information about the patterns of healthcare use will be needed. The aim of this study is to describe the patterns of use of acute hospital based services by older adults in the last year of life.

Methods: The Hospital In-Patient Enquiry (HIPE) system in our institution was used to generate a list of patients admitted under the general internal medicine services in 2014. Patients who died within one year of their hospital admission were included in our analysis. Deaths were determined by accessing the hospital’s clinical information system, RIP, the local Births, Deaths and Marriages Registry Office and, if required, by contacting the patient’s general practitioner.

Results: Overall, 263 patients were included in the analysis. The mean age of patients was 81. The median number of bed days was 24. Forty-five percent of patients had more than 3 hospital admissions in the last year of life (median 2); 41.8% spent more than 30 days in hospital, 32.5% presented to the emergency department on 3 or more occasions. Of those patients whose place of death could be determined, 49.5% died in the acute hospital and 12% died in a hospice bed.

Conclusion: Our study indicates that, for many older patients, the last year of life is a period of profound symptom burden with frequent and prolonged hospital admissions. Further work is needed to determine how best to use resources to improve the end of life experience for these patients.

MISSED OPPORTUNITIES: WHAT THE FRAX?

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Objective: To compare pre morbid FRAX score with or without Bone Mineral Density (BMD) in older patients admitted with acute hip fracture secondary to fragility, with pre admission treatment for osteoporosis.

Methods: Assessing 25 acute fragility hip fractures in older patients (age >65), admitted between July 2016 to December 2016 for demographics, correlation between pre morbid fracture risk (FRAX) and prior diagnosis or treatment for osteoporosis by primary care in the community. Electronic patient record system was used to record and retrieve pre admission medications and prior diagnosis of osteoporosis.

Results: 20 out of 25 patients had 10-year (FRAX) intermediate to high risk of developing hip fracture pre admission (10 intermediate, 10 high). Out of these 20, only 6 (30%) were treated for osteoporosis or osteopenia, either by calcium/vitamin D supplement or bone protection medication, or both. 5 patients were deemed in the ‘low risk’ category as per FRAX score, with recommendations for lifestyle changes only, despite the fact that they were admitted with hip fracture during the time of the study.

Conclusion: 1) There is a major role in the primary care setting for starting bone protection medication by only using FRAX score with or without BMD measurement as demonstrated (40% in ‘high risk’ category), 2) Individualised investigation and treatment for people with low to intermediate risk as guided by FRAX, taking into account clinical risk factors such as smoking and steroid use.

Reference
www.sheffield.ac.uk/FRAX

DEVELOPMENT AND IMPLEMENTATION OF A HIP ATTACK PATHWAY

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Background: Blue book standards recommend patients with hip fracture be admitted to an orthopaedic ward within 4 hours of arrival in the Emergency Department. The national average for the 4 hour time frame in Ireland in 2016 was 14.1%. In an urban tertiary referral hospital only 5.1% of patients were admitted to the orthopaedic ward within 4 hours. We introduced a ‘Hip Attack Pathway’ to improve this standard.

Methods: A Hip Attack Pathway was introduced in December 2016.

Components of the pathway included the establishment of an Acute Orthopaedic Unit, a dedicated hip fracture bed, an MDT board round at 9.30 AM every Monday, CNS to phone directly when hip fracture was suspected, provision of a mobile phone and staff education. Time frames for each of the steps along the pathway were also introduced. Feedback was given to the MDT.

Results: The median time for a patient to be admitted to the ward from the Emergency Department dropped from 11 hours to 5 hours. The improvement occurred over a number of months and improvement was gradual. A number of components listed above were required and the feedback system proved a useful tool in the implementation.

The length of stay for all orthopaedic admission on the Orthopaedic ward fell from an average of 10 days to 8 days.

Conclusions: The development of a “Hip Attack Pathway” has improved the time for patients to be admitted to an Acute Orthopaedic Unit. It has also delivered a reduced length of stay for all orthopaedic patients by improving the outflow.

Reference
1. Irish Hip Fracture Database.

SURVEY OF STAFF KNOWLEDGE ABOUT DEMEN TIA PRIOR TO THE IMPLEMENTATION OF THE BUTTERFLY SCHEME IN AN IRISH UNIVERSITY HOSPITAL

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Background: The Butterfly Scheme is an established dementia awareness and education programme, originating in the United Kingdom that trains hospital staff to respond appropriately to people with dementia and their families. Studies in Ireland suggest that hospital staff have a poor understanding of dementia care. Prior to the introduction of the Butterfly Scheme for the first time in Ireland, we investigated staff awareness and knowledge about dementia to better prepare for implementing the programme.

Methods: We conducted an online survey targeting all healthcare and support staff working in a large university hospital in the West of Ireland (Galway University Hospital) over a one-month period in September 2016.

Results: There were 300 responses, a rate of 60%. The majority of respondents were female, 87%(261/300), and most were aged between 25–34, 29%(87/300). Most (85%+) knew that dementia is a gradually progressive, incurable, and heterogeneous neurological disease. Knowledge and awareness of complications such as delirium (93%), disorientation (88%), falls risk (88%), and the importance of nutrition (85%) and provision of clear, simple instructions to those with dementia (85%) was also high. Despite this, few (19%(51/300) reported feeling ‘very confident’ caring for people with cognitive impairment, most responding that they were either fairly or moderately confident, 62%(187/300). Those working as health and social care professionals (nurses, doctors and health, social care professionals) were more likely to report being moderately very confident,(X² = 14.5; p<0.005). Possessing a postgraduate degree was not associated with confidence,(X² = 2.49; p = 0.12).

Conclusions: Knowledge of key dementia facts was high in this sample of Irish health-care workers, suggesting that overall awareness of dementia may have increased since the 2014 National Dementia Strategy. As expected those with more relevant clinical experience reported greater confidence managing the care of persons with dementia. Repeating the survey, to investigate if the introduction of the Butterfly Scheme has increased the confidence of staff, is planned.

LONG TERM CARE STAFF’S EDUCATIONAL NEEDS AND CONFIDENCE IN PROVIDING END OF LIFE CARE BEFORE AND AFTER AN EDUCATIONAL INITIATIVE

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To update long term care staff in the provision of end of life care. Staff were asked to rate their confidence and knowledge in providing end of life care before and after an educational initiative.

Results: Staff assessed their confidence and knowledge of end of life care to be poor before the educational initiative and rated it as very good after the initiative, increasing their confidence and knowledge to work with people with dementia in a dignified manner.
Background: Rising life expectancy, a growing older population and societal trends, have led to increasing numbers of older people residing and ultimately dying in long term care (LTC). It is essential therefore that LTC staff be knowledgeable, skilled and supported in providing high quality end of life (Eol) care. Research has found those dying in LTC have unmet palliative care needs and suboptimal palliative care education amongst LTC staff.

Methods: In this qualitative descriptive study, LTC staff completed detailed questionnaire before, and after delivery of a palliative care educational programme tailored to the educational needs identified by staff, which included advance care planning (ACP) training.

Results: There were 179 completed questionnaires. Before the programme, up to 58% of staff had no prior palliative care training, this fell to 32% in the period after the educational initiative, while 92% of attendees found useful. There were many common learning needs for nurses and healthcare assistants (HCAs), but nurses looked more for training on pain and symptom management whilst HCAs highlighted symptom assessment, recognising dying and addressing the emotional needs of the patient. Staff who had received palliative care training (and staff overall in the “after” period) were more confident in discussing end of life issues, dealing with bereaved families and nurses were more confident and knowledgeable in using a syringe driver. Interestingly the barriers to ACP changed amongst staff engaged in the process. Delivering education was challenging due to staff turnover and difficulties releasing staff to attend.

Conclusions: The tailored palliative care training was well received and had a beneficial effect.

ARE WE APPROPRIATELY CATHETERISING OUR OLDER INPATIENTS?
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Background: Older patients are perceived to be catheterised inappropriately during hospitalisation, leading to an increased number of urinary tract infections – an issue of concern, in the context of the emergent increase in resistant microorganisms (1).

Methods: We predefined the following indications as valid reasons for catheterisation: acute urinary retention, need for accurate fluid balance, maintain skin integrity, long term catheter that needs to be changed, palliative care. The clinical notes of 114 patients admitted under medical teams on five wards were reviewed, over a four day period, using the retrospective analysis method. We looked for documentation about the indication and insertion of urinary catheters. Where we could not find an explicit indication, we read all the notes prior to catheterisation to ascertain whether catheterisation was indeed necessary. The data acquired from the medical notes was then compared with local and international guidelines (2).

Results: Out of 114 patients in total, 20 older patients had an indwelling urinary catheter inserted during their admission. 15 catheters were inserted in ED and 5 on the wards. Catheterisation met the predefined criteria for appropriateness in 16/12 (ED & 4 on the wards) out of 20 cases, the indication being explicit in 6 cases and implicit, from notes review in 10. 16 out of 20 cases had incomplete documentation about the procedure, whilst this information was absent in 4 cases.

Conclusions: We have determined that, in 4 out of 20 cases, urethral catheters were inserted inappropriately. The indication for insertion was not specified in 14/16 cases. The documentation about the procedure and the post-insertion care was absent in 4 cases and incomplete in 16 cases. We feel that time has come to introduce a clear protocol for urinary catheter insertion.

REFERENCES:

DANGER ZONE OF INJURY TO THE INFERIOR EPIGASTRIC ARTERY (IEA) FROM SUBCUTANEOUS INJECTION OF LOW MOLECULAR WEIGHT HEPARIN (LMWH)
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Background: Ruptus sheath haemorrrha (RSH) is a condition with significant mortality and morbidity in older people. A case series of N = 4 RSH in medical and surgical inpatients prompted further investigation of subcutaneous injection site of LMWH as potential risk for arterial injury with resultant RSH.

Methods: A direct observation of injection sites in a cross-sectional inpatient cohort in medical and surgical wards of a University Teaching hospital was recorded. The injection positions were recorded with regard to defined abdominal anatomical sections. Danger zones and safety zones were outlined according to IEA course. This definition resulted in

The central areas of the epigastrium, umbilical and hypogastric regions being identified as a danger zone for arterial injury. The study received ethical approval from the local research ethics committee.

Results: A total of 160 patients (mean age 75 + 6) inpatients on medical and surgical wards were reviewed. When abdominal sites alone were considered the most common site was within the umbilical region at N = 47(34%). At the abdominal site alone N = 85 (62%) were in the safe zone, with N = 53(38%) in the danger zone as defined. Extra abdominal sites accounted for N = 22(14%).

Conclusions: In a cross specialty observational study abdominal subcutaneous injections of LMWH were being administered in the danger zone for traumatic injury to the IEA in almost 40% of cases. These results highlight an increasing need for education awareness and training with regard to administration of LMWH injections with regard to the risk of RSH in older people, carers and non-medical personnel.

REFERENCE:

DEVELOPMENT OF THE CHINESE VERSION OF THE QUICK MILD COGNITIVE IMPAIRMENT (QMCI-CN) SCREEN
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Background: Separating mild cognitive impairment (MCI) from those with subjective memory complaints and dementia is important but challenging, particularly in busy clinical practice. The Quick Mild Cognitive Impairment (Qmci) screen is useful in differentiating those cognitive states but has not yet been widely translated or culturally adapted. The objective of this study was to translate and begin to validate the Chinese (Mandarin) version, the Qmci-CN screen.

Methods: We translated the Qmci screen into Chinese. Preliminary data from 25 patients comparing the Qmci-CN screen with the standardised Mini-Mental State Examination (MMSE) were analysed for test-retest reliability (TRT) using Pearson’s correlation coefficient and accuracy using the area under the curve (AUC) of receiver operating characteristic curves.

Results: Patients were recruited from a rehabilitation unit in a large university hospital. The majority (21/23) were Han Chinese. Most 57% (13/23) were female. The median age of the sample was 53 (interquartile +/−15) years and the median number of years in education was 9 (+/−8.5). The median Qmci-CN screen score was 54/100 (+/−18) and median MMSE score was 25/30 (+/−3.5). Four patients had MCI with a median Qmci-CN screen score of 43/100 (+/−5) compared to 36/100 (+/−13) for dementia (n = 4) and 60/100 (+/−13) for normal controls (n = 15). TRT was excellent, r = 0.90. Median time to re-test was one day. The Qmci-CN screen was more accurate in separating patients with cognitive impairment (MCI or dementia): from controls, AUC 0.95 (95% confidence interval: 0.86–1.0) compared to the MMSE (AUC 0.79, 95% confidence interval: 0.57–1.0).

Conclusions: This analysis to assess the TRT and preliminary validity of the Qmci-CN screen showed that the translated version was reliable and had face validity. Data collection is ongoing to recruit a larger sample to show concurrent and construct validity of this culturally adapted and translated version of the Qmci-CN screen.

FAT IS PROTECTIVE! ORTHOSTATIC HYPOTENSION AND HIGH BMI
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Background: Orthostatic hypotension has increasingly been associated with a higher risk of future mortality risks. Low BMI has been linked to orthostatic hypotension in the general population but few studies have analysed a potential protective effect of high BMI in OH.

Methods: A retrospective cohort of 5401 patients who attended an acute tertiary Irish hospital for head up tilt syncope testing between 2001–2017 were analysed. Demographic data on all patients was recorded, including height and weight. Active tilting parameters recorded were baseline systolic & diastolic BP and heart rate and then Min30 recordings (minimum haemodynamic measurement within 30 secs of tilt) and difference recorded.

Results: 3146 were female and 2102 male. Median age 75m IQR (62, 82). Median weight 70kg IQR (60, 80). The BMI categories were summarised and 2546 were under-weight (48.6) the most common category. When the Tilt systolic BP values were tested of future mortality risks. Low BMI has been linked to orthostatic hypotension in the general population but few studies have analysed a potential protective effect of high BMI in OH.

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METHODS:
A retrospective cohort of 5401 patients who attended an acute tertiary Irish hospital for head up tilt syncope testing between 2001–2017 were analysed. Demographic data on all patients was recorded, including height and weight. Active tilting parameters recorded were baseline systolic & diastolic BP and heart rate and then Min30 recordings (minimum haemodynamic measurement within 30 secs of tilt) and difference recorded.

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Background: The National Council for the Elderly estimates that 20–25% of older Irish people have a mental disorder of varying severity at some point in their lives. The rise in awareness and acceptance of Mental Health Disorders (MHD) coupled with recent pharmacological advances have led to increases in both diagnosis and prescription of medications among older people. Our study focused on the prevalence of polypharmacy in Long-Term Care (LTC) residents, particularly those with MHD and Neurological Disorders (ND).

Methods: Data was collected from a randomly selected group of LTC residents. Rates of polypharmacy (>4 medicines) and excessive polypharmacy (>10 medicines) along with co-morbidities such as MHD/ND were determined from analysis of the Integrated Residential Assessment and Support Programme (IRASP), inpatient drug Kardex and clinical notes. The results were analysed using Microsoft Excel.

Result: 55 residents were included. 71% were female and 29%, male. Median age was 81. 98% were observed to have polypharmacy, with equal prevalence among male and female residents. All 76.3% residents with documented MHD and/or ND were shown to have polypharmacy. Residents without any diagnosis of MHD/ND had an average of 10 medications compared to an average of 12 in the MHD/ND group.

Conclusion: Polypharmacy in those with MHD/ND was prevalent among LTC residents. Regular review of their medications is essential as polypharmacy places these older patients at a high risk of adverse effects. This can be facilitated by electronic medication recording and remote review by Geriatricians and Old Age Psychiatrists.

References

Background: Recognising the often complex medical, functional and social care needs of frail older patients presenting to the Emergency Department provided the impetus to improve the care model at the front door. In line with best practice, the principles of A) awareness and acceptance of Mental Health Disorders (MHD) coupled with recent pharmacological advances have led to increases in both diagnosis and prescription of medications among older people. Our study focused on the prevalence of polypharmacy in Long-Term Care (LTC) residents, particularly those with MHD and Neurological Disorders (ND). B) Early identifi...
email reminder was circulated to clinicians highlighting the importance of vaccination, and identifying those patients under their care who had yet to be vaccinated. Following this intervention, a subgroup of 42 of the original cohort were re-audited.

Results: Of the 104 patients reviewed, 20% received vaccination. 24% MedEl patients were vaccinated compared to 17% medical, and 18% surgical. Average age of patients reviewed was 77 years, 86% were >65. On re-audit of 42 unvaccinated patients that remained in hospital 4 weeks later, a further 8 patients had been vaccinated although overall vaccination rates remained low at 19%.

Conclusion: Delayed discharge of older patients out of the acute hospital environment necessitates consideration of this important public health intervention for those patients with prolonged admissions. Awareness of the need for influenza vaccination among hospital physicians and surgeons is low, with only 20% of eligible patients receiving vaccination. Despite prompting, a re-audit showed persistently low levels of uptake. Given the strong indications for vaccination and prior inpatient outbreaks, we recommend hospital-wide physician education with regards to influenza vaccination of patients. Compliance will be optimised in the next influenza season through use of reminders on electronic prescribing for older people.
Environmental Approaches to Cognitive Ageing: An Investigation of the Role of Population Density and Disability  079
Staff, Volunteer and Family Experiences of Life Story Work with Residents who Have Moderate to Severe Cognitive Impairment  092
Can Social Robots Help to Reduce Loneliness and Social Isolation in People with Dementia? A Delphi Survey  095
Diagnosing Cognitive Disorders in General Practice  099
Influences on Appropriate Antipsychotic Prescribing in Residents with Dementia: A Qualitative Exploration Using the Theoretical Domains Framework  109
Dementia Screening for People with Down Syndrome: A Qualitative Exploration of Relatives’ Experiences and their Perspectives on Improving this Process  125
Is Orthostatic Hypotension at Baseline Associated with a Decline in Cognitive Function at Four Year Follow-up?  139
An Experience in the Development and Evolution of a Memory Assessment and Support Clinic in a HSE Level three Hospital  141
What Training do Hospital Staff Want in Relation to Dementia?  150
The Prevalence of Dementia and Cognitive Impairment in our Acute Medical Admissions  158
Screening Tool Performed by Informal Carers, The Quick Memory Check, Correlates with Quick Screen for Mild Cognitive Impairment  166
Intensive Homecare Packages: Are they Feasible for Supporting People with Dementia Living Alone?  171
Range of Diagnoses Received by Patients Aged 50 and under Attending a Memory Clinic for First Assessment  175
The Alzheimer’s Questionnaire: Optimising Cut Points for an Irish Memory Clinic Population  178
Can we Assess Visuospatial Function Verbally in Older Medical Inpatients?  192
A Retrospective Review – Correlating the Mini-Mental State Examination Result and the Diagnosis of Dementia  206
Identifying Prodromal Alzheimer’s Disease - Clinical Incorporation of CSF Biomarkers into the Diagnostic Paradigm in a Memory Clinic Setting  213
A Month to Forget, two Case Reports of Transient Global Amnesia  215
Development and Evaluation of a Dementia Education Workshop for Primary Care Teams in Ireland  223
Diagnosing Dementia in the Rehabilitation Setting: Prevalence, Patient Characteristics and Rehabilitation Outcomes  224
Indicators on Home Based Care for People with Dementia: A Tool for Informing Policy Implementation and Planning  232
Middle Gait Abnormalities in People with Type two Diabetes  234
Midlife Gait Abnormalities in People with Type two Diabetes  232
Indicators on Home Based Care for People with Dementia: A Tool for Informing Policy Implementation and Planning  260
Profile of a North Dublin Community Outreach Service  291
Vitamin D De
Development of the Chinese Version of the Quick Mild Cognitive  286
Survey of Staff Knowledge about Dementia Prior to the Implementation of a Dementia Education Program in Nursing Homes  33
What Training do Hospital Staff Want in Relation to Dementia?  35
The Prevalence of Dementia and Cognitive Impairment in our Acute Medical Admissions  36
Screening Tool Performed by Informal Carers, The Quick Memory Check, Correlates with Quick Screen for Mild Cognitive Impairment  38
Intensive Homecare Packages: Are they Feasible for Supporting People with Dementia Living Alone?  38
Range of Diagnoses Received by Patients Aged 50 and under Attending a Memory Clinic for First Assessment  38
The Alzheimer’s Questionnaire: Optimising Cut Points for an Irish Memory Clinic Population  8
Can we Assess Visuospatial Function Verbally in Older Medical Inpatients?  42
A Retrospective Review – Correlating the Mini-Mental State Examination Result and the Diagnosis of Dementia  45
Identifying Prodromal Alzheimer’s Disease - Clinical Incorporation of CSF Biomarkers into the Diagnostic Paradigm in a Memory Clinic Setting  45
A Month to Forget, two Case Reports of Transient Global Amnesia  45
Development and Evaluation of a Dementia Education Workshop for Primary Care Teams in Ireland  46
Diagnosing Dementia in the Rehabilitation Setting: Prevalence, Patient Characteristics and Rehabilitation Outcomes  46
Indicators on Home Based Care for People with Dementia: A Tool for Informing Policy Implementation and Planning  46
Middle Gait Abnormalities in People with Type two Diabetes—Data from TILDA  48
Processing Speed is Associated with Multiple Independent Domains of Gait under Different Conditions  53
Outlining the Development of a National Dementia Post-diagnostic Support Pathway  53
‘It’s Tricky’. General Practitioners’ (GPs’) Experience of Talking to Patients with Mild Cognitive Impairment about Fitness to Drive in Ireland  54
Duration of Symptoms Prior to Attending a Multidisciplinary Memory Service  54
Survey of Staff Knowledge about Dementia Prior to the Implementation of the Butterfly Scheme in an Irish University Hospital  56
Development of the Chinese Version of the Quick Mild Cognitive Impairment (Qmi-CN) Screen  57
Vitamin D Deficiency and Cognition Function: A Case Control Study  57

Community Based Programmes
020 Providing Holistic and Equitable Access to Specialist Geriatric Medicine Expertise in a Community Setting  14
025 An Audit of Emergency Department Presentations of Nursing Home Residents  15
035 Reducing the Use of Psychotropic Medication in Nursing Home Residents: A Multidisciplinary Intervention  19
054 LAMP in Action: the Feasibility of Social Prescribing in the Medicine for the Elderly Outpatients  19
076 “Ageing Well Groups” – Development and Effectiveness of 8 Week Community Based Health Promotion Groups  4
081 Attitude and Perceptions of Self-management and Health Monitoring of Community-dwelling Older-adults Participating in Residential Activities in Japan  23
085 Southern Trust Acute Care at Home Service for Older People  4
087 Pressure Ulceration in Long Term Care: Lessons from a Four Year Health Service Evaluation  24
090 Supporting Older People with Multimorbidity: Experiences of Caregiver Burden among Paid Care Workers in Ireland  25
108 Barriers to Access and Utilisation of GP Out-of-Hours for Older People  27

What Price Choice: Cost of facilitating the Preference of Frail Older People. Where Should Money be Spent?  33
Evaluation of a Tele-mentoring Initiative to Support Inter-professional Education for Health Professionals Caring for Residents in Nursing Homes  33
Why do Nursing Home Patients Need Acute Hospital Admission?  34
A Realist Evaluation of Intensive Home Care Packages for People with Dementia  7
Tullaght Integrated Care for Older Persons Team – Bridging the Gap  47
Bone Health Review in Patients Attending Community Reablement Unit (CRU), Harold’s Cross  49
Profile of a North Dublin Community Outreach Service  52

Economics of Ageing
016 Examining Frail Older People’s Use and Experience of the Irish Healthcare System: A Mixed Methods Study  1
086 Economic Analysis of a Physician-implemented, Medication Screening Tool in Older Irish Hospitalised Patients  4
098 Better off at Home or in Long Term Care? A Balance-of-care Analysis of People with Advanced Dementia  5
113 Analysing the Burden of Care of Informal Carers of People with Moderate or Severe Dementia  28

Education and Training
018 The Implementation of an Education, Training, Development and Partnership Programme for Nursing Homes  1
035 Exploring the Impact a Training Programme has on Acute Healthcare Professionals’ Attitudes and Understanding of Dementia  17
057 Orthostatic Hypotension: Healthcare Providers’ Knowledge on its Identification and Measurement  20
093 Feasibility of the 4-AT Rapid Assessment Tool for Delirium Screening in the Older Patient in the Emergency Department  25
114 Hybrid Hi Fidelity Simulation: A Novel Method of Delivering Stroke Medicine Education  28
180 A Participatory Evaluation Framework for the Primary Care Education, Pathways and Research of Dementia (PREPARED) Primary Care Team Training Program  40
233 Defining the Curriculum for Medical Care in Nursing Homes  47

Frailty and Delirium
028 The Point Prevalence of Delirium in the Over 65 Population with a Hip Fracture in an Irish University Hospital  16
060 Frailty in the Acute Hospital Setting: an Analysis of Patient Data  20
103 A Questionnaire to Determine Knowledge of Delirium Recognition in the Emergency Department  26
119 Impact of Frailty on Healthcare Outcomes after Ischaemic Stroke in Patients with Atrial Fibrillation  29
122 Defining Stressors Leading to Acute Hospitalisation in Frail Older Adults  30
123 A Study of Vitamin D Levels in a Screened Frail Older Population  30
163 Overcomin Frailty: Evaluating the Role of an Occupational Therapist on a Frail Elderly Team  37
164 Finding the Frail in the Emergency Department - A Retrospective Review  37
193 Rates of Refusal of Cognitive Screening Tests in Older Medical Inpatients  43
212 Screening Frailty in the Emergency Department: The Utility of the SHARE-FI in Predicting Outcomes in a Cohort of Older Patients  5
258 Identifying Common Frailty Syndromes Using Comprehensive Geriatric Assessment in the Acute Care Setting  11
262 An Overview of Dentition and Mouth Care in Older Inpatients in University Hospital Waterford  52
279 Frailty in an Acute Hospital: Point Prevalence and Change in Baseline Status during Hospitalisation  12
294 Working Differently to Greatly Improve Care for Frail Patients Attending the Emergency Department  58

Gerontechnology
080 Developing a Questionnaire to Understand Perceptions towards Home-care Robots Among Older People who Receive Home-care, Family Caregivers, and Home-care Professionals  23
084 Perceptions and Use of Technology to Support Self-management for Older Adults Living with Multiple Health Conditions within a Care Ecosystem  24
097 How Do People Perceive Home-care Robots? A Questionnaire Study with Older People, Family Caregivers, and Care Professionals in Japan  5
Age and Ageing

133 The Great Escape: Virtual Reality as a Complementary Therapy in the Elderly in Residential Settings, a Pilot Study 16
261 IRAP – Where GP and Hospital Physician Gets to Live and Long-Term Care Residents Stay Alive 52
263 IRAP – Cutting Down on Writing, Focusing on Caring: Role of Electronic Record in Improving Nursing Care 52

Medication

032 Potentially Inappropriate Medication (PIMs) Use and Anticholinergic Burden in Memory Clinic Referrals in an Irish Setting 16
051 The Impact of Age on the Incidence of Adverse Drugs Event (ADEs) Causing Hospitalisation in Patients with Cancer 19
052 Prevalence of Potentially Inappropriate Medications (PIMs) According to STOPP/FFrail in an Older Frailer Cohort with Limited Life Expectancy 2
068 Antipsychotic Prescribing Rates in Older Adults: An Acute Hospital Setting Point-Prevalence Review 21
075 Atrial Fibrillation and Stroke Prevention: An Audit of Anticoagulation Use and Monitoring 23
078 A Study of the Prevalence and Appropriateness of Proton Pump Inhibitor Prescriptions in an Irish Nursing Home Cohort 23
100 Potentially Inappropriate Prescribing of Proton Pump Inhibitors – A Qualitative Study 26
105 Inappropriate use of Aspirin among Over 65-Year Old Admissions to a Rehabilitation Hospital 27
115 Non-Consultant Hospital Doctors’ Attitudes and Knowledge towards Sedative Prescription in an Acute Hospital 29
127 A Multimodal Intervention to Reduce the Prescription of Night Sedation 31
165 Association of Drug Burden Index with Physical Function in Irish Older Adults with Intellectual Disability 38
178 Nursing Home Prescribing Practices: An Observational Study of a Single Centre Managed by a Geriatrician 40
237 Monitoring and Commonly Prescribed Medications in a Single Nursing Home Centre; An Observational Study 48
257 Computerised Medication Analysis Designed to Minimise Inappropriate Prescribing in Older Hospitalised Patients: A Systematic Review 51
268 A Review of Medication in Inpatient Fallers in the Acute Hospital 53
270 Sedatives Usage in Inpatient Fallers in an Acute Hospital 54
271 Modification of the STOPP-START Criteria for Improved Local Applicability 54
278 Medication Burden in the Last Year of Life 12
289 Danger Zone of Injury to the Inferior Epigastric Artery (IEA) from Subcutaneous Injection of Low Molecular Weight Heparin (LMWH) 57
293 Polyparmacy in Long Term Care Residents: What’s at Stake for Patients with Mental Health and Neurological Disorders? 58

Palliative Care and End of Life

040 Advance Care Plans – A Missed Opportunity? 17
043 The Patient with Parkinson’s Disease in Extended Care 18
072 Oral Health Training Programme for Palliative Care 3
073 Anticipatory Grief in Carers of People with Parkinson’s Disease 22
074 Demonstrating the Potential Benefit of Palliative Care Input for People with Dementia, Using Case Studies 3
107 Seven Dementia Palliative Care Guidance Documents 27
134 Palliative Care in Nursing Home Residents: Are we Doing Enough? 32
136 Does an Interactive, Teleconference-Delivered, Palliative Care Lecture Series Empower Nursing Home Staff to Manage Patients More Autonomously? 6
161 Advance Care Plans - A Day Hospital Perspective 37
163 End of Life Care in Two Academic Adult Hospitals. Care Experiences from the Perspective of Bereaved Relatives - Voices That Matter 10
253 Staff Perception of End of Life Experience of Residents in Long Term Care 11
281 Acute Services Utilisation amongst Older People in the Last Year of Life. 56
287 Long Term Care Staff’s Educational Needs and Confidence in Providing End of Life Care Before and After an Educational Initiative 57
295 Compassionate End Of Life Care in Residential Care Settings - A Quality Improvement Approach 58

Public and Patient Involvement

011 Knowledge and Preferences of Older Patients Regarding Cardiopulmonary Resuscitation in an Acute Hospital in Ireland 13
030 Healthcare Interactions and Patient Encouragement: Perspectives from Older Adults in Ireland 2
132 Key Considerations in the Development of a Participatory Action Research Network of Family Carers of People with Dementia 6
187 Participants’ Perspectives and Preferences on Clinical Trial Result Dissemination: The TRUST Thyroid Trial Experience 42
244 The Readability of Internet Information on Lewy Body Dementia 49
245 Introducing a Novel Volunteer Service: Learning from the Implementation of the Service, and User, Provider and Hospital Staff Experiences 49

Rehabilitation

014 Interrupted Geriatric Rehabilitation Requiring Transfer to Acute Hospital Setting: Incidence and Outcome 13
033 Transition from a Surgical Ward to an Exemplar Specialist Geriatric Ward (SGW) 16
039 How well do Measures of Tongue Strength Correlate with Oropharyngeal Dysphagia in Older Persons? 17
047 The Effectiveness of Stroke Rehabilitation in Older Old Patients Compared to a Group of Younger Stroke Patients 18
059 Rehabilitation for Acutely Unwell Older Patients: How Well Does it Work? 20
065 Developing a Care Committee for Dementia Patients in a Rehabilitation Setting 21
154 Healthcare Professionals’ Attitudes, Practice and Influencing Factors with Regard to Considering Older Persons’ Spirituality during Rehabilitation: A Mixed-Methods Study 35
241 Characteristics and Rehabilitation Outcomes of Older Parkinsonian Patients Attending a Day Hospital 007
251 Patients in a Step Down Geriatric Rehabilitation Hospital – What are the Reasons for Transfer Back to an Acute Hospital? 000

Social Gerontology

038 ‘It Was Obvious We Were Friends, Because We Were Friends in Action’: Exploring the Conduits to Adult Intergenerational Friendship Formation 2
062 Social Determinants and Older People Hospital Outpatient Non-Attendance 3
151 Older People and Homecare: “And one week nobody came at all…. It really was upsetting, I was watching the door” 35
153 Implementing Digital Life Story Work for People with Dementia: The Relevance of Context to User Experience 7
157 Change in Religious Affiliation in Middle Aged and Older Adults in Ireland. What are the Implications for Health? 36
168 Re-evaluating the Relationship between Caret Stress and Institutional Care Utilisation 000
179 Alcohol Misuse in Self-Neglecting Older Adults 40
184 Self-Neglect: Views and Experiences of Health and Social Care Professionals 41
208 Ageing in Diverse Urban Neighbourhoods: Social Exclusion and Life-Course Relationships with Place 8
218 A Review of Long Term Care Assessments in an Inner City Teaching Hospital 45

Social Inclusion and Policy

077 Community-based Approaches to Looking After Older People in Tokyo 23
089 The Effects of Discrimination and Perceptions of Ageism on Community Participation among Older Adults 5
156 What Does Community Living Mean for Older People Experiencing Disability? 7
200 Future Care Planning Amongst Parent and Sibling Carers with Ageing Family Member with an Intellectual Disability 44
226 Engagement in Community by Older People with an Intellectual Disability in Ireland 47
250 The Placement of Younger People with Disabilities in Nursing Homes: An Analysis of Assessment Forms Accompanying NHS Applications 50

Stroke and Neurology

032 Short-term Morbidity Outcomes of Acute Stroke – Comparing Patients in Atrial Fibrillation versus Sinus Rhythm on Admission 16
041 Enlarged Perivascular Spaces of Subjects with Silent Lacunar Infarction from A National Longitudinal Study on Ageing 2
048 TIA or not TIA ? That is the Question. A Review of Diagnoses Seen in a Rapid Access TIA Clinic 18
049 Self-Management: A Patient-Centred Option for Managing Daily Challenges Post-Stroke 18
053 Decompressive Craniectomy for Malignant Middle Cerebral Artery Syndrome: The Irish Experience 3
Author Index

A

Adams, D 192, 193
Adams, N 194
Aherne, E 27, 186
Akpan, A 20, 62
Alice, M 282
Ali, B 258
Allen, A P 166
Alshaaili, N 154
Anne Kenny, R 41, 50, 157, 236
Ansari, A 32
Armstrong, C 222
Asti, N A M 261, 263
Austin, N 206, 280
Azman, A 73

B

Baeta, C 15
Bagina, R 15
Balasa, M 171, 173
Baldwin, L 62
Bambrick, P 66, 67, 68
Barham, K 153
Barrett, E 95
Barry, M 87, 277
Bassirat, A 158
Beatty, P 116
Beaumont, C 29
Begley, E 264
Beirne, A 191
Beirne, A M 274, 291
Beirne, E 88
Bejleri, J 141, 143, 214, 255, 256
Benicio, T 36, 144
Benmari, F 96
Bernard, P 294
Bhadriraju, H A 285
Binions, I 259
Blake, C 126
Blanco-Campal, A 296
Bourke, R 78, 181, 182, 188, 228
Bowman, M 60
Boyle, G 54
Boyle, M 294
Boyle, S 223
Brearley, M 88
Bracken-Scally, M 98
Bracken-Scally, M 113
Bradley, C 272
Bradley, D 210, 254
Brady,Anne-Marie 98, 113
Brazil, E 137
Brennan, D 174, 200
Brennan, S 186
Brent, L 27, 285
Breslin, T 137
Breuer, L 26, 31, 101, 181, 221, 228, 294
Briggs, R 162, 172, 206, 212, 213, 280
Brosnan, M 35, 69
Brown, P 195
Browne, E 181
Browne, J 16, 109, 209, 268, 270, 297
Browne, P 218
Bruce, I 171, 173
Buckley, A 41, 56
Buckley, M 244, 245, 282
Buggy, A 63, 230
Burke, E 165
Burke, M 95
Burn, D 170
But, H 144

Byrne, A 43
Byrne, C 189
Byrne, D 114, 268, 270, 297
Byrne, M 277
Byrne, S 86, 109, 112, 257
Byrne, T 181

C

Cahill, S 74, 175
Callaia, E 101
Calnan, M 166
Cahalan, M 185
Calimi, R O 216, 253
Carey, T 138
Carolan, N 221
Carragher, L 108
Carroll, Áine 47
Carroll, R 226
Casey, D 72
Casey, D 95
Casey, M 123, 204, 155, 195, 229, 240
Casey, M C 238, 222, 274, 291
Cassarino, M 79
Cassidy, T 47, 135, 140, 220
Caulfield, B 126
Chan, J 249
Chasim, D N 61
Charlwood, A R 218
Chen, Z 290
Cheung, A 187
Choroszczuk, A N 125
Chytilova, E 217
Clibis, A 98, 113
Claffey, P 54, 55, 147, 171, 173, 198, 238, 254
Clancy, I 294
Clare, J 32
Clarke, G 166
Clarke, S 277
Cloney, T 310
Coyle, R 40, 161, 239
Codd, M 231
Cocor, R 171, 173
Coffey, A 275, 287, 253
Cogan, L 47, 137, 177, 178, 217, 237
Cogan, N 197
Coomin, D O 29
Coomin, D O 231
Cormick, S 225
Collins, C 272
Collins, R 111, 148, 162, 197, 206, 212, 213, 241, 246, 280
Compton, N 215
Conic, R Z 179
Connolly, A 27, 285
Connolly, E 116
Connolly, A 206, 280
Connolly, K 164
Connolly, M 175
Connolly, W 28, 29, 36, 33, 144
Connor, E O 9, 49
Connor, M O 185, 292
Cooke, J 262, 265, 288
Cooke, J P 247, 248
Cooksey, T 88
Cooney, M 47, 178
Corcoran, A 242
Corcoran, G 26, 31, 294
Cornally, N 283
Cornally, N 275, 287
Corry, M 149
Costello, S 126, 161
Costello, O 232
Costea, A 262, 288
Costea, A I 248

Costelloe, A 185
Cotter, P 219
Coughlan, T 39, 111, 148, 162, 197, 206, 212, 213, 241, 246, 280
Coveney, S 48
Cowley, S 158
Coyle, S 161
Crawford, C 288
Cragh, A 236
Crimin, G 26, 31
Cronin, F 249
Cronin, J 188, 277
Crowe, A 101
Crowe, C 127
Crowe, M 43, 47, 177
Crowley, F 244
Cullen, C 271
Cullinan, S 112
Cunningham, C J 198, 218
Cunningham, N 242, 267
Curly, G 181
Curran, C 57, 67, 91, 181, 194
Curran, M 221
Curtin, D 276, 278, 281

D

Dahly, D 30
Dalton, K 257
Daly, B 166
Daly, P 181
Daly, L 98
Daly, L 113
Daly, P 32
Daly, P 189
Darcy, C 23, 294
Davis, A 65
Day, M R 179, 184
de Siún, A 264
de Wilde, C 70
Deweghiose, J 63, 230
Dilatjah, N 115
Di Mascio, N 224
Dillon, A 155, 195
Dillon, J 189
Dinan, T G 166
Dinmore, J 158
Dinmore, J 184, 90
Diskin, M 146
Dolan, E 143, 190, 214, 215, 224, 255, 256
Donald, M 294
Donegan, C 57, 66, 68, 91, 164, 165, 182, 294
Donlon, K 94, 114, 117, 119
Donnell, C O 262
Donnelly, T C 25
Donnelly, U 26, 31
Donoghue, M O 31
Donohoe, D 240
Donohoe, O 142
Dossot, S 126
Dowling, M 136
Dowling, P 33, 99
Doyle, J 58, 84, 90
Doyle, R 188, 235, 239, 277, 285
Drumm, B 204
Duffy, M 250
Duggan, E 33
Duggan, J 28, 33, 99, 296
Dukelow, T 166, 245, 288
Dunleavy, C 174
Dunmore, C 62
Age and Ageing

Walsh, V. 86
Ward, Mark 83, 89
Ward, Mary 274, 291
Wareing, W. 20
Waters, R. 279
Whelan, S. 95
White, B. McC. 181
Wihlen, L. 170
William Molloy, D. 287
Williams, D. 57, 67, 182, 194, 228
Williams, DJ. 53
Williams, E. 120

Wilson, L. 66
Windle, G. 153
Wisemann, E. 286
Woods, B. 153
Wren, Maev-A. 16

X

Xu, YangF. 290

Y

Yu, W. 80, 97
Yu, Y. 290

Z

Zabat, J. 263
Zaheer, M. S. 247, 248
Zainal, T. 222, 229, 240