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As our innovation partner, Daiichi Sankyo has sponsored our conference Age & Ageing abstracts e-journal, and our gerontechnology symposium, by means of an unrestricted educational grant.

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Oral presentations

4 THE INTERSECTION OF HUMAN RIGHTS AND DECISION MAKING CAPACITY LEGISLATION WITH PERSON CENTRED APPROACHES
Amanda Prehle1, Patricia Rickard Clarke2
1University College Dublin, Dublin, Ireland
2Chair, Safeguarding Ireland, Dublin, Ireland

Background: A major focus on decision making capacity (as opposed to cognitive capacity and competence) legislation in many Western countries is the integration of a human rights approach focused on self-determination and autonomy. This paper examines modern day concepts of personhood and person centred care and presents Irish and United Kingdom legal commentaries which focus on health services’ and society’s approaches to risky decision making. Integrating human rights into decision making capacity legislation has been central in contemporary discourses on health and welfare.

Methods: A literature review was undertaken charting the emergence of personhood, person centred care and human rights. Case studies of influential legal commentaries in Ireland and the United Kingdom where decision-making capacity was addressed were mapped to person centred care principles.

Results: Findings point to a convergence of discourses of human rights in contemporary approaches to health and social care as well as the evolution of legislation to support person centredness in fostering safeguarding and promoting autonomy and self-determination. Specific legal commentaries point to the need of health and social care to be mindful of paternalism and to conceptualise the concept of ‘risk’ with a particular emphasis on the inclusion and defence of the voice of the older or vulnerable person.

Conclusion: This intrinsic worth of each human is articulated through an implicit and explicit vindication of their human rights. The emergence of the third generation of human rights has argued the value of self-determination and autonomy, articulated through robust national legislation on decision-making capacity based on the core principles of person centred care approaches. This move from paternalism is imperative and is imbued in contemporary legislation and legal commentaries, which has noted the need for revisions in health and social care case management perspectives.

5 AN ANALYSIS OF THE IMPACT OF ESTABLISHING AN AMBULATORY STROKE TEAM
Colin Menagh, David Wilson, Kevin Dyman, Michael Power, Karen Hull, Charlotte McCaillon, Maureen Matthews
Ulster Hospital, Belfast, United Kingdom

Background: The South Eastern Trust established an Ambulatory Stroke Team (AST) in October 2017. This consisted of Stroke Nurses and a Specialist doctor with Stroke consultant support. During the initial pilot the AST team worked Monday – Friday 9-5pm. The majority of assessments took place in the emergency department. The overall aims were to improve length of stay for TIsA / stroke mimics and improve the percentage of strokes being admitted directly to the Stroke Unit.

Methods: Using quality improvement methodology we worked through several Plan, Do, Study, Act (PDSA) cycles. The most significant intervention was the introduction of a protected direct to stroke unit bed. A database was kept of all patients seen, including final diagnoses and patients discharged after assessment, preventing admission and saving bed days.

Results: A 6 month period was analysed from April to September 2018. 312 patients were reviewed - 159 (51%) stroke mimics, 108 (35%) strokes and 45 (14%) TIA. 54 patients were identified for early discharge and appropriate follow-up. Bed days saved was estimated at 110 days. Direct to stroke unit percentage improved from 30% in October 2017 when the AST was introduced to 82% in January 2019.

Conclusion: A dedicated Ambulatory Stroke Team can prevent hospital admissions and save bed days due to rapid identification and specialist assessment of suspected TIAs and strokes. Multidisciplinary team working as part of a quality improvement project can improve the percentage of strokes admitted directly to the stroke unit.

6 IS PHENOTYPICAL PREFRAILTY ALL THE SAME? A LONGITUDINAL INVESTIGATION OF TWO PREFRAILTY SUBTYPES IN A POPULATION-BASED LONGITUDINAL STUDY OF AGING
Raman Romero-Ortuno1,2, Siobhan Scarlett1, Rose Anne Kenny1
1The Irish Longitudinal Study of Ageing, Trinity College Dublin, Dublin, Ireland
2Discipline of Medical Gerontology, School of Medicine, Trinity College Dublin, Dublin, Ireland

Background: Fried’s frailty phenotype is defined by five criteria: exhaustion, unexplained weight loss, weakness, slowness and low physical activity. Pre-frailty (PF) meets one or two criteria. PF is of interest as a target for preventative strategies, but it is not known if it is a homogenous syndrome. The objective of this study was to compare the longitudinal trajectories of two PF groups: one defined by exhaustion and/or unexplained weight loss (PF1) and one defined by one or two of the following: weakness, slowness, low physical activity (PF2).

Methods: Design and setting: population-based longitudinal study of aging.

Methods: Generalised Estimating Equations (GEE) were used to assess the effect of PF type across waves to predict cumulative mortality and disability in basic (ADL) and independent (IADL) activities of daily living, adjusting for baseline characteristics (age, sex, education, living alone, self-rated health, comorbidity, body mass index).

Results: In wave 1, there were 687 PF1 and 973 PF2 participants. By wave 5, 64 (9.3%) PF1 and 145 (14.9%) PF2 participants had died. In PF1 participants, mean numbers of ADL and IADL disabilities both increased from 0.2 to 0.3 from wave 1 to wave 5, whilst in PF2 increases were from 0.2 to 0.5. Adjusted GEE models suggested significantly divergent trajectories of IADL disability by wave 2. ADL disability by wave 3, and mortality by wave 4.

Conclusion: Prefrailty may not be a homogenous biological syndrome. This may have relevance for the design of interventions to delay or reverse frailty in populations.

30 OCCUPATIONAL THERAPISTS DELIVERING PATIENT AND CAREGIVER HOME SAFETY EDUCATION IN A REHABILITATION SETTING
Cara Webster, Monica Devine, Caolín O’Connor, Emma O’Brien, Edel O’Grady, Joanne Murphy, Claire O’Brien, Eileen O’Gorman
1 Cantor Hospital, Dublin, Ireland
2 Beaumont Hospital, Dublin, Ireland

Background: The patient profile in a 160-bed rehabilitation hospital is evolving with increasing numbers of older adults admitted with falls and frailty. In 2018 a snapshot audit revealed over 60% of patients obtained scores indicative of cognitive impairment. Traditional falls prevention education delivered in a group format relies on attendees having an adequate level of sensory registration and cognitive abilities to comprehend and recall information given. The Occupational Therapists (OTs) proposed greater benefits from caregiver inclusion in such education to enhance understanding for both patients and caregivers on falls prevention and home environment modifications to facilitate safer home discharges.

Methods: A mixed-methods design was used. Quantitative data was gathered using a pre and post education 10-point Likert scale to assess attendees’ perceived knowledge in four domains: (1) Falls risk factors (2) Modifiable environmental factors (3) Managing falls (4) Accessing support/information to reduce risk of falls. Qualitative data was gathered through written feedback. Referrals were generated by OTs. Evening sessions facilitated increased caregiver attendance. OTs delivered a 45 minute PowerPoint presentation, demonstrated adaptive equipment and engaged in discussion with attendees. Information packs were provided to caregivers including a Home Safety Assessment Tool to aid with home environment modifications.

Results: Data from April 2018-2019 was analysed using Microsoft Excel. 21 groups were facilitated with 385 attendees overall. Average percentage increase in knowledge in each of the four domains was 30%. Overall knowledge increased by 32%.

Conclusion: Increased knowledge of modifiable falls risk factors and supporting persons at risk of falls in the home was demonstrated. OTs reported reduced caregiver concerns regarding home environment modifications. Home assessments completed after group attendance found caregivers had implemented recommendations made in the presentation. Further data could be collected to measure the degree of environmental modification completed prior to OT home assessments. Additional qualitative data is required to fully assess benefits to both patients and caregivers.

33 “STRIKING BACK AGAINST STROKE”
Lisa Donaghy, Laura Morrison, Julie Prendergast, Eamon Dolan, Marie O’Connor
Connolly Hospital Blanchardstown, Blanchardstown, Ireland

Background: 2 million brain cells die every minute increasing the risk of permanent brain damage, disability or death. Despite the fact that IV Thrombolysis and Thrombectomy are now the standard of care, optimal rates of door to needle times and door to decision times have not been managed to be achieved throughout Ireland. There is a gap between what we know and what we do.

Treatment within a shorter time frame improves patient outcomes.

Aims: To reduce door to decision time for Thrombectomy to <90minutes in conjunction with the National Thrombectomy Quality Improvement Programme.

Methods: A Stroke Committee was set up consisting of a wider group of Stakeholders involved in FAST positive calls. A pre-audit of baseline times was conducted. Each step was mapped out in a process map and areas of delays were identified to reduce the overall KPI times.
**abstract**

Delays and areas for change:

1. Pre-alert by ambulance ✓ Audit ✓ Education
2. Alerting the Stroke Team ✓ Audit ✓ Training of referrers ✓ Education with ED staff
3. Registration ✓ Pseudo MRN ✓ Nervous Diffusiss
4. IVC ✓ Red “FAST Stroke” labels
5. Urgent INR ✓ Education with laboratory staff
6. Equipment for transfer ✓ No cardiac monitoring for stable patient

Results:
- Door to CTA time reduced from 35 minutes to 28 minutes (5 minutes)
- Door to Thrombolyis reduced from 65 minutes to 30 minutes (35 minutes)
- CTA to time of contact Beaumont (5 minutes)
- CTA to time of contact Beaumont (5 minutes)
- Door to decision re: Thrombectomy or not reduced from 166 minutes to 24.5 minutes (141.5 minutes)

Conclusion: This is an ongoing process which continues to ultimately improve patient outcomes.

**IMPACT OF ADVERSE EVENTS ON THE OLDER INPATIENT POPULATION: A SUBGROUP ANALYSIS OF THE IRISH NATIONAL ADVERSE EVENTS STUDY (INAES)**

Warren Connolly1, Natasha Rafter1, Anne Hickey1, Ronan Conroy2, Sarah Condel1, Paul O’Connor1, David Vaughan1, Gillian Walsh1, David Williams1

1 Department of General and Stroke Medicine, Royal College of Surgeons in Ireland, Dublin, Ireland
2 Division of Population Health Sciences, Department of Psychology, Royal College of Surgeons in Ireland, Dublin, Ireland
3 Office of the Nursing and Midwifery Services Director, Health Service Executive, Dublin, Ireland
4 Discipline of General Practice, National University of Ireland, Galway, Ireland
5 Quality Improvement, Royal College of Physicians of Ireland, Dublin, Ireland
6 Department of Research, Royal College of Physicians of Ireland, Dublin, Ireland

Background: Adverse events are any injuries caused by healthcare management, which result in disability, increased length of stay or death. The Irish National Adverse Event Study (INAES)(1) used the Harvard Medical Practice, 2-step methodology of retrospective chart review(2) to determine the adverse event rate in the Irish inpatient cohort.

Methods: We further analysed the INAES data in order to calculate the prevalence and determine the impact of adverse events on the older inpatient population.

Results: INAES captured 1574 randomly selected adult inpatient admissions from 8 hospitals across the Republic of Ireland in 2009. 53% were female and the median age was 55 years (IQR 37 years to 72 years). The prevalence of adverse events was higher in those aged ≥65 compared to those aged < 65 (15.4% versus 9.3%, P < 0.001). When an adverse event did occur it was more likely to result in death in the ≥65 years old group (11.4% versus 2.1%, p = 0.01). Furthermore, it was 9 times more likely that an admission would result in a fatal adverse event in those aged ≥65 compared to those aged < 65 years. A further 9% of adverse events in the ≥65 age group resulted in permanent disability and over half were thought to be preventable. Older patients who suffered from an adverse event had an increased length of stay compared to older patients who did not suffer an adverse event (16 days versus 8 days, p < 0.001) at a cost of €9,090 for each adverse-event-associated admission.

Conclusion: Older inpatients are more likely to suffer from an adverse event than their younger counterparts. These adverse events are more likely to contribute to increased morbidity but over half are preventable. The follow-up INAES-2 study, which is currently underway, will determine if an improvement has been made after implementation of the National Clinical Programmes.

**PATIENT AND ENVIRONMENTAL FACTORS INFLUENCING RECOGNITION, RESPONSE TIME, AND TREATMENT OF IN-HOSPITAL STROKE**

Sarah Melia, Nicola Cogan, Suzanne Greene, Ronan Collins, Dan Ryan

Tallaght University Hospital, Dublin, Ireland

Background: Approximately one in ten strokes occur in hospital whilst the patient is hospitalised for another reason. Existing research suggests that delays in recognition of in-hospital stroke (IHS) results in poorer outcomes compared to those with community-onset stroke. We aim to describe the characteristics of an IHS population and to phenotype the patient and/or environmental factors most likely to account for delays in recognition and response times.

Methods: Patients diagnosed with having an ischemic stroke while admitted to hospital for a non-stroke reason were identified through our hospital’s stroke registry. We collected patient demographics along with the ward and service they were admitted under and if they underwent any invasive procedures prior to the stroke event. The patient cohort was dichotomised based on patient-specific or environmental factors. We then calculated the likelihood of symptom recognition, medical review, and neuroimaging occurring within the 4.5 hour thrombosis window between the two groups using the chi squared test.

Results: Fifty IHS occurred in the study time period. 52% were male, average age 74 (SD 12.4 years). 34 (68%) were admitted medically, and 16 (32%) surgically. 27 (54%) were assessed within the time frame for thrombolysis. Of these, seven received acute stroke treatment and the remaining 19 had contraindications to treatment. Patients presenting with NIHSS ≥6 were more likely to receive treatment (85% vs 39%, p < 0.051) or be identified as having an IHS (63% vs 9%, p = 0.019) were more likely to be recognised. Patients whose symptoms were recognised by a non-staff member (52% vs 78%, p=0.026) and those presenting out of hours (50% vs 70%, p=0.047) or with delirium (85% vs 39%, 0.051) were more likely to be missed.

Conclusion: In-hospital strokes are frequently missed due to the complexities of the patients involved. Education programs targeted at enhancing stroke pickup among hospital staff could potentially decrease delays and improve patient outcomes.

**ACCESSING RESPITE SERVICES FOR PEOPLE WITH DEMENTIA AND THEIR CARERS: A QUALITATIVE STUDY WITH MULTIPLE STAKEHOLDERS**

Emma O’Shea1, Suzanne Timmins1, Eamon O’Shea3, Kate Irving1

1 Dublin City University, Dublin, Ireland
2 University College Cork, Cork, Ireland
3 National University of Ireland, Galway, Galway, Ireland

Background: People with dementia and carers do not always access respite services in a timely manner, and in some cases, they do not access respite services at all. While carers’ perspectives on respite access have been explored, other stakeholder perspectives, especially those of people with dementia, are under-represented in the existing literature. The aim of this study was to synthesise multiple stakeholders’ perspectives, including people with dementia, on accessing respite services.

Methods: Purpose sampling was employed. Semi-structured interviews were conducted with 35 key stakeholders, including people with dementia (N=6), carers (N=9), respite front-line staff (N= 4), respite managers (N=8), primary care professionals (N=3) and policy-makers/academics (N=5). Informed consent was obtained from all stakeholders who could give this. Dewings’ process consent’ method was employed in relation to people with dementia. Data were interpreted inductively using thematic analysis. We aimed to move beyond the semantic level of meaning, and to interpret patterns of meaning in the data. Reflexivity was considered throughout the research process.

Results: Three themes (‘Service Acceptability’, ‘Navigational Knowledge and Skills’, ‘Constructing and Judging Respite Need’) were identified that relate to how access to respite services is negotiated between service providers and dyads.

Conclusion: A number of the findings support previous research; however novel findings discussed relating to the access negotiation process include 1) the ambiguous legitimacy of respite needs, in a system configured to deliver a biomedical model of care and which considers non-medical care as a family responsibility, and 2) the constraining effects of disparate conceptualisations of ‘respite’ between carers and providers. Future research should interrogate the appropriate boundaries of public responsibility in relation to respite service planning/delivery for dementia, with particular reference to client preferences for community and in-home provision.

**HEALTH AND SOCIAL CARE PROFESSIONALS’ PERCEPTIONS REGARDING HOME-CARE ROBOTS FOR OLDER PEOPLE IN IRELAND: A QUESTIONNAIRE STUDY**

Naongiri Kodait1,2, Sarah Donnelly1, Mayako Tsujimura3, Sayuri Suwa3

1 School of Social Policy, Social Work and Social Justice, University College Dublin, Dublin 4, Ireland
2 Public Policy Research Centre, Hokkaido University, Sapporo, Japan
3 Graduate School of Nursing, Chiba University, Chiba, Japan

Background: Home-care robots have been developed as one of the assistive technologies, and benefits and challenges of their use have been debated in many countries. Research teams in Japan, Finland and Ireland carried out a questionnaire to explore perceptions of potential users (older people, family caregivers, and health and social care professionals (HSCPs)) towards the use of home-care robots. As part of a larger tri-country comparative study, this paper reports preliminary findings from the data collected from the online survey of HSCPs in Ireland.

Methods: Questionnaire was developed iteratively among the research teams in three countries. Questions related to the use of advocates in deciding whether to use home-care robots, desirable functions in such robots, and perceptions of privacy protection. Based on interviews and focus groups with stakeholders in Japan, Finland and Ireland carried out a questionnaire to explore perceptions of potential users (older people, family caregivers, and health and social care professionals). The questionnaire, and 46 fully completed the questionnaire.

Results: Out of 46 respondents (44 female, 1 male and 1 did not wish to specify), 80% answered that they are open to the use of home-care robots. Safety monitoring and alert functions were considered to be most desirable in home-care robots. 76% of the respondents placed importance on the guarantee of entitlement to receiving human care, irrespective of...
the use of home-care robots. 30% answered that they have a negative impression of robots, to some extent. The overall majority (N=39, 85%) felt strongly that a decision as to whether to use home-care robots should be made by the user, and that the access to data collected in any form by robots requires extra care.

Conclusion: While there was generally a positive perception of the use of home-care robots among Irish HSCPs, cautious attitudes were evident in the areas of decision-making and privacy. This study was funded by the Pfizer Health Research Foundation.

54 IMPROVING DOOR TO NEEDLE TIMES IN ACUTE STROKE

Daukarn Khali, Fiona Connaughton, Danielle Carolan, Mihela Sirbu, Bernadette Lynch, Juanne Daries, Patrick Sullivan, Tony Stringer, Shane Carter, Thomas Fleming, Conor Kelly, Mian Bast, Martin Muiray, Olywn Lynch
Our Lady of Lourdes Hospital, Drogheda, Ireland

Background: During an acute stroke, 2 million neurons are lost every minute. When compared with aged, 2 million neurons are lost every 22 days. Prompt reperfusion of an acute stroke, in the form of intravenous thrombolysis (IV tPA) or intracranial thrombectomy (IAT) would save these neurons and result in saving significant disability. We endeavoured as part of a quality improvement (QI) project to improve our times.

Methods: A local QI steering group was formed which comprised of representatives from the stroke team, radiology, emergency, laboratory, telephone and clerical departments. We outlined our stroke pathway from when the patient arrives to when the patient received IVtPA or IAT. Data was collected prospectively and retrospectively from real time, chart reviews, radiology Picture Archiving Communication System (PACS) and Hospital Inpatient Patient Enquiry (HIPE) stroke data system. We recorded times from door to computed tomography (CT), CT to issue of report and CT report to IVtPA or IAT. The data was reviewed to ascertain if there were any delays at each stage of the pathway.

Results: There were steps in the pathway that were non-variable and those that were highly variable. In general, steps from door to CT, were consistent each time. In contrast, steps from CT completion to IVtPA or IAT, was highly variable dependent on a patient’s clinical condition and decision making expertise available. We addressed duplication of tasks and additional non-urgent investigations. The presence of the stroke team for IVtPA and IAT made decision making faster. The overall median door to CT time reduced by 9 minutes, from 22 to 13 minutes. The overall median door to IVtPA time decreased by 24 minutes, from 83 to 59 minutes.

Our hospital had the fastest door to CT time for IAT patients in 2018 nationally.

Conclusion: Delays in the stroke pathway were rectifiable by change of practice. Most changes were simple without need of any additional resource.

58 HOSPITALISATION RATES AND CAUSES FOR PEOPLE WITH DEMENTIA IN NORTHERN IRELAND

Evi Zafiridis, Alan McMichael, Bernadette McGuinness
Queen’s University Belfast, Belfast, United Kingdom

Background: People with dementia are almost 50% more likely to have an acute hospital admission due to a common age-related illnesses, such as urinary tract infection. They also have an 18% higher risk of admission following discharge and approximately one quarter of hospital beds are occupied by people with dementia. Furthermore, people with dementia have an increased mortality rate in hospital and for six months after discharge compared to age-matched community dwelling people. The study assessed the hospitalisation and re-hospitalisation rates for people with dementia in Northern Ireland, as well as exploring whether mortality rates increase during or following these hospitalisations. A secondary aim was to explore the causes of hospitalisations between people with dementia and a representative age-matched control group.

Methods: Data from over 50,000 people with dementia and the control group from national databases in Northern Ireland were retrospectively analysed.

Results: The results showed that dementia does not affect hospitalisations; however, the number of hospitalisations can predict mortality in people with dementia. The most common causes for hospitalisation did not differ between the dementia and the control groups and included pneumonia, urinary tract infection and fractures.

Conclusion: The results inform health care professionals on whether a reduced number of hospitalisations increases life expectancy and may result in reducing some of the financial strain currently being experienced by the National Health Service.

60 IMPACT OF DEDICATED GERIATRICIAN INVOLVEMENT ON NATIONAL EMERGENCY LAPAROTOMY AUDIT STANDARDS AND OUTCOMES

Roisin Coary1, Cath Jenkings2, Ermoa Mitchell3, Anne Pullyblank4, David Shipway5

1Department of Geriatric Medicine, Southmead Hospital, North Bristol NHS Trust, Bristol, United Kingdom
2Department of Anaesthesia, Southmead Hospital, North Bristol NHS Trust, Bristol, United Kingdom
3Department of Surgery, Southmead Hospital, North Bristol NHS Trust, Bristol, United Kingdom

Background: Older patients undergoing emergency laparotomy (EmLap) have high levels of mortality and morbidity. The National Emergency Laparotomy Audit (NELA) in the United Kingdom records processes and outcome measures for patients undergoing EmLap.

Recent data shows that geriatrician review is associated with reduced post-surgical mortality (Olive C.M. et al., British Journal of Anaesthesia 2018). Geriatrician review of all patients aged >70 years is a NELA standard. However, the most recent national report shows only 23% compliance, falling short of the target of 80% and consistently the poorest performing standard.

Methods: In August 2018, we established a dedicated gastrointestinal surgery liaison service to replace ad hoc geriatrician reviews. We evaluated the impact on NELA standard compliance and patient outcomes.

Data were extracted from the local NELA database on all patients aged ≥70 years, for the first six months of the service (September to February). These were compared to the same time period in the preceding year prior to service launch.

Results: Following service introduction, increased numbers of patients aged ≥70 years underwent EmLap: 50 (2018-9) vs 31 (2017-8). Geriatrician reviewed occurred in 86% (n=43) in 2018-9, compared to 16% (n=5) in 2017-8. Inpatient mortality fell from 29% (n=7) in 2017-8 to 14% (n=7) in 2018-9. Discharge to own home rose to 76% (n=38) in 2018-9 from 68% (n=21) in 2017-8. One patient in each cohort was newly discharged to a nursing home. Mean length of stay was 17.9 days in 2018-9 (range 3-75), versus 17.6 in 2017-8 (range 3-34).

Conclusion: Introduction of a dedicated geriatric surgical liaison service is associated with increased compliance with NELA standards. Despite more emergency laparotomies being performed on older patients, this was associated with improved mortality and rates of home discharge, consistent with published data. Targeted investment in surgical liaison services may therefore be warranted.

62 ENGAGING OLDER ADULTS IN CO-CREATING A VIRTUAL COACHING ASSISTANT (CAPTAIN) TO SUPPORT INDEPENDENT LIVING AT HOME

Joanne Carroll, Louise Happer
Dublin City University, Dublin, Ireland

Background: As population age increases (CSO, 2010), the CAPTAIN project aims to prevent premature or unnecessary transfer to long-term residential care by offering a safe environment where older adults can retain their autonomy, dignity and independence. CAPTAIN (Coach Assistant via Projected and Tangible Interface) will develop a virtual eCoach assistant to facilitate independence in the home using augmented reality projections, voice and speech recognition, artificial intelligence and a user interface designed by older adults with their peers in mind.

Methods: Using Design Thinking and participatory research principles, older adults (n=10), caregivers (n=8) and healthcare professionals (HCPs) (n=2) co-create the CAPTAIN system with the research team. Co-creation occurs in cycles. Two co-design cycles use participatory workshops to identify older adults’ needs through discussion of typical older adult ‘personas’, examine how technology can support these needs and translate these outputs into system requirements. Four co-production cycles will evaluate CAPTAIN prototypes (hardware and software) to determine the effectiveness of person-centred technologies.

Results: Participants found the personas helpful in terms of generating conversation in the co-design sessions. They confidently described older adult needs, suggested where technology could provide useful support, and features they thought CAPTAIN should offer. Requirements across seven thematic areas (health, nutrition, physical and cognitive activity, accessibility, social interaction, education and safety) have now been sent to technical developers. Data from each cycle will continue to inform the development of CAPTAIN until system completion.

Conclusion: Participant contributions have ensured the continued development of an accessible, easy-to-use assistive technology system that will facilitate independent living and support older adults’ “...to do the things they want to do, when they want to do them”.

65 THE HEALTH AND WELL-BEING OF FAMILY CARERS OF OLDER PEOPLE: AN EXPLORATORY CROSS-SECTIONAL ANALYSIS

Deirdre O’Donnell
University College Dublin, Dublin, Ireland

Background: Family carers are critical to supporting older people to live well in their homes and demand for care at home is projected to increase dramatically into the future. The Irish state and health system, therefore, are dependent upon the supply of family care now and into the future. The health and well-being of family carers, and carers providing care to older people in the community, is under-researched.

Methods: A combination of online and postal survey distribution achieved a convenience sample (N=1102) of carers from the membership and network reach of Ireland’s largest family care support and advocacy agency. However, the most recent national report shows only 34% (n=391) of family carers aged over 64. Among family carers of older adults, 72% reported diagnosis or treatment for physical illness and 42% reported diagnosis or treatment for mental illness. The most frequently cited source of worry for this group was their own health and wellbeing (73%) followed by lack of appropriate supports/services.
abstract

HOW USEFUL IS AN INTEGRATED ASSISTIVE TECHNOLOGY SYSTEM IN A NURSING HOME? UNDERSTANDING ITS EFFECTIVENESS ON USERS AND THEIR PERCEPTIONS

Kazuko Obayashi1,2, Naonori Kodate6,3,1, Hiromasa Kondo3, Yoshihisa Okamoto2, Yukio Ishii1, Shigeru Matsuyma3,5,6

1 Tokyo Seishin-kai, Nishitokyo, Japan
2 Tokyo Shintoshin-kai, Nishitokyo, Japan
3 Universal Accessibility Aging Research Centre, Nishitokyo, Japan
4 School of Social Policy, Social Work & Social Work, University College Dublin, Dublin, Ireland
5 Public Policy Research Center, Hokkaido University, Sapporo, Japan
6 Tokyo Medical University, Tokyo, Japan

Background: With the arrival of a super-ageing society, the use of technologies in social care is not only necessary but inevitable. However, there is a dearth of evidence to demonstrate how assistive technologies (AT) can improve standards of care while improving the working conditions of care professionals and carers. Furthermore, little is known about users’ perceptions of such technologies.

Objectives: The objectives of this paper are: first, to test the effects of an integrated AT system on users (both care recipients and staff) in a residential care home; and second, to understand their perceptions of such technologies.

Methods: We combined an infrared monitoring camera with communicative robots and a sheet-shaped body vibrometer. A 4-week pre/post-intervention study was conducted, during which the evaluation was carried out before, during and after the intervention. Twenty care recipients (average age of 89.5) and 15 care professionals participated in the study. In order to measure the effectiveness of the integrated system, the care recipients’ quality of life was examining using the interRAI method. Regarding the impact on professionals, stress levels were examined during night shifts. Perceptions towards use of the system were also explored by the system usability scale (SUS) and semi-structured interviews.

Results: After the system was introduced, the number of unnecessary visits by care professionals during the night was dramatically reduced (by 8.2 times per person on average), and staff’s stress levels were also reduced. The SUS and interview data showed mixed results in terms of perceptions of care recipients and staff towards using the technologies.

Conclusion: Overall, the use of integrated assistive technologies yielded positive results. However, some issues were identified with regard to future implementation of such technologies in a residential care home. This study was financially supported in part by the Japanese Council of Senior Citizens Welfare Services.

CHALLENGES IN DEVELOPING AN AGE-FRIENDLY COUNTY PROGRAMME IN IRELAND: TRANSLATING GLOBAL WHO POLICY INTO LOCAL PRACTICE

Bernard McDonald
Irish Centre for Social Gerontology, NUI Galway, Ireland

Background: Developing age-friendly communities is a significant global policy issue. The WHO (2007) age-friendly cities and communities initiative has had a significant influence on the development of Ireland’s Age-Friendly Programme. With research on such programmes still at an early stage, this paper critically examines the utilisation of the WHO age-friendly planning framework in an Irish context. It explores older adults’ experience of living in two towns in an ‘age-friendly’ county and, in parallel, examines stakeholders’ perspectives on the development of the county’s age-friendly programme. This multi-perspective approach facilitates an assessment of how the age-friendly county programme addresses older residents’ needs, and illustrates how the WHO conceptual and planning framework has worked in an Irish context.

Methods: The paper reports on a study which employed a mixed-method, qualitative case-study research design, using a constructivist grounded theory approach to explore the lived experience of older adults, and a case-study framework for the stakeholder perspective.

Results: The research identifies salient social and cultural dimensions of the day-to-day lived experience of older people which, although they impact on the age-friendliness of places in which they live, are neglected in the WHO framework. It also identifies a unique combination of economic, political, cultural, and organisational factors which have impacted on age-friendly programme development in Ireland.

Conclusion: In critically analysing use of the WHO age-friendly model, the paper suggests ways in which the model can be modified to better accommodate the diverse experience of older adults not only in Ireland, but also in other geographic and cultural contexts.

PHYSICAL ACTIVITY PROMOTION USING MHEALTH: A SYSTEMATIC REVIEW AND META-SYNTHESIS OF ADULTS’ EXPERIENCES

Daniel Carter1,2, Katie Robinson1,2,1, John Forbes2,4, Sara Hayes1,2

1 School of Allied Health, University of Limerick, Limerick, Ireland
2 Health Research Institute, University of Limerick, Limerick, Ireland
3 Ageing Research Centre, University of Limerick, Limerick, Ireland
4 Graduate Entry Medical School, University of Limerick, Limerick, Ireland

Background: Well-documented health benefits are associated with 150 min/week of moderate-to-vigorous physical activity (PA). However, a majority of older adults do not follow this guideline and calls to address this disparity with technology have been made (1). Recommendations from the wider PA literature suggest the incorporation of mobile and wireless technology, i.e., mobile health (mHealth), into PA interventions (2). This study aims to identify and synthesise the evidence base on the experiences of adults using smartphone applications for the promotion of PA.

Methods: A systematic search of CINAHL, Embase, ERIC, Medline and PsyCINFO was conducted from November 2016 to October 2017. Primary qualitative studies with contactable data on the experiences of adults using mHealth for the promotion of PA were included. Data were analysed in NVivo using a meta-ethnographic approach.

Results: The initial search yielded 4,420 articles. After screening, fifteen articles were included, which included young adults, two included young adults and middle-aged adults, six included middle-aged and older adults and three included young, middle-aged and older adults, while one study did not report age. Because findings were not stratified by age, data were analysed collectively. Our inductive findings included the idea that end-users value the experience of personalisation offered by smartphone applications. Furthermore, mHealth raised awareness of individuals’ PA level, supporting them to strategise ways of incorporating PA into their routines. Finally, negative experiences were not uncommon, though were largely caused by poor design and technical faults (e.g. battery life/inaccurate data).

Conclusion: Our review provides evidence of the paucity of studies focused on the experiences of older adults using mHealth for the promotion of PA. Given recommendations for PA interventions to be tailored, particularly across the lifespan (2), and the positive findings noted in the current study, further primary qualitative studies exploring the perspectives of older adults are warranted.

DOES DUAL-TASK GAIT SPEED PREDICT COGNITIVE PERFORMANCE IN MIDLIFE TYPE 2 DIABETES? BASELINE RESULTS FROM THE ENBIND STUDY

Adam Dyere1,2, Isabelle Killean3, Nolliag Bourke3, Connor Woods5,7, James Gilney5,7, Desmond O’Neill2,1, Richard Reilly2,1, Sean Kelly2,7

1 Department of Age-Related Healthcare, Tallaght University Hospital, Dublin, Ireland
2 Department of Medical Gerontology, Trinity College Dublin, Dublin, Ireland
3 Trinity Translational Medicine Institute, Dublin, Ireland
4 School of Medicine, Trinity College Dublin, Dublin, Ireland
5 Department of Endocrinology, Tallaght Hospital, Dublin, Ireland
6 Department of Medical Gerontology, Trinity College Dublin, Dublin, Ireland

Background: Type 2 Diabetes (T2DM) in middle age is associated with a greater risk of dementia in later life. The longitudinal ENBIND Study is examining novel approaches
ACCURACY OF OFF THE SHELF ACTIVITY TRACKERS IN AMBULATORY SETTINGS IN YOUNG AND OLD ADULTS

John Barton1, Suzanne Timmants2, Salvatore Tedesco3, Marco Sica4, Colum Crowe1,5
Brendan O’Flynn3
1Trinity National Institute, University College Cork, Cork, Ireland
2Centre for Gerontological Rehabilitation, School of Medicine, University College Cork, Cork, Ireland
3University of Limerick, Co. Limerick, Ireland

Background: Wrist-worn activity trackers have experienced a tremendous growth lately. Robust studies of the comparative accuracy of currently available, mainstream trackers, in young adults versus older adults are still scarce in literature. This study explores the performance of ten trackers estimating steps, travelled distance, and heart-rate measurements against gold-standardled in two cohorts of young and old adults.

Methods: Overall, 38 subjects completed a structured protocol involving walking tasks, simulated household activities, and sedentary activities, including less standardised activities, such as dusting, vacuuming, or playing cards, in order to simulate real-life scenarios. Both wrist-mounted and chest/ wrist-mounted devices were considered. Gold-standards included treadmill, waist-mounted pedometer, ECG-based chest strap, direct observation or video recording according to the activity and parameter.

Results: Every tracker shows a decreasing accuracy with slower walking speed, which resulted in a significant step under-counting. Large mean absolute percentage error (MAPE) was displayed by every monitor at slower walking speeds.

During household activities, the MAPE in young adults climbing up/down-stairs ranged from 5.91-11.41% and 4.34-11.92% (dominant and non-dominant arm), respectively. However, for the same activities older adults displayed a larger MAPE, at 8.36-19.9% and 10.06-19.01%, respectively. Chest-worn or waist-worn devices had a more uniform performance. However, unstructured activities (dusting, vacuuming, playing cards), and accuracy in people using a walking aid represent a challenge for all consumer-level trackers.

Conclusion: This study shows a number of limitations to current, mainstream consumer-level wrist-based activity trackers, requiring caution if adopted in healthcare, whether clinical or research. This study demonstrates the particular delicts in commercial devices for use in an aging population, and provides some indications on how to best measure these health parameters in this population.

THE FACTORS WHICH IMPACT NON-FAMILIAL INTERGENERATIONAL INTERACTION WITHIN PUBLIC SPACE: AN INTEGRATIVE REVIEW

Clown Kennedy1, Pauline Boland2
1University of Limerick, Co. Limerick, Ireland
2School of Allied Health, Ageing Research Cluster and Health Research Institute, Co. Limerick, Ireland

Background: Intergenerational interaction is the communication which occurs between people from two or more generations and known benefits include improved psychological wellbeing and decreased social isolation. Intergenerational programs therefore have the potential to decrease risk of loneliness for older people. Public spaces are accessible and open for use to all people, irrespective of age or ability, and are therefore an important environment to consider for intergenerational interaction development. The aim of this review was to identify factors which impact non-familial intergenerational interaction within public spaces.

Methods: An integrative review of qualitative and quantitative peer reviewed literature was completed, from inception through January 2019. Academic Search Complete, Avery Citation Index and Web of Science were searched. The search yielded 488 articles, 16 of which were included. Research studies were critically appraised using the Crowe Critical Appraisal Tool and key data were extracted and synthesised to identify the factors which impact non-familial intergenerational interactions in public spaces, through a method of constant comparison analysis.

Results: Three key themes were identified: ‘Comparing naturally occurring non-familial intergenerational interactions with structured intergenerational programs’, ‘Barriers to non-familial intergenerational interactions in public spaces’ and ‘Successful non-familial intergenerational interaction achieved through shared activity’.

Conclusion: The findings highlighted that structured intergenerational programs have a greater chance of facilitating positive intergenerational interaction, as the presence of a group facilitator directly enabled non-familial intergenerational interactions. Successful non-familial intergenerational interactions were achieved through shared experiences of fun and meaningful activities. Barriers to non-familial intergenerational interaction in public spaces included lack of opportunities, negative attitudes towards intergenerational interactions, age stereotypes and age segregation. Older people have the potential to benefit most from non-familial intergenerational interaction, due to increased risk of loneliness and high participation rates in non-familial intergenerational interactions in public spaces.

THE CHARACTERISTICS OF FRAIL OLDER PATIENTS ADMITTED THROUGH AN EMERGENCY DEPARTMENT, WHO EXPERIENCE NEW DISABILITY DUE TO ACUTE ILLNESS

Sara Inglis, Siobhan Ryan, Jennifer Maher, Ciara Pender, Karen Sayers, Christina Donnellan, I Owen Pitty
South Tipperary General Hospital, Clonmel, Tipperary, Ireland

Background: No current tool reliably predicts functional decline risk. The modified Barthel Index (mBI) is a validated measure of disability, ideal for use within an interdisciplinary assessment. The aim of this prospective cohort study was to determine the proportion and characteristics of newly admitted frail older patients who experience drops in their Barthel index, requiring intervention.

Methods: Consecutive acute emergency patients identified as Variable Indicative of Place- mBI was compared, from January 1st 2019 to March 31st 2019. Data was entered into an excel database on demographics, baseline mBI and inpatient (within 72 hours) mBI, frailty-associated co-morbidities and multi-disciplinary interventions and analysed using Student’s T-test. Results: 150 consecutive patients were assessed with a mean age (±SD) of 83.1(±7.4). mBI scores were recorded for 111(74%) of patients. Mean mBI prior to current illness was 15.4(±4.9). Post-illness mBI was 12.5(±3.5), 65(58.6%) patients experienced an mBI drop. Mean drop was 4.9 (±2.8) points. There was no difference in an anatomical mobility between those who did or did not experience an mBI drop. Patients with a drop had higher mean pre-illness mBI (16.2 vs. 14.2;p-value 0.017, 4AT score (1.98 vs. 1.11; p-value 0.035) and increased falls history (40 vs. 18 patients;

Results: Five-hundred and ten patients with AD were included (mean age 72.8 ±1.8 years; 62.5% female). The median number of prescribed medications was 5 (IQR 3-7). Over half (62%) were prescribed at least one PIM, whilst a minority of patients (14.8%) were prescribed three or more PIMs. The most frequent PIMs were benzodiazepines >4 weeks without indication (n = 55), long-term Proton-Pump Inhibitor (PPI) use without appropriate indication (n = 49), use of non-steroidal antiinflammatories without use of PPI (n=19) and antimuscarinic use in dementia (n=18). On multivariate analysis, significant predictors of PIM use were higher total number of medications (p=0.001; OR 1.52, 1.36-1.59) in addition to greater AD severity, as rated using the Clinical Dementia Rating Scale Sum of Boxes (CDR-SB) (p=0.024; OR 1.18, 1.02-1.35).

Conclusion: The majority of older patients with AD were prescribed at least one PIM. Usage of PIMs was associated with greater number of medications and increased dementia severity. Particularly concerning is the potentially inappropriate use of benzodiazepines and anti-muscarinic agents in this population, given recent evidence for the adverse cognitive and motor associated with these medications. Des-prescribing and medication review interventions aimed particularly at patients with AD are warranted.

POTENTIALLY INAPPROPRIATE MEDICATIONS IN PATIENTS WITH ALZHEIMER’S DISEASE: DATA FROM NILVAD

Claire Murphy1, Adam H. Dyer1, Brian Lawlor2, Sean P. Kennedy3
1Tallaght University Hospital, Dublin, Ireland
2St. James Hospital, Dublin, Ireland

Background: Prescription of Potentially Inappropriate Medications (PIMs) is common in older adults and is associated with adverse drug events, hospitalisation and mortality. Less well described are the patterns and predictors of PIM usage in patients with Alzheimer’s Disease (AD), a patient group who may be particularly vulnerable to polypharmacy and medication associated adverse events.

Methods: Secondary analysis of the NILVAD trial, an international phase three trial of Nilotinidine in mild/moderate AD. The v2 STOPP/START criteria were individually applied by a physician to each participant’s medication list and cross-reference with their medical history to identify PIM usage. Predictors of PIM usage were modelled using binary logistic regression.

RESULTS: 103 AD ADMITTED THROUGH AN EMERGENCY DEPARTMENT, WHO EXPERIENCE NEW DISABILITY DUE TO ACUTE ILLNESS

Sara Inglis, Siobhan Ryan, Jennifer Maher, Ciara Pender, Karen Sayers, Christina Donnellan, Owen Pitty
South Tipperary General Hospital, Clonmel, Tipperary, Ireland

Background: No current tool reliably predicts functional decline risk. The modified Barthel Index (mBI) is a validated measure of disability, ideal for use within an interdisciplinary assessment. The aim of this prospective cohort study was to determine the proportion and characteristics of newly admitted frail older patients who experience drops in their Barthel index, requiring intervention.

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OPTIMISING EARLY ASSESSMENT AND INTERVENTION BY HEALTH AND SOCIAL CARE PROFESSIONALS IN THE ED: PRELIMINARY FINDINGS FROM THE OPTIMEND RCT

Ide O’Shaughnessy1, Stephen White1, Eimear Smaffe1, Marica Cassarino2, Katie Robinson3, Rose Quinn4, Boland Fiona5, Marie Ward5, Rosa McNamara4, Gerard McCarthy4, Margaret O’Connor4, Damien Ryan1,8, Rose Galvin1,8
1Emergency Department, University Hospital Limerick, Limerick, Ireland
2School of Allied Health, Faculty of Education and Health Sciences, Ageing Research Centre, Health Research Institute, University of Limerick, Limerick, Ireland
3Emergency Department, Our Lady of Lourdes Hospital, Drogheda, Louth, Ireland
4HRB Centre for Primary Care Research, Royal College of Surgeons in Ireland, Dublin, Ireland
5School of Psychology, Trinity College Dublin, Dublin, Ireland
6Emergency Department, St. Vincent’s University Hospital, Dublin, Ireland
7Emergency Department, Cork University Hospital, Cork, Ireland
8Clinical Age Assessment Unit, University Hospital Limerick, Limerick, Ireland
9Retrieval, Emergency and Disaster Medicine Research and Development Unit (REDSPoT), Emergency Department, University Hospital Limerick, Limerick, Ireland
10Graduate Entry Medical School, Faculty of Education and Health Sciences, University of Limerick, Limerick, Ireland

Background: Older adults are frequent users of emergency services and demonstrate high rates of adverse outcomes following emergency care. There is some evidence to suggest that Health and Social Care Professionals (HSCP) teams working in the emergency department (ED) can enhance the care of older adults but the quality of these studies is mixed. This trial was a controlled trial (Trial registration: NCT02739513) that explores the impact of early assessment and intervention by an ED-based HSCP team on the quality, safety and cost-effectiveness of care of older adults.

Methods: Consecutive ED attendees aged ≥65 years were considered eligible for inclusion in the trial and were screened for eligibility based on pre-defined inclusion criteria. Participants were randomised to either early assessment/intervention by interdisciplinary team comprising a senior occupational therapist, senior physiotherapist and senior medical social worker or standard care. Primary outcomes included: ED length of stay and hospital admission rates. Secondary outcomes included: patient satisfaction, function, quality of life, incidence of ED re-visits, hospital admissions, nursing home admission, healthcare utilisation and mortality at 30-day and 6-month follow-up.

Results: Considering the first 140 participants, the intervention group spent significantly shorter time in the ED than the control group (7.5 vs. 15.2 median hours, p<0.001) and experienced lower admission rates (18.6% vs. 64.3%). At 30-day follow up, healthcare utilisation rates were higher in the intervention than control group (77.2% vs. 61.4%, p=0.04). There were no significant differences between the groups regarding satisfaction with their ED visit, function, quality of life of incidence of adverse outcomes at 30 days.

Our cost-effectiveness analysis is ongoing.

Conclusion: Preliminary findings from our trial indicate that HSCPcs working in the ED contribute to improved older patients’ care by reducing their duration of stay in the ED and increasing rates of discharge home. Participant recruitment and six month follow-up is continuing.

ADDING NUANCE TO THE ROCKWELLICIALIFIEDRAILTY SCALE

William McKeown1, Simon Wright2, Rosemary Kelly1
1Lagan Valley Hospital, Lisburn, United Kingdom
2Cruagon Area Hospital, Cruagon, United Kingdom

Background: The Rockwell Clinical Frailty Score (CFS) is a well validated tool for assessing frailty. However, there is a paucity of data in the literature demonstrating how severity of clinical frailty correlates with adverse outcomes. This gap in the literature limits the ability of physicians, who predominantly use measures of frailty in day-to-day practice such as CFS, to fully construe the implications of increasing frailty for patients in their care.

Methods: In this prospective cohort study, participants (n=186) aged ≥65 years admitted for unscheduled medical care to a district general hospital, were assigned a clinical frailty score within 24 hours of admission. Patients were then followed up for 12 months and assessed in terms of mortality, discharge to institutional care, length of hospital admission, polypharmacy and re-admission rate.

Results: This study found significant differences between frail and non-frail populations in terms of adverse patient outcomes including mortality, length of hospital admission, polypharmacy, co-morbidity and re-admission rates. Of greater importance still, this study found that increasing risk of adverse outcomes correlated with increasing CFS. For CFS ≤4, 5, 6, 7, 8, 9 12-month mortality rate 7.75%, 28.6%, 31.4%, 37.14%, 87.5% and 100% respectively. For CFS ≤4, 5, 6, 7, 8, 9 rates of discharge to institutional care were 1.88%, 6.12%, 34.3%, 41.66%, 50% and 40% respectively.

Conclusion: These results are important as they begin to help physicians form a more nuanced interpretation of CFS. With growing emphasis on individualising patient care, binary categorisation of patients into ‘frail’ and ‘non-frail’ groups is felt to be an increasingly inadequate way of viewing frailty. This study adds information to the discourse which helps both physicians and patients to make more informed decisions regarding their ongoing medical care. Larger prospective cohort studies will now be required to understand correlation between severity of frailty and patient outcomes.

TO EXAMINE THE FACTORS AFFECTING THE HEALTH AND WELLBEING OF CENTENARIANS LIVING IN IRELAND

Alison Fagan, Lorraine Gaffney, Mary McDannel-Naughton
Athlone Institute of Technology, Athlone, Ireland

Background: The notable increases in life expectancies worldwide combined with advances in contemporary medicine, escalating healthcare costs and increased demands on social services has driven the interest in centenarians as a model for healthy ageing. According to the United Nations, the global number of centenarians is set to continue to climb, expecting to reach more than 25 million people in 2100 (Robine & Cubaynes, 2017). Though the role of genetics in the context of successful ageing is irrefutable, it is important to recognise that the determinants of ageing go beyond genetics alone and equal credence needs to be given to one’s social and economic circumstances, to their physical environment and finally, to one’s own individual characteristics and behaviours.

Methods: The study focused on selecting a subsample of participants who were 100 years or older until the saturation point was reached. This study employed story telling (one to one interviews) in order to give centenarians a voice. Stories help us to answer the “big” questions about the meaning of life in general and of our lives specifically.

Results: A number of key themes emerged from the study denoting the factors that affect the health and wellbeing of Irish centenarians including, social connectedness, resilience & robust personality, continued participation in life throughout the life course and spirituality.

Conclusion: This research demonstrates that the successful attainment of longevity goes beyond the maintenance of physical health and concludes that in order to promote optimum well-being among older people, it is necessary to take note of the experiences, views and values, of the older person themselves.


THE ROLE OF HEALTH AND SOCIAL CARE PROFESSIONAL TEAMS IN THE Emergency Department: A QUALITATIVE STUDY OF KEY STAKEHOLDERS’ VIEWS

Marica Cassarino1, Katie Robinson3, Rose Quinn4, Fiona Boland5, Marie E. Ward4, Rosa McNamara4, Gerard McCarthy4, Damien Ryan1,8, Margaret O’Connor3,8, Rose Galvin1,8
1School of Allied Health, Ageing Research Centre, Health Research Institute, University of Limerick, Limerick, Ireland
2Our Lady of Lourdes Hospital, Drogheda, Ireland
3HRB Centre for Primary Care Research, Royal College of Surgeons in Ireland, Dublin, Ireland
4School of Psychology, Trinity College Dublin, Dublin, Ireland
5Emergency Department, St. Vincent’s University Hospital, Dublin, Ireland
6Emergency Department, Cork University Hospital, Cork, Ireland
7Retrieval, Emergency and Disaster Medicine Research and Development Unit (REDSPoT), Emergency Department, University Hospital Limerick, Limerick, Ireland
8Graduate Entry Medical School, University of Limerick, Limerick, Ireland
9Clinical Age Assessment Unit, University Hospital Limerick, Limerick, Ireland

Background: Introducing Health and Social Care Professional (HSCP) teams to the emergency department (ED) has increasingly demonstrated benefits for ED patient and process outcomes. However, there is a dearth of research exploring the views of key ED stakeholders in the role of HSCP teams in care delivery the ED. This qualitative study investigated the perspectives of a wide range of ED stakeholders about HSCPcs teams working in the ED.

Methods: A total of 65 participants including older adults who had recently attended the ED and their carers/relatives, ED doctors and nurses, HSCPcs and pre-hospital staff participated in four World Café style focus groups and individual interviews across two Irish hospital sites. Written and audio-recorded data were transcribed and thematically analysed.

Results: Overall, participants expressed positive views on HSCPcs working in teams in the ED, with benefits for patients, staff members and the hospital (Theme 1). Having an ED-based HSCP team was described as promoting effective and timely decision-making and a more integrated approach to patient care, particularly for frail older adults with complex needs (Theme 2). Barriers and enablers for effective implementation were identified at multiple levels (Theme 3) including the ED physical environment, (e.g., space and equipment), operational factors (e.g., working hours), and relations (e.g., patient-staff or staff-staff communication); factors at system level included availability of community resources and financial pressures.

Conclusion: Our study indicates overall acceptability of HSCPcs working in teams in the ED and positive views on their contribution to enhance the quality care of older adults. However, a number of operational and relational factors need to be considered to ensure feasibility and effectiveness. This information is crucial to inform implementation.

USING RANDOM FOREST PLOTS TO EXAMINE PREDICTIVE AND DISCRIMINATIVE ABILITY OF MOBILITY MEASURES FOR FUTURE FALLS

Oma Donoghue1, Belinda Hernandez2, Matthew O’Connell2, Rose Anne Kenny1
1Department of Psychology, University of Ulster, Jordanstown, Northern Ireland
2School of Psychology, Trinity College Dublin, Dublin, Ireland

Background: Falls are a major cause of illness, disability and mortality in the older population. The ability to predict future falls using mobility measures has been shown to be possible. Using a random forest analysis, the study examined the ability of mobility measures to predict, with the most predictive being used to develop a future falls prediction model.

Methods: A longitudinal dataset was used consisting of 3 groups of older adults (n=300, age ≥65 years) recruited in a university and 2 community settings. Mobility measures were collected over a 2-year period (2012-2014) and included a mobility questionnaire, a mobility task score, and a mobility rank score. The data were used to develop a falls prediction model using random forests.

Results: The random forest analysis identified 4 mobility measures as being the most predictive of future falls: mobility questionnaire score, mobility task score, mobility rank score, and mobility rank score squared. The model achieved a maximum area under the receiver operating characteristic curve of 0.85, indicating high predictive ability.

Conclusion: The results demonstrate the potential of using mobility measures to predict future falls in older adults, with the random forest analysis providing a useful tool for identifying the most predictive measures for future falls prediction.


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ADVANCE CARE PLANNING IN PATIENTS WITH DEMENTIA: THE USE OF A MULTIDISCIPLINARY TEAM DISCHARGE REVIEW

3Mercer’s Institute for Successful Ageing (MISA), St James’s Hospital, Dublin, Ireland

Age and Ageing abstract

burdensometreatments, ensures dignity and comfort is prioritized enabling patients to live...days prior to death. Palliative care were involved in 40% of cases. Two patients did not have...was 84 and 53% were female. The commonest cause of death was respiratory (79.5%).

Methods: Data from the first three waves of The Irish Longitudinal Study on Ageing (TILDA), a population-based study of community-dwelling adults aged ≥50 years were used. Baseline physical, neuro-cognitive, sensory and behavioural health were assessed. The outcome was incurred (≥2) falls at Wave 2 or Wave 3. Poison regression analysis was used to examine associations between UGS, TUG and falls adjusting for covariates. Random forest models were used. Predictive accuracy was calculated using 5 fold cross-validation and as there was class imbalance, the algorithm was trained using undersampling of the larger class. Classification rate, area under the receiver operating characteristic curve (AUC) and area under the precision recall curve (PRROCC) were obtained to assess predictive accuracy.

Results: In poisson regression analysis (n=4918), TUG predicted recurrent falls independent of covariates including UGS (IRR=1.06, 95% CI: 1.01, 1.12, p<0.05). The random forest model correctly predicted 61.85% of non-fallers; 55.37% of fallers. AUC was 0.63 and PRROCC was 0.28.

Conclusion: Impaired mobility i.e. slower TUG performance, is an independent predictor of future recurrent falls, however it does not discriminate well between fallers and non-fallers. This is higher than our previously published PRROCC which provides a more conservative estimate of predictive accuracy than AUC as it accounts for the ability to identify both fallers and non-fallers. The analysis highlights the multifactorial nature and complexity of falls, and supports the need for comprehensive falls assessment.

ADVANCE CARE PLANNING IN PATIENTS WITH DEMENTIA:
AN AUDIT ON END OF LIFE CARE IN HOSPITAL DEATHS

Rachel Sullivan1, Clodagh Power2, Elaine Greene2, Rosin Purcell1

1Mercer’s Institute for Successful Ageing, Department of Medicine for the Elderly, St James’s Hospital, Dublin, Ireland
2Mercer’s Institute for Successful Ageing, Department of Psychiatry for the Elderly, St James’s Hospital, Dublin, Ireland

Background: End of life care (EOLC) planning is a difficult and often neglected area in dementia. Advanced care discussions play an important role in the planning of future care for patients with dementia. The NICE guidelines recommend that patients with dementia should be given every opportunity to discuss their wishes and preferences regarding their future care. The goal of our study was to explore the extent of EOLC planning in patients with dementia who died in hospital.

Methods: Patients with dementia who died in a large tertiary referral hospital in 2017 were identified via the Hospital Inpatient Enquiry (HIPe) database. A retrospective chart review was completed examining the documentation of Advance Care Planning (ACP) and discussions around end of life care. Charleston Comorbidity Index (CCI) was used to predict 1 year mortality.

Results: HIPe identified 49 patients with dementia who died in hospital. The average age was 84 and 53% were female. The commonest cause of death was respiratory (79.5%). Two thirds lived at home and 30% were nursing home residents. The mean CCI was 3.97 indicating 52% 1 year mortality, however only 34% were hospitalized in the last year. Only 14% had an ACP. Only 22% had resuscitation status recorded on admission. The majority had resuscitation status documented 15 days prior to death. In these cases 70% had clearly documented the discussion with family or patient and 84% documented ceilings of care 6 days prior to death. Palliative care were involved in 40% of cases. Two patients did not have resuscitation status documented prior to death and 3 received CPR.

Conclusion: Our study highlights the urgent need to facilitate conversations around end-of-life care with people with dementia. Advance care planning reduces the use of burdensome treatments, ensures dignity and comfort is prioritized enabling patients to live well until they die.

THE USE OF A MULTIDISCIPLINARY TEAM DISCHARGE "HUDDLE" TO IMPROVE PATIENT FLOW AND PLANNING

Mary Randles, Sylvia Hickey, Suzanne Cotters, Carmel Walsh, Kieran O’Connor, Catherine O’Sullivan, Keith McGrath, Aine O’Sullivan, Eileen Looney, Sharon Maher, Jane McGuan, Anna Higgins, Anne Quirke, Yvonne Allen

Mercy University Hospital, Cork, Ireland

Background: Patient flow, the movement of patients is an integral part of the patient care pathway. With the goal of improving overall patient care and discharge planning, a hospital wide, multidisciplinary team based, patient discharge meeting or ‘HUDDLE’ was devised with the goal of facilitating onward care planning for all inpatients especially those with complex discharge needs in a city centre teaching hospital.

Methods: The patient flow huddle has evolved to include a Patient Flow Clinical Nurse Manager, Bed Manager, Medicine for Older Persons Clinical Nurse Specialist, Physiotherapist/Occupational Therapist, Consultant Geriatrician and Geriatric Medicine Registrar. Each team in the hospital are requested to attend at least twice a week. Predicted discharge dates are established. Teams discuss patients who have a requirement for rehabilitation, either short-term or complex rehabilitation and patients over 65 years who may need review from Older Persons Services. We sought to optimise issues including housing, home care packages, interim home supports, community intervention team referrals, integrated care and Nursing Home Support Scheme applications.

Results: There were 3918 Emergency Department presentations by adults over 75 in 2018 and 2133 admissions (3704, 2081 respectively in 2017). Accuracy for discharge within one day of PDD ranged from 52.5% (Jan) to 72.6 % (Nov). The average length of stay was 6.2 days (SD 0.47). 172 patients (84 female, 88 male) were admitted for slow stream rehabilitation (median length of stay 30 days).

Conclusion: Rather than using a negative view of older adults as potential ’bed blockers’, the discharge huddle allowed a pro-active approach to assist medical and surgical teams in the management and re-enablement of patients with complex care needs. Early identification of such patients with complex care and discharge needs allowed greater focus on appropriate planning earlier in the patient’s hospital journey.

ORTHORHIGIATRICS, JUST THE BEGINNING

Hannah Smyth1, Siofra Hearne1, Peadra Monahan1, Rebecca Bermingham1, Sidra Nawabi1, Hadeer Ameen1, Shirley Tyrnouns1, Anant Mahapatra1, Blathnaid Ni Bhuaichail1, Cwynlyn Lynch1, Paul Bast1, Martin Murin1, Helen O’Brien1

1Our Lady of Lourdes Hospital, Drogheda, Ireland
2Our Lady of Lourdes, Droghed, Ireland

Background: The most common cause of admission to the orthopaedic ward are low trauma falls resulting in a hip fracture. These fragility fractures occur in older, frail, multimorbid patients and they are associated with a high mortality rate and significant loss of independence. The Irish Hip Fracture Database is a national clinical audit that aims to improve hip fracture care and patient outcomes. Using the Irish Hip Fracture Standards, we went to audit the care of hip fracture patients in an Irish Model 3 Hospital pre- and post- implementation of an orthogeriatrics service.

Methods: Local Irish Hip Fracture Database was reviewed to assess the six Irish Hip Fracture Standards prior and 4 months following the introduction of a consultant-led dedicated orthogeriatrics service.

Results: There were 63 hip fracture patients (mean age 81) in the pre-service group and 69 (mean age 81) in the post-service group. Standard 1: 5.2% of hip fractures were admitted to the orthopaedic ward within 4 hours in the pre-service group versus 18.8% post-service introduction (national average 11%, 2017). Standard 2: 67.9% underwent surgery within 48 hours and during working hours versus 67.8% (national average 69%, 2017). Standard 3: 3.5% developed a pressure ulcer during their stay pre-service versus 1.6% post-service (national average 3%, 2017). Standard 4: 4.8% were assessed by a Geriatrician pre-service versus 84% post-service (national average 50%, 2017). Standard 5: 24.6% received a bone health assessment versus 87.5% post-service (national average 73%, 2017). Standard 6: 1.8% received a falls assessment prior to discharge versus 82.8% post-service (national average 47%, 2017).

Conclusion: The introduction of a dedicated orthogeriatrics service has led to a more collaborative multi-disciplinary approach to patient care with evidence of improvements in all Irish Hip Fracture Standards. Commitment to a resourced orthogeriatric service providing rapid comprehensive geriatric assessments is essential to advance improvements in older patients’ care.

SATISFACTION WITH FOOD-RELATED LIFE OF IRISH ADULTS OLDER THAN 55 YEARS

Maria Dierrabi1, Jennifer Poppel2

1Institute of Technology Sligo, Sligo, Ireland
2Mary Immaculate College, University of Limerick, Limerick, Ireland

Background: Food is an important part of older people’s life; contributing to their physiological and mental well-being and to their satisfaction with life. The aim of this study was to investigate the factors that contribute to the satisfaction with food-related life of Irish community-dwelling adults older than 55 years.

Methods: A mixed methods approach was employed. Quantitative data were collected through a survey which tested how socio-demographic characteristics, food habits, mood and self-perceived health were correlated (Spearman correlation) with the 5 items from the satisfaction with food-related life (SWFL) questionnaire. Qualitative data were collected through open-ended questions which investigated the factors determining food satisfaction levels of the 81 adults (54 women) older than 55 years who participated in the study.

Results: The highest score (4.3/5) was given to the item from the SWFL questionnaire: “I am satisfied with the time I have to eat”. A mixed methods approach was employed. Quantitative data were collected through a survey which tested how socio-demographic characteristics, food habits, mood and self-perceived health were correlated (Spearman correlation) with the 5 items from the satisfaction with food-related life (SWFL) questionnaire. Qualitative data were collected through open-ended questions which investigated the factors determining food satisfaction levels of the 81 adults (54 women) older than 55 years who participated in the study.

Conclusion: Meats and food play an important role in older adults’ life; however, participants did not consider their life in relation to meals and food as ideal. Therefore, strategies need to be employed to improve food and meal experience for community-dwelling older adults to keep them healthy for longer. Food industry should focus on developing nutritious and sensory-appealing food for the older consumers. Finally, the finding that consumption of fruit leads to satisfaction with food-related life could be used as a health promotion message to change eating behaviour.
SEVERE DRUG INTERACTIONS (SDIS) AND POTENTIALLY INAPPROPRIATE PRESCRIPTIONS (PIPs) IN OLDER ADULTS WITH CANCER

Amanda Lawless1,2, Deirdre O'Mahony1,2, Mary Buckley1,2, Denis O'Mahony1,2, Paul Gaffney1
1 Cork University Hospital Cork, Ireland 2 University College Cork, Cork, Ireland

Background: The objectives of this study were to identify the prevalence of severe drug interactions (SDIs) and potentially inappropriate prescriptions (PIPs) in older adults with cancer.

Methods: A 12-month prospective observational study of patients ≥65 years admitted to an oncology centre was conducted. SDIs were assessed using Stockley's interaction checker. PIPs were identified using STOPP/START criteria. Logistic regression was applied to determine the influence of age, gender, co-morbidities and medication number on the likelihood of an SDI and a PIP.

Results: We enrolled 186 participants; mean age 72.5 (SD5.7) years, 46.2% female, mean co-morbidity number 7.5 (SD3.4), median medication number 7 (IQR4-9). Polypharmacy (≥6 medications) and major polypharmacy (≥11 medications) were identified in 60.8% and 17.7% respectively. Systemic anti-cancer therapies (SACTs) were concomitantly prescribed to 60.2%.

SDIs were identified in 50.5% participants; 7.5% ≥1 drug-drug SDI, 41.4% ≥1 drug-dosage SDI and 10.2% ≥1 drug-SACT SDI. The most common SDIs were beta-blocker/alpha blocker (n=12), Selective serotonin re-uptake inhibitor (SSRI)/proton pump inhibitor (PPI) (n=11) and SSRI/Aspirin (n=8). A strong correlation between medication and SDI number was identified (r=0.61, p-value < 0.001). For each additional prescription, the odds of an SDI increased by 50.8% (Odds ratio 1.508, 95% CI:1.288-1.764, p<0.001).

PIPs were observed in 73.1%; median 2(IQR-3). The most common PIPs were drugs prescribed beyond the recommended duration (46.8%), high-dose PPIs >8 weeks (34.9%) and regular opioids without naloxone (20.4%). Patients prescribed ≥1 PIP had more co-morbidities (8.4(I5-3.4) vs 5.2(S2-4.5), p<0.001), a higher cumulative illness rating score (18(IQR12-28) vs 11(IQR10-14), p<0.001) and more prescribed medications (8(IQR6-10) vs 5(IQR1-25), p<0.001). For each additional prescription, the odds of receiving a PIP increased by 79.2% (Odds ratio 1.792, 95% CI:1.459-2.28, p<0.001).

Conclusion: SDIs and PIPs are common in older adults with cancer and higher than previously reported. Comprehensive specialist medication evaluation, by a Geriatrician, may benefit patients.

BARRIERS AND ENABILERS OF ASSISTED DECISION-MAKING FOR OLDER PEOPLE IN ACUTE CARE HOSPITALS: A MULTI-STAKEHOLDER INQUIRY

Sarah Donnelly1, Diarmuid O’Coimín3, Deirdre O’Donnell1, Carmel Davies1, Ethni Ní Shé1, Francesco Fattori1, Marie Therese Cooney1, Diarmuid O’Shea1, Lorraine Kyne2, Marie O’Shea1, Thilo Krol1
1 University College Dublin, Dublin, Ireland 2 Mater Misericordiae University Hospital, Dublin, Ireland 3 St. Vincent’s University Hospital, Dublin, Ireland

Background: Ireland’s Assisted Decision-Making (Capacity) Act 2015 breaks from traditional views of capacity to consider the uniqueness of each decision with relation to topic, time, place and with a capacity to consider the uniqueness of each decision with relation to topic, time, place and each individual’s preferences. Communication outcomes were assessed using the Functional Independence Measure (FIM) for patients not referred.

Methods: Single-centre retrospective review of all stroke admissions from January to December 2018. Communication outcomes were assessed using the Functional Independence Measure (FIM) for patients not referred.

Results: SLT received referrals for 66% (n=41) of all stroke admissions (n=62). Mean age was 68 years (SD±14), compared with 70 years (SD±14) for patients not referred. 65% were female and 35% male. Patients requiring SLT had significantly longer length of stay (p=0.0072). 83% of referrals were for communication, 12% dysphagia, and 5% inappropriate. Of communication referrals, primary diagnoses were as follows: 17.5% dysarthria (n=6), 26.5% dysphasia (n=9) and 56% CCD (n=19). Patients with dysphasia showed greater improvement in FIMFAM scores (ks=1.3) than patients with CCD (ks=0.9) or dysarthria (ks=0.7). Patients with CCD comprised the largest cohort who required SLT on discharge (68%).

Conclusion: CCDs are highly prevalent and represented the largest subtype of communication disorders in this cohort. FIMFAM scores appear useful in assessing CCDs however they display insufficient sensitivity in capturing change within this population. This audit highlights the need for further interdisciplinary research, education and training into cognitive-communication difficulties with post-stroke populations.

PROGRAMME THEORY TO GUIDE THE ADOPTION OF ASSISTED DECISION MAKING WITH OLDER PEOPLE IN ACUTE HEALTHCARE: REALIST EVALUATION

Carmel Davies,1 Deirdre O’Donnell1, Ethni Ní Shé1, Sarah Donnelly2, Francesco Fattori1, Diarmuid O’Coimín3, Marie Therese Cooney1, Michelle O’Brien4, Diarmuid O’Shea1, Lorraine Kyne2, Marie O’Shea1, Thilo Krol1
1 School of Nursing Midwifery & Health Systems, University College Dublin, Dublin, Ireland 2 School of Social Policy, Social Work and Social Justice, University College Dublin, Dublin, Ireland 3 Mater Misericordiae University Hospital, Dublin, Ireland 4 St. Vincent’s University Hospital, Dublin, Ireland

Background: In Ireland, the Assisted Decision-Making (ADM) (Capacity) Act and emerging Codes of Practice provide a legal framework for Healthcare Professionals (HCPs) to enable ADM for patients with impaired capacity. ADM ensures that a person’s will and preference is at the centre of all decisions related to their care. This study conducted a
realist evaluation and developed a Programme Theory (PT) to highlight how ADM for older people can be operationalised within an Acute Care (AC) context.

**Methods:** Key informants with interest in ADM informed this evaluation. Interviews were conducted in two acute care (AC) sites with multidisciplinary HCPs working within older person services (n=20). Interviews with informants that recently received care within an AC setting involved older people (n=3) people with dementia (n=4) and family carers (n=5). Ethnographic observations from AC multidisciplinary team meetings also informed the review. The framework that guided the qualitative analysis was from a PT informed by literature on ADM implementation in healthcare (O’Donnell, Ní Shé, Davies et al. 2018).

**Results:** The refined PT is supported by credible evidence that is informed by authentic experiences of decision making support in the AC setting. Validation groups (n=4) with the key informants verified the PT. Three mechanisms were identified as a positive climate and receptive environment for the adoption of formal ADM. These are: AC that is guided by a clear policy process. • Acute care and practice that is informed by a shared commitment to person-centred care and shared decision making. • HCPs that operate within an AC setting where organisational learning informs practice through inter-professional training, mentorship and peer support.

**Conclusion:** Involving stakeholders in PT development enhances the utility, feasibility and applicability of the results. This PT provides a framework for those planning ADM implementation within the AC settings.

### Sarcopenia, Frailty and Malnutrition in the Older Adults in the Emergency Department Setting

Karen Lyons, Christopher Lee
Boston College, Boston, USA

**Background:** Little research focuses on the older adult with life-threatening illness and their carer simultaneously, nor the role of the interpersonal and familial context around them. The purpose of this study was to identify factors associated with poor mental health and lack of shared appraisal of symptoms.

**Methods:** Multicriteria Gerontological ED team using a standardised assessment tool, incorporating the Clinical Frailty Scale (CFS) and the mini-nutritional assessment short form (MNA-SF). Patients at risk of malnutrition (MNA-SF <12) were referred for dietetics assessment and screened for sarcopenia, using the European Working Group on Sarcopenia in Older People (EWGSOP2) algorithm for case finding, followed by grip strength and calf muscle measurement.

**Results:** In a convenience sample of patients referred to dietetics following initial screen in ED, 57% were female (25/44) and the mean age was 83 years (range 75-94). Eighty-eight percent (39/44) were at risk of malnutrition/malnourished and 25% (11/44) were diagnosed with malnutrition (MNA-SF score <6.7). Seventy-three percent (32/44) scored ≥4 on the CFS. Fifty-two percent of all patients (22/44) had a sarc-F ≥ 4 suggestive of sarcopenia, while 65% (20/44) had a probable diagnosis of sarcopenia and 39% (17/44) met diagnostic criteria for sarcopenia. Risk of malnutrition was more commonly observed in those patients with a CFS score ≥4 (94% vs. 75%), as was risk of sarcopenia (81% vs. 17%). Fifty percent (22/44) of all patients screened positive for suspicion of both frailty and sarcopenia (frailty score ≥4 and Sarc-F score ≥4).

**Conclusion:** Frailty, malnutrition and sarcopenia are frequently observed in older patients in the acute setting. The integration of screening measures for malnutrition, frailty and sarcopenia in clinical practice can facilitate the identification of patients for multi-component targeted interventions.

### A Dyadic Approach to Life-Threatening Illness in Older Adults and Their Spouse Carers

Karen Lyons, Christopher Lee
Boston College, Boston, USA

**Background:** Life-threatening illness and their carer simultaneously, nor the role of the interpersonal and familial context around them. The purpose of this study was to identify factors associated with poor mental health and lack of shared appraisal of symptoms.

**Methods:** Multicriteria Gerontological ED team using a standardised assessment tool, incorporating the Clinical Frailty Scale (CFS) and the mini-nutritional assessment short form (MNA-SF). Patients at risk of malnutrition (MNA-SF <12) were referred for dietetics assessment and screened for sarcopenia, using the European Working Group on Sarcopenia in Older People (EWGSOP2) algorithm for case finding, followed by grip strength and calf muscle measurement.

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**Conclusion:** Frailty, malnutrition and sarcopenia are frequently observed in older patients in the acute setting. The integration of screening measures for malnutrition, frailty and sarcopenia in clinical practice can facilitate the identification of patients for multi-component targeted interventions.

### Evaluating a Clinical Pharmacist Service in a Residential Care Unit

Claire Kavanagh, Eimear O’Dwyer, Rásín Purcell, Niamh McMahon, Morgan Crowe

**Background:** This study assessed the pharmacist role in a 80 bed residential care unit by:
• Quantifying the number and type of pharmacist interventions made and their acceptance rate.
• Assessing impact of pharmacist interventions on patient care.
• Assessing staff attitudes towards the clinical pharmacist service.

**Methods:** This was a non-blinded, non-comparative evaluation of the existing clinical pharmacist service in the unit. All residents were included. All pharmacist interventions over a 10-week period were recorded, then graded according to the Eadon scale by a consultant gerontologist and an experienced pharmacist to assess their impact on patient care.

**Results:** There were 619 pharmacist interventions. The most common interventions were: Drug Therapy Review, 34% (n=209) Technical Prescription, 26.5% (n=163) Administration, 19.3% (n=94) Drug Interaction, 10.4% (n=64) Medication Reconciliation, 8.5% (n=52) and 98% (n=596) of interventions were rated as having significance to patient care, of which: 48.4% (n=298) and 41.8% (n=257) of the interventions were rated as significant and resulting in an improvement in the standard of care.

**Conclusion:** The pharmacist has an important role in our residential care unit. Their involvement in the medicines optimization process positively impacts patient outcomes and prevents harm. Staff perceived a positive impact of the clinical pharmacist service provided on patient care and patient safety.

**Reference:**
2. STOPP/START criteria were used to assess for potentially inappropriate prescribing and continued need for each medicine.
A NATIONAL SURVEY OF CLINICIANS WHO ASSESS PEOPLE WITH SUSPECTED DEMENTIA: SERVICE CHARACTERISTICS AND PRACTICE

Suzanne Timmons1, Anna de Sui2, Emer Begley3, Mary Manning4
National Dementia Office, Tullamore, Ireland

Background: The Irish National Dementia Strategy (2014) identified timely diagnosis and multidisciplinary involvement as key priority areas. The National Dementia Office established a Diagnostic Project to develop a framework for diagnostic services nationally. As part of preparatory work, a national survey explored baseline peri-diagnostic practice in geriatric medicine, neurology and psychiatry of old age services.

Methods: A survey was developed by the project steering group, piloted, and then distributed to all 86 Geriatricians, 39 Neurologists, and 34 Psychiatrists of Old Age Psychiatriasts in Ireland. Two reminder e-mails were sent.

Results: In total, 56 clinicians responded (response rate 35%). The majority (74%) saw 1-20 people with suspected dementia (PwSD) per month. Most referrals came from General Practitioners or other physicians; but rarely from Health and Social Care Professionals. Most people were referred specifically for their memory complaint, rather than a co-morbidity. Waiting times for urgent review varied between 24 hours and 4 years; neurology services had the longest waiting times. Only 39% saw PwSD in a dedicated clinic; about the same proportion saw PwSD in their own home; or in residential care settings. About half reported assessing people with intellectual disability and suspected dementia, mainly the neurologists.

Conclusion: The Montreal Cognitive Assessment was the most commonly used cognitive tool (89%), followed by the Addenbrook’s Cognitive Examination (56%). Only 17% commonly used functional brain imaging in diagnosis, mainly neurologists; half of respondents ‘never’ or ‘rarely’ used cerebrospinal fluid analysis. Multidisciplinary input was mainly from Occupational Therapists (61%), Psychology/Neuropsychology (52%), and Nursing disciplines (33%). When asked which discipline would most benefit their diagnostic service, neurologists all chose psychology input; geriatricians selected a range of disciplines.

A MULTI-COUNTRY SURVEY TO EXPLORE WHAT KEY STAKEHOLDERS CONSIDER TO BE IMPORTANT IN A MODEL OF DEMENTIA PALLIATIVE CARE

Siobhan Fox1, Niamh O’Connor1, Jonathan Brennan2, Suzanne Guerin3, George Kernohan4, Aileen Murphy5, Suzanne Timmons1
1Centre for Gerontology and Rehabilitation, University College Cork, Cork, Ireland
2School of Nursing, Midwifery and Health Systems, University College Cork, Cork, Ireland
3School of Psychology, University College Dublin, Dublin, Ireland
4Institute of Nursing and Health Research, Belfast, Ireland
5Department of Economics, University College Cork, Cork, Ireland

Background: The Model for Dementia Palliative Care Project will develop a service delivery model for community-based dementia palliative care in Ireland. This responds to palliative care now being recognised as a priority in care for people with dementia. Various dementia palliative care services exist internationally; however little is known about what the service priorities would deem to be the most important aspects of service provision. The aim of this study was to identify what key stakeholders consider to be essential components of a model of dementia palliative care.

Methods: A web-based survey was developed, piloted (n=5), and revised. It was distributed electronically within five healthcare jurisdictions, in the Republic of Ireland, Northern Ireland, England, Scotland, and Wales. The target population was healthcare professionals, policy-makers, and academics, with an interest in dementia and palliative care. Content analysis of open ended questions was used to identify common themes within the data.

Results: Complete surveys were received from 112 stakeholders. The majority of respondents were female (86%). Identified key principles of care incorporated the philosophies of palliative care and good dementia care, with many describing ‘holistic’ and ‘person centred’ care as core. Important individual components were identified, including support for carers, advanced care planning, information, education and training, activities for ‘meaningful living’, comprehensive disease management, coordinated care management, and linking in with community health services and social activities.

Conclusion: Numerous components of a ‘good’ model were identified, along with possible barriers to implementation of the model. This study, as part of the larger project, will inform a model of dementia palliative care for the Irish Healthcare system with the potential to improve the experiences of people with dementia and their families.

INTERLEUKIN-6 AND C-ReACTIVE PROTEIN PREDICT ALL CAUSE DEATH AND POOR FUNCTIONAL OUTCOME AFTER NON-SEVERE STROKE AND TRANSIENT ISCHAEMIC ATTACK

Sarah Cavenagh1, John J. McCabe2, Murphy Sean1, Olina Belton3, M. Crowe4,1, Eamon Dolan5, Tim Cassidy5, Monica De Gaetano5, Maria Fitzgibbon6, Joe Harbisson5,1, Gillian Horgan5, Michael Marnane7,1, Anne Merwick8, David Williams2,1, P.J. Kelly2,1
1SCN7, Dublin, Ireland
2I. Stroke Service, Mater University Hospital and University College Dublin, Dublin, Ireland
3J. University College Dublin, Conway Institute, Dublin, Ireland
4St Vincent’s University Hospital, Dublin, Ireland
5James Connolly Memorial Hospital, Dublin, Ireland
6Mater Misericordiae University Hospital, Dublin, Ireland
7Beaumont University Hospital, Neurology, Dublin and Royal College of Surgeons in Ireland, Dublin, Ireland

Background: Inflammation plays a role in the development of ischaemic cerebrovascular events. High sensitivity C-reactive protein (CRP) is known to predict recurrent events. Little data exists for upstream serum markers of inflammation.

Methods: BIO-STROKE and BIO-TIA were multi-centre prospective biomarker and imaging studies of patients with non-severe stroke. TIA and controls. Exclusion criteria were malignancy, infection, recent trauma / surgery, recurrent stroke before phlebectomy/MRI. Serum biomarkers analysed included Interleukin (IL) – 6, CRP IL-1, IL-8, IL10, IL2p70, IFN and TNE/Plasma CRP and IL-6 were measured by mass spectrometry. Additional biomarkers were measured using ELISA. Follow up was performed at 7, 28, 90 days and 1 year.

Results: 680 patients (439 strokes, 241 TIA’s) and 68 controls were included in the analysis. The median age was 70 for cases. Carotid stenosis was present in 23.6% of cases. Median CRP was 5.75mg/L, 2.36mg/l and 1.87mg/L in the stroke, TIA and control groups (p<0.001). Median IL-6 was 5.86mg/L (stroke), 4.25gpg/ml (TIA), 3.06gpg/ml (control) (p<0.001).

On multivariate cox regression analysis baseline IL6 and CRP were independent predictors of all cause death at 1 year with a HR of 1.005 (95% CI 1.002-1.007, p<0.001) and 1.0055% CI 1.002-1.007, p<0.001) per unit increase. Both IL6 and CRP were associated with vascular death at 1 year. In adjusted analyses, IL6 and CRP were associated with poor functional outcome at 1 year (OR of 1.02 (CI 1.01-1.03) and 1.02 (CI 1.01-1.05) per unit increase, for IL6 and CRP respectively. On adjusted analysis, when IL6 was analysed as quartiles, there was a strong association with death at 1 year with an OR 1.87 (95% CI 1.19-2.93). CRF analysed as quartiles, demonstrated an OR for death at 1 year of 1.64 (1.18-2.46).

Conclusion: IL-6 and CRP may be a useful prognostic factor for the prediction of outcome and death after stroke at 1 year follow up.

A STRUCTURED LITERATURE REVIEW OF DIAGNOSTIC PROCESSES AND PATHWAYS FOR PEOPLE LIVING WITH YOUNGER ONSET DEMENTIA

Caroline Kity1, Suzanne Cahill2, Siobhan Cahill3, Tony Foley4, Bernadette Rack5, Brian Sweeney5, Rachel McGowan2, Siobhan Fox1
1School of Nursing and Midwifery, University College Cork, Cork, Ireland
2Assessment and Treatment Centre, St Finbarr’s Hospital, Cork, Ireland
3Department of General Practice, University College Cork, Cork, Ireland
4Alzheimer Society of Ireland, Dublin, Dublin, Ireland
5Cork University Hospital, Cork, Ireland

Background: Currently, 1 in 10 people diagnosed with dementia in Ireland are aged under 65, this is termed ‘Young Onset Dementia’ (YOD). Though small in numbers these figures (4000 people) are increasing, and important differences exist between people diagnosed with (PwYOD) and those diagnosed with later onset dementia (LOD). As dementia is now associated with younger age, clinicians are noted always on the alert for its diagnosis in younger people. Diagnosing YOD can be especially challenging since presentation may be atypical and there is a lack of clinical ownership in this area.

Methods: A structured literature review was conducted to identify optimum models of diagnostic processes and pathways for PwYOD. Two research questions were addressed: (i) what models for the diagnosis of PwYOD exist nationally and internationally, and what evidence supports these and (ii) what are the differences between diagnostic processes and pathways for PwYOD compared with PwLOD. A systematic search strategy was devised to identify all relevant scientific papers. Key databases were used, supplemented by grey literature searches. A narrative synthesis approach was undertaken to assess the literature identified.

Results: Pathways and processes to the diagnosis of YOD are unclear and complex and coordinated with LOD, diagnosis takes more time. PwYOD are more likely to have multiple referrals to different specialists, have their memory and cognitive complaints

abstract
misattributed to other factors such as depression and experience longer delays in obtaining a diagnosis.

Conclusion: Few evidence-based best-practice models or guidelines for the diagnosis of YOD exist internationally. Increased awareness of the signs and symptoms of YOD among all healthcare professionals is necessary. There is a need for improved linkages to be developed between Geriatric Medicine, Neurology, Psychiatry, and Primary Care services and in certain instances for suspected cases of YOD to be referred to neurology-led memory clinics.

DEPRESCRIBING IN FRAIL OLDER PEOPLE APPROACHING END-OF-LIFE: DEVELOPMENT AND VALIDATION OF STOPPFRAIL VERSION 2

Dennis Curran1,2, Paul Gallagher1,2, Denis O’Mahony1,2
1 Cork University Hospital, Cork, Ireland
2 University College Cork, Cork, Ireland

Background: Older people with advanced frailty are commonly prescribed lengthy, burdensome medication regimens. When life expectancy is likely to be limited, many of the prescribed drugs may be inappropriate. STOPPFrail Criteria were developed in 2016 to assist clinicians with deprescribing decisions in frail older people with limited life expectancy. Due to an expanding evidence base, updating of the criteria was required.

Methods: A focused literature review was performed to reassess the original criteria and propose new criteria. Eight panels, with expertise in geriatric medicine, general practice, palliative medicine, psychiatry and clinical pharmacology, reviewed and critiqued a new draft of STOPPFrail criteria. The revised list of criteria was then validated using Delphi consensus methodology.

Results: The expert panel agreed a final list of 27 criteria after two Delphi validation rounds. STOPPFrail version 2 proposes a method for identifying older people approaching end-of-life and emphasizes shared decision making in the deprescribing process. New criteria relating to the discontinuation of anti-hypertensive medications, anti-thrombotic therapies and vitamin D are included.

Conclusion: STOPPFrail version 2 has been expanded and updated for the purpose of assisting clinicians with deprescribing decisions in frail older adults approaching end-of-life. The criteria are based on an up-to-date literature review and consensus validation among a panel of experts.

A NOVEL INTEGRATED CARE APPROACH: SUPPORTING OLDER PERSONS TO REMAIN AT HOME

Sarah Tormey, Laura Binions, Aoife Dunne, Josephine Sis, Marie O’Connor, Siobhan Ferrell
Cork University Hospital, Cork, Ireland

Background: An Integrated Care Team (ICT) was established within our Day Hospital in September 2018 serving a catchment of older persons encompassing 3 Community Healthcare Organisations. The geographical spread of our patients poses challenges to the ICT in establishing an integrated network of services for patients. Provided here is a descriptive analysis of our patient cohort including basic demographics, co-morbidities, interventions and outcomes.

Methods: The team comprises of a Senior Physiotherapist, Occupational Therapist and Medical Social Worker supported by two Geriatricians. Referrals to the ICT are via the Day Hospital with a weekly multi-disciplinary team (MDT) meeting where they are discussed and prioritised. Interventions offered include domiciliary and day hospital based assessments. Following assessment appropriate targeted therapeutic interventions are provided which includes rapid access to enabling equipment, access to community supports and rapid access Geriatrician review. Additionally the ICT communicate with the acute and primary care services to identify existing or previous resource utilisation.

Results: In the inaugural 15 weeks of the service, 132 referrals were received. This cohort had a mean age of 81.81 years (SD 2.70 years); 58% female; 42.6% male. The Charlson Co-morbidity Index (CCI) score ranged from 2.9 to a mean score of 5.0. Of these, 56% had a Dementia diagnosis, 33% had a Falls history and 17% had a Stroke diagnosis. The mean Rockwood Clinical Frailty Scale score was 5; range (2–7). 62% of referrals were reviewed by both Physiotherapy and Occupational Therapy, 58% by Medical Social Work. 34/132 required input from all 3 disciplines.

Conclusion: The ICT has augmented the existing Day Hospital with timely multi-disciplinary assessment and treatment enabling older persons’ independence within their home in addition to forward planning if dependency levels increase. Additional benefits include reduction of primary care team waiting lists and forging links with our community and local rehab services. Future ambitions include recruitment of specialist nursing and direct referral pathways from our community colleagues.

INVESTIGATING THE DELIVERY OF FALLS PREVENTION INTERVENTIONS TO OLDER PEOPLE FOLLOWING MULTI-FACTORIAL RISK ASSESSMENT: A CROSS-SECTIONAL STUDY

Rebecca Danesky1, Patrick J. Barry2, Kieran A. O’Connor3, Finola Cronin3, Spencer Turvey1, Eileen McManus1, Elise O’Reilly1, John P. Browne1, Sheena McHugh1
1 University College Cork, Cork, Ireland
2 Cork University Hospital, Cork, Ireland
3 Mercy University Hospital, Cork, Ireland

Background: Falls are one of the most common threats to older peoples’ independence. In Ireland, approximately one in three adults aged ≥65 years fall each year. Multifactorial interventions, which include an assessment of an individual’s risk of falling followed by customised interventions or referrals have been shown to reduce the rate of falls among community-dwelling older people. As part of an Integrated Falls Prevention Pathway initiated in 2016, six multidisciplinary risk assessment clinics were established in Cork city and county. The aim of this study is to examine whether recommended follow-on interventions were following a falls risk assessment in the community.

Methods: Routinely collected administrative data for clients who attended a falls risk assessment clinic are being collated. Data include client demographics, onward referrals, waiting times and receipt of intervention. A process map of the patient pathway following a falls risk assessment is under development and will be refined based on the study findings.

Results: Preliminary analysis of a two-year implementation period (April 2016–2018) indicates that following assessment, clients received an average of 2.4 onward referrals. Most referrals were made to general practice (29%, n=315), community physiotherapy (25%, n=272), and community occupational therapy (15%, n=165). Other referrals were to public health nurses (n=104, 10%) and falls prevention classes (n=60, 6%). Further analysis will identify the percentage of individuals who receive interventions, the type of interventions received, the percentage of patients who do not attend and the waiting lists.

Conclusion: The Integrated Falls Prevention Service is the sole example of an operational integrated falls pathway in Ireland. This research will identify potential roadblocks for providers and clients along the pathway and will identify opportunities to. The results will also be used to inform service planning and resource allocation to ensure that this model of care is sustainable.

PREVALENCE OF DEPRESSION AMONG PEOPLE WITH DIABETES: COMPARATIVE ANALYSIS OF OLDER ADULTS ACROSS THREE HEALTH SYSTEMS USING NATIONALLY REPRESENTATIVE DATA

Niamh McGrath1, Sheena McHugh1, Elaine Tormey, Patricia Kearney1
1 School of Public Health, University College Cork, Cork, Ireland
2 School of Psychology, National University of Ireland, Galway, Galway, Ireland

Background: The co-occurrence of depression and diabetes is an emerging global challenge but any association is influenced by variations in prevalence, study design and measure used. We compared depression prevalence in older adults with and without diabetes across three health systems using a validated measure to examine the causal association between diabetes and depression.

Methods: We used data of adults aged over 49 years, from three nationally representative ageing datasets; The Irish Longitudinal Study on Ageing (TILDA), the English Longitudinal Study on Ageing (ELSA) and the Health and Retirement Study (HRS). Data were collected during 2009–2011 (TILDA), and 2010 (ELSA, HRS). The 8-item CES-D scale captured depression using recommended cut-off scores of ≥3 for ELSA and HRS and ≥4 for TILDA. Self-reported individual, environmental, behavioural risk, and health system exposure variables were selected a-priori using literature and a directed acyclic graph.
Prevalence was presented as a percentage with corresponding 95% confidence intervals. Binomial logistic regression examined the odds of depression by diabetes status. Data were analysed in Stata v15 using the svy function.

Results: Diabetes prevalence (Ireland:8% [95%CI:7.5–8.6], England:11% [95%CI:10.6–12.0] and USA:19% [95%CI:18.8–20.1]; p<0.001) and depression prevalence (Ireland:10% [95%CI:9.0–10.6], England:16% [95%CI:15.1–16.9], USA:14% [95%CI:13.5–14.7]; p<0.001) varied across countries. Depression was consistently higher among people with versus without diabetes (Ireland:14% [95%CI:10.9–16.6], England:9% [95%CI:7.8–10.3], p<0.001), England:25% [95%CI:21.7–27.7], vs. 15% [95%CI:14.2–15.9]; p<0.001) and USA:19% [95%CI:16.9–20.0] vs. 13% [95%CI:12.4–13.8]; p<0.001). The odds of depression were significantly higher in people with versus without diabetes (Ireland:OR=1.5 [95%CI:1.2–1.9], p=0.001, England:OR=1.8 [95%CI:1.5–2.2]; p<0.000, USA:OR=1.8 [95%CI:1.3–1.7]; p<0.000), but only remained significant in the English sample after adjustment (England:OR=1.2 [95%CI:1.0–1.6]; p=0.045, USA:OR=1.3 [95%CI:1.0–1.6]; p=0.009). 

Conclusion: Among older adults in different health systems, depression was consistently higher among people with versus without diabetes. The findings support incorporation of holistic approaches to diabetes management across health systems.

DANCE ARTIST AND PHYSIOTHERAPIST COLLABORATION IN STROKE REHABILITATION

Gillian Harte, Ailish Claffey, Desmond O’Neill
Tallaght University Hospital, Dublin, Ireland

Background: Many studies have measured the benefits of dance for patients, in particular those with neurological disease, with positive effects demonstrated in functional outcomes, wellbeing and patient experience. However, neither the value of dance when used as an adjunct to stroke rehabilitation nor the act of collaboration between dance artist and physiotherapist has previously been studied.

Aim: To explore the experience and process of collaboration between the physiotherapist and dance artist when dance is used as an adjunct to conventional physiotherapy post-stroke in a geriatric medicine and stroke service in a university teaching hospital.

Methods: The study used a descriptive qualitative design and a convenience sample of 8 participants were recruited from the stroke rehabilitation ward. The physiotherapist advised the dance artist on specific movement goals for each session. The physiotherapist and dance artist kept individual diaries which included subjective and professional assessment of outcomes. Exploratory analysis was used to discover emerging themes.

Results: Themes identified fell into the categories of physiotherapist learning, dance artist learning, collaborative process, language, and the therapeutic relationship. While benefits such as greater liberation of patients’ movements and higher endurance rates were recorded, what was particularly of note was the communication between the physiotherapist and the dance artist. The language used was key: physiotherapy discourse tends to be more specific to particular movements whereas the dance artist relates more to the overall movement of the individual, identifying movement patterns and habits.

The dance artist uses the lens of chorological studies (the science of movement) when working with patients and this way of working was particularly beneficial. In particular the use of metaphor writing became an invaluable resource in terms of communication.

Conclusion: Within this study we questioned: what is required to create successful collaboration within a medical context? We hope that describing how this particular collaboration was successful will benefit those interested in similar collaborations.

SCREENING FOR FRAILTY IN THE EMERGENCY DEPARTMENT: COMPARISON OF TOOLS

Steve Macdonald1, Simon Gray2, Laura Kenny3, Edin Ni She1, Marie Therese Cooney2
1 University College Dublin, Dublin, Ireland
2 St. Vincent’s University Hospital, Dublin, Ireland

Background: Numerous tools exist to screen for frailty in clinical settings but a single internationally accepted standard has not been adopted. Recent research indicates that more than one tool is often deployed by clinicians to diagnose frailty. This study aimed to compare the use of two screening tools in the emergency department and assess the predictive ability of keywords in triage notes to detect frailty.

Methods: Frailty screening was carried out on 198 individuals (100 female / 98 male) attending the emergency department of a large urban teaching hospital, using the Rockwood Clinical Frailty Scale and the Variable Indicative of Placement Risk (VIP) scale. Average screening time for Rockwood was 43.1 ± 21.7s, whilst average screening time for VIP was 11.8 ± 8.5s. Results were dichotomised to frail, corresponding to Rockwood scores of ≥2 or VIP scores of ≥2, or non-frail (Rockwood=1 or VIP=0) for comparisons. 

Triage notes were reviewed to find keywords associated with frail patients.

Results: Among 198 individuals screened, 149 (75.3%) were frail according to Rockwood, and 143 (72.2%) according to VIP. 25 (12.6%) of the 198 individuals were categorised as frail according to Rockwood but were non-frail according to VIP. Among these, 8 were female (8% of all female patients; 6 were 75+ years of age, and 2 were under 75) and 17 were male (17.3% of all male patients; 11 were 75+ years of age and 6 were under 75). Key VIP was associated with frailty when identified from triage notes, across two different categories: Falls/ mobility/ balance; Cognition; Living circumstances; Nutrition; Other frailty-associated conditions; and General deterioration.

Conclusion: Comparison of the two scales suggests that frailty could be missed if relying on a single index. This effect may be more frequent in men than women. Screening triage notes to identify frailty-associated keywords may be a helpful adjunct to existing tools.

THE TIMING OF “DO NOT ATTEMPT RESUSCITATION” DECISIONS IN AN OLDER, FRAIL INPATIENT POPULATION

Anna McDonough, Shane O’Hanlon
St. Columcille’s Hospital, Dublin, Ireland

Background: Ascertaining and discussing resuscitation status should be a routine part of medical practice. However, it is frequently neglected until a patient is acutely unwell. The National Consent Policy1 recommends that discussion around “Do not attempt cardiopulmonary resuscitation” (DNACPR) orders should occur for patients with “an identifiable risk of cardiorespiratory arrest occurring”. The Clinical Frailty Scale is a useful tool for providing predictive information about the risk of death in older patients2. Along with the presence of comorbidities, it can assist with determining prognosis and identifying patients for whom early discussion about resuscitation status is appropriate.

Methods: A chart review was carried out of all 106 inpatients in a model 3 hospital. Data was extracted on demographic information, frailty score and resuscitation status.

Results: The average age of inpatients was 79.8 years. On admission, the average Clinical Frailty Scale score was 5 (mild frail), with 15% having a frailty score of 7 or more, and 28% a diagnosis of dementia. 25.5% of inpatients had a DNACPR order in place. It took an average of 32.4 days (range 0-224 days) from admission until this decision was made.

Conclusion: As we are caring for an older population with frailty; care planning, including resuscitation status should be discussed at an earlier stage. Ideally, this should occur on admission for certain patients, particularly those with high levels of frailty and multiple comorbidities. Our current practice, in which DNACPR decisions sometimes take place after a prolonged admission, is suboptimal. A change to the medical admission proforma, adding a prompt for discussion of DNACPR orders will be considered.

References:

PYJAMA PARALYSIS: TIME TO MAKE A MOVE!

Donal Fitzpatrick, Kate Doyle, Gerard Finn, Paul Gallagher
Genetric Department, Cork University Hospital, Cork, Ireland

Background: The adverse effects of inpatient falls are well known. The harms of unwarrented bedrest and prolonged immobilisation present insidiously but, arguably, have a greater impact. Deconditioning, itself, is a major contributor to falls in older adults. There is still a troubling assumption that falls can be prevented through restraint and preventing at-risk patients from mobilising.

Methods: We reviewed medical and nursing notes and conducted brief-structured inter-views with nurses and brief bedside observations for medical inpatients aged ≥75. We constructed a research template based on the UK National Falls audit 20153 and the Hospital Elder Life Program (HELP) - mobility toolkit4. We included all patients on medical wards over the age of 75, admitted for 3 or more days. We excluded patients who were critically unwell or imminently dying.

Results: We reviewed 100 medical inpatients aged over 75. Patients’ mobility deteriorated significantly from their baseline, with 73% of patients requiring assistance compared to 22% at baseline. PJ paralysis was endemic with only one third of patients wearing day clothes. 75% of patients spent more than half of the day in bed. There were 8 falls during the entire study period. Poorer levels of mobility correlated with delirium and incontinence.

Conclusion: The deleterious effects on older patient of the traditional model of acute hospital care with gratuitous bedrest are universally acknowledged. Falls should be prevented through supervision rather than restraint. Campaigns such as “End PJ Paralysis” and the HELP mobility toolkit could enable a cultural change within hospitals. Such change is impossible without the staffing and leadership to endorse it.

SOCIOECONOMIC AND SOCIAL FACTORS AMONG COMMUNITY-DWELLING DEPENDENT OLDER PEOPLE WITH COGNITIVE IMPAIRMENT IN IRELAND

Lauren Swan1, Maria O’Sullivan2, Austin Warters3, Kate Irving4
1 Trinity College Dublin, Dublin, Ireland
2 Trinity College Dublin, Centre for Health Sciences, St. James’ Hospital, Dublin, Ireland
3 Services for Older People, Health Service Executive, Community Healthcare Organisation, Ballymun Healthcare Facility, Dublin, Ireland
4 School of Nursing and Human Sciences, Dublin City University, Dublin, Ireland

Background: Dementia, and related cognitive impairment, is prevalent in dependent older adults in receipt of formal home care. For many, this is a determinant of transition into long-term care (Agepall., 2019). Our study aimed to explore social and socioeconomic factors in community dwelling older people in receipt of formal home care. To our knowledge social deprivation has not been previously investigated in this population in Ireland.

Methods: This study comprised a large cohort (n=1597) of community-dwelling adults aged 65 years or older who were in receipt of formal home care. Demographic, living setting, dependency (Barthel Index) were recorded; cognitive dysfunction (CD) included dementia and related cognitive impairment (Agepall., 2019). Social deprivation was captured by the Pobl HEP Deprivation index which categories affluence or disadvantage by residential area in Ireland.

Age and Ageing
Results: The study population (n=1597) was of mean age 83.3 ± 7.2, supported by 11.1 ± 7.2 hours of home care per week and 10.8% and 31.7% were categorised as of disadvantaged and affluent deprivation status, respectively. Those who received home support in areas of disadvantage were significantly younger than in affluent areas (79.1 ± 7.3 vs 85.6 ± 6.87 years, p < 0.001). Prevalence of CD was 43.3%. CD vs non-documented CD were characterised by a significantly higher proportion of females (66.5% v 61.4%, p < 0.05), widowed (8% vs 9.5%) and very disadvantaged (7.4% vs 5.0%, p < 0.05). Furthermore, the CD group had a significantly higher falls risk but lower physical dependency (Barthel), lower requirement for mobility support and higher need for meal assistance. Home care hours were higher (11.6 ± 7.2 vs 10.8 ± 7.2 p < 0.001) for the CD group, and comprised generic, rather than dementia-specific support.

Conclusion: The findings have implications for developing personalised dementia-specific home support and interventions. Further research is needed into disadvantaged deprivation and the need for home support at a younger age.

### SYSTEMATIC REVIEW OF FIBRINOGEN AND RISK OF RECURRENT STROKE AND VASCULAR EVENTS AFTER ISCHAEMIC STROKE OR TRANSIENT ISCHAEMIC ATTACK (TIA)

John J McCabe,1,2,3 Emear O’Reilly,2,3 Sarah Caveney,1,2 Ronan Collins,4,5 Simon Cronin,1 Joe Harbison,1 Tim Cassidy,1 Eamon Dolan,1 Margaret O’Connor,1,2 David Williams,1,2,3 George Pope,1 Sean Murphy,2,1,3,5 Peter Kelly,1,2,3

1 Health Research Board Stroke Clinical Trials Network Ireland (SCTNI), Dublin, Ireland
2 Mater Misericordiae University Hospital, Dublin, Ireland
3 Water Manorscare University Hospital, Dublin, Ireland
4 University College Dublin (UCD), Dublin, Ireland
5 Trinity College Dublin (TCD), Dublin, Ireland

Background: Inflammation is thought to play an important role in atherosclerotic stroke mechanisms. There is growing interest in the prognostic role of inflammatory biomarkers as risk factors for recurrent vascular events, after ischaemic stroke or transient ischaemic attack (TIA). Elevated fibrinogen levels are independently-associated with the risk of first-ever stroke. However, the prognostic value of fibrinogen, after ischaemic cerebrovascular events is uncertain.

Methods: We searched EMBASE and Ovid Medline, from 1970-2019 January, for any study that measured Fibrinogen after stroke or TIA, and related it to the risk of recurrent stroke or recurrent vascular events. All records were assessed by 2 independent reviewers. Any disagreements between authors regarding eligibility were resolved by consensus.

Results: We identified 2,520 publications, of which, 15 articles from 16 individual studies were eligible (11 observational cohorts, 3 cohort studies within randomized control trials, 2 case-control studies). The sample size for recurrent stroke and recurrent vascular events was 9,963 and 7,181 patients, in 11 and 10 studies, respectively. The time from event to phlebotomy was < 7 days in 5, 7-90 days in 6, and >90 days in 5 studies, respectively. There was marked heterogeneity in statistical methodologies employed to examine the relationship between fibrinogen and outcomes, which did not allow valid meta-analysis (above/below specified threshold (n=6), differences in mean/medians (n=5), risk per unit increase (n=1), per standard deviation (n=3), per quartile (n=1), per decile (n=1) or not specified (n=10)). 4 studies adjusted for all conventional vascular risk factors (age, smoking, diabetes, hypercholesterolaemia/statin use, and hypertension). 2 of 11 studies found a positive association with recurrent stroke. 5 of 10 studies found a positive association with recurrent vascular events.

Conclusion: The prognostic value of Fibrinogen after stroke or TIA remains unclear. Standardised methods and fully-adjusted multivariable analysis are needed in future prognostic studies.

### PHYSICIANS’ PERCEPTIONS TO ELECTRONIC ALERTS FOR DELIRIUM AND DEMENTIA SCREENING - QUALITATIVE ANALYSIS OF BYPASS REASONS IN AN ELECTRONIC PATIENT RECORD

Darragh Rice,1 Lucy Chapman,1 Mel Corbett,1 Grainne Courtney,1 Brian Lavelor,1,3 St. James’s Hospital, Dublin, Ireland
2 University of Limerick, Limerick, Ireland
3 Global Brain Health Institute, Trinity College Institute of Neuroscience, Dublin, Ireland

Background: Delirium and dementia are common cognitive disorders within an inpatient hospital population (Mukadam & Sampson 2010) Efforts were made to improve detection by embedding the 4AT Test (4AT) cognitive screening tool within the hospital electronic patient record (EPR). Non consultant hospital doctors (NCHDs) and consultants were prompted to complete the electronic 4AT on all inpatients aged 65 years and over at 24 hours into admission. Doctors could opt to bypass completion of the screening assessment but a reason for bypassing was required.

Methods: Reasons for bypassing the 4AT electronic alert were analysed using mixed methods during a seven week time period between June 28th and August 16th 2018. Free text entries were grouped into 15 qualitative categories. Quantitative methods using descriptive statistics were subsequently applied to qualitative categorisation.

Results: During seven weeks of analysis, hospital doctors bypassed electronic 4AT screening on 2473 occasions equating to a mean of 50.5 bypasses per day. Overall 40% of free text entries documented were below specified threshold (n=6), differences in mean/medians (n=5), risk per unit increase (n=1), per standard deviation (n=3), per quartile (n=1), per decile (n=1) or not specified (n=10). 4 studies adjusted for all conventional vascular risk factors (age, smoking, diabetes, hypercholesterolaemia/statin use, and hypertension). 2 of 11 studies found a positive association with recurrent stroke. 5 of 10 studies found a positive association with recurrent vascular events.

Conclusion: The findings have implications for developing personalised dementia-specific home support and interventions. Further research is needed into disadvantaged deprivation and the need for home support at a younger age.
Results: Thirty-two questionnaires were completed by PwP's. Four semi-structured focus groups were held (n=24 participants). Participants were overall positive about wearable technology in PD and perceived benefits in wearable technology for improved management of symptoms. Wearables should be user-friendly, have an appealing design, and demonstrate clinical usefulness. Comfort and discrete design were emphasised for greater usability.

The value of sharing information between PwP's and health professionals for improved outcomes was highlighted. PwP's perceived that increased patient data in the form of reliable information from a wearable device may allow for more accurate management of PD. Participants also felt that a device could help increase physical activity, and potentially track compliance with medication. There was little focus on device safety and privacy/ownership of data. We, the participants anticipated that there may be challenges for some in wearing a device, they believed overall potential benefits would outweigh these.

Conclusion: Engagement of PwP's in the design of wearable technology is vital for the development of devices that improve the management of PD. This study will directly inform a multi-country feasibility-study of wearable devices for older people, with a particular focus on the needs of PwP's.

261 SLEEP AND FRAILTY: EXAMINING THE EFFECTS OF FRAILTY ON SLEEP DISTURBANCE IN HOSPITALISED OLDER ADULTS
Helen Mannion1, Rónán O’Carroll2,3
1 National University of Ireland, Galway, Galway, Ireland
2 Mercy University Hospital, Cork, Ireland
3 University College Cork, Cork, Ireland

Background: Sleep disturbance is common in hospital, potentially resulting in poor clinical outcomes. Frailty is a prevalent and assessable with multiple adverse events. Despite this, little is known about the interaction between frailty and sleep among older hospital inpatients.

Methods: Consecutive, non-critically ill patients aged ≥70, admitted medically through a large university hospital emergency department (ED) during the preceding 24 hours, were evaluated with measures assessing overnight sleep quality (Richards Campbell Sleep Questionnaire/RCSQ); baseline sleep (Pittsburgh Sleep Quality Index/PSQI) and insomnia (Insomnia Severity Index/ISI). Additional variables included medications, frailty (PRISMA-7 scores ≥3 and Clinical Frailty Scale/CF(S) scores ≥5), functional and cognitive status, and night-time noise levels. Patients were reassessed 48 hours later.

Results: Over four weeks, 152 patients, mean age 80±6.8 years were included; 61% were male (n=92). In all, 43% were frail (mean CPS score 4.23±1.6), median PRISMA-7 score was 4.5±4.4. 72% were further classified as pre-frail. The median Charlson Comorbidity Index score was 6±2. The majority, 72% (110/152), reported impaired baseline sleep quality (PSQI ≥5) and 15% (20/152) had clinical insomnia (ISI ≥15). The median time spent in ED was 23±13 hours, median duration asleep was only one hour (range 0-8). After adjusting for possible confounders, frailty status was significantly associated with lower PSQI (p=0.001) but not ISI (p=0.07) and RCSQ (p=0.07) scores. Frail patients were twice as likely to report poor baseline sleep OR 2.95 (95% CI 1.3-3.2). Baseline and overnight sleep disturbance were not associated with prolonged length of stay (LOS) or 30-day readmission rates.

Conclusion: The prevalence of sleep disturbance and clinical insomnia among older adults admitted through ED is high and overnight sleep quality low, although these did not impact on LOS or 30-day re-admission rates. Frail patients reported significantly poorer baseline sleep but did not have higher rates of insomnia or experience worse overnight sleep.

273 CHARACTERISTICS OF CENTENARIANS IN THE IRISH HIP FRACTURE DATABASE
Patrick Hogan1, Helena Ferris1, Louise Brent2, Paul McElwane3, Tiera Coughan4
1 Dept Age-Related Healthcare, Tallaght University Hospital, Dublin, Ireland
2 National Quality Improvement Team, Health Service Executive Ireland, Dublin, Ireland
3 National Office of Clinical Audit, Dublin, Ireland
4 Dept Medical Gerontology, Trinity College Dublin, Dublin, Ireland

Background: In 2017 the Central Statistics Office reported that there were 465 people over the age of 100 in Ireland. This number is likely to increase and, as hip fractures increase exponentially with age, we can expect to see more centenarians experiencing hip fracture. In the UK we have comparative data on such a cohort. We sought to define and describe those aged 100 years and over included in the Irish Hip Fracture Database from 2013-2017.

Methods: A secondary analysis of the 15,603 data entries in the IHFD between 2013 and 2017 was conducted. Those patients aged 100 years and over were identified and the cohort described.

Results: 57 patients 100 years and over (average 101 range 100-105) were registered in the IHFD over these 5 years. 91% were female. The most common fractures were intertrochanteric (46%) and displaced intracapsular (30%). 55 patients underwent an operative procedure, the most common being bipolar hemiarthroplasty (28%). Over one third were mobilised on the day of or day after surgery. The average length of stay was 22.5 days with only 13 ICU days for the entire cohort. 7 patients died in hospital. Of those surviving to discharge, discharge destination was recorded for 20. 10 patients returned to nursing home, 5 admitted de novo to nursing home, 5 to offsite rehabilitation and one person discharged directly to home.

Conclusion: This data provides the first insight into hip fractures in the oldest old in an Irish context. Rate of operative intervention was reassuringly high with in-hospital mortality outcomes of 12% which is low by international standards. The age of those sustaining hip fractures is increasing with numbers of the oldest old expected to rise. Orthogeriatric input results in improved outcomes for this population and will require increased resourcing for future cohorts of patients.

277 FRAILTY AND EARLY SUPPORTED DISCHARGE (ESD) POST-STROKE: ARE FRAIL PATIENTS REFERRED TO ESD AND IS FRAILTY ASSOCIATED WITH REHABILITATION OUTCOMES?
Marie Condon1, Louise O’Regan2, Lucy Pope1,2, Arne Barrett1,2
1 Cork University Hospital, Cork, Ireland
2 Mercy University Hospital, Cork, Ireland

Background: Frailty presents in one in four stroke survivors and can be a determinant of recovery post-stroke. Healthcare services provided at home, instead of in hospitals, results in improved outcomes for frail patients. Early supported discharge (ESD) provides multidisciplinary rehabilitation at home post-stroke. It is unknown if frail stroke survivors receive ESD and if they benefit from it. The objectives were to evaluate the prevalence of pre-stroke frailty among ESD patients and examine if frailty is associated with rehabilitation outcomes.

Methods: Consecutive patients in the ESD programme were assessed for pre-stroke frailty using the Clinical Frailty Scale (CFS) from November 2018 to April 2019. Baseline characteristics and programme outcomes were recorded, including admission and discharge scores on the Functional Independence Measure and Functional Assessment Measure (FIM+FAM) and the Stroke Aphasia Quality of Life-39 measure (SAQOL-39). The duration of ESD rehabilitation and number of therapy sessions provided were also recorded. Distributions using Pearson’s Chi Squared test and associations using the Mann–Whitney U test were calculated.

Results: From results 23 patients were analysed, median age 75±14.8 years, 82.6% male. The prevalence of frailty (CFS ≥ 5) was 4.3% (1/23) and pre-frailty (CFS=4) was 26.1% (6/23). Patients who were frail or pre-frail (CFS=4) were less likely to receive speech and language therapy (SLT) (p=0.03) and have a lower SAQOL-39 on discharge (p=2.294; p=0.02). No significant differences were noted in the FIM+FAM or the number of physiotherapy and occupational therapy sessions provided.

Conclusion: Frail patients are not routinely referred for ESD post-stroke. Patients who are pre-frail or frail make similar improvements with ESD compared to non-frail patient in functional independence but not quality of life. Comparable levels of physiotherapy and occupational therapy are provided but frail patients require less SLT. Further research is needed to ascertain if frail patients are appropriate for ESD.

280 ACUTE HOSPITAL PRESENTATIONS AMONG NURSING HOME RESIDENTS: A RETROSPECTIVE OBSERVATIONAL ANALYSIS
Buaini Winters1, Robert Murphy1, Edel Mammion1, Laura Gaffney1, Kate Donlon1, Michelle Carman1, Shaun T O’Keeffe2
1 Galway University Hospitals, Galway, Ireland
2 Department of Nursing, Galway University Hospitals, Galway, Ireland

Background: Nursing home residents are prone to acute illness due to their advancing age, underlying illnesses and immobility. The decision to refer a nursing home resident for acute hospital admission is a complex one, and there is no consensus among health care professionals about what constitutes an ‘appropriate admission’ to hospital from a nursing home. We aimed to explore patterns of acute nursing home patient presentations to the emergency department.

Methods: This was a retrospective cohort study of emergency hospital admissions to a tertiary university teaching hospital. Emergency admissions through the emergency department were included. Elements assessed, patient admissions, outcome of hospital transfers were excluded. Cases were validated by scrutiny of the patient medical records, and where possible an assessment of the Rockwood clinical frailty scale (CFS) was carried out.

Results: There were 126 nursing home residents who presented to ED over a two month period for emergency assessments. 87.3% (n=115) presented via ambulance. Just over half had a GP referral letter (53.2%). 72.3% of patients who presented to ED were admitted. 25.2% of patients were re-referred to ED within 30 days of hospital discharge. All patients were classified as frail. 21.3% of patients had died at the 90 day follow up mark, 66% of those with a CFS 8 or 9 died, in comparison to 16% of those with a CFS or either 6 or 7.

Conclusion: We noted high numbers of patients from nursing homes attending our emergency department. A very high proportion were admitted, along with a high number of subsequent re-presentations. Death rates were higher in those with more advanced frailty status. We would suggest advanced care planning and strategies to improve the patient experience. This study highlights the requirement for improved advance care planning in the nursing home setting. This is however a complex issue. Early discussion about end of life preferences with patients and family is required.

293 IMPROVING THE QUALITY OF DEMENTIA CARE IN GENERAL PRACTICE: A QUALITATIVE STUDY
Meghan Bourque1, Tony Foley2
1 Department of Nursing, Galway University Hospitals, Galway, Ireland
2 Department of General Practice and Liaison Medicine, Galway University Hospitals, Galway, Ireland

Age and Ageing
Title: A REVIEW OF A DOMICILIARY-BASED MULTIDISCIPLINARY DOCTOR TEAM: A TELECONFERENCE-DELIVERED EDUCATIONAL PROGRAMME (ECCHO) PROVIDED TO NURSING HOMES REDUCE EMERGENCY HOSPITAL TRANSFERS?

Authors: Nichola Boyle1,2, Smead McDornell2, Subha Balasubramanian4, Niamh Reynolds1, Niamh Geary2, Peter Fegan2, Diamund O'She6, Eilis Hession7,8

Affiliations: 1Waterford Integrated Care of Older Persons, University Hospital Waterford, Waterford, Ireland 2HSE Community Healthcare East, Dublin, Ireland 3All Ireland Institute of Hospice and Palliative Care, Dublin, Ireland 4Department of Medical Gerontology, Trinity College Dublin, Dublin, Ireland 5Irish Association for Emergency Medicine, Dublin, Ireland 6St. Francis Hospice, Dublin, Ireland 7National Audit of Clinical Audit, Dublin, Ireland 8Trauma Audit and Research Network, Dublin, Ireland

Background: Nursing home staff manage increasingly complex patients yet struggle to access education programmes due to geographical logistical barriers. The aim of this study is to measure the impact on emergency hospital transfers of a novel teleconference-delivered palliative care education programme (ECCHO) has on patient transfers from nursing homes to emergency departments.

Methods: Ten interactive sessions were provided to staff from 20 nursing homes, using teleconferencing technology through the "Project ECHO" model. "Transfer forms" were completed by participating staff 6 months before echo, and 6 months from commencement of echo. Details of emergency hospital transfers were evaluated. Participating sites must attend 4 or more of 10 sessions for study inclusion.

Results: Of 20 nursing homes, 15 attended sufficient sessions, and they submitted data regarding 260 emergency transfers over a 12-month period. There was no significant difference in the number of transfers pre vs post ECCHO (137 vs 123 of 260), p = 0.62. There was no significant difference in likelihood of hospital admission, length of stay, or number of weekend transfers to hospital (p = 0.26, 0.68 and 0.6 respectively). Post-echo, patients were less likely to have pain documented as the primary symptom (11 of 137 vs 1 of 123, p = 0.006), and it was more likely that transfer wishes were documented in advance (62 of 137 (45%) vs 82 of 123 (67%), p < 0.001). Increase in transfer wishes documentation was explained primarily by an increase in a "for transfer" decision (27 of 62 vs 67 of 82 (0.001)).

Conclusion: This teleconference, ECHO delivered palliative care education programme did not affect overall rates of emergency hospital transfers from nursing homes. However, it did significantly lower rates of transfers reporting pain as the primary symptom, tentatively suggesting a possible impact on "reversible" hospital transfers. ECHO significantly increased likelihood of transfer status discussion, while most "extra" discussions resulted in a "for transfer" decision.

METHODS

A quantitative retrospective review of all referrals received in four timeframes, commencing 1st July 2017 to date, was carried out. Each referral was classified into four subcategories: (1) Immediate Crisis (IC) (2) Budding Crisis (BC) (3) Stable but Needs Optimisation (SN) (4) Stable and No in-patient Intervention required. The origin of the referral was also categorised into four subgroups: (1) Day Hospital (2) GP (3) AHP (4) Other. The Average Length of Stay (AvLoS) was calculated for, acute and community admissions, for each period breakdown.

Results: We compared 1st July 2017 to 31st December 2017 pre-establishment of the new referral pathway and the same six month period in 2018 post-establishment of the pathway.

The streamlined pathway facilitated improved access to in-patient rehabilitation from multiple sources and resulted in an increase in referrals from 25 to 79. Waiting time for admission was reduced from 37 days to 5 days. Community admissions increased from 16 to 48. There was no difference in AvLoS between the two time periods: Acute 22 & Community 17 to Acute 22.25 & Community 18.

Conclusion: This work highlights the effectiveness of an improved co-ordinated referral pathway, within an integrated care hub, from community to in-patient rehabilitation beds with improved accessibility and reduced waiting times. AvLoS figures suggest that appropriate patients were admitted to the rehabilitation units. Also, it confirms the efficiency of a patient centred approach in maximising appropriate services for Right Person, Right Place, Right Time.
in the audit and the coverage is now 86%. Data has been collected on more than 15,000 trauma patients to date.

Results: There were 5,061 recorded major trauma cases of which 2,233 (44%) were over 65 years in 2017. The most common form of injury (57%) was falls less than two metres (low falls) and this began aged 45 years. 50% of injuries occurred in patient's own home. Only 11% of people were received by a trauma team and this was even lower in the older adult. Older patients were very unlikely to be pre-alerted to the Emergency Department prior to arrival. 64% of the mortality from major trauma occurred in the over 65 years. 6%, 7% and 10% of patients aged 65-74, 75-84 and over 85's respectively were discharged directly to nursing home.

Conclusion: There was a marked change in the age profile sustaining major trauma since the late 1990’s. Patients today are older with more complex medical needs, have greater lengths of stay and many do not return to independent living. The most common mechanism of injury for older people is a low fall at home. We need to provide low falls using a multidisciplinary, multi-agency approach.

AN INTEGRATED CARE APPROACH TO THE USES OF SOCIAL PRESCRIBING IN AN ACUTELY FRAIL OLDER ADULT COHORT

Petra McLaughlin1, Eleanor Murphy1, Fiona O’ Sullivan1, Ciara Connellan1
1 Sligo General Hospital, Sligo, Ireland
2 St John’s Community Hospital, Sligo, Ireland

Background: Community Health Organisation Area 1 has the highest age dependency in Ireland (37.5 vs 34.5) and the highest proportion of its population engaged in unpaid care (6.7%). Social prescribing is a novel tool used by the Integrated Care Team for the Older Person in Sligo to address social determinants of health such as social isolation and to minimise the impact of carer burden.

The study aim is to quantify social needs and carer burden in this acutely frail group and describe the interventions used to address this.

Methods: A descriptive study compiled from Comprehensive Geriatric Assessment of patient care profile and social prescribing from June to December 2018.

Results: 50% of patients studied did not have a supportive, able person living with them. 1 in 4 had no local support while 1 in 5 were supported only by neighbours or friends. 53% were not receipt of home help while 24% paid for private care or cleaning services. Carer burden was reported in half of cases with a 2.2 times increased risk with a patient co-morbidity of cognitive decline and a 1.8 times increased risk with a complex medical needs patient.

Conclusion: Intervention increased community service usage such as the public health nurse from 70% to 86% and home help applications by 26%. Social prescribing increased day centre use from 18% to 46% and Meals on Wheels usage by 50%.

ATRIAL FIBRILLATION, ORTHOSTATIC HYPOTENSION AND CEREBRAL PERFUSION – DATA FROM THE IRISH LONGITUDINAL STUDY ON AGING

Trixia McNicholas1, 2, Paul Claffey1, 2, Susie O’Callaghan1, 3, Robert Briggs1, Louise Newman2, Katy Tobin3, Rose Anne Kenny1, 2
1 The Irish Longitudinal Study on Ageing, Department of Medical Gerontology, Trinity College Dublin, Dublin, Ireland
2 Mercer’s Institute on Successful Ageing, St. James’s Hospital, Dublin, Dublin, Ireland
3 Department of Medical Gerontology, Trinity College Dublin, Dublin, Ireland

Background: It is thought that cerebral hyperperfusion in Atrial Fibrillation (AF) increases the risk of falls, cognitive impairment, and worse outcome in stroke. This aim of this study is to assess frontal lobe perfusion in response to active stand, and to assess the impact of AF on this association.

Methods: Data from wave 3 of the Irish Longitudinal Study on Ageing were used, a cohort study of community-dwelling adults aged over 50. Frontal lobe perfusion in response to orthostasis was measured using near-infrared spectroscopy (NIRS), reported as tissue saturation index (TSI%). Orthostatic hypotension (OH) was assessed using beat-to-beat blood pressure measurement. Linear regression assessed whether AF was associated with lower TSI at 10 second increments – 10, 20, 30, 40 60, 90, and 120 seconds. The analysis were repeated including an interaction with OH to assess the impact of OH on this association.

Results: There was no difference in baseline TSI in participants with AF compared to those without. Mixed effects models demonstrated lower TSI at 10 seconds in AF (β = -0.52; 95% CI -0.98, -0.06, p-value 0.004), at 60 seconds (β = -0.40; 95% CI -0.76, -0.04, p-value 0.031) and at 60 seconds (β = -0.40; 95% CI -0.76, -0.04, p-value 0.028). Including an interaction with OH found that in isolated AF, TSI was lower at 10 seconds (β = -0.62; 95% CI -1.04, -0.19; p-value 0.005). Those with both AF and OH had lower TSI at 40 (β = -0.89; 95% CI -1.55, -0.24; p-value 0.007), 60 (β = -0.89; 95% CI -1.54, -0.23; p-value 0.008) and 90 (β = -0.68; 95% CI -1.33, -0.05; p-value 0.041) seconds.

Conclusion: There is evidence that frontal lobe perfusion is lower during orthostasis in individuals with AF, and that the presence of OH modifies this association.

THE RELATIONSHIP BETWEEN LATE LIFE DEPRESSIVE SYMPTOMS AND CEREBRAL WHITE MATTER DISEASE IS MODIFIED BY SYSTEMIC AND ORTHOSTATIC BLOOD PRESSURE

Robert Briggs, Anne Buckley, Silvin Knight, Jim Meaney, Sean Kennedy, Rose Anne Kenny
The Irish Longitudinal Study on Ageing, Dublin, Ireland

Background: Cerebral white matter hyperintensity (WMH) burden is a key biological risk factor underpinning late life depression (LLD) and cerebral hyperperfusion has been identified as an important cause of WMH. The aim of this study therefore is to clarify if orthostatic hypotension (OH) and lower systemic blood pressure (BP), both of which cause reduced cerebral blood flow, modify the relationship between depression and cerebral white matter disease in a cohort of community-dwelling older people aged ≥70 years.

Methods: A descriptive study data from wave 3 of TILDA. Participants were included if they were aged ≥70 years and had undergone assessment for depressive symptoms, brain MRI and cardiovascular measures.

Depressive symptoms were measured using the 8-item Centre for Epidemiological Studies Depression Scale. Scheltens Score was used by a trained radiologist to calculate overall WMH burden. Orthostatic BP was measured by active stand. OH was defined as a drop in Systolic BP ≥20 mmHg or drop in diastolic BP ≥10 mmHg at 30, 60 or 90 seconds post standing.

Results: Participants with depressive symptoms (8%, 16/202) had a significantly higher burden of WMH measured by Scheltens Score (14.6 (95% CI 11.0-18.2) vs. 11.0 (95% CI 10.1-11.8); p = 0.0211).

Two-way interaction models demonstrated that the association between depressive symptoms and WMH burden is significant only in those with co-existing OH. Similarly, the two-way interaction between depressive symptoms and systolic BP shows that this association remains statistically significant only in those with both depressive symptoms and lower BP: i.e. <110 mm Hg.

Conclusion: This study demonstrates that depressive symptoms are associated with cerebral WMH in a cohort of community-dwelling people aged ≥70 years but this relationship is modified by co-existing OH or lower BP.

DEVELOPING A FRAILTY INDEX: DOES THE COMPOSITION OF FUNCTIONAL AND DISEASE OR RISK ITEMS INFLUENCE FRAILTY ESTIMATES?

Mark O’Donovan1, Duygu Sezgin1, Aaron Lieve1,2, Bárður Ólafsson1,3,4
1 National University of Ireland, Galway, Galway, Ireland
2 Portucaeus University Hospital, Co Galway, Ireland
3 University College Cork, Cork, Ireland
4 Mercy University Hospital, Cork, Ireland

Background: Frailty is a multi-factorial, age-related syndrome, often defined in terms of accumulation of deficits. This approach uses the proportion of a list of age-associated items (signs, symptoms, diseases, impairments, etc) available to identify frailty. Some frailty indexes (FI) include more functional aspects than others. This study examines whether functional components and diseases or risk factors predict the same phenomena.

Methods: Data were included from The Survey of Health, Ageing and Retirement in Europe (SHARE) wave seven for participants age ≥50 years. A 52-item FI was constructed from physical health data with 26 functional and 26 non-functional items. Functional items were obtained from activities of daily living questions (ph048 & ph049), and health-related activity limitation (gali question). Non-functional items were obtained from questions on BMI, self-perceived health, disease/risk (ph006), medication use (sleep, anxiety/depression, osteoporosis), and frailty related symptoms (ph040). Participants missing one or more of the 52 items were excluded. Data were analysed at individual and country-level to assess for significant differences.

Results: In total, 75,510 (97.3%) participants had complete frailty data available and were included. The mean score for the FI-52 was 0.12 (95% CI 0.11-0.12). The FI-52 scores for the functional and non-functional components were 0.12 (95% CI 0.12-0.12) and 0.11 (95% CI 0.11-0.11), respectively, representing a significant difference (p<0.001). For a cut-off of 0.25 for frailty this difference was 5.4% (95% CI 3.5%-6.2%). Spearman’s correlation between two components was 0.66 for individual participants and 0.72 for country mean scores, indicating moderate to strong correlation. These were similar using a cut-off of 0.25, at 0.45 and 0.71, respectively.

Conclusion: Findings suggest that having more functional items in a frailty index results in significantly higher frailty estimates but this only amounted to an approximately 5% difference. Although moderate-strong correlation was observed, further research is needed to investigate whether the proportion of functional components influences risk-prediction at population-level.

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| EXAMINING THE RESILIENCY OF VISUALLY IMPAIRED OLDER ADULTS WITH COGNITIVE DECLINE AGING IN PLACE |
| Patricia Fletcher |
| Union Institute and University, Cincinnati, USA |

**Background:** Visual impairment is a leading chronic condition among older adults and is usually connected with a decline in their performance of instrumental activities of daily living. Understanding the challenges of those with visual impairment is paramount as the population ages over the next four decades. This study examined the hypothesis that older adults who were diagnosed with juvenile macular degeneration as young adults and now have a mild cognitive impairment have better coping mechanisms than older adults who were recently diagnosed with age-related macular degeneration.

**Methods:** This study utilized a mixed-methods approach to address the complexities in health science research and align with the interdisciplinary field of gerontology.

**Results:** Participants were 27 older adults aged 65 years of age and older. There was no quantitative difference in resiliency between participants with juvenile macular degeneration ($n = 7$, $M = 77.71$, $SD = 9.46$) and those with age-related macular degeneration ($n = 10$, $M = 72.60$, $SD = 8.25$). $r(15) = 1.185, p = .254$.

**Conclusion:** The qualitative results revealed that older adults living with visual impairment develop strategies to improve their quality of life and help them age in place.

| PROFILE OF A GERIATRIC NEUROSURGICAL SERVICE |
| Kaneema Malone, Fiona Kinsella |
| Beaumont Hospital, Dublin, Ireland |

**Background:** According to the 2016 CSO figures the age category of 65 and older saw the largest increase in the Irish population since 2011, rising by 102,174 to 637,567, a rise of 19.1%. This remains a major concern for a north Dublin teaching hospital as its catchment area has a 20% higher proportion of > 65% and > 85% than the national average. This catchment area profile has the potential to impact on the profile of the in-catchment admissions while the National profile will impact on the national specialities including neurosurgery.

**Aim:** To profile the geriatric neurosurgical population and provide insight that facilitates future service planning and delivery.

**Methods:** To accurately capture the data, all ward files for the month of June and July 2017 were reviewed to identify appropriate patients. All patients on any ward within the hospital, under the care of a neurosurgeon, were included in the data collection. Patients in intensive care that did not transfer to the wards were excluded.

**Data points including age, sex, consultant, co-morbidities, mobility status and surgical interventions were captured.**

**Results:** 120 patients ≥ 65 years were admitted to the neurosurgical service between June and July 2017; 45 (38%) between 60-69, 60 (50%) 70-79, 13 (10%) 80-89 and two (2%) ninety years or older. The two most common reasons for admission were non-traumatic cerebral bleeds (40, 34%) and cerebral tumours (38, 32%). Patients had on average four co-morbidities, with cardiac being the most common. 17 patients were admitted post a traumatic event; 13 low impact falls, 3 high impact falls and one assault. The average LOS for these patients was 11.3 days.

**Conclusion:** This profile highlights the complex needs of this population and the increasing burden on existing neurosurgical resources as the population continues to age. Future resource allocates and service development, including the National Trauma Strategy, needs to consider the needs of the aging neurosurgical population.

| REHABILITATION IN PATIENTS WITH DEMENTIA FOLLOWING HIP FRACTURE |
| Cliiona Smed1, Emma Lennon2, Rebecca Doyle3, Shane O’Hanlan1 |

1Orthogeriatrics Department, St Vincent’s University Hospital, Dublin, Ireland
2Department of Medicine, University College Dublin, Dublin, Ireland
3Department of Medicine, University College Dublin, Dublin, Ireland

**Background:** Hip fractures are an increasing phenomenon in the older population. Receiving post-operative rehabilitation is associated with better outcomes and a higher likelihood of returning to preexisting level of functioning. Best rehabilitation practices for people with dementia have not been established.

**Methods:** All patients >60 years old with a hip fracture admitted under the orthopaedic team between March 2016-February 2018 were reviewed. Those with a diagnosis of dementia were extracted from the database. Clinical Frailty Scale (CFS), Zuckermann Functional Recovery Score (FRS) and New Mobility Score (NMS) were documented at baseline and at one year. Outcomes assessed included 1 year mortality, decline FRS/NMS, change in CFS and nursing home (NH) admission rates.

**Results:** 465 patients’ hip fractures were recorded: 175 patients had dementia. 67 patients were dead at 1-year post fracture (38.285% mortality rate). Of the 108 patients with dementia who were living at 1-year; 30.5% (n=33) received offsite rehab. 58.4% (n=63) received routine in-patient rehab. 12 lost to follow-up. Of the 33 patients that received off-site rehab the mean FRS at baseline was 66 and decreased to 45.56 at 1 year (30.9% reduction). The mean CFS at baseline was 5.1, increasing to 6 at 1-year (17% increase). Mean NMS was 5.7 decreasing to 3.7 at 1-year. In those patients with dementia that did not receive off site rehab (n=63); baseline mean FRS was 38 reducing to 30 at 1 year (26.6% reduction). Mean CFS was 6.25 increasing to 6.47 at 1 year. 41% of patients admitted from home who did not receive off-site rehab were discharged to NH. Of the group discharged to off-site rehab: at 1 year 33% were in a NH and 72% remained at home.

**Conclusion:** Both groups demonstrated decline in function. Those that received off-site rehab had higher premorbid functioning/mobility and reduced frailty. There was a reduced NH admission rate at 1-year in the group that received off-site rehab.

| COMPLETING A COMPREHENSIVE GERIATRIC ASSESSMENT? |
| Paula Loery1, Sinead O’Connor2 |

1St. James’s Hospital, Dublin, Ireland
2St. James’s Hospital, Dublin, Ireland

**Background:** Bed rest is a contributor to iatrogenic complications including delirium and muscle atrophy (Liu et al. 2017). Getting patients up and moving has been shown to reduce falls and improve patient experiences. Clothes help people maintain their self-esteem and orientation and would also remind their care professionals to recognize them as people (Blackwell, 2014).

**Methods:** A pre campaign audit on fall and new incidence of delirium was conducted prior to the pilot campaign. To assess what patients were in bed, dressed in pyjamas or up dressed for 2 weeks prior. Education was delivered to both staff and patients with information leaflets on the ward. Informing patients and families the appropriate clothing and foot wear to bring into hospital. Effective patients were notified by post to explain what we were doing and why, whilst asking them to pack their day clothes. At 12:00 every day roaming teams surveyed the amount of patients out of bed and dressed in their day clothes.

**Results:** 37% (n=226) more patients were up, dressed and moving on Medical and Surgical wards. 25% (n=153) less patients were in bed on both the medical and surgical ward. This pilot project demonstrated a decrease in the number of reported falls from 16 to 4 as well as a decrease in the number of reported new episodes of Delirium from 4 to 0.

**Conclusion:** Overall, the endiparalysis initiative resulted in positive outcomes for patient’s small change can impact incidents of falls and acute delirium within our organisation. Inter-disciplinary approach to roll out this initiative to other wards across the hospital changing our culture of care. In line with the patients charter empower patients to take control of their care needs thus, promoting their independence.

| PLAYING OUR PART - ARE THE OCCUPATIONAL THERAPISTS COMPLETING A COMPREHENSIVE GERIATRIC ASSESSMENT? |
| Helen Acheson1, Fiona Kinsella1, Karen Young2 |

1Department of Medicine, University College Dublin, Dublin, Ireland
2Department of Medicine, University College Dublin, Dublin, Ireland

**Background:** Ten per cent of people over 65 years have frailty, rising to between a quarter and a half of those over 85. Comprehensive Geriatric Assessment (CGA) is the gold standard for the management of frailty in older people; it’s a process that involves a holistic, interdisciplinary assessment of the older person. Evidence shows that CGA is effective in improving outcomes for older people. The National Clinical Programme for the Older Person outlines the role of the occupational therapist in CGA. A clinical audit was completed to investigate whether the occupational therapists in the Medicine for the Older Person service are adhering to guidelines for CGA.

**Methods:** Following a literature review, a retrospective audit of occupational therapy (OT) initial assessments was completed using paper count method. Data pertinent to CGA OT assessment was collected. Audit results were presented to the OT team alongside a CGA education session. A re-audit was completed, using above methods.

**Results:** 10 inpatient initial assessment forms were reviewed pre and post audit. Activities of Daily Living Assessment:
- Pre result: 60% Post result: 90%
- Home Environment:
- Pre: 80% Post: 100%
- Performance Components Assessment:
- Vision: Pre: 90% Post: 100%
- Hearing: Pre: 80% Post: 100%
- Upper Limb: Pre: 70% Post: 100%
- Mood: Pre: 60% Post: 80%
- Cognition: Pre: 90% Post: 100%
- Sleep: Pre: 70% Post: 80%
- Social Assessment: Pre: 60% Post: 90%
- Falls Assessment: Pre: 60% Post: 90%
- Driving: Pre: 60% Post: 90%

**Conclusion:** This audit identified that the occupational therapists in the medicine for the older person service were not CGA compliant. CGA training now forms an important part of our OT induction programme. We are now “playing our part” in CGA with improvements in all domains. CGA is now commonplace practice within our team, in line with international and national best practice guidance for management of frailty.
Background: 'Risk feeding' is a term commonly used when an individual continues to eat and drink despite a perceived risk of choking or aspiration. It is suspected that there is significant variance around how a decision of 'risk feeding' is made for older people in the acute hospital setting, particularly whether or not the individual and/or family are involved. This is of particular interest under the Assisted Decision Making (Capacity) Act 2015.

Aims:
• To investigate individuals’ participation in decision-making regarding ‘risk feeding’
• To investigate the duration individuals are kept NPO pending ‘risk feeding’ decisions

Methods: A retrospective case series was completed. 18 medical charts were reviewed for collection of the following data:
• Average length an individual was NPO pending decision regarding oral intake
• Discussion between individual and medical team regarding oral intake
• The individual’s capacity for decision making regarding oral intake
• Discussion of what is in the best interests of the individual
• Discussion with family/NOK
• Explicit plan regarding oral intake

Results:
• Average length NPO: 1 day (range 0-4 days)
• Discussion with patient: 17%
• Patient capacity for decision making: 17%
• Best interests discussion: 66%
• Discussion with family/NOK: 77%
• Explicit plan: 66%

Conclusion: There is significant variability in decision making for ‘risk feeding’ with older adults in the acute hospital setting. Individuals are not consistently involved in their plan to risk feed. In some cases there was reliance on family members to decide on ‘risk feeding’, in others the medical team made decision in the best interests of the individual. Individuals are being kept NPO for a period of time to allow decision making, without knowledge of why this is so.

The review highlights the need for individual involvement in decision regarding dysphagia and oral intake. Multidisciplinary education and guidance is recommended to ensure consistent ethical decision making.

12 ‘RISK FEEDING’ FOR OLDER PEOPLE: A RETROSPECTIVE CASE SERIES TO REVIEW THE DECISION MAKING PROCESS

Namh O’Loughlin, Oonagh McCarthy
Connolly Hospital Blanchardstown, Dublin, Ireland

Background: ‘Risk feeding’ is a term commonly used when an individual continues to eat and drink despite a perceived risk of choking or aspiration. It is suspected that there is significant variance around how a decision of ‘risk feeding’ is made for older people in the acute hospital setting, particularly whether or not the individual and/or family are involved. This is of particular interest under the Assisted Decision Making (Capacity) Act 2015.

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The review highlights the need for individual involvement in decision regarding dysphagia and oral intake. Multidisciplinary education and guidance is recommended to ensure consistent ethical decision making.

13 EFFECTS OF BENZODIAZEPINES ON ORTHOSTATIC BLOOD PRESSURE IN OLDER PEOPLE

Gilda Ruas1, Rose Anne Kenny2, Andrea Ungar1, Román Romaro-Ontuño2
1Department of Geriatrics and Geriatric Intensive Care Unit, Careggi Hospital and University of Florence, Florence, Italy
2Discipline of Medical Gerontology and Falls and Syncope Unit, Mercer’s Institute for Successful Ageing, St. James’s Hospital, Dublin, Ireland

Background: Older people taking benzodiazepines (BDZs) have higher risk of falling, which is mainly attributed to unfavorable drug-related effects on cognition and psychomotor functioning. BDZs may also have hypotensive effects, but evidence concerning the relationship between BDZs and orthostatic blood pressure (BP) behaviour in older people is scarce. We investigated the effects of BDZs on BP response to an orthostatic active stand test.

Methods: We performed a retrospective analysis of data from an outpatient research clinic in an Irish university hospital, where people aged 60 or older underwent a clinic assessment. Of 624 community-dwelling people who underwent a clinic assessment, orthostatic BP was measured during active stand, with systolic BP assessed at 30s, 60s and 90s. Participants were divided into two groups based on whether they were taking BDZs or not. Orthostatic BP response was compared between the two groups and the effect of BDZs on orthostatic BP was investigated using multiple linear regression.

Results: Of 624 community-dwelling people who underwent a clinic assessment, orthostatic active stand data was collected in 541. Information on regular BDZ use was available in 538 people. Of 538 participants, mean age was 72.7 ± 7.2, 67.7% were female and 33 (6.1%) reported regular use of BDZs. History of falls (p = 0.027) and fear of falling (p < 0.001) were more prevalent in this subgroup. During active stand, participants on BDZs had a significantly greater systolic BP drop 10 seconds after the posture change (‘immediate’ BP drop). No significant differences were detected in orthostatic systolic BP in the latter phases of the active stand. After adjusting for possible confounders, BDZs use was independently associated with a mean immediate systolic BP drop of 12 mmHg after standing.

Conclusion: BDZs may confer higher risk of an immediate systolic BP drop after standing in older people, which may contribute to their known falls risk. BDZ should be avoided in older people at risk of falling.
disease were used. Reference lists of retrieved studies were hand searched. Studies were assessed for inclusion against pre-specified eligibility criteria. Data extraction was carried out using a standardised data extraction table. Critical appraisal was undertaken using the JADAD score, CASP Randomised Controlled Trial (RCT) checklist, “Quality Assessment tool for before-after studies with no control group” and the TREND statement checklist.

Results: The search resulted in 612 records of which five met inclusion criteria (3 RCT, 2 before-after studies). A total of 496 PD patients were included. Intentional strategies investigated were educational intervention, adherence therapy, effect of a Parkinson’s Tracker App (PTA) and intervention by a pharmacist. Five (100%) of the studies included in this review reported a statistically significant improvement in medication adherence post-intervention and some improvements in symptoms.

Conclusion: This is the first review of medication adherence in the PD population. Several different interventions proved effective in enhancing medication adherence, but the studies were small, short term and the risk of bias ranged from moderate to high. Consequently, the results may not be generalizable to other PD populations.

Reference:

Methods:
In this small study, STOPPFrail-defined PIMs were highly prevalent in older terminally ill patients. Prescribers should carefully review the medication lists of terminally ill older patients in order to minimize inappropriate polypharmacy.

The Implementation of a Hospital “Buddy Walking Programme” to Improve Access to Mobility for Acute Hospital In-Patients

Eileen Lombard1, Anna Higgins1, Suzannette Timm2, Ruth McCullagh2
1Mercy University Hospital, Cork, Ireland. 2University College Cork, Cork, Ireland

Background: An acute hospital admission often means that patient’s mobility can decline if not maintained and encouraged throughout their inpatient stay. The “Buddy Walking Programme” is a joint initiative between the physiotherapy department, nursing department and hospital volunteers. The aim of this research was to implement a hospital “Buddy Walking Programme” within a teaching hospital in Cork to allow the provision of accompanied walking sessions by members of the hospital’s volunteer team.

Methods: Ward based physiotherapy staff and nursing staff identify suitable patients and add their bed number and mobility status to a list each morning. Patients are identified who are independently mobile or can safely mobilise with the supervision of one person, with or without a mobility aid and who are cognitively capable of simple commands. Physiotherapists and nursing staff are made aware of the programme at induction. Volunteers partake in an educational session and manual handling training prior to offering supervised walking sessions.

Results: A standard operating procedure has been developed for the “Buddy Walking Programme”. Training has been rolled out hospital wide amongst nursing staff, physiotherapy staff and hospital volunteers.

Conclusion: This programme will help encourage a culture of physical activity within the hospital to patient setting and improve mobility levels. Further research is warranted to explore the beliefs and perceptions of hospital staff and volunteers regarding the initiative and to examine barriers and facilitators to the programme.

Stoke Risk Factors, Aetiology, and Outcomes in a Multi-Ethnic Irish Stroke Population

John Finnegan, Sarah Mello, Suzanne Greene, Nicola Cogan, Ciara Ryan, Tatjana Coughlan, Sean Kennedy, Des O’Neill, James Mahon, Ronan Collins
Tallaght University Hospital, Dublin, Ireland

Background: Stroke aetiology, risk factors and outcomes vary among ethnic groups. The profile of patients presenting to hospital with stroke in Ireland is changing as immigration increases. We aim to describe differences that exist between a multi-ethnic immigrant population and native Irish residents.

Methods: Using our hospital’s stroke registry we identified all non-Irish (NI) patients admitted to the stroke unit over a two year period through surname recognition (N=44). Country of birth was confirmed by a chart review. The Irish patients admitted over the same time frame were used as a comparison group (N=437). Data was collected on demographic details, stoke subtype and outcomes, co-morbidities, and socio-economic factors. Patients were grouped based on ethnicity and stroke subtype. Chi squared test was used to analyze the relationship between groups.

Results: NI patients made up 9.1% of all stroke unit admissions. NI patients were younger than Irish patients (average age 75.7 vs 69.6 years, p < 0.001) and there was a higher prevalence of ICH in the NI group (34.1% vs 11.7%, p < 0.01). Hypertension was the most common vascular risk factor in both groups (72.7% vs 68.2%, p = 0.54). Mortality and morbidity was lower in the NI group, with more patients being discharged to home. Conclusion: Our study demonstrates that NI stroke patients have a different risk factor profile and stroke sub-type profile compared to Irish patients. NI patients are more likely to be young, hypertensive, male, and have higher rates of ICH. Cultural and linguistic barriers may adversely influence health seeking behaviour in this group. These findings underscore the need to identify the root causes of these ethnic differences so targeted primary prevention campaigns can be established.

Prevalence of Potentially Inappropriate Medications (PIMs) in Older Palliative Patients, Defined by STOPP/FRxR Criteria

Adelina Fag1, Tony O’Brien1,2,1, Denis O’Mahony1
1College of Medicine & Health, University College Cork, Cork, Ireland
2Mercy University Hospital & Hospice, Cork, Ireland

Background: Polypharmacy is common in older persons with multi-morbid illness, increasing the risk of adverse drug events. Drug pharmacokinetics and pharmacodynamics are often altered in this group increasing the risk of adverse drug events and many prescribed drugs take considerable time to benefit. STOPP/FRxR criteria are designed to help prescribers to identify potentially inappropriate medications in older sicker patients with short life expectancy. The aim of this pilot study was to estimate the prevalence of STOPP/FRxR defined potentially inappropriate medications (PIMs) in older patients with terminal illness at the point of admission to specialist hospice care.

Methods: We conducted a prospective analysis of inpatient case records and drug kardexes at a university teaching hospital over a period of one month. We recorded patients’ demographic details, principal symptoms, co-morbidities, medications at admission and at day 3-7. STOPP/FRxR criteria were applied to patients’ medications lists at both time points.

Results: Of 22 patients studied, 13 were female with a mean (+/- SD) age of 80 years (+/-6). Eighteen patients were transferred directly from an acute hospital, 4 patients from the community. Common symptoms were pain (72%) and severe lethargy (68%).

Twenty out of 22 patients had cancer as the life-limiting condition. There was a significant reduction in the mean (+/- SD) number of medications from admission (11 ± 4.7) to post-palliative care review (8 ± 4.7, p=0.002). 90% of patients had polypharmacy i.e. ≥ 6 daily medications, 87% had ≥ 1 STOPP/FRxR PIM on admission. The median number of STOPP/FRxR PIMs per patient was 1 (1-2, IQR), most commonly high dose proton pump inhibitors, multivitamin supplements, calcium supplements and lipid lowering therapies. Conclusion: In this small study, STOPP/FRxR-defined PIMs were highly prevalent in older terminally ill patients. Prescribers should carefully review the medication lists of terminally ill older patients in order to minimize inappropriate polypharmacy.
26 PREDICTORS OF IN-HOSPITAL MORTALITY POST HIP FRACTURE: WHAT REALLY MATTERS?
Helena Ferris1, Louise Brett1, Jennifer Martin1, Philip Crowley1, Tara Coughlan1
1National Quality Improvement Team: Health Service Executive, Dublin, Ireland
2National Office of Clinical Audit, Dublin, Ireland
3Director, National Quality Improvement Team, Health Service Executive, Dublin, Ireland
4Dept of Medical Gerontology, Trinity College Dublin, Dublin, Ireland

Background: The Irish Hip Fracture Database is a national clinical audit developed to improve fracture care and outcomes. Lack of integration with other databases, such as a National Death Register makes determination of longer term outcomes challenging. In hospital mortality is one quality indicator that can be very accurately measured. We sought to determine in-hospital mortality in the Irish Hip Fracture Cohort between 2013 and 2017 and to determine which factors most influenced this outcome with particular reference to the IHFD quality standards.

Methods: A secondary analysis of the 15,603 patients in the IHFD between 2013 and 2017 was conducted. Descriptive and analytical statistics were produced.

Results: In-hospital mortality was 4.5% for the 5 years. Univariate logistic regression revealed 11 statistically significant predictors of in-hospital mortality of which only 4 (age, gender, pre-fracture mobility, mobilised day of/surgery) remained significant after multivariate analysis. The most striking finding was that those patients not mobilised on the day of surgery were 46% more likely to die in hospital (OR 1.46, p < 0.000, 95% CI 1.25-1.70).

Conclusion: Measuring care is challenging and often one standard cannot reflect all aspects. The aim for the programme was to develop a good composite measure of both patient and organisational factors in hip fracture care: timely surgery; adequate pain relief, prevention of delirium, admission to a ward with philosophy, skills and resources to encourage early mobility. While early mobility has always been encouraged this data suggests its adoption as a formal standard to which all units must comply.

27 DECISION-MAKING CAPACITY ASSESSMENT: OCCUPATIONAL THERAPY’S CONTRIBUTION WITHIN A MULTIDISCIPLINARY APPROACH
Ruth Usher1, Tadhg Stapleton2
1Trinity College Dublin, Dublin, Ireland
2Beaumont Hospital, Dublin, Ireland

Background: Increasing age and life expectancy, alongside the growing incidence of chronic conditions and dementia-related diseases, indicate more older individuals are likely to experience challenges regarding decision-making capacity. In Ireland, the Assisted Decision Making (Capacity) Act 2015 provides a statutory framework for adults who are experiencing difficulties with decision-making. This legislation has significant implications for all who work in health and social care, especially those working with older adults. An online survey was conducted to explore occupational therapy practices regarding decision-making capacity assessment and factors impacting on engagement in this area.

Methods: Occupational therapists in Ireland were invited to participate in a cross-sectional online questionnaire.

Results: One hundred and seventy-two occupational therapists responded. Most occupational therapists (65.77%, n=98) reported involvement in decision-making capacity assessments, particularly those working with older adults. Occupational therapists were more frequently requested to contribute to assessments of capacity regarding independent living (79.19%, n=118), driving (45.89%, n=67), and financial management (44.44%, n=66). Occupational therapists reported using a combination of approaches to inform decision-making capacity assessment, including interviews, observations and assessments of cognition and functional performance, and emphasised a strengths-based approach. Many participants reported decision-making capacity assessment is more difficult than other aspects of practice and that they are not satisfied with decision-making capacity assessment procedures in their workplace. A large majority (91.80%, n=113) reported occupational therapists would benefit from additional training and practice resources for decision-making capacity assessment.

Conclusion: The study confirms that occupational therapists have a role to play in assessment of decision-making capacity assessment, particularly regarding independent living. However, the recommended approach to assessment should include all appropriate multidisciplinary team members. There is need for further education, resources and guidelines for occupational therapists and other healthcare professionals to better guide decision-making capacity assessment.
old patients occurring prior to hospital admission is as a result of acute illness however deterioration following admission can be as a result of polypharmacy, excessive bedrest, sleep deprivation, institutionalisation and inadequate nutrition and may be amenable to changes in the processes of hospital care (Coleman et al, 2012) In terms of reducing costs in an ever-increasing older population, maintaining people in their own homes is more cost effective than high numbers going to residential care.

Methods: In an ever-increasing older population, maintaining people in their own homes is more cost effective than high numbers going to residential care.

Results: 34 patients had active disease, and these were mainly older patients (n=6). 8 different biologics were used. 8 different biologics were used. 8 different biologics were demonstrated.

What if it could be delayed or reversed?). An exercise leaflet was provided and strength exercises were demonstrated.

Results: 18 of 27 over-65-year-old patients attended the group discussion, mean age 75, 11 female (61%). 2 participants were interested in doing strength exercises at the start of the session (11%, 0 female) when asked. Most participants had not been aware that strength exercises can delay and reverse frailty. 14 participants (78%, 8 female) declared interest in doing strength exercises at the end. Interested participants used the exercise leaflet for independent exercise in hospital and brought it home on discharge.

Conclusion: The EP was lacking in emphasis on the benefits of exercise to improve the levels of physical activity among inpatients. As part of a local quality improvement (QI) initiative, the EP set out to incorporate the provision of patient education on the benefits of strength exercises in delaying and reversing frailty. Here we describe the development of this QI initiative and its evaluation.

Methods: New health education content was added to an EP group discussion to address four key aspects of frailty, namely: definition, risks, screening and interventions. The Sociocultural education method was used in the next week group discussion (eg. What does frailty mean to you? What are the consequences? How would you measure frailty? What if it could be delayed or reversed?). An exercise leaflet was provided and strength exercises were demonstrated.

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Conclusion: The EP at our hospital has been improved to include greater emphasis on the benefits of strength exercises in delaying and reversing frailty. QI initiatives can allow translation of research evidence into patient education.

ADDRESSING POLYPHARMACY IN THE FRAIL OLDER PERSON - THE WIDE (WHOLISTIC, INTEGRATED, DEPRESCRIBING, EVALUATION) REVIEW

Clare Kinahan1, Nazir Soomro, Florrie Daniels, Wafa Hussain, Helen Heery

Paradise Hospital University, Ballinrobe, Ireland

Background: People are living longer, with more chronic conditions and are prescribed more medications according to disease specific guidelines. The WIDE Review is an innovative model of comprehensive medication review devised to treat the whole patient. Frail patients are twice as likely to be prescribed inappropriate medications and are more vulnerable to their harmful effects. Use of the STOPP/START criteria and the Medication

USING THE VARIABLE INDICATION OF PLACEMENT TOOL TO DRIVE DE-PREScribing IN THE FRAIL OLDER PERSON IN AN INTERDISCIPLINARY INTEGRATED TEAM

Athanasia’yi, Vincen Pillay, Aine O’Reilly, Eamonn Cooney, Jennifer Maher, Cara

Pender, Sebhan Ryan, Karen Sayers, Christina Donnellan

South Tipperary General Hospital, Clonmel, Ireland

Background: The variable indicator of placement (VIP) tool is designed to identify patients at risk of frailty. The risk of harm in a frail older person increases as the number of prescribed drugs increases. Polypharmacy may be either appropriate or inappropriate. Deprescribing, aims to withdraw inappropriate medication under supervision, in order to improve outcomes.

Methods: 50 consecutive patients, attending an emergency department, were triaged with the VIP tool, triggering a single interdisciplinary assessment (SIA) by an integrated care team member. The SIA identified polypharmacy. Drugs which may be causing harm, may no longer be of benefit or were potentially interacting with other drugs, were identified. The Anti-cholinergic Burden Score was calculated. Appropriate medication changes were made following interdisciplinary and patient/carer discussion. Patients were selected for frailty and facilitated by a doctor in an informal, open forum. Feedback from nurses, doctors and patients suggested that the EP was lacking in emphasis on the benefits of exercise to improve the levels of physical activity among inpatients. As part of a local quality improvement (QI) initiative, the EP set out to incorporate the provision of patient education on the benefits of strength exercises in delaying and reversing frailty. Here we describe the development of this QI initiative and its evaluation.

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Conclusion: The EP at our hospital has been improved to include greater emphasis on the benefits of strength exercises in delaying and reversing frailty. QI initiatives can allow translation of research evidence into patient education.

FROM WARD TO CLASSROOM: SERVICE EVALUATION OF EDUCATION TO INCREASE AWARENESS OF FRAILTY AND RESILIENCE AND ENCOURAGE GREATER PHYSICAL ACTIVITY

John Travers 1, Roman Romero-Ortuno2, Declan Lyons1, Marie-Therese Cooney4

1 St. Patrick’s Hospital, Dublin, Ireland

2 Global Brain Health Institute, Trinity College Dublin, Dublin, Ireland

3 Mercer’s Institute for Successful Ageing, St. James’s Hospital, Dublin, Ireland

4 St. Vincent’s University Hospital, Dublin, Ireland

Background: Our hospital routinely offers a weekly group discussion session for inpatients on aspects of ageing as part of an ‘evergreen programme’ (EP) of health education. Topics are varied and facilitated by a doctor in an informal, open forum. Feedback from nurses, doctors and patients suggested that the EP was lacking in emphasis on the benefits of exercise to improve the levels of physical activity among inpatients. As part of a local quality improvement (QI) initiative, the EP set out to incorporate the provision of patient education on the benefits of strength exercises in delaying and reversing frailty. Here we describe the development of this QI initiative and its evaluation.

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Conclusion: The EP at our hospital has been improved to include greater emphasis on the benefits of strength exercises in delaying and reversing frailty. QI initiatives can allow translation of research evidence into patient education.

A REVIEW OF THE IMPLEMENTATION OF A STROKE EDUCATION PROGRAMME IN A DUBLIN TEACHING HOSPITAL IN 2018

Lisa Donaghy1, Eamon Dolan2, Marie O’Connor

Conway Hospital Blanchardstown, Blanchardstown, Ireland

Background: Aim: To commence Stroke education in a specific Dublin Hospital to improve the assessment of management of Stroke patients.

Methods: Seven 1 day study days were organised in 2018. These 7 days were multi-disciplinary team (MDT) led with theory in the morning session delivered by the Stroke Clinical Nurse Specialist (CNS) followed by MDT led workshops in the afternoon.

Stroke education was delivered to Emergency Department (ED) doctors on each rotation. Whiteboard education sessions were carried out for nurses on Medicine for the Elderly Ward/Stroke Unit.

Results: A total of 103 health professionals were trained over the 7 study days. Stroke Study Day attendances consisted of 69 RGN/CNMs 26 student nurses (21 intern nurses who are now staff nurses working in the hospital), 2 Allied Health Professionals, 1 CNS and 5 from Practice development. 32 ED doctors were trained over 3 separate induction days. Weekly scenario based sessions with nurses on the Stroke Ward.

Conclusion: Staff applying the learned knowledge and competencies to Stroke patients has significantly improved following the commencement of the education.

100% of staff who attended the Stroke study day stated that the training improved their knowledge and skills. 100% of staff would recommend the Stroke Study Day to other colleagues.

We aim to continue the study days and whiteboard sessions with health professionals in all wards in 2019.

USE OF BIOLOGICS IN OLDER PATIENTS WITH INFLAMMATORY ARTHRITIS

Adam Donnelly1, Evelyn Hannan2, Mary Buskley3, Grainne Murphy4

1 University College Cork, Cork, Ireland

2 Cork University Hospital, Cork, Ireland

Background: Biologics are a key component of the treatment armamentarium for inflammatory arthritis (IA). Questions remain surrounding the prescription, efficacy and safety of biologics in the older population. This study aims to describe the use of biologics in older patients with IA and compare it to younger patients.

Methods: This was a retrospective cohort study of patients with a diagnosis of IA who were receiving a biologic. Data was collected from medical charts at rheumatology outpatient clinics. Patients were divided into two groups: younger group (age 45 – 65) and older group (age >70).

Results: Each group had 30 patients (total n=60). 58% were female and the mean age overall was 65 years. Rheumatoid arthritis was the most common diagnosis (57%). 8 patients had active disease, and these were mainly older patients (n=6). 8 different biologics were used. The majority of patients received the standard dose of biologic (87% of younger, 80% of older). The incidence of biologic discontinuation due to drug ineffectiveness was the same for both groups (16%). 1 older patient had a biologic discontinued due to a serious adverse event. Infections requiring hospitalisation were not common (total n=5) but were more frequent amongst older patients (n=4). 47% of younger and 60% of older patients received concomitant therapy; most received a disease-modifying antirheumatic drug (DMARD) (72%), and those who received a steroid (n=6) were more likely to be older (n=5).

Conclusion: Biologic prescribing was similar between both groups with regard to the dosage administered, but there were differences in the types of biologics prescribed to each group. Rate of side effect reaction was low overall, however they were more prevalent amongst the older population. More older patients had active disease, and more were prescribed concomitant steroid therapy, which may represent under-dosing of biologic therapy in this older cohort.
Appropriateness Index (MAI) has been shown to improve patient outcomes. This study examined the impact and cost effectiveness of pharmacist led WIDE Reviews.

Methods: A retrospective prospective cohort study was conducted over 8 weeks in a Model 3 hospital. Inclusion criteria: patients age ≥ 65 years; prescribed ≥ 6 regular medications and screened positive for frailty (PRISMA 7 score ≥ 3). Critically ill patients were excluded. Eligible patients were randomly allocated to intervention or control group.

The intervention group received a pharmacist led WIDE Review: Holistic (establishing patients’ priorities), Integrated (collaborating with primary care providers), Deprescribing Evaluation of medication harms versus benefits. Medications were screened using the STOPP/START criteria and the MAI was calculated. In conjunction with the patients and their consultants, de-prescribing plans were devised and communicated to their CDS and community pharmacists.

Results: A total of 20 intervention and 20 control group patients were enrolled. Patient characteristics (age, sex and length of stay) were similar for both groups: 65% of STOPP and 62% of START criteria were addressed in the intervention group versus 12% and 5% respectively in the control group. In the intervention group 83 medications were stopped, 23 dose reduced and the total MAI score was reduced by 64%. Cost savings to the annual drug budget alone represented a 9.1% return on investment in hospital pharmacist time.

Conclusion: Pharmacists performing WIDE Reviews significantly improved medication appropriateness and realised compelling cost savings. A larger scale study of this innovative approach to medication review is planned.

### EVALUATION OF A CLINICAL PHARMACY SERVICE ON AN INPATIENT WARD IN AN ACUTE HOSPITAL

Clara McGarr, Bernie Love, James Cart; Marie O’Connor, Eamon Dolan, Connolly Hospital, Blanchardstown, Ireland

Background: Intensive clinical pharmacy input from admission to discharge has been shown to improve patient outcomes. The clinical pharmacy service in our institution has historically been under-resourced. The aim of this study is to develop a ward-based clinical pharmacy service and to evaluate its impact using a number of clinical, safety and financial metrics.

Methods: A clinical pharmacist was assigned to provide pharmaceutical care to patients on a Medicine for the Older Person ward. Over an eight week period, the pharmacist prospectively recorded her interventions/activities. To assess impact on patient care, interventions were graded according to the Eadon criteria. The potential cost avoidance associated with interventions was estimated. Medication incident reporting was analysed to assess the impact on patient safety.

Results: 87% of patients had at least one pharmacist intervention, across a spectrum of activities including medication reconciliation and clinical review.

- 90% of interventions requiring follow-up with the medical team were accepted and resulted in a change to patient’s care.
- Eadon grading of interventions deemed 99% to be significant, with 81% improving the standard of patient care.
- Two different methods were used to estimate potential cost avoidance: one estimated annual savings of €154,103; €344,926; the other estimated these at €174,373. Given current pharmacist salary costs, this equates to a cost-benefit ratio of 2.81 to 6.31. (This does not include the 27% reduction in drug spend observed during the study period. However, more longitudinal data are required to confirm and characterise this phenomenon.)
- A five-fold increase in medication incident reporting from the ward was observed, suggestive of an enhanced culture of patient safety.

Conclusion: This study assessed and quantified a wide spectrum of pharmacist contributions to medication management and safety. Costing of these contributions estimates the cost-benefit ratio of the clinical pharmacy service, providing compelling support for the extension of this service throughout the hospital.

### INFLUENCE OF PEOPLE WITH DEMENTIA AND CAREGIVERS IN IRISH DEMENTIA RESEARCH: EXPERIENCES, CHALLENGES AND OPPORTUNITIES

Laura O Phribin, Kevin Quaid, 1 The Alzheimer Society of Ireland, Dublin, Ireland 2 The Dementia Research Advisory Team, Dublin, Ireland

Background: People with dementia and caregivers of people with dementia have the right to inclusion and involvement in research that pertains to them. They can bring unique insights that add significant value to research. Person/Patient Public Involvement (PPI) occurs when the public/patients work in partnership with researchers in setting priorities, planning and managing research studies, as well as in disseminating findings and putting results into practice. In line with Alzheimer Europe’s position, a dementia charity is working hard to support and build capacity for PPI in Irish dementia research.

Methods: The Dementia Research Advisory Team was established in April 2019 and is supported by the charity. It is a group of Experts by Experience (5 caregivers and 5 people living with dementia) who influence, advise and work with researchers across Ireland in a PPI capacity. Team members collectively developed terms of reference detailing their expectations of researchers, the charity, and their role in all PPI activities. Team members will focus on becoming active stakeholders in Irish dementia research, and the charity will support them to build their capacity to be involved through capacity-building workshops and continuous evaluation.

Results: This joint presentation will discuss the development, capacity building, and experiences of the Dementia Research Advisory Team. A person with dementia, will discuss the progress of the team and report on members’ experiences of being involved in Irish dementia research. They will also discuss the impact of involvement on team members, and on the research they have been involved in. Practical ‘lessons learned’ on what did and did not work well will be presented, in addition to how the Dementia Research Advisory Team has navigated challenges and opportunities for involvement of people living with dementia and caregivers in research.

Conclusion: Members of the Dementia Research Advisory Team represent key stakeholders in Irish dementia research.
A REVIEW OF STROKE DEMOGRAPHICS AND OUTCOMES AT A REGIONAL HOSPITAL WITHOUT A STROKE UNIT

Lusheen Pillay, Kushan Galal, Deepthi Tulis, Joanna McGlynn, John Doherty, Teresa Donnelly
Department of Genitourinary Medicine, Midlands Regional Hospital Tullamore, Tullamore, Ireland

Background: According to the 2017 National Stroke Register Report, 75% of strokes occur in patients aged 65 years and older. Within the audit 19 stroke units reported that 70-80% of stroke patients were admitted to a stroke unit and their median length of stay was 9 days. Numerous studies have shown better outcomes in patients admitted to a stroke unit versus a medical unit leading to national stroke networks and bypass protocols for stroke patients. However, stroke patients can still be found in non-stroke units such as our own.

Methods: Demographics from HIPE data was collected on all stroke patients admitted to our hospital between January 1st and December 31st 2017. Basic statistical methods were used to analyse the data.

Results: We analysed 103 patient records. The average age at presentation was 73 years (range: 35-97) and 60.1% were males. The length of hospital stay was 16.1 days (range 1-130 days). Ischaemic (77%) events were more common than haemorrhagic events (23%). The three most common co-morbidities were hypertension (45%), hyperlipidaemia (30%) and atrial fibrillation (19%). Discharge destination was home (66%), nursing home (14%), national rehabilitation (2%) and an 18% mortality rate within 3 months.

Conclusion: The average length of stay was 16.1 days, considerably higher than the national stroke unit average of 9. The overall mortality rate was 5% higher than the national of 13%. Limited rehabilitation services and time awaiting national stroke networks and bypass protocols for patients. However, stroke patients can still be found in non-stroke units such as our own.


Erita Valtis, John McCabe, Sean Murphy, Dearbhla Kelly, Emer Nicholson, Emily Killeen
Mater Misericordiae University Hospital, Dublin, Ireland

Background: Acute blood pressure (BP) lowering to a target of <150 mmHg systolic improves outcomes in patients with acute spontaneous intra-cerebral haemorrhage (sICH). It is thought that the beneficial effect of BP-lowering in sICH is time-sensitive and mediated through a primary prevention mechanism. This was supported by a subgroup analysis of the NINDS t-PA for the acute treatment of intracerebral haemorrhage (NITE) study, which showed that the beneficial effect of BP-lowering in sICH was greater in patients admitted within 6 hours of symptom onset. However, the recent American Heart Association guideline states that BP lowering to <150 mmHg or lower is safe and can improve functional outcome. Our aim was to re-evaluate the performance of clinicians in meeting target SBP levels of <150 mmHg in patients with acute sICH within 1 hour of presentation, following the introduction of a BP-lowering protocol in our centre.

Methods: We undertook a retrospective chart review of consecutive patients with an acute sICH admitted to our centre between September 2017 and May 2018. Any patient who did not receive active medical management from the onset of presentation due to immediate initiation of palliative measures were excluded. The time from presentation to target BP and BP measured at 1 hour were recorded. Any protocol violations were also documented.

Results: 11 patients were included (mean age 77.7 years, 55% female). The mean BP at presentation and 1 hour was 186±93 mmHg and 161±53 mmHg respectively. The median and mean times from presentation to first achieved target BP was 129 and 120 minutes respectively. At least 1 protocol violation occurred in 66.6% of cases. The most common protocol violation was the failure to escalate to an intravenous infusion of a BP-lowering agent in a timely manner when bolus therapy had failed.

Conclusion: The introduction of a BP protocol for patients with an acute sICH did not improve performance on achieving rapid SBP-lowering to target levels of <150 mmHg. Strategies to improve awareness of this protocol are required to improve adherence and its successful implementation.

THE WORKLOAD DISTRIBUTION AND RESPONSE TIMES OF FAST SCANS IN A LEVEL 3 HOSPITAL IN IRELAND

Caoimhe McGarvey, Paul O’Brien
Naisi General Hospital, Naisi, Ireland

Background: With the advent of time sensitive treatments like thrombolysis and thrombectomy for acute ischaemic stroke, it would be expected that stroke CT would place an increased demand on CT services out of hours. Our aim is to demonstrate the change in the workload distribution in the investigation and management of acute stroke over the last year.

Methods: Data was collected from the radiology systems used in our hospital (NIMIS-PACS). Firstly, CT multiphase angiograms done between 17/10/2017 and 17/10/2018 were examined, followed by all FAST-positive CT brains in the same period. Arrival times for FAST positive patients were collected from the ED Symphony system. These details were used to calculate time to CT and time to report in hours and minutes. Scans were categorised into 5-time windows, in and out of hours. The process was repeated for CT brain and all other CT scans for comparison.

Results: 58.14% of all FAST-positive CT scans were performed out of hours. FAST positive scans accounted for 9.49% of all out of hour CT scans, which rose to 20% when examining the out of hour scans from Monday to Friday. The most common indication for non-FAST positive CT was trauma. There was a higher likelihood of receiving a CTA during hours as opposed to out of hours, (73.33% vs 66.94%). Median time to CT in FAST positive patients: window 1 – 18 minutes, window 2 – 49 minutes, window 3 – 49 minutes, window 4 – 34min, window 5 – 39minutes.

Conclusion: Stroke CT will continue to increase the out of hours work load for CT departments across the country especially with our ageing population. It is vital that services, particularly in level 3 stroke centres, are adequately equipped in terms of staffing to meet the highest standard of care in the management of acute stroke.

MALE FAMILY CARERS’ PERCEPTIONS OF FORMAL SUPPORT SERVICES, A META-ETHNOGRAPHY

Caroline Finn1, Pauline Boland1,2,3
1 School of Allied Health, University of Limerick, Limerick, Ireland
2 Faculty of Education and Health Sciences, University of Limerick, Limerick, Ireland
3Ageing Research Centre (ARC), Limerick, Ireland
4Health Research Institute, University of Limerick, Limerick, Ireland

Background: Family carers provide thousands of hours of unpaid work every year, a third of whom are men, however this group are generally under-represented in research. Comparative studies have shown that male carers experience their caring role differently to female carers in several respects. Social concepts related to masculinity can help to explain help-seeking and service-seeking behaviours of male carers, as well as their attitudes to accessing outside support. Compared to women carers, men have lower rates of uptake of formal support services. This aim of this review, therefore, was to examine accounts of male carers’ experiences and perceptions of receiving formal support.

Methods: The study followed a meta-ethnography process starting with a systematic literature search of five electronic databases. The methodological quality of the included studies was evaluated using the McMaster checklist. Using NVivo 12 software, primary qualitative data was analyzed and key themes were identified. Results were synthesised using Noblit and Hare’s (1988) process of meta-ethnography, retaining direct quotes from the studies.

Results: Eighteen studies were included in the final paper. Three main themes were identified: 1) asserting control over the caring role 2) desire to excel in caring role and 3) coping without formal support.

Conclusion: For the most part, male carers expressed a desire to be competent in their caring role. Perceived loss of control within the caring relationship was a key factor when men had low trust and dissatisfaction with services. Support services that were collaborative, 

strategies to improve awareness of this protocol are required to improve adherence and its successful implementation.
OPENING THE NARRATIVE ON DEPRIVATION OF LIBERTY FOR THE OLDER PERSON IN RESIDENTIAL HEALTHCARE FACILITIES: A LEGAL AND ETHICAL DILEMMA

Florencia Hogan1, Adrian Ahern1
1Leopardstown Park Hospital, Dublin, Ireland
2Royal College of Surgeons, Dublin, Ireland

Background: While many people enter residential care of their own free will and because it is their preference, the evidence tells us that there are also many who if they had the choice would remain in their own homes. Lack of appropriate community supports may provide some impetus to enter residential care. According to Care Alliance Ireland, an additional four million hours of homecare needs to be provided to cope with the successful aging demographics, at a cost of €110 million.

There is no statutory or common-law power to detain a patient in a Healthcare Facility outside of the application of the Mental Health Act 2001. This presents legal, ethical and moral dilemmas for Healthcare Providers when the wishes of the person who lacks capacity needs to be adhered to.

Education-based and gender-sensitive were favoured by the men. To engage more male carers, service providers should acknowledge men’s experience and capabilities as well as their wish to stay involved in decision-making around care for their family member. For men over the age of 85 male family carers outnumber females in Ireland (CSO 2016). It is important to understand male carers’ experience to develop more inclusive supports and consequently increase service uptake.

60 HOW WELL IS OSTEOPOROSIS CHECKED FOR AND TREATED IN THOSE ADMITTED WITH FRACTURE FRACTURES ON GENERAL MEDICAL CALL?

Muhammad Ridwan Salehmohamed1, Sarah O’Riordan1, Rachael Doyle1, Clodagh O’Dwyer2
1St. Columcille’s Hospital, Dublin, Ireland
2St. Vincent’s University Hospital, Dublin, Ireland

Background: Patients suffering a fragility fracture should be assessed and considered for treatment for osteoporosis according to current guidelines. This retrospective audit set out to assess if diagnosis and treatment of osteoporosis occurred appropriately in those admitted to a Model 2 Hospital with non-hip fractures on general medical call under all specialties.

Methods: Hip fracture patients admitted with fragility fractures, between January and June 2018, were included. Hip fracture patients treated through a separate ortho-geriatric rehab pathway were excluded. Data including source of admission, length of stay, type of fracture, investigations, treatments initiated or planned, were identified from patient's records and collated using excel statistical analysis.

Results: From a total of 64 fracture admissions, 38 cases were non-Hip fractures. 34% (n=13) male, average age was 84 and 40% (n=15) patient had a history of previous fracture. Once admitted 68.4% (n=26), 60.5% (n=23) and 50.0% (n=19) had Vitamin D levels checked, bone mineral density, and profit healthcare provider Electrophoresis checked respectively. Three patients passed away. 37% (n=13/35) of patients had a DXA scan performed either during or after their admission, all of whom were diagnostic for osteoporosis. 50% (n=19/38) were on Vitamin D at time of admission while 77% (n=27/35) were discharged on Vitamin D supplementation. 8% (n=3/38) were on osteoporosis treatment at time of admission while 31% (n=11/35) were discharged on, or had a plan in place for, osteoporosis treatment.

Conclusion: Investigation for and management of osteoporosis in patients admitted with fragility fractures are not being adhered to as per recommended guidelines. A new pathway requiring the supervision of a newly appointed c/RANP is being developed, in line with osteoporosis guidelines as a result, with a view to re audit and better follow-up of these patients.

AUTONOMIC IMPAIRMENT AND ITS MANIFESTATIONS IN PATIENTS WITH DELIRIUM

Elaine Shanahan1,2, Sheila Ryan1, Aine Costelloe1, Tia Sheehy1, Catherine Peters1, Declan Lyons1, Margaret O’Connor1,2
1University Hospital Limerick, Limerick, Ireland
2University of Limerick, Limerick, Ireland

Background: Delirium is common among unwell older adults. Despite this the pathophysiology remains poorly understood. It is hypothesised that autonomic dysfunction may be associated with the development of delirium.

Methods: 35 participants completed a case-control study. Delirium was assessed using DSM-IV and CBS-R. Autonomic function was assessed with Head-Up Tilt testing (HUT), baroreflex sensitivity (BRS) testing using Baroreflex Effectiveness Index (BEI), 24-hourly blood pressure variability (BPV), nocturnal blood pressure dipping status and 24-hour heart rate variability (HRV). A subgroup analysis of those without pre-existing cognitive impairment (CI) was completed.

Results: During titling the delirium group (DG) had a median decrease of 11mmHg (IQR 20.75) in the control group (CG) (p=0.04). Increased delirium severity correlated with a reduction in the decrease in SBP (r=-0.42, p=0.03). In those without CI, BRS testing during HUT showed that increases in blood pressure were not followed by an appropriate reduction in heart rate with a mean BEE of 36.87% (SD 22.26) in the DG and 56.03% (SD 23.04) in the CG (p< 0.05). Nocturnal dipping differed during subgroup analysis. 58.3% (7) of DG were reverse dippers, 33.3% (4) were non-dippers and 8.3% (1) had a normal dipping pattern. In CG 57.1% (4) were non-dippers, 14.3% (1) had a normal dipping pattern and 28.6% (2) were extreme dippers (p=0.01).

BPV was measured by average real variability (ARV). In those without CI mean ARV was 15.81 (SD 5.98) in the CG and 9.69 (SD 2.75) in the DG (p=0.05).

No difference was detected in HRV.

Conclusion: We identified differences in autonomic function between the DG and CG. This is the first study to look at several components of autonomic function in delirium and thus can provide insights into physiological abnormalities present during, or contributing to delirium.

67 CAN A WHOLEFOOD PLANT-BASED DIET AFFECT HEALTHY AGEING?

Ailin O’Mullan
Mary Immaculate College, Limerick, Ireland

Background: This study sought to examine existing evidence regards the effects of a wholefood plant-based diet on healthy ageing. As of March 2018 the average life expectancy in Ireland was 81.4 years, ten years above the global average. However approximately 1 million people suffer from chronic disease with 64.8% of people over 65 living with comorbidity (TILDA 2014). The prevention and treatment of these diseases is central to the healthy ageing of our population.

Methods: This systematic review of the literature explored diet, health, ageing and disease. A scoping search, with relevant key words, was followed by an in-depth search with reference to a pre-ordained search syntax template. Specific eligibility criteria, determined by a PICOSSS system were applied to the results. All included studies underwent quality assessment in line with the critical appraisal checklist for cross sectional studies. Extracted data was displayed in table format initially and then explained through narrative synthesis.

Results: A large body of evidence was found to suggest that cardiovascular disease, metabolic disorders and inflammatory conditions improved with a wholefood plant-based diet. Evidence in relation to certain cancers was present but not conclusive. Breast cancer was the exception to this. Evidentiary support, for reductions in BMI and in the need for polypharmacy were also found.

Conclusion: More research is needed into the benefits of a wholefood plant-based Diet. However as this diet is a low cost, low risk intervention it could be applied beneficially in the interim. Ageing was found to be a life-wide, life–long process so the research concluded that this diet could provide benefit to all.

“The side effects of a plant-based diet could be the elimination of the need to take drugs, and further research is needed to find ways to make Plant-Based Diet the new normal” (Tuos, et al 2013).

ADULT SAFEGUARDING, ABUSE OF VULNERABLE ADULTS AND MANDATORY REPORTING: A RAPID REALIST REVIEW OF THE LITERATURE

Sarah Donnelly
School of Social Policy, Social Work and Social Justice, University College Dublin, Dublin, Ireland

Background: The continuing evolution of adult safeguarding legislation, policy and practice is in reaction to the abuse of vulnerable adults reflects a growing awareness of the nature and extent of such abuse in Ireland. The Adult Safeguarding Bill, 2017 represents a progressive step in safeguarding older people and vulnerable adults. The intention of the Bill is to put in place additional protections for adults, in particular, for those who may be unable to protect themselves, such as older people or those lacking capacity. Part 3 provides for mandatory reporting by specified/named persons/professionals. This paper sets out to critically analyse the concept of mandatory reporting within adult safeguarding using international comparators as case studies.

Methods: A rapid realist review of adult safeguarding reporting typologies and systems in five key jurisdictions: Australia, Canada, England, Northern Ireland and Scotland, were explored to answer the question: ‘what works, for whom and in what circumstances?’ [1]

Results: Jurisdictions differ as to who the mandated reporters are, the scope and powers of mandatory reporting, and the types of abuse subject to reporting. Of significance is that the debate on mandatory reporting has increasingly focused on institutional settings, rather than more broadly across services. Key concepts identified are those of protection, empowerment and proportionality. Adult safeguarding legislation must therefore ensure
that interventionist and compulsory measures to protect do not excessively restrict the rights of the individual.

Conclusion: Mandatory reporting may offer professionals increased powers to prevent and reduce the abuse of adults and older people, but this could also change the dynamic of relationships within families, and between families and professionals. Ultimately, the success of any legal approach will rest with professional judgment in balancing autonomy with protection.

Reference:

### GPS KNOWLEDGE OF AND ATTITUDES TOWARDS THE MANAGEMENT OF BEHAVIOURAL AND PSYCHOLOGICAL SYMPTOMS OF DEMENTIA: A DESCRIPTIVE CROSS SECTIONAL STUDY

Aisling A. Jenning1, Sheelah Bbi Fatmah Dhuny2, Tony Foley1
1Dept. of General Practice, University College Cork, Cork, Ireland 2University College Cork, Cork, Ireland

Background: Evidence suggests that the current management of behavioural and psychological symptoms of dementia (BPSD) in general practice is sub-optimal. Non-pharmacological strategies are recommended first-line but uptake of these strategies is low. Despite their adverse effects and minimal effectiveness antipsychotics are frequently employed to manage BPSD. The aim of this study was to explore general practitioners (GPs) knowledge of and attitudes towards the management of BPSD with a view to informing future interventions.

Methods: A questionnaire was adapted from existing study. Additional questions were included, informed by the findings of a qualitative study previously conducted by the authors. The questionnaire was piloted with 3 GPs and was posted to a census sample of all GPs in county Cork and county Kerry in the south of Ireland. Statistical analysis was performed using SPSS.

Results: Of the 456 questionnaires sent 168 completed questionnaires were returned (36.8% response rate). The sample was representative of GPs nationally in terms of years of practice (p=0.0001). 62.5% (105/168) of respondents had a nursing home commitment. The majority of GPs (60.7%) agreed that they required more training to improve their management of BPSD. ‘Lack of resources in the primary care team’ was cited as the main barrier to GPs recommending non-pharmacological strategies in the community. Nursing staff were identified as the group of people that most influenced the GPs prescribing of antipsychotic medications in a nursing home setting. The majority of respondents (84/168) did not monitor their prescribing of antipsychotics to people with dementia. 63.1% (106/168) of GPs were concerned that withdrawing these medications would negatively impact on the quality of life of the person with dementia.

Conclusion: This study identified several factors that influenced the management of BPSD in general practice. These findings will be used to guide future interventions in this area.

### AN INCORRECTLY SET WATCH MAY SUGGEST COGNITIVE IMPAIRMENT IN THE OLDER PATIENT

Martina Feyzakhmanova, Owen Killian, Evelyn Fennelly, Samuel Toland, Dermot Power
Mater Misericordiae University Hospital, Dublin, Ireland

Background: Disorientation to time can be used as a guide to determining the presence and severity of dementia. The inability to maintain one’s wrist watch at the correct time is a barrier to GPs recommending non-pharmacological strategies in the community. The most striking finding of this study was that any patient with an incorrectly set watch could be considered as an instantaneous, approximate “test” for dementia in clinical practice. This test would have a sensitivity of 37% and specificity of 100%.

Methods: Inpatients in a post-acute care unit with a mean age of 76.2 (±12.4 years) were assessed with regard to the time on their wristwatch. The time was recorded as correct or incorrect with a permitted discrepancy of 15 minutes. A current Mini-Mental State Examination (MMSE), the Neuro-Psychiatric Inventory Questionnaire (NPI-Q), and the Disability Assessment for Dementia (DAD) scale were used to assess the severity of dementia. The secondary aim is to identify risk factors which may be contributing to this perceived burden.

Methods: Fifty-two people with dementia (PwD) and their informal caregivers were recruited by convenience sampling, and data was collected as part of the CHESS research trial. Data was collected during baseline assessments between April 2017 and September 2018. Dementia disease severity was measured using the Mini-Mental State Examination (MMSE), the Neuro-Psychiatric Inventory Questionnaire (NPI-Q), and the Disability Assessment for Dementia (DAD) scale. These outcome measures were then compared to levels of caregiver burden, which was measured using the Zarit Burden Interview (ZBI). These comparisons were completed using Spearman’s correlations. Socio-demographic characteristics of both the carer and PwD were then compared to caregiver burden, using Mann-Whitney and Kruskal-Wallis tests.

Results: The results of the study substantiate that behavioural disturbances (p=0.000) and increasing disability (p=0.022) of the PwD are associated with higher carer burden. The study also identified potential non-modifiable risk factors for increased carer burden. These include spousal relationship (p=0.006), older caregiver age (p=0.208), female carer gender (p=0.083) and higher educational attainment of the carer (p=0.035). Some of these differ from factors influencing burden in other international populations.

Conclusion: This preliminary analysis is the first study of its kind to be carried out in Ireland. It sheds light on potential predictors and risk factors for carer burden and shows need for future research to be carried out in this area. Such research would help to clarify interventions which could minimise the prevalence of the burden experienced by informal caregivers.

### COMPARING THE MANAGEMENT OF FRAILTY BETWEEN A RAPID ACCESS FRAILTY TEAM AND GENERAL MEDICAL TEAMS AT A LEVEL THREE HOSPITAL

Deepthi Tulsi, Lushen Pillay, Ibrahim Ogutuembola, Alice Farrell, Joana McGlynn, John Darby, Teresa Donnelly
Department of Geriatric Medicine, Midlands Regional Hospital Tullamore, Tullamore, Ireland

Background: Frailty represents a particularly high risk group of geriatric patients whom require specialized care. Dedicated multidisciplinary frailty teams led by Geriatricians have been shown to provide better outcomes. The aim of this study was to compare the inpatient interventions and length of stay (LOS) between patients under the care of a dedicated Rapid Access Frailty Team (RAFT) versus general medical teams.

Methods: Data was collected on a total of 163 patients who were screened as frail positive using a screening tool, over a period of 10 months in 2018. Basic Statistical Analysis was used to analyse data.

Results: Of the 163 patients, 113 were managed by the RAFT and 50 by a medical team. 61.9% were assessed as frail immediately in the Emergency Department, while the remainder where referred to the RAFT from other medical teams. The main reasons for referral were: cognitive impairment (51.3%), poor mobility and safety awareness (70.8%), polypharmacy (82.3%), poor functioning in ADLs (76.1%) and medical reasons (77.9%). Interventions made by the frailty team included: medication rationalization (82.3%), MDT assessment (91.2%) and discharge planning (87%). 49.5% of patients seen by the RAFT had a MOCA score < 22. Of patients managed by the RAFT 100% received Physiotherapy and 96.5% were seen by Occupational Therapy, while in the medical group this was 50% and 42% respectively. The mean length of stay was 9 days in the RAFT group, and 12.4 days in general medical groups.

Conclusion: Patients managed by the RAFT had an average LOS of 3.4 fewer days. We hypothesize that this is linked to earlier identification by the RAFT, earlier referral and more intensive intervention by allied health services, and specialized Geriatric Medical input. We aim to increase the availability of our frailty service within our hospital to optimize the management of our frail patients.

### SLEEPING BEAUTY

Nora Cunningham1, John McManus2, Margaret O’Connor2, Ahmed Gabr3, Sheila Ryan1
1University Hospital Limerick, Limerick, Ireland 2University Hospital Limerick, Limerick, Ireland 3University Hospital Limerick, Limerick, Ireland

Background: The artery of Percheron is a rare anatomic variant of arterial supply to the paramedian thalamus and rostral midbrain, and occlusion of the artery of Percheron results in bilateral paramedian thalamic infarcts with or without midbrain involvement. Early diagnosis of artery of Percheron infarction can be challenging because it is infrequent and early computed tomography or magnetic resonance imaging may be negative. Thus, it can be confused with other neurological conditions such as tumours and infections.

Methods: This is a retrospective case study of a gentleman admitted to a teaching Hospital in Limerick and diagnosed with an artery of Percheron infarction. Medical records and the neuro-radiological database were reviewed, and the diagnosis was made based on typical symptoms and radiological findings of artery of Percheron infarction.
Results: We report the case of a gentleman who was found unconscious in his car on the roadside during the daytime. He had a decreased GCS and upon arrival in the Emergency Department he was intubated and transferred to ICU. The initial head computed tomography performed on admission was reported as unremarkable. Bilateral ischemia in the paramedian thalamic nuclei was documented on a follow-up computed tomography on day 24 after hospitalization. He was extubated after 24 hours. He made a full recovery and was discharged home on day 5.

Conclusion: Ame Identity Percheron infarcts are rare. The radiological diagnosis can initially be difficult, often requiring computed tomography on day 24 after hospitalization, as improved hospital to home transition and potential reduction in LOS.

Further research is required to evaluate the effectiveness of this therapy intervention in improving mobility, preparation for home and re-integration into the community.

Background: Frail older adults in a post-acute orthogeriatric unit present a complex challenge for rehabilitation professionals. This study aimed to explore the experience and perspectives of patients, carers, occupational therapists and physiotherapists in a post-acute orthogeriatric unit.

Methods: A qualitative methodology was used involving semi-structured interviews with 14 patients, 7 carers and 10 professionals. Interview data were transcribed and thematically analysed.

Results: Participants described a range of experiences in the unit, including positive aspects such as increased confidence and independence, as well as negative aspects such as confusion, lack of communication and difficulty with movement. Participants highlighted the importance of time and space for rehabilitation, as well as the need for clear communication and support from staff.

Discussion: The findings suggest that the post-acute orthogeriatric unit can be an effective setting for rehabilitation, but requires careful planning and provision of resources. The experience of patients, carers and professionals is important in guiding the development and delivery of rehabilitation services.
Conclusion: There has been a significant increase in primary prevention practices for AF and this is reflected in the number of stroke patients presenting with known AF on a NOAC, however more needs to be done as there are still patients who have AF that are not being anticoagulated in the community.

Background: Falls are a common cause of morbidity and mortality in older adults, with most being caused by identifiable risk factors. This study aimed to assess demographics and clinical characteristics of patients who had recurrent falls attending the medicine for the older person (MFTOP) outpatient department at a tertiary centre.

Methods: Retrospective analysis of patients seen at MFTOP OPD between January 2018 and December 2018. Data was obtained from clinical notes. Age, gender, blood pressure, cognitive tests, blood tests, diagnoses and medications that could contribute to falls were recorded.

Results: 100 patients were reviewed. 60% were female (60). Mean and median ages were 83. Causes of falls included: gait/balance disorders or weakness 56.0%, environment-related 51.0%, alcohol 19.0%, alopecia areata 19.0% and Old monitors' 19.0%. Of patients with known AF, 100% were on an OAC (11 on warfarin) and 40(78%) on a Non- Vitamin K antagonist oral anticoagulant (NOAC).

Conclusion: The rate of emergency admissions for ACS conditions studied is in line with research in the United States, although COPD and angina account for a higher proportion of admissions in our study. There is significant geographical variation in ACS admission rates among older adults in Ireland. Further research should explore local factors influencing emergency admission, particularly in socio-economically disadvantaged areas and those with lower GP supply.

**DEMOGRAPHICS AND CHARACTERISTICS OF PATIENTS WITH RECURRENT FALLS ATTENDING TERTIARY HOSPITAL OUTPATIENTS DEPARTMENT**

Micheal Schwan Marion, Paula Beatty, Tarig Zainal, Marie-Anne Riordan, Toddly Daly, Lorraine Kyne, Joseph Duggan
Mater Misericordiae University Hospital, Eccles St, Dublin 7, Ireland

Background: Hospitalisation for specific conditions considered to be 'ambulatory-care sensitive' (ACS) could signifies problems with primary or outpatient care access. The aims of this study are to quantify and explore potential causes for geographical variation across emergency hospital admissions for relevant ACS conditions in older adults in Ireland.

Methods: The number of emergency hospital admissions among adults aged 65+ with a diagnosis of an ACS condition between 2012-2016 were extracted from Ireland's Hospital Inpatient Enquiry system according to condition, sex, age-group, residence area and year. Conditions included chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), diabetes complications, anemia (excluding therapeutic procedures), pyelonephritis and urinary tract infections (UTI), dehydration and pneumonia. Age-sex standardised discharge rates (SDRs) were calculated for 21 areas. Systematic components of variance (SCV) quantified variation. Regression analyses were conducted between SDRs and year, unemployment rate, % urban population, General Practitioner (GP) supply, and % short emergency hospital stays.

Results: In total, 147,722 emergency hospital admissions (50 per 1,000 eligible population; 49% male) were included. COPD was the most common condition (31%), followed by pneumonia (22%), pyelonephritis/UTI (21%) and CHF (16%). CHF showed low geographic variation (SCV=2-3). COPD, diabetes, pyelonephritis/UTI and pneumonia showed high variation (SCV>12). Anemia and dehydration showed very high variation (SCV=12-50). In multivariable analysis, higher unemployment was associated with higher SDRs for COPD. Lower GP supply was associated with higher SDRs for CHF, diabetes and pneumonia. Rurality was associated with SDRs for anemia.

Conclusion: The descriptive analysis elucidates clinical presentations, severity and responsible drugs of incident ADRs in the SENATOR (Software ENgine for the Assessment & optimization of drug and non-drug Therapy in Older peRsons) phase I feasibility study. Methods: SENATOR-phase I was a European multicentre-prospective-observational study. Participants were ≥ 65 years, experiencing acute-hospitalisation and on pharmacological treatment for ≥ 3 conditions. Adverse reactions (AERs) were identified by trigger list at recruitment, day-14/discharge and classified as ADRs when association with an administered drug was adjudicated as being probable/certain, according to the World Health Organization Uppsala Monitoring Centre ADR causality criteria.

Results: Of 642 participants recruited, 382 (59.1%) experienced 732 AEs. 363 AEs (49.6%) being incident. 139 participants (21.6%) experienced 244 (31.4%) ADRs. Full ADR causality criteria. 95(21.6%) were classified as ADRs when association with an administered drug was adjudicated as being probable (55, 35.3%) being incident. 139 participants (21.6%) experienced 244 (31.4%) ADRs. Full ADR causality criteria. 95(21.6%) were classified as ADRs when association with an administered drug was adjudicated as being probable/certain. Any drug class showed a significant association with an administered drug was adjudicated as being probable/certain. Any drug class showed a significant association with a higher proportion of admissions in our study. There is significant geographical variation in ACS admission rates among older adults in Ireland. Further research should explore local factors influencing emergency admission, particularly in socio-economically disadvantaged areas and those with lower GP supply.
MEDICATION RELATED QUALITY OF LIFE (MRQOL) IN AMBULATORY OLDER ADULTS WITH POLYPHARMACY AND MULTI-MORBIDITY – A MEASURABLE OUTCOME!

Emma Jennings1,2, Katrine Jørgensen1,2, Natasha Lewis1, Stephen Byrne1, Paul Gallagher1,2, Denis O’Mahony1,2
1Department of Geriatric Medicine, Cork University Hospital, Cork, Ireland
2Department of Medical University College Cork National University of Ireland, Cork, Ireland
3School of Pharmacy, University College Cork National University of Ireland, Cork, Ireland
4Department of Pharmacy, Faculty of Health and Medical Sciences, University of Copenhagen, Copenhagen, Denmark

Background: With increasing numbers of older multi-morbid people being exposed to polypharmacy, research needs to focus on medication-related outcomes affecting quality-of-life (QoL). This study examines older-patients’ medication-related QoL (MRQoL), its relationship to medication burden/complexity, frailty, health-related QoL (HRQoL) and potentially inappropriate medications (PIMs).

Methods: A cross-sectional-study was conducted in older-patients attending our-patients and day-hospital services of a tertiary-teaching-hospital. Participants were aged ≥65 years, first-time attendees, taking ≥5 chronic medications for ≥3 chronic-conditions and mini-mental state examination score ≥26/30. Demographic, medication, comorbidity, frailty status, PIMs (STOPP/STARTv.2 criteria), MRQoL (MRQoL-LS v1.0) HRQoL (SF12-PCS, SF12-MCS) and potentially inappropriate medications (PIMs)

Results: Over 12 months, 234 patients (attending 78 clinics) were screened, 59 met inclusion criteria and 50 were recruited; 3 patients were subsequently identified as ineligible. Eighteen patients were female (66%), mean age was 79.4 years (SD±6.2), median number of daily medications was 10 (IQR 8-13), median number of comorbidities was 11 (IQR 9-14).

Participants were generally drug-compliant, median MARS score of 9 (IQR 6.5-10). Patients’ median MRQoL score was 14 (IQR 12.25-15); mean LMQ v2 score was 115.64 (SD±25.18). Mean age-specific mean difference SF12-PCS and SF12-MCS scores were 22.61 (SD±11.77) and -22.1 (SD±17.5) respectively. There was no significant correlation between MRQoL and number of daily medications, number of comorbidities, LMQ, HRQoL or PIMs (Pearson’s r<0.1).

Conclusion: This study demonstrates that MRQoL-LS v1.0 is not applicable to most patients attending geriatric ambulatory services. Furthermore, polypharmacy, multimorbidity, presence of PIMs poorer HRQoL do not correlate significantly with MRQoL.

A MULTIDISCIPLINARY APPROACH TO RESTRICTIVE INTERVENTIONS IN RESIDENTIAL CARE

Laura Conway
Neuromed Hospital, Dublin, Ireland

Background: A residential service in Dublin is home to 100 older persons with wide-ranging, complex care requirements. Traditionally restrictive interventions (RI) for residents in the setting were the decision of the Nursing/Medical team. Evidence based best practice stipulates that RI must be supported by a systematic and collaborative assessment between the resident, their family/representative and members of the multi-disciplinary team (MDT).

Methods: A Restrictive Interventions Working Group (RIWG) was set up to facilitate an overall change in practice in respect of RI. The working group developed pathways for planned/emergency RI with particular focus on the development of a Planned RI form to guide MDT discussion. The pathways were implemented across the service. The RIWG drafted a new RI Policy to reflect the changes in practice, followed by education sessions facilitated by Occupational Therapy and Practice Support. Feedback was sought after each education session.

Results: The project was launched on August 1st 2018. Sixteen Planned RI Forms were presented to MDT from August 2018 to February 2019. Seven of those restrictions were discontinued following MDT discussion. 43% reduction in mechanical RI and a 54% reduction in PRN psychotropic prescription between August and December 2018.

Conclusion: An MDT forum for discussing RI provides improved governance over the introduction, review and discontinuation of RI. Further education in respect of RI, management of restrictive behaviours and staff competency assessment will further improve practice, with the goal of achieving a RI free home.

A PATHWAY OF CARE FOR PATIENTS WITH PARKINSON’S DISEASE IN CAVAN MONAGHAN PHYSIOTHERAPY DEPARTMENT

Mary Sweeney1, Maura Creggan2, Michelle Hall3, Donna McGroarty4, Jane Graham5
1Cavan General Hospital, Cavan, Ireland
2Cavan Primary Care Services, Cavan, Ireland
3Adult Disability Services, Cavan, Ireland
4Adult Disability Service Monaghan, Monaghan, Ireland
5Monaghan: Primary Care Services, Monaghan, Ireland

Background: New European guidelines for the physiotherapy management of patients with Parkinson’s disease were published in 2014. Following on from this publication it was decided to review the current physiotherapy service delivered to our patients with Parkinson’s disease across both counties and develop a new pathway of care in line with the guidelines.

Methods: A working group of physiotherapists was selected representing acute, primary care and disability services. This group initially met to review current practice. Once the service was evaluated, the group created a new assessment form for use across all physiotherapy services in both counties using validated outcome measurements as recommended in the guidelines. A training program was put in place to improve staff’s skill level in using the new assessment form and treatment methods for this client group. It was decided that a yearly assessment would now be carried out on each patient with Parkinson’s disease.

Feedback was sought from therapists and any issues were addressed by the working group. As part of a pathway a new Parkinson’s exercise group was created which runs twice weekly in both counties.

Results: In 2018, 18 patients attended an exercise class in Cavan, 16 attended in Monaghan while yearly assessments were also completed.

Patient feedback from the classes has been very positive and outcome measurements have shown an improvement. Patients enjoy the class setting immensely and physiotherapy staff feel their patients are benefiting from receiving a more prolonged period of intervention.

Conclusion: This new pathway of care has been an effective and efficient way of treating patients with Parkinson’s disease. It has led us to identify changes in disease progression in a more timely fashion. Outcome measurement is audited yearly to monitor quality of classes and benefit to patients.

We will continue to highlight the pathway with new staff and monitor staff satisfaction with its use.

SERVICE PRIORITIES FOR PEOPLE WITH DEMENTIA IN IRELAND: A MIXED METHODS STUDY OF HEALTH CARE PROFESSIONALS

Fiona Keogh1, Tom Pierse2, Eamon O’Shea2
1National University of Ireland Galway, Galway, Ireland
2National University of Ireland Galway, Galway, Ireland

Background: Public services for people with dementia living in the community face significant resource constraints. The aims of this study are to identify an optimum mix of services for six dementia case types and to gain a greater understanding of the resource allocation decision making process.

Methods: Irish datasets were used to identify dementia cases representing 46% of cases in the datasets. Vignettes were prepared for six case types ranging from low to high dependency and needs. Carers, people with dementia and health and social care professionals (HSCP) took part in mixed methods workshops. Initial findings for the HSCP are reported here (N=23). HSCP participants firstly quantitatively identified an optimum care package for a set of six vignettes, then qualitatively discussed the needs and individual case factors that were driving service recommendations. The quantitative exercise was repeated with a budget constraint. The workshops finished with a discussion on service and case prioritisation.

Results: When no budget constraint is imposed, participants recommended the use of a wide range of services. Home help, in-home respite and day care services comprised 62% of spending in this scenario. When a budget constraint was imposed, participants focused on essential care and reduced services aimed at prevention, quality of life and carer support. Resources were not redistributed between cases (e.g. from low need to higher need cases) as a similar proportion of the budget was allocated to each of the cases in both scenarios.
Conclusion: People with dementia living in the community and their families have a wide range of health and social care needs. Optimum dementia care packages included a wide range of services to meet these needs. However, a budget constraint resulted in a much narrower range of services with consequent implications in terms of unmet need and a reactive rather than preventive approach to care.

USE OF DRGS WITH ANTICHOLINERGIC PROPERTIES IN PEOPLE LIVING WITH ALZHEIMER’S DISEASE: DATA FROM NILYAD

Sean P Kennedy1, Adam H Dyer1, Claire Murphy1, Brian Lavello2
1 Tallaght University Hospital, Dublin, Ireland
2 St James Hospital, Dublin, Ireland

Background: Prolonged exposure to anticholinergic medication, particularly in midlife, is associated with increased risk of cognitive impairment/dementia. Less well explored is the ongoing use of drugs with anticholinergic properties in patients with Alzheimer’s Disease (AD), where the potential to accelerate cognitive decline may be greater.

Methods: We analysed medication data from the NILYAD trial, a clinical trial examining the efficacy of Nilvadapine in mild-moderate Alzheimer’s Disease (AD). Drugs were coded based on their Anatomical Therapeutic Chemical (ATC) classification and Anticholinergic Burden Scale (ABS) applied to each participant’s medication list. Logistic and linear regression were used to model predictors of potential anticholinergic medication use/total ABS score.

Results: Of 510 participants with AD (mean age 72.8 +/-8.3 years; 62% female), just over one-quarter (N = 134, 26.27%) were prescribed a drug with potential/definite anticholinergic properties. Half of these had an anticholinergic burden score of 3 or greater (N = 67, 13.4%). The most frequent definite anticholinergics prescribed included quetiapine (N = 27) oxirontin (N = 22), paroxetine (N = 14) and amitriptyline (N = 8). Usage did not significantly differ by country or study arm. Overall, 88.4% of patients were prescribed a cholinesterase inhibitor. On multivariate analysis of potential/definite anticholinergic usage, age (p=0.044; OR 1.03, 1.01-1.06), total number of medications (p=0.001, OR 1.3, 1.18-1.41) as well as a greater dementia severity rated using the Alzheimer’s Disease Assessment Scale (ADASS-Cog) (p=0.008; OR 1.01 1.01-1.07) were associated with likelihood of anticholinergic use.

Conclusion: Over one-quarter of community-dwelling older patients with AD are prescribed a drug with potential or definite anticholinergic properties. Use of drugs with potential/definite anticholinergic properties were associated with total medication burden in addition to greater dementia severity at baseline. This is particularly pertinent given the deleterious cognitive effects of anticholinergic medication. Further attention to reducing total anticholinergic burden in patients with dementia is warranted.

SAFER MOBILITY: PRACTICE VS PREACH

Sive Carey, Adefunke Salawu, Marian Glynn
Physiotherapy Department, St Mary’s Hospital, Phoenix Park, Dublin, Ireland

Background: Activity levels in older people undergoing inpatient rehabilitation are low. Intervention by the rehabilitation team accounts to 2% of a patient’s day. Interdisciplinary working helps to ensure that therapy continues beyond the physiotherapy gym. However, safe handling is required.

Aims: • Examine the awareness of ward staff of the mobility status of their patients.
• Investigate if staff on a general geriatric rehabilitation ward are compliant with physiotherapy mobility recommendations.

Methods: Data collection took place on a general geriatric rehabilitation ward from February to March 2019. Staff Awareness was assessed by individually asking ward staff (Nurses and Health Care Assistants) to identify the mobility status of their patients. Their responses were recorded and compared with the physiotherapy mobility recommendations as per the MDT (multidisciplinary) communication whiteboard.

The mobility status of each patient was observed by means of random visual audits. Observations were recorded and subsequently compared to the physiotherapy mobility recommendations as above for compliance.

Results: For the staff awareness audit, 95 responses were obtained from 10 different staff members. 50.5% of responses (n=48) correctly identified patients’ mobility status. 49.5% (n=47) incorrectly identified patients’ mobility status.

From 10 visual audits, a total of 1% of patient observations were recorded. In 37.2% (n=73) of observations, patients were not mobilising as per physiotherapy recommendations. 39.3% (n=77) of observations were as recommended. In 23.5% (n=46) of observations, patients were not mobilised at all.

Conclusion: There was limited awareness among ward staff of the mobility status of their patients. Over 3/5 of patients were not mobilised as per physiotherapy recommendations. These findings can compromise both patient and staff safety. The visual audit also highlighted low physical activity levels in some patients.

Implications for clinical practice include the need for education on safer mobility and the promotion of patient physical activity at ward level. Physiotherapy led educational and practical handling sessions for ward staff have proven to be beneficial in this regard.
Background: As illustrated in a cross-sectional study at a Galway hospital, delirium is common with a 29% incidence in hospitalised older adults. This is associated with adverse clinical outcomes. Guidelines support specialised environments in the management of delirium to reduce morbidity and mortality. A delirium bay is a specialised unit with a standardised approach to comprehensive geriatric assessment for older adults with delirium.

Methods: We aimed to improve the care of the delirious older adult within our existing framework by creating a ‘Delirium Bay’ utilising the principles of quality improvement. An interdisciplinary team completed ‘Quality Improvement in Action’ training run by the Royal College of Physicians of Ireland from October 2018-March 2019. This involved defining our problem statement and ‘SMART’ aim (Specific, Measurable, Achievable, Realistic, Timely). Measures for improvement included the rate of adverse events, the duration of episodes, patient/family satisfaction, and the use of one-to-one supervision of patients.

Results: Stakeholder analysis included nursing, catering, multidisciplinary and healthcare assistance staff. We liaised with hospital management regarding restructuring staffing and maintenance regarding environmental changes. An educational programme on delirium was delivered. We collected baseline data utilising the ‘Plan, Do, Study, Act’ Model and utilised this to guide our changes. A Standard Operating Procedures document was drafted. We opened our four-bedded delirium bay on 11th March 2019. Preliminary data indicates improved patient/family satisfaction levels. Interventions have been implemented with minimal funding and infrastructural changes. Staffing reconfiguration involved standardised pre-planning replacing a pre-existing ad-hoc system.

Conclusion: Delirium in hospitalised older adults is common and associated with increased morbidity and mortality, yet amenable to interventions. We demonstrate that a delirium bay can be set up with a quality improvement approach. Pilot data suggests improved management of these patients within the framework of existing resources. Further collection of data on clinical outcomes is ongoing.

A PROSPECTIVE AUDIT AND REVIEW OF PROTON PUMP INHIBITORS (PPIs) IN OLDER ADULTS IN A REABLEMENT UNIT
Amy Byrne, Nor Fiszka, Hila Ludin, Sharon Byrne, Róisín Purcell
Our Lady’s Hospice & Care Services, Dublin 6W, Ireland

Background: The audit and review was carried out in a 24-bed reablement unit designed to improve independence and mobility in those ≥65 years. PPIs have been identified as a significant source of drug expenditure and evidence has shown that they are often prescribed inappropriately. PPIs are effective for conditions including dyspepsia and gastro-oesophageal reflux disease (GORD) but can also be associated with adverse effects and contribute to polypharmacy. The aim of the audit was to:

• Determine the number of patients admitted on PPIs.
• Determine the appropriateness of PPI prescriptions.
• Review any inappropriate prescriptions.

Methods: Prospective data collection was carried out for all newly admitted older adults over a 9 week period using a pre-approved data collection tool. Information was collected on PPI prescription details, indications and risk factors. PPI appropriateness regarding indications and dosage was reviewed by the pharmacist using guidelines and clinical experience. The pharmacist’s recommendation was then reviewed by the medical team and changes to prescription made where deemed appropriate.

Results:
• n=40 patients assessed.
• n=24 (60%) prescribed a PPI.
• n=19 (79.2%) deemed inappropriate by the pharmacist.
• Interventions made for n=13 (65.4%) of PPIS deemed inappropriate:
  ◦ n=8 (42.1%) were dose reduced.
  ◦ n=5 (23.8%) were discontinued.
  ◦ n=6 (31.6%) deemed unsuitable for review.
  ◦ n=1 deemed high risk for a gastrointestinal bleed.
  ◦ n=3 with GORD symptoms despite PPI use.
  ◦ n=1 for GP follow-up.
  ◦ n=1 previous unsuccessful dose reduction.

Conclusion:
• Most patients on a PPI did not have a clear indication.
• The majority of inappropriate PPIS were deemed suitable for review and were subsequently dose reduced or discontinued.
• Some patients were unsuitable for PPI review due to multiple risk factors or ongoing symptoms of reflux.
• The continued need for PPIS should be assessed regularly and a risk-benefit analysis should be carried out.

Reference:

IMPACT OF TRANSPORT MODE ON PSYCHOSOCIAL WELLBEING IN COMMUNITY-DWELLING ADULTS AGED ≥ 50 YEARS: RESULTS FROM TILDA
Orna Donoghue,1 Christine McGarrigle1, Rose Anne Kenny1,2

Background: Older adults with access to a car report increased social participation, better quality of life and better mental health. Existing research often compares the car to public transport, however we hypothesise that individuals who drive themselves or are driven by spouses have better outcomes compared to those driven by family or friends or taking public transport. This study examined how differences in transport mode affect psychosocial wellbeing in community-dwelling adults aged ≥50 years in Ireland.

Methods: Data were collected from 8092 adults during wave 1 of The Irish Longitudinal Study on Ageing (TILDA), a nationally representative cohort study. Participants indicated their most frequent mode of transport: car, car (driven by partner/spouse), car (driven by family/friends/taxi), public transport. Regression analysis was used to examine associations between transport mode with depressive symptoms, quality of life and loneliness.

Results: 89.8% of adults travel most frequently by car with 72.2% driving themselves. Driving was independently associated with lower depressive symptoms (beta=-1.9, 95% CI: -2.59, -1.30, p<0.001) and loneliness (beta=-0.45, 95% CI: -0.70, -0.21, p<0.001) and better quality of life OR=4.11, 95% CI: 3.13, 5.08, p<0.001) compared to relying on lifts from family/friends/taxi. Being driven by a spouse/partner or taking public transport were also associated with more positive effects although to a lesser extent. Interaction analysis showed that men who regularly travelled by public transport had higher loneliness scores than women (beta=0.67, 95% CI: 0.16, 1.18, p<0.05).

Conclusion: Men most adults aged ≥50 years in Ireland rely on the car for transport. Driving, being driven by a spouse/partner or taking public transport are associated with better psychosocial wellbeing compared to being driven by others, highlighting the importance of independent travel, whether by car or public transport. Opportunities to support this should be considered when planning the future transport needs of ageing populations.

A CRITICAL EVALUATION OF THE VIP TOOL IN IDENTIFYING FRAILTY IN THE OLDER ADULT IN A KERRY HOSPITAL
Amanda Brolly1, Lisa Bergin1, Paudie McQuinn1, Shinnam Buckley O’Sullivan1, Corina Naughton2
1 University Hospital Kerry, Tralee Co Kerry, Ireland
2 University College Cork, Cork, Ireland

Background: The Variable Indicative of Placement risk (VIP) is a tool that was developed in Belgium to identify older people at risk of adverse health outcomes at the time of hospital admission (Vandewoude et al 2008). VIP is a simple 3-item screening tool for the selection of hospitalized patients aged 70 and older who are at increased risk of problems at discharge. It asks three simple questions about frailty factors already existing before admission. This tool has been validated to select patients who would benefit from a geriatric assessment (Vandewoude et al 2008).

As part of the implementation process, it is important to critically review VIP as a frailty screening and selection tool for the Frailty Intervention Therapy Team (FITT) service compared to age criteria alone. There is a risk that patients screening negative on VIP could be inappropriately excluded from the FITT review.

Methods:
• All patients over 75 were screened using the VIP tool over a 6 week period by nursing staff in triage
• The “Think Frail” tool was also used to screen all patients reviewed by FITT: both positive & negative VIP
• Data was retrospectively gathered and VIP positive/negative patients reviewed by FITT were analysed

Results:
• 55% were VIP positive
• 45% were VIP negative
• 16.5% of VIP negative patients were screened positive for frailty using the “Think Frail” tool
• We found VIP under-recognised patients presenting with reduced mobility (5.3%, n=20), acute confusion (2.7%, n=10) and polypharmacy (8.1%, n=29), all potentially modifiable frailty

Conclusion:
• The VIP tool is not sensitive to identifying the presence of pre-frailty markers including acute confusion, polypharmacy and acute confusion.
• Further research is needed into the use of the VIP tool in Ireland.
• It is recommended that this tool is not used independently to identify frailty in the ED.

PHARMACIST INTERVENTIONS AT DISCHARGE AND THE QUALITY OF OLDER PATIENTS’ CARE: A SYSTEMATIC REVIEW
Rehan Kam1, Niamh McMahon1,2, Sheila Ryder1
1 Trinity College Dublin, Dublin, Ireland
2 St. James’s Hospital, Dublin, Ireland

Background: Discharge and transfer between healthcare facilities puts older adults at risk of medication-related problems and early readmission. This review examined the evidence for pharmacist interventions at discharge and patients’ care quality.
Methods: Eight databases were searched systematically from inception to date, using the appropriate search strategy for each. A search for grey literature was conducted on eight further websites. No filters (e.g. language/dates) were applied.

Only prospective randomized/ quasi-randomized controlled studies involving patients > 65 years of both genders, discharged alive from hospital, were included. The criteria outlined in the Cochrane Handbook for Systematic Reviews of Interventions formed the basis of the assessment, conducted using RevMan 5.3.

Results: 9738 articles were obtained: 8120 unique articles after duplicate removal. Following screening, 12 studies were identified for inclusion. Interventions comprised follow up, medication review and patient counselling at discharge. Of these, 10 were delivered by pharmacists alone, while the remainder were delivered by pharmacists within a multidisciplinary team. Outcome measures included readmission rates, length of stay, medication adherence and care quality.

Nine studies showed significant improvements over standard care, e.g. a decrease in hospital admissions (0.68 OR, p=0.002), improved compliance (P<0.001) and a 47% reduction in emergency department visits (95% CI, 0.37-0.75).

However, three studies did not report positive results: Two reported non-significant improvement but the third reported poorer readmission rates. Risk of bias was low but the high baseline standard of care reduced the scope for improvement in the two of these studies.

Conclusion: The review summarizes pharmacist interventions’ efficacy and their effect on care quality indicators where possible. The majority of interventions at discharge significantly enhanced patients’ care quality. The findings should prove valuable to decision-makers when planning or improving discharge and post-discharge services.

[1] AUSTOMS AN OUTCOME MEASURE TO DETERMINE THE IMPACT OF ENVIRONMENTAL ADAPTATIONS ON FUNCTIONAL PERFORMANCE
Elaine Cannon, Siobhan Delaney
The Royal Hospital Donnybrook, Dublin, Ireland

Background: Occupational Therapists routinely perform pre-discharge home assessment visits. The import of a supportive home environment to successful ageing has been established in the literature (Tanner, Tike & Desleigh de Jonge, 2008), with housing adaptations and aids recognised as a method of promoting independence within the home (Stark et al, 2009).

In this hospital, home assessment visits review functional mobility, functional transfers and assess for environmental barriers within the home. The purpose of this study was to detect any change in functional performance following a pre-discharge home assessment visit and implementation of OT recommended aids/raillings or both. The AusTOMs (Australian Therapy Outcome Measures) for Occupational Therapy scale was used as the outcome measurement tool.

Methods: The study was applied to a cohort of 20 consenting inpatients over 65 years of age. Convenience sampling was used for the purposes of the study. Inclusion criteria comprised of patients that satisfied a minimum of one pre-discharge OT home assessment visit. It was conducted over a ten week period in 2018. The study was conducted by two occupational therapists (OTs) on the general rehabilitation team. The scale was applied to review the following functional transfers within the home environment on initial home assessment visit and following the implementation of OT recommended aids/raillings.

1. Access
2. Stairs
3. Bed
4. Toilet
5. Bath/Shower
6. Seating

Results: The group Average AusTOMs Resultant score at initial home assessment was 3.05. The group average score following implementation of recommendations was 4.08. This indicates a change in performance from a Moderate Limitation experience to a Mild Limitation experience. This is reflected in Paired T test results. The two-tailed P value is less than 0.0001.

Conclusion: The AusTOMs Activity Limitation/Transfers scale indicated there is a positive correlation with the provision of OT recommended aids and equipment at improving functional transfer performance within the home context.

[1] THE PERCEPTIONS OF OLDER PATIENTS AND THEIR FAMILY OR CAREGIVERS TOWARDS PHYSICAL ACTIVITY AND EXERCISE IN HOSPITAL: A QUALITATIVE STUDY
Bláthnaid Mealy1,2,3, Aoiife O’Neill1, Dervilla Danaher1, Helen French2
1Mater Misericordiae University Hospital, Dublin, Ireland
2Royal College of Surgeons in Ireland, Dublin, Ireland
3St. James’s Hospital, Dublin, Ireland

Background: Between 30-60% of older people experience functional decline after hospitalisation which can be accelerated by inactivity in hospital. Family or caregivers can positively affect activity levels of hospitalised older people. We aimed to explore the perceptions of hospitalised older people and their family or caregivers towards physical activity and exercise during an admission to a Specialist Geriatric Ward in an acute hospital

Methods: A qualitative approach was taken, using semi-structured interviews with eleven patient participants and semi-structured focus groups with four family or caregivers. Theme analysis was utilised to identify key themes.

Results: Three similar themes emerged from both groups: 1) personal feelings towards exercise or inactivity, 2) the role family/caregivers could play in facilitating exercise and 3) the role of hospital staff, which all impacted on participants’ perceptions towards exercise in hospital.

Personal influences including self-efficacy and appreciation of the importance of exercise resulted in more positive views towards activity. There was an acute awareness among some family of the dangers of inactivity. Uncertainty existed regarding the role family or caregivers have in increasing patient activity levels. Some patient participants believed family involvement may increase activity levels, while others thought it would compromise their independence.

Both groups identified a need for more patient-specific information regarding activity in hospital. Hospital staff largely did not encourage rather than restricting activity and felt that more doctors encouraging exercise would be helpful. The need for more opportunities for meaningful activity in hospital was highlighted.

Conclusion: Physical activity and exercise were perceived as important during hospital admission. Hospital staff should facilitate and enable increased opportunities for patient activity, and empower family or caregiver involvement in this where appropriate.

[12] PATIENTS WITH PROLONGED LENGTHS OF STAY: A POINT PREVALENCE STUDY
Eimear Short, Maeve O’Alton, Eamon Dolan, Aoife Dunne, Denise Hartigan, Claire Jones, Laura Morrison, Marie O’Connor
Connolly Hospital, Dublin, Ireland

Background: A hospital’s trolley count is often highlighted as a measure of its performance. However, there is a more complex reality for each organisation in accessing suitable resources for often frail older patients to improve care and capacity. Coupled with this is the need for pathways that identify these patients early in their admission and access the appropriate specialist care. In 2018, 65% of this hospital’s bed days were occupied by those whose hospital stay was greater than 14 days. Nationally this was 57%. We undertook to review processes locally around the care of older acute patients.

Methods: On the 20th November 2018 we conducted a chart audit of 85 in-patients who had been in the acute setting for more than 14 days. A proforma was completed for each patient by a doctor and multi-disciplinary team member.

Results: The length of stay ranged from 15 – 527 days with the median being 41 days. The average age was 76 years. A history of falls/deficitteria/“apecia” was recorded on admission in 57%. The mean time for referral to MDT was 5 days. Social history was only documented in 47% of cases. Ward transfers was a significant issue with 69% moving wards at least once and 9% moving three times or more. A care planning meeting had not been held in 49% of cases. Over 17% of charts audited were awaiting home care package hours whilst 20% were awaiting long term care. In 62% of cases there was no ongoing medical reason keeping them in hospital and 56% of this cohort could have been cared for elsewhere.

Conclusion: Deficits in clear communication and appropriate timely planning for patients resulted in significant delays in discharge. The findings of our research informed a decision to conduct a root and branch analysis of discharge planning utilising the Lean Six Sigma model.

[12] ARE WE EFFECTIVE PRESCRIBERS? A RETROSPECTIVE AUDIT OF DOAC PRESCRIBING POST EMBOLIC STROKE FOR NON VALVULAR ATRIAL FIBRILLATION
Karen Derney, Joseph Morris, Diarmid Hughes, Kate Donlon, Thomas Walsh
Galway University Hospital, Galway, Ireland

Background: Direct oral anticoagulants (DOAC) are indicated for stroke prophylaxis in non-valvular atrial fibrillation, which is responsible for up to 20% of all ischaemic strokes(1). We performed a retrospective audit of all consecutive stroke patients in an Irish teaching hospital over a 1-year period to investigate the rate of incorrect dosing and any risk factors for this occurring.

Methods: We assessed our hospital stroke database from January to December 2017. Our research focussed on DOAC prescribing in non valvular atrial fibrillation post embolic stroke. We collected data on baseline characteristics, choice of anticoagulation, dosing and assessment of renal function, with follow up renal function if available. We reviewed electronic discharge summaries, online laboratory systems and completed a chart review.

Results: There was a total of 116 people with atrial fibrillation who developed an embolic stroke in our centre, of which 68 were eligible for anticoagulation using a DOAC (59%). The main reasons for omission were CKD and haemorrhagic transformation. Patients were discharged on either Apixaban (32 patients), Rivaroxaban (32 patients), or Dabigatran (4 patients).

Following our review, we established that 54/68 (79%) of patients were correctly anti-coagulated. Over 20% of patients were incorrectly dosed and there was a clear tendency to under-dose 13/14 (93%). There were significant differences between the correct and incorrect dosing groups, with the latter group of patients being older and more at risk of polypharmacy. Renal function did not differ significantly between the groups at discharge or follow up and none of the incorrectly dosed patients were on a concurrent anti platelet.


EMPOWERING PATIENTS AFTER STROKE: DEVELOPMENT OF A STROKE INFORMATION BOOKLET
Karen Dennenhy, Padraig Smyth, Robert Murphy, Patricia Galvin, Michelle Caravan, Thomas Wrenn, Martin O’Donnell, Donnell
Galway University Hospital, Galway, Ireland

Background: Patient involvement in healthcare is key to the provision of patient-centred care. The national patient experience survey 2018 found that up to 40% of patients did not get adequate information about their condition after discharge. (1) As the planning phase in introducing a stroke information booklet, we sought to examine what patients, families and healthcare professionals feel are important components in such an information booklet.

Methods: We performed a cross sectional cohort study. A questionnaire was developed after a panel discussion among physicians, allied health professionals, and clinical nurse specialists about what would be important facets to include. Thirteen items were shortlisted and assessed using a Likert scale.

Results: There were 76 respondents to the questionnaire including nurses (17), allied health professionals (20), patients/families (13), doctors (28), and stroke carers (11). Items viewed as most important to include were: an introduction to stroke, future stroke risk, and effects of stroke on daily life. Items viewed as least important to include were - an overview of medical treatments for stroke and information on equipment needs post stroke. A Mann Whitney U test found that patients/families rated information about future stroke risk as more important to include than healthcare professionals (p=0.021). Free text found that psychological effects of stroke, and sexual health post stroke were commonly suggested.

Conclusion: Patients/Families are keen to receive information regarding stroke, particularly about future risk of stroke. Empowering patients with information about stroke that is relevant to them and their care providers is a fundamental part of secondary stroke prevention. We also need to focus more on the psychological impact of stroke. Our booklet will incorporate information we have gathered in this study to make it a truly patient centred resource.

CREATING GREATER PUBLIC UNDERSTANDING OF DEMENTIA: FINDINGS ON THE IMPACT OF A COALITION-LED NATIONAL AWARENESS PROGRAMME
Fiona Foley, Roisin Gurry
HSE Health Service Executive, Dublin, Ireland

Background: Dementia Understand Together is a public support, awareness and stigma reduction campaign aimed at inspiring people from all sections of society to stand together with the 55,000 Irish people living with dementia. Led by the HSE working with The Alzheimer Society of Ireland and Genio it is supported by over 40 partner organisations with the 55,000 Irish people living with dementia. Led by the HSE working with The Alzheimer Society of Ireland and Genio it is supported by over 40 partner organisations.

Methods: The campaign uses personal testimonial TV commercials, radio advertising, social media and national and local news stories to build understanding among the general public about dementia. At a local level the campaign is growing a movement of people who are taking action to creative inclusive communities across Ireland.

Results: A cross sectional cohort study established a partnership approach between the leading organisations working in the area of dementia. Findings show that the campaign is creating better understanding of dementia amongst the general public, increasing awareness of the condition and risk reduction, and is inspiring people to take actions.

MODIFIABLE CARDIOVASCULAR RISK PROFILE IN PEOPLE WITH MILD COGNITIVE SYMPTOMS ATTENDING A MEMORY SERVICE - AN OPPORTUNITY TO PROMOTE BRAIN HEALTH
Josh Doshi1, Cathy McHale1, Sean Kelly1,2, Tara Coughlan3, Ruanan Collins3, Dan Ryan1, Desmond O’Neill3
1Memory Assessment & Support Service, Tallaght University Hospital, Dublin, Ireland
2Department of Medical Gerontology, Trinity College Dublin, Dublin, Ireland
3Age Related Department, Tallaght University Hospital, Dublin, Ireland

Background: Current evidence strongly implicates the burden of vascular risk factors (VRF) in the development of stroke, cognitive decline and dementia. This effect is mediated through several mechanisms, including amyloidogenesis, chronic neuroinflammation, cerebral perfusion and white-matter changes. Vascular risk profiling is well-embedded in stroke and cardiac services, but less so in memory services.

Methods: A review of established modifiable VRF (hypercholesterolaemia, Body Mass Index (BMI), hypertension, Hba1c, smoking and alcohol habits) of people with mild cognitive complaints (mild cognitive impairment and subjective memory decline) in a memory service was performed. Risk factors measured in clinic were classified as: systemic ≥140mmHg/ diastolic ≥90mmHg hypertension; LDL cholesterol >3mmol/L; Hba1c ≥39mmol/mol; weekly alcohol >21units; smoking and BMI >24.9kg/m².

Results: Thirty-seven people, including 16 females (mean age 71 ± 4.8 range of 49-83 years), were reviewed. 13/37 (35%) were aged ≤69 years. A total of 91 VRFs were identified in the study population. 29/37 (78%) had ≥2 VRF present. 5/37 (8%) had five VRF. 18/37 (49%) had prior history of either stroke, vascular or heart disease.
Five of thirty-seven, (13.5%) and 13/37 (35%) were current and ex-smokers respectively. 2/37 (5%) consumed excess alcohol, 24/37 (65%) had elevated BMI and 13/37 (35%) had elevated LDL cholesterol. 21/37 (74%) had hypertension. Of these, 11/21 were known but poorly-controlled and 10/21 were identified de novo. All of the 32% (12/37) who had hyperglycaemia were de novo.

Conclusion: This study highlights the high prevalence of unidentified or poorly controlled VRF in people with mild cognitive symptoms attending a memory service. Given its importance to brain health and mitigation of future cognitive decline, a structured focus on identifying and managing these VRF in this setting is necessary. Exercise-based lifestyle programs should be embedded in post-diagnostic services for this population.

Methods: A consecutive sample of inpatients (age > 65 years) were included from a geriatric ward in a tertiary hospital. Medical notes and admission pro-forma were reviewed. Relevant demographic and clinical information was extrapolated and analysed descriptively using the Statistical Package for the Social Sciences software.

Results: Data from thirty-one patients was included. Mean age of the cohort was 81.58 years (SD=6.67) and 51.6% (n=16) were female (SD=6.67). The primary reasons for admission were increased care needs (n=6, 19.4%), and collapse/weakness (n=6, 19.4%), thereafter stroke (n=4, 12.5%). Urinary catheters were inserted in 45.2% (n=14) for patient care (n=4, 28.57%) and management of acute urinary retention (n=3, 21.42%). The insertion was warranted as per guidelines in only 42.85% (n=6); for urinary retention (n=3, 21.42%), sepsis/ICU (n=2, 14.28%) and at patient’s request for comfort (n=1, 7.14%). Urinary incontinence was present in 25.8% (n=8), 35% (n=11) were found to be incontinent. Mean hospital admissions in the previous twelve months was 1.61 (SD=2.20) and mean urinary tract infection in the same timeframe was 1.00 (SD=1.57). Trial without catheter was unsuccessful in 3.2% (n=1). Healthcare associated infection was recorded in 6.5% of cases (n=2).

Conclusion: Although this audit represents a small cohort, the results demonstrate a high rate of urinary catheter insertion without adequate indication. This audit should be repeated using a larger sample size. Appropriate education at ward level and with admitting NCHDs about appropriate catheterisation practice should be performed with a view to re-auditing subsequently. Update of current guidelines is warranted.
Background: While hypertension is the leading cause of stroke, early blood pressure (BP) management post event can be a challenge. Adjustment of antihypertensive medications is largely based on daytime ward readings. Abnormal nocturnal BP patterns may go undetected with increased risk to the patients from either extreme of BP. 24-hour ABPM has been shown to provide additional prognostic information over routine clinic measurements. We evaluated stroke patients for abnormal circadian BP profiles early after their event.

Methods: Patients admitted with a stroke, whose BP had normalised for at least 48 hours, were invited to participate. ABPM was fitted for 24 hours and readings compared with routine ward BP measurements. Daytime BP was calculated between 9am-9pm; nighttime midnight-6am. Additional information was gathered on medical history, cardiovascular risks and neuroimaging.

Results: Twenty-nine patients were recruited (median 6 days post event) with mean age 70.5, 62% male. The majority (86.2%) had ischaemic stroke or TIA. Seventeen had hypertension and were taking median of 2 medications. Mean baseline ward systolic BP was 129mmHg (range 104-148 mmHg). Mean systolic BP on ABPM was 126mmHg (range 92-154 mmHg) and 123mmHg (range 93-181 mmHg) for daytime and nighttime respectively. Patients with a history of atrial fibrillation (N=13) had a higher prevalence of a non-dipping pattern, with an average 10.4 mmHg rise in their nighttime systolic BP compared with a 5mmHg fall in those without atrial fibrillation (p = 0.011).

Their also exhibited greater BP variability.

Conclusion: In this pilot study, through the use of early ABPM we found high rates of non-dipping nocturnal BP in patients following stroke, particularly in those with underlying atrial fibrillation. The availability of 24-hour BP might allow for more individualised antihypertensive management particularly at this high-risk acute stage. Furthermore the presence of abnormal circadian patterns might be a marker for conditions such as atrial fibrillation and obstructive sleep apnoea that compound stroke risk.

The Clinical Frailty Scale (CFS) is widely used to assess frailty in older adults and reflects functional independence. We examined its use as an outcome measure in an acute hospital setting for patients over 65 transferred from an acute hospital following medical/surgical admission.

Methods: Patients were given a CFS score by consensus opinion from the multidisciplinary team on admission and on completion of rehabilitation. We included data on diagnosis, length of stay and discharge destination

Results: Thirty patients, with a mean age of 80, completed rehabilitation over a four-month period. The most common diagnosis was fracture of hip or pelvis (53%). Median CFS was 6 on admission and 5 on discharge (range 3-8). Twenty-one (70%) patients saw an improvement in CFS of an average of one point on the scale irrespective of admission score. Of those that improved, 81% were discharged directly home with no need for increased support services, compared with 11% of those who did not improve. Mean length of stay was significantly less in those with mild/moderate frailty (CFS 5-6) at admission versus severe frailty (31 vs 53.8 days, p<0.001).

Conclusion: Frailty score improved in the majority of patients undergoing rehabilitation, regardless of admission score; CFS alone did not predict rehabilitation potential, emphasising the importance of offering rehabilitation to frail older adults – better judged by experienced clinical assessment. CFS is a broad 9-point tool that can miss small improvements in physical function based on other objective scores e.g. FIM+FAM. Severe frailty was associated with longer length of stay in rehabilitation, possibly reflecting more complex discharge planning as well as rehabilitation progress in this group.
AN AUDIT ON HIP FRACTURE REHABILITATION USING A COMMUNITY INTEGRATED CARE PROGRAMME

Rachel Sullivan1, Sarah Khan1, Elizabeth Gannon1, Aoife Byrne1, Michelle Spencer1, Maire Whitter1, Terry Noble1
1Mercer’s Institute for Successful Ageing, Department of Medicine for the Elderly, St James’s Hospital, Dublin, Ireland
2Older Person Team, The Meath Community Unit, The Meath Campus, Dublin, Ireland

Background: Téitripe sa Bháile (TéSB) is an integrated rehabilitation programme that provides Early Supported Discharge (ESD) to patients following hip fractures. It involves weekly multidisciplinary domiciliary visits to patients under the guidance of a community geriatrician. ESD in hip fractures has been proven to be safe, more effective at improving functional recovery than inpatient rehab with a reduced average length of stay (LOS) (Chudyk 2009) and better outcomes in mobility and quality of life. (Langeland 2019)

Methods: A retrospective chart review was carried out on patients enrolled in TéSB since July 2018. The Chartered Society of Physiotherapy Hip Fracture Rehabilitation state that following discharge from hospital, rehabilitation should commence within 72 hours and all patients should receive two hours of rehabilitation per week until they have reached their goals. An appropriate outcome measure is recommended to measure progress against each rehab goal. The Functional Independence Measure (FIM) which looks at their level of assistance with Activities of Daily Living, was recorded pre and post completion of the programme.

Results: Fifteen patients completed TéSB over 3 to 8 week period. The male to female ratio was 3:1. The average age was 80.75 years. The average LOS in hospital post hip fracture was 54 days. The average LOS in hospital with TéSB was 14.8 days. This equates to 4 days saved per week. Each patient was seen within 72 hours of referral and received on average 3 hours per week of rehabilitation until their rehabilitation goals were achieved. Average improvements in FIM were 36.85 (≥20 is clinically significant). The average Rockwood frailty scale pre-rehabilitation was 5.6 (mild to moderately frail). This improved to 3.14 (managing symptoms) on discharge. No patients were readmitted within the 30 days post discharge from hospital.

Conclusion: TéSB is a home based integrated rehabilitation programme that enables patients to receive rehab in their homes and reduces the likelihood of complications such as hospital acquired infections and deconditioning.

THE LIVED EXPERIENCE OF CARER RESILIENCE TOLD BY CARER ADVOCATES

Laura Reid1, Aisling Harmon2
1The Alzheimer Society of Ireland, Dublin, Ireland
2Dementia Carers Campaign Network, Dublin, Ireland

Background: Established in 2015 this network of volunteer family carers is a national advocacy group that presents a vital opportunity for carers to use their voice to raise awareness of issues facing families living with dementia in Ireland. The network is facilitated by a dementia specific service provider. These carer advocates wish to present on a piece of qualitative research they have recently conducted on the topic of carer resilience at the advanced stages of caring for a loved one with dementia.

Methods: There are 43 family carer advocates on the network, all of whom were invited to participate in this research. The piece of qualitative research conducted by the network with its members took the form of a questionnaire. The research sought to ascertain how informed and supported carers felt as their loved ones transitioned to long term residential care and the stage thereafter.

This research did not discuss the level of professional care given to their loved one but what supports and services were offered to the carer at that time and how this affected their resilience.

The aspect of caring for a loved one availing of hospice care naturally emerged during the research process and this topic was also explored in relation to carer resilience.

Conclusion: Carers are not properly informed or supported when their loved one transitions to or resides in long term residential care and this negatively affects their resilience.
Implementation has increased the use of the integrated care team, hospital and community MDT (multidisciplinary team).

**THE DEVELOPMENT OF A NATIONAL TRANSFER DOCUMENT FOR OLDER PERSONS, WHEN TRANSFERRING BETWEEN RESIDENTIAL AND ACUTE CARE SETTINGS**

Pauline O’Reilly1, Pauline Mestell2, Owen Doody1, Michelle Keiley1, Jane O’Doherty1, Liz Dore, Louise Barry1, Anne Fahy1, Margaret Graham1, Jill Murphy1, Jonathon O’Keeffe1, Brid O’Brien1, Dympna Tuohy1, Alice Coffey1

1 University of Limerick, Limerick, Ireland
2 Health Research Institute, Limerick, Ireland
3 Cork Kerry Community Healthcare, Cork, Ireland
4 St. Vincent’s Hospital, Dublin, Ireland

Background: The transition of older persons between care settings is recognised as a particularly critical and vulnerable period (Renom-Guitierrez et al. 2014). Appropriate documentation and processes are key in assisting the provision of quality, safe, person-centred care when transferring older persons from residential to acute care settings. This paper reports on the design phase of a national transfer document for older persons. The objective was to inform the development of a draft national transfer document.

Methods: Development consisted of two phases 1) an integrative review and 2) focus group interviews with stakeholders. The review was guided by Whittmore and Knafli’s (2005) integrative review framework. Data from studies using both qualitative and quantitative methodologies were extracted and thematically analysed. Using a qualitative descriptive approach, focus group interviews (n=8) were conducted with a convenience sample of key stakeholders (n=68) to establish their perspectives regarding transfer documents. Data were analysed using content analysis. Results from both phases were integrated to guide the development of the draft document. A multidisciplinary panel of experts in older persons care, reviewed and provided feedback on the draft transfer document.

Results: Within the review, thirty identified papers focused on transfer documentation. Qualitative interview findings highlighted important aspects for consideration regarding the layout, content and format of future transfer documentation. Following collaboration with the expert panel the transfer document was developed for piloting.

Conclusion: Consistency and clarity of information in the draft transfer document for older persons from residential to acute settings. Information needs to be evidence-based, current, and subject to response and change in accordance with best available international practice.

**REVIEW OF OUTCOMES OF A DEDICATED GERIATRIC SURGICAL LIAISON SERVICE**

Roisin Coarry1, Kathryn McCarthy1, Haythem Sunnrie2, David Shipway3

1 Department of Geriatric Medicine, Southmead Hospital, North Bristol NHS Trust, Bristol, UK
2 Department of Surgery, Southmead Hospital, North Bristol NHS Trust, Bristol, UK
3 University of Bristol, UK

Background: In the United Kingdom, the 2010 National Confidential Enquiry into Patient Outcome and Death report ‘An Age Old Problems’ outlined significant shortcomings in the perioperative care of older people. Other than hip fractures, the care of older patients undergoing surgical procedures is largely devoid of routine geriatrician input. In August 2018, we introduced daily geriatric review (GR) on the gastrointestinal surgical wards, aiming to improve length of stay (LOS) and mortality.

Methods: All acute general surgery admissions for patients ≥70 years were reviewed between September and October 2017 (pre-introduction) and 2018 (post-introduction), and outcomes compared. For 2018, comparisons were also made between those who had GR and those who didn’t.

Results: There were 173 admissions in 2017, vs 190 in 2018. In both 2017 and 2018, median age was 80, median LOS was 4 days, and clinical frailty scale (CFS) 4. Twenty-two percent (38/173) of patients had a surgical procedure in 2017, vs 33% (65/190) in 2018. Inpatient mortality was 8% (13/173) in 2017 (median CFS 6), vs 6% (11/190) in 2018 (median CFS 6).

In 2018, 21% (40/190) of patients had GR median time to review 3 days. 54% (n=22) of the patients with GR underwent a surgical procedure, 37% (n=15) were admitted to ICU, and inpatient mortality was 5% (n=2), vs 28% (n=42), 4% (n=6) and 6% (9=n) respectively for those without GR. 30 day readmission for those with GR was 12.5% (n=5), vs 18.4% (n=28) for those not seen.

Conclusion: While more surgical procedures were performed in 2018 (post-introduction), overall LOS remained unchanged and improved mortality was observed compared to 2017. Geriatricians are seeing more post-operative and ICU patients, and despite presumed increased complexity, both mortality and readmission rates remain low. Screening for frailty and specific inclusion criteria may improve rates of GR.

**MALNUTRITION SCREENING BY AN INTERDISCIPLINARY INTEGRATED CARE TEAM IS AN ESSENTIAL COMPONENT OF COMPREHENSIVE GERIATRIC ASSESSMENT**

Claire Pender, Karen Sayers, Inveran Pillay, Christina Donnellan, Jennifer Maher; Siobhan Ryan, Aine O’Reilly, Eamonn Cooney

Malnutrition Screening by an Interdisciplinary Integrated Care Team is an Essential Component of Comprehensive Geriatric Assessment

South Tipperary General Hospital, Clonmel, Ireland

Background: Malnutrition plays a key role in the pathogenesis of frailty and nutritional interventions may reduce the incidence. Comprehensive Geriatric Assessment (CGA) is the gold standard in assessment once frailty has been identified. Recent Nutritional Screening Data indicated that only 20% of Irish hospitals screened 76-100% of patients. Twenty-three of those of aged 60-79 years and 30% of those >80 years were at risk of malnutrition (Russell & Elia, 2011). This emphasises the importance of a validated malnutrition screening tool as an integral component of CGA. This study evaluates the use of the Malnutrition Screening Tool (MST) by an integrated interdisciplinary team aimed at early identification of frail patients at risk of malnutrition.

Methods: A prospective study of consecutive frail patients, admitted through the emergency department (ED) to an acute hospital over five months was performed. Each patient/consultant interdisciplinary team (MDT) performed MST (MST) on all patients. Patients were identified as frail using the Variable Indicative of Placement (VIP), Team members, consisting of a physiotherapist, speech and language therapist and advanced nurse practitioner candidates were trained by the team dietitian to use MST. Age, gender, Clinical Frailty Score (CFS) and MST were recorded in an excel database. A patient scoring ≥2 on the MST indicated risk of malnutrition and the need for Dietetic Assessment (Whitie et al. 2012).

Results: Thirty-six and sixty CGAs were completed by an integrated interdisciplinary team over five months. The mean age (±SD) was 82.4 (±7). The male to female ratio was 1:1. The mean CFS (±SD) was 5.5 (±1.2) (mildly to moderately frail). Ninety-two percent (n=331) were screened using the MST. Thirty-five percent (n=115) were at risk of malnutrition.

Conclusion: Integrated interdisciplinary team training on the MST, resulted in successful identification of 35% (n=115) of frail patients “At Risk of Malnutrition”. Identification, combined with appropriate dietetic intervention, may reverse frailty in some of these patients.

**GEOGRAPHIC ACCESSIBILITY AND CAPACITY OF DAY CARE SERVICES FOR PEOPLE WITH DEMENTIA**

Tom Pierse, John Callinan, Fiona Keogh, Eamonn O’Shea

NUI Galway, Galway, Ireland

Background: Day care is an important service for some people with dementia and their carers. In Ireland, day care services for people with dementia are delivered by a mix of dementia specific day-care centres and generic centres that cater for people with dementia to various degrees. In this paper we map the geographic variation in the supply of day care services for people with dementia relative to potential need.

Methods: Using a national HSE survey of day care centres, we estimate the current supply of day care services for people with dementia. Day care services for people with dementia in both generic and dementia specific centres are included.

Results: There is significant variation across the country in the existing capacity of day care centres to cater for people with dementia. The number of places per 100 persons with dementia varies from 9 to 16 across the Community Health Organisation areas. We show that 20 per cent of people with dementia are not living within a 15km radius of a day care centre that caters for people with dementia.

Conclusion: Day care has a place in the menu of service for people with dementia living in the community. As the number of people with dementia grows, investment in day care centres needs to be targeted to areas of greatest need. In many parts of the country, the current day care centres have limited capacity to provide a service for people with dementia that live in their catchment area. There is considerable geographical inequality in day care provision for people with dementia across the country.

**CROSS SECTIONAL STUDY OF PHARMACOLOGICAL MANAGEMENT OF RHEUMATOID ARTHRITIS IN PATIENTS OVER THE AGE OF 70**

Catriona Reddin, Maria Costello, Bernadette Lynch

University Hospital Galway, Galway, Ireland

Background: Rheumatoid arthritis (RA) is a common inflammatory joint disease. It can lead to joint destruction resulting in joint deformity, functional impairment and reduced mobility. With a growing older population, prevalence of RA is increasing and due to the associated morbidity it is essential to prioritise disease control.

Conventional treatment of RA has comprised of disease modifying anti rheumatic drugs (DMARDs) along with analgesia and corticosteroids. Recently, the development of biologics has revolutionised management of inflammatory arthritis. We now strive for tighter control to prevent joint damage and preserve function. However, studies have shown that uptake of biologic medications in the older population has been slower than their younger counterparts. (1)

Methods: Our departmental electronic record system, Cellma, was interrogated for patients aged 70 and over with a diagnosis of RA. Decreased patients were excluded. The current medication chart was reviewed using our online rheumatology outpatient system.

Results: A total of 514 patients over the age of 70 were identified with a diagnosis of RA (67% (n=345) female, 33% (n=171) male). 24.5% (n=126) were on biologic therapy, 13% (n=68) patients were on a single DMARD in combination with a biologic, 42%
AN AUDIT OF COMPREHENSIVE GERIATRIC ASSESSMENT IN THE SOUTHERN TRUST ACUTE CARE AT HOME SERVICE

Ann McCarthy, Patricia McCaffrey, Deborah Toal
The Southern Health and Social Care Trust, Craigavon, United Kingdom

Background: The population is ageing. Acute Care at Home (AC@H) is a consultant led multidisciplinary team, providing acute non-critical care to our older population, preventing hospital admissions and promoting a better quality of life and supporting led multidisciplinary team, providing acute non-critical care to our older population, preventing hospital admissions and promoting a better quality of life and supporting

Methods: One-hundred patient charts were selected at random who had been under the admission to hospital are more likely to be living at home and are less likely to be admitted to a nursing home at up to a year after hospital admission. The results of this audit have been presented to the team, adjustments have been made to our electronic assessments so that we can record and capture this data better. There will be a readout in 6 months to evaluate improvement.

REHABILITATION TO NURSING HOME - THE WAITING PERIOD

Adefunke Salaiwa, Jaimon Patilay, Marian Glynn
St. Mary's Hospital, Phoenix Park, Dublin 20, Dublin, Ireland

Background: The average application processing time for the National Nursing Home Support Scheme (NHSS) has seen drastic improvement from 15 weeks in 2014 to 4 weeks in 2016. There is no available data of the duration of stay in rehabilitation beds after approval of NHSS application and reasons for delay in transition to nursing home.

Aims: (1) To examine average length of stay in rehabilitation before multidisciplinary team (MDT) decision is made for nursing home care. (2) To examine average length of stay in rehabilitation bed from the time of NHSS approval to discharge into nursing home. (3) To examine reasons for delay in discharge to nursing home after NHSS approval.

Methods: A retrospective chart review of patients discharged into nursing homes between January to June, 2018 from geriatric rehabilitation units. Data collected include age, length of stay in rehabilitation unit before multidisciplinary decision was made in conjunction with patients/family to seek nursing home care (LOS 1), length of stay in rehabilitation bed following decision for nursing home care (LOS 2), reasons for the delay in the transition from rehabilitation bed to nursing home bed were also documented.

Results: Seventeen patients were discharged into nursing homes, LOS 1 of 43.12 days and LOS 2 of 50 days. Complexity of application in terms of financial evaluation especially for patients who were deemed cognitively incapable of managing their finances, lack of suitable nursing homes for patients with complex needs/challenging behaviours, family dynamics with regards to choice of nursing homes and medical stability to facilitate such transfers were reasons for delay in transition to nursing home beds.

Conclusion: Transitional care beds, which are generally acknowledged to be more appropriate to these patients’ care needs and are less expensive than rehabilitation beds, need to be utilized more. Education of healthy adults over 65 years to proactively plan for future care needs and promote awareness of legislatures regarding capacity and decision making.

DEMENTIA, A FAMILIAL AFFAIR

Aqeel Qureshi, Ahmed Gabir, Daniel Zulkilli, Elijah Chaila, Margaret O’Connor
University Hospital Limerick, Limerick, Ireland

Background: In Ireland, there are approximately 55,000 cases of dementia. One of the rare causes of dementia is Creutzfeldt-Jakob disease (CJD), affecting one person per million each year worldwide. It is a rapidly progressive degenerative fatal disorder with an estimated mortality of 70% within one year. In this case report we present a rare case of possible familial CJD which presented intermittently as a stroke mimic.

Methods: A 64-year old female referred via GP with abnormal left arm ataxic movements and in-coordination. MRI brain demonstrated a small sub-acute hyper-intense lesion in the right basal ganglia on diffusion weighted imaging. Her symptoms were apyric for acute stroke, however an alternative cause was not evident. She was monitored closely with early supported discharge. However the left sided ataxic movements worsened and were associated with intermittent myoclonic jerks and dys tonic posturing. She was reassessed with a wider differential including focal impaired seizures, Rasmussen’s encephalitis, and CJD. EEG showed periodic lateralizing epileptic discharges, however patient failed to show any response to anti-epileptic treatment and her clinical course was one of rapid deterioration. Clinical findings and subsequent MRI findings showed new areas of hyper-intensity supporting CJD.

Results: Ultimately our patient deteriorated rapidly resulting in an akinetic and abducic state, resulting in death. A final diagnosis of sporadic-CJD was made based on rapid progressive deterioration and findings on MRI as well as confirmation on post-mortem brain pathology. A deep review of family history revealed a sister who had passed away years prior with rapid progressive neurological illness. Her work-up showed clinical signs and EEG findings supporting CJD, however there was no post mortem to confirm her diagnosis.

Conclusion: This case highlights the importance of genetics shaping phenotypes and that consideration should always be given to a full relevant family history. It also shows a rare case of rapidly progressive dementia confirmed due to CJD with a likely underlying familial predisposition.

LEARNING FROM OTHERS: A REVIEW OF DEMENTIA REGISTRIES AND THE VALUE OF DEMENTIA DATA WITHIN THE IRISH CONTEXT

Louise Hopper, Christina Bowen
Dublin City University, Dublin, Ireland

Background: Since the 1980’s, the number of established dementia registries worldwide has grown considerably and new registries continue to develop (e.g. Cuba, Netherlands, Greece and Australia). Ireland does not currently collect data relating to dementia in any systematic way. A National Dementia Registry model has been commissioned by the National Dementia Office (funded by Dormant Accounts through the Department of Health) to address this gap.

Methods: Despite a growth in dementia registry numbers (30+), no international standard has emerged, nor does Ireland have national guidelines in relation to patient registries. We commenced with a review of research, volunteer, epidemiological, and quality of care registries to examine similarities and differences in their design, governance, data collection, outputs and perceived value, so that we can mirror and learn from these and determine the possibilities for value creation in an Irish context.

Results: Key models have emerged along with a willingness to share experiences and support our learning (e.g. France, Spain, Sweden, Norway and USA). Common data includes patient characteristics, diagnostic work-up, diagnosis, treatment (point in time) and service provider details. There is a clear shift towards quality models that identify variation in best practice; follow the patient over time (only Sweden to date), and provide feedback on performance in an effort to stimulate quality improvement and motivate change. No jurisdiction has perfect conditions. The creation of a registry can itself drive the change required to enable it to add value to the health system.

Conclusion: Existing dementia registries evidence the value that a dementia registry provides, in particular the fostering of clinical best practice and improvement in patient outcomes. Notwithstanding the challenges of integrated data collection in Ireland, these registry models illustrate that the time is right to develop a national dementia registry. The value and importance in having dementia data cannot be underestimated.

AN ALTERNATIVE TO THE EMERGENCY DEPARTMENT FOR FRAIL OLDER PEOPLE

Elaine Shanahan, Alisa Antonenko, Siobhán Kenneally, Chie Wei Fan, Frances McCarthy
1 St. Mary’s Hospital, Dublin, Ireland
2 Mater Misericordiae University Hospital, Dublin, Ireland
3 Connolly Hospital, Dublin, Ireland

Background: 53% of hospital inpatient beds are occupied by patients >= 65 years. These patients often experience functional decline. In those transferred to our post-acute rehabilitation unit the average length of stay prior to transfer is 16 days and 38 days post transfer. Our hospital has a Community Response Unit (CRU) which provides an alternative to this care pathway, offering direct admission to a 15 bed unit with 24-hour medical cover and full multidisciplinary input. This study reviews the use of this unit over a one year period.

Methods: We retrospectively reviewed the discharge letter or medical notes of patients admitted to the CRU during 2018. The referral source, indication for admission, length of stay and discharge destination were recorded.
Results: One-hundred and fourteen patients were admitted over the one year period. Source of referral was identified for 81 patients and included day hospitals (53.1%), acute hospitals (14.8%), respite/transitional care wards (12.3%), nursing homes (8.7%), home visits (6.2%), community sources (3.7%) and other specialties (1.2%).

The most common indications for admission were mobility/functional decline (26.3%), falls (17.5%), requirement for medical investigations (14.9%), cognitive decline with behavioural issues (11.4%), blood transfusion (10.5%), pain management (7%), oral deterioration (7%), requirement for increased home supports (7%), treatment of infection (6.1%), rehab post fracture (5.3%), wound management (4.4%), alcohol detoxification (1.8%) and self-neglect (1.8%). Multifactorial reasons for admission frequently occurred.

The median length of stay was 24 days (1-176 days), 67% of patients were discharged to their original residence, 17.4% were newly admitted to residential care, 9.2% required transfer to an acute hospital and 6.4% died during their admission.

Conclusion: The CRU provides comprehensive Geriatrician led care for a wide variety of indications. This model of care offers a valid alternative to Emergency Department presentation and acute hospital admission.

EXPLORING PHYSICAL ACTIVITY AND SLEEP IN COMMUNITY-DWELLING PEOPLE WITH DEMENTIA AND THEIR ASSOCIATION WITH COGNITIVE FUNCTION AND QUALITY OF LIFE

Anne Mahon1, Ruairi Kirwan1, Laura Macley2, Estefania Guisado-Fernández3, Brian Caulfield4, Fiona Curran1, Deirdre Power1, Darrmid O’Shea2, Rachel Doyle3, Catherine Blake1
1University College Dublin, Dublin, Ireland
2Mater Misericordiae University Hospital, Dublin, Ireland
3St. Vincent’s University Hospital, Dublin, Ireland

Background: The incidence of dementia has reached epidemic levels, both globally and here in Ireland. Many adults with dementia living in the community remain inactive with some also suffering from sleep disturbances. There is evidence to suggest sufficient exercise and sleep can have a positive influence on cognition also. In this study, we explore:

- physical activity levels
- sleep patterns
- of community dwelling people with dementia and explore the association they have on:
- cognitive function
- quality of life.

Methods: Each individual was assigned a Withings-Go wrist-watch to wear over a period of 3 months which measured their:
- daily steps taken
- time in deep sleep
- time in light sleep
- total sleep each night

MMSE and DEM QoL were used to measure cognitive function and quality of life respectively. Assessed at baseline & after 3 months. This data was coded and analysed using Microsoft Excel and SPSS.

Results: An RHO = 0.617 was detected between the DEMQoL scores and the mean steps taken over the last 5 days of data collection. An RHO = 0.127 was detected between steps and sleep time which implied that as steps increased, sleep time was reduced with the opposite being applicable also. The average total sleep time for the same period was 08:03:00 (h:mm:ss) while the average daily steps taken by the group was 3,266 steps.

Conclusion: People with dementia living in the community were found to be physically inactive. This study has displayed that increased levels of physical activity can show signs of improved quality of life. This study was a correlational study and causality was not investigated. The association we have identified may provide support and foundation for future studies that explore causal components.

EXAMINING THE ASSOCIATIONS BETWEEN FRAILTY, OBESITY AND ALLOSTATIC LOAD IN THE IRISH LONGITUDINAL STUDY ON AGEING (TILDA)

Kevin McCarthy1,2, Triona McNicholas3, Eamon Laird1, Mark Ward1, Roman Romero-Ortúzar4, Rose Anne Kenny1,2
1The Irish Longitudinal Study on Ageing (TILDA), Trinity College Dublin, Dublin, Ireland
2Department of Medical Gerontology, Trinity College Dublin, Dublin, Ireland

Background: Fried’s frailty phenotype is defined by five criteria: exhaustion, unexplained weight loss, weakness, slowness and low physical activity. Frailty can also affect obese people. Little is known about how body mass index (BMI) or waist-hip ratio (WHIR) are associated with frailty or pre-frailty in the face of confounding factors, including markers of allostatic load which are known to be involved in frailty biology. We cross-sectionally examined these associations in a population-based study.

Methods: A cross-sectional analysis of data collected at Wave 1 (2010) of TILDA was undertaken. Participants aged <50 and those who did not have measurements of their BMI, WHIR, chronic disease status, HbA1c, CRP sex and educational status were excluded. Two multivariate logistic regression models (one with BMI and another with WHIR as markers of obesity) were computed adjusting for these covariates, with frail/pre-frail versus non-frail as the outcome variable.

Results: 4,568 participants were included: 3,277 non-frail and 1,291 frail/pre-frail. The frail/pre-frail group had a mean BMI of 29.2 (versus 28.3) kg/m² and a mean WHIR of 0.912 (versus 0.889). In the adjusted regression model, BMI had a significant association with frailty/pre-frailty (OR 1.02, 95% CI: 1.01-1.04, p=0.001). However, in the model using WHIR, the latter had a stronger association with frailty (OR 4.52, 95% CI: 1.60-12.72 p=0.004). In both models, age, education, chronic disease status, HbA1c and CRP had the expected associations with frailty/pre-frailty. Female sex was significantly associated with frailty/pre-frailty in the WHIR model (OR 1.26, 95% CI 1.06-1.50, p=0.008).

Conclusion: While obesity is associated with frailty, the distribution of body fat may be more important as a marker of frailty. These physical traits should not be over-looked in the over 50 population. The association between frailty, obesity and markers of ‘inflammaging’ could be examined longitudinally to further understand their complex biology.

BENEFITS OF A SELF-MANAGEMENT PROGRAM FOR THE OLDER COUPLE LIVING WITH PARKINSON’S DISEASE: A PILOT STUDY

Karen Lyons1, Alex Zapack2, Melissa Greer3, Holly Charmoy4, Nathan Diedenhofen4, Julie Carter5
1Boston College, Boston, USA
2University of Nevada, Las Vegas, USA
3Parkinson’s Resources of Oregon, Portland, USA
4Oregon Health & Science University, Portland, USA

Background: Although community-based self-management workshops have been found to benefit older adults with Parkinson’s disease (PD), it is unclear if there could be added value for the couple if the spouse also participated.

Methods: A quasi-experimental two-wave design (0 and seven week follow-up) was used to explore the effects of a self-management program on the health and relational outcomes of older adults with PD and their spouses in comparison to a wait-list control condition. Thirty-nine couples were enrolled and completed the study (19 in the intervention group and 20 in the wait-list control).

Results: Adjusting for baseline outcome values, spouses in the intervention group had significantly greater engagement in mental relaxation techniques (p < .001; d = 1.28) than those in the control condition at seven weeks. Additionally, moderate effect sizes were observed for increases in the mental relaxation (d = 0.44) and aerobic activity (d = 0.44) of older adults with PD and the strength-based activities of spouses (d = 0.33) in the intervention group. Small to moderate effects were observed for declines in the depressive symptoms of spouses (d = 0.29) and older adults with PD (d = 0.14) and care strain of spouses (d = 0.15) in the intervention group. Finally, perceptions of marital quality improved for older adults with PD (d = 0.46) and spouses (d = 0.41) and reports of protective buffering (i.e. hiding concerns) declined for older adults with PD (d = 0.24) and spouses (d = 0.33) in the intervention group compared to the wait-list control condition.

Conclusion: Preliminary data showed promise for self-management programs benefiting couples living with Parkinson’s disease. Although larger samples and randomized controlled trials are needed to establish the full benefits of such programs, greater attention to interventions for the older couple is warranted.
Age and Ageing

THE IMPACT OF INTER-GENERATIONAL CARE ON THE EMOTIONAL WELL-BEING OF OLDER PERSONS WITH DEMENTIA LIVING IN LONG TERM CARE SETTINGS

Seabrim Mcguigan 1, Lisa O’farrell 1, Sarah O’dwyer 1
1Fit for Life, Ltd Dublin, Ireland
2Highfield Healthcare, Dublin, Ireland

Background: A significant number of older persons with dementia highlight feelings of low mood following admission to care settings. There needs to be ongoing development in addressing the emotional well-being of this group as highlighted by 2013 NICE quality standard: Mental well-being of older persons in care homes. This exploratory study evaluates the impact of an inter-generational care group with emphasis on the emotional well-being of the older persons. A structured programme of shared experiences between the older persons group and pre-school age children was introduced.

Methods: Approval was sought from the safeguarding committee and insurance board of the care facility. Consent was obtained from residents to participate. Risk assessments were completed for the activities and the participants. Cognitive screen score and communication ability of each resident was noted in selecting the focus group (n=10). Outcome measures included qualitative interviews completed after each session. A qualitative wheel was completed with residents before and after the session had taken place.

Results: Focus group data supported the programme’s impact on emotional well-being. Eighty percent of participants reported mood elevation. Other benefits identified included excitement for the next session and bringing back memories of raising their own children and grandchildren. A singular negative aspect identified was that on occasion overstimulation impacted mood and participation level of one resident. Ninety percent of participants were female. The costs incurred were minimal to the organisation. Provision of resources were shared between the care facility and preschool facility.

Conclusion: The findings of this study support the use of inter-generational care groups in long term care facilities for residents with dementia. It confirms the benefits of improving emotional well-being of this cohort. Adequate supervision measures must be in place to regulate the stimulation level of the environment and facilitate individuals to exit the session.

RELIGIOUS PARTICIPATION AND HEALTH IN A CHANGING IRELAND: A QUALITATIVE EXPLORATION OF WOMEN AGED 65 AND OVER

Joanna Ort 1, Christine McCarrrigle 1, Rose Anne Kenny 1, Linda Hogan 2
1The Irish Longitudinal Study on Ageing, Trinity College Dublin, Dublin, Ireland
2Irish School of Ecumenics, Trinity College Dublin, Dublin, Ireland

Background: The previous decades have seen tangible changes in Ireland’s religious landscape. Religion has been investigated as an important factor in wellbeing for many populations, including those aged 65 and over. Women in this age group in particular have higher religiosity while also being more likely to face challenges such as widowhood and demanding caring roles. We explored the ways in which women relate their religious belief, practice and participation to their wellbeing in later life within the Irish context.

Methods: A qualitative research design was employed. In-depth, semi-structured interviews were conducted with women aged 65 and over (n=11), who self-identified as religious. Women were sampled from church congregations in the North Dublin area. Interviews were recorded and transcribed. Thematic analysis was carried out using NVivo. Women were invited to speak on their life course religious trajectories, relationships, and health, using a flexible interview instrument. Both predetermined and emerging themes were explored.

Results: Participants were aged 67 to 89, and were Catholic-affiliated (n=10) and Church of Ireland-affiliated (n=1). The participants described a range of religious identities, and these coloured their strategies for facing the changing role of the church in Irish society. Church abuse scandals were discussed unprompted by the majority of participants. Apprehension regarding the future of the church was common, as was concern for the religious identities and practices of younger generations within their families. Nevertheless, the majority of participants outlined ways in which religious practice, in particular, was conducive to their wellbeing.

Conclusion: Religious feeling, identity and practice was not homogenous in the sample. Feelings of uncertainty around the future were common, and participants employed a range of strategies to cope with these. The study is limited in how generalisation can be made, but provides insight into some of the mechanisms that can link, both positively and negatively, health and religiosity.

FEASIBILITY AND USABILITY OF A NEW NATIONAL TRANSFER DOCUMENT FOR OLDER PERSONS: A PILOT STUDY

Alice Coffey 1, Pauline O'Reilly 2, Pauline Messick 1, Dymna Tushy 1, Brid O'Brien 1, Jill Murphy 1, Owen Doody 1, Margaret Graham 1, Anne Fahy 1, Louise Barry 1, Jonathan O'Keefe 1, Michelle Kielty 3, Jane D'Oboherty 3
1University of Limerick, Limerick, Ireland
2St. Vincent's University Hospital, Dublin, Ireland
3Health Service Executive, Cark, Ireland

Background: There is an increasing number of older persons experiencing transfer episodes between residential and acute care facilities (Griffiths et al. 2014). Current transfer documentation is diverse; often only containing basic information and very little person centred patient information. The objective of this HSE National Clinical Programme for Older People funded study was to develop a national person centred transfer tool, for use during patient transfer between residential and acute services. Following an extensive literature review, focus group interviews with stakeholders and input from an expert panel, a pilot transfer document was developed. This paper reports on the pilot study of this document.

Methods: Researchers, in consultation with the expert panel, developed questionnaires. Questionnaires were quantitative, with three open-ended questions. Of the 28 residential settings and 3 acute settings that were contacted, 26 residential and 3 acute settings (93%) participated in the study. The pre-pilot questionnaire asked staff in residential settings their perceptions on current transfer documentation (n=875). The post-pilot questionnaire asked staff in residential and acute care settings their thoughts on the new transfer document which was used for the pilot (n=1085).

Results: Findings suggest that staff agree that the new transfer tool is person centred, contains relevant patient information and could help communication between healthcare professionals in these settings. Findings also indicate that the length of time to complete the document is of concern, particularly in an emergency and there were suggestions from staff in residential care services that some sections could be prepopulated.

Conclusion: In order to have a transfer document that is efficient, and person centred, there is a need for it to be available electronically and easy for staff to fully complete particularly in an emergency transfer.

RISK OF HYPOGLYCAEMIA IN OLDER PATIENTS IN RESIDENTIAL CARE ON ORAL HYPOGLYCAEMIC MEDICATION

M Brennan 1, A Crowe 1, C Tiernan 1, M Smith 1, L Cogan 2, R Purcell 3, C Griffin 3
1Our Lady’s Hospice Harold’s Cross, Dublin, Ireland
2Our Lady’s Hospice Harold’s Cross, Dublin, Ireland

Background: Diabetes mellitus (DM) is common in older patients in residential care (RC) with prevalence ranging from 11.5-60% Guideline 1 on glucose targets to avoid the risk of hypoglycaemia or hyperglycaemia respectively in older people recommend avoiding a fasting glucose on treatment of 6mmol/L or a random glucose level higher than 11.0mmol/L. An HbA1c of 5.3% 9.5mmol/mol (7.7-5.5%) should be aimed for although this may need adjusting in RC and StopPall guidelines suggest a target of HbA1c of <7% (66mmol/mol). We assessed the prevalence, drug treatment and glycaemic control in 107 older patients in residential care at two sites in Dublin.

Methods: Patients with DM were identified from review of medical notes. Hypoglycaemic treatment whether oral hypoglycemic drugs(OHDD) or insulin, capillary blood glucose measurements(CBGM) over the previous 24 hours, HbA1c values and weight change over the previous year were tabulated from patient record.

Results: Sixteen patients (15%) aged 66–93 were documented with DM. Eight (50%) were on no hypoglycaemic treatment in whom OHDD had been discontinued in 2 patients over the previous 6 months because of risk of hypoglycaemia. Six patients (38%) were only on OHDD, whilst 2 were on insulin. Of the 6 patients on OHDD, CarbGm were below 6mmol/L in 3 patients (50%) with no values above 11mmol/L. All 3 patients had lost weight (2.5-6.8Kg) over the previous year and HbA1c levels were below 5mmol/mol (7%) in all 3 patients.

Conclusion: Although our numbers are small, 50% of our patients in residential care on OHD may be appropriate.

REVISING COMPREHENSIVE GERIATRIC ASSESSMENT IN THE EMERGENCY DEPARTMENT

Lucinda Edge 1, Brian O'Rourke 1, Canon Cunningham 1, Frances Horgan 1
1St James’s Hospital, Dublin, Ireland
2Royal College of Surgeons in Ireland, Dublin, Ireland

Background: In a large teaching hospital, a specialist interdisciplinary team identify frailty and begin comprehensive geriatric assessment of older adults in the Emergency Department (ED). This study aimed to determine the clinical utility of a range of measures: grip strength, calf circumference, frailty and functional mobility to evaluate whether these help to estimate the care pathways for patients. Objectives included: (1) To ascertain the prevalence of frailty and (2) To profile this population’s demographics, falls history, calf circumference and grip strength.

Methods: This was a cross-sectional study. Inclusion criteria were persons ≥ 70 who presented to ED weekdays during research hours 9:00 – 16:00, with Manchester triage score ≥3. Information on gait aids, social supports and falls in the past 6 months was self-reported. Grip strength was assessed using hydraulic hand-held dynamometry. Sarcopenia was measured using calf circumference as a proxy. Frailty was determined using the Clinical Frailty Scale (CFS). Functional mobility was assessed by an interdisciplinary team member. Onward referrals and admission to hospital were recorded. Data was analysed using SPSS statistical software.

Results: One hundred and three participants were included, 39 male (58.6%) and 62 female (61.4%), mean age 79.3 years. Thirty-five percent (n=56) were considered frail (a CFS score of ≥5), 35.6% (n=56) lived alone, 52.5% (n=53) used a gait aid. Outcomes included admission to hospital (27.7%, n=28) and discharge with onward referral (25.7%, n=26). The most common referral was respiratory physiotherapy (11.9%, n=12). The population
BACKGROUND: Over one third of people with dementia in Ireland reside in Long Term Care (LTC) settings. Dementia palliative care is complex; healthcare staff in LTC settings have requested specific guidance to support practice. This participatory action research project will introduce national evidence-based guidance documents relating to pain, hydration/nutrition, and medication management, into three LTC settings in Munster, using a tailored Work-based Learning approach, informed by a baseline multi-modal situational analysis.

METHODS: and staff data were collected using a site profile tool; staff demographic and learning needs surveys; and the ‘VOCALISE’ readiness-to-change survey, in the three sites.

RESULTS: Within the sites, 42-88% of residents had probable/definite dementia. Multidisciplinary input varied considerably between sites. In total, 69 staff (predominately nurses and healthcare attendants) completed learning needs surveys. Many reported prior dementia education (range 53% across sites). This was twice as often on hydration/nutrition and medication topics than pain. Reflecting this, staff in all sites identified knowledge deficits, but particularly in pain identification, assessment and management. Other learning needs included supporting and communicating with families; resident care planning and advance care planning; and resident ‘comfort’.

Of 58 staff with completed VOCALISE data, 33% were rated as ‘ready to change’, 14% ‘not’, and the remainder ambivalent. Interestingly, staff had high confidence in the ability of the intervention to happen, but low motivation scores; and overall ambivalence toward their own power to make change happen. Some barriers were site-specific, but overall, staffing levels, managing risk during change and perceived reluctance in others were common barriers to change, as was the possibility that patient wishes hadn’t informed the change process.

Conclusion: Our baseline data highlights that education and implementation needs to be tailored to the recipient site, recognising site-specific barriers to change. We will now use this data in our Work-based Learning intervention.

CAPTURING THE PROVIDERS OF SERVICES TO OLDER PERSONS – AN EXERCISE IN INTEGRATION OF CARE

Patrice Kelly1, Frances Dockery1,2, Una O’Leary1, Sinead Grogan1, Joan Walsh1, Lydia Traynor1

1 Dublin North HSE CHO 9, Dublin, Ireland
2 Beaumont Hospital, Dublin, Ireland

BACKGROUND: There is much focus on the dearth of resources within healthcare systems, with a focus on health services. In 2018, we held a speed networking event for two local areas of a HSE Community Healthcare Organisation. This highlighted the vast array of supports available to assist older people to live well. This, alongside a Listening to Older Person’s Workshop, highlighted the need for a local directory of services.

METHODS: In considering potential networking attendees, a social determinants of health approach (Dahlgren and Whitehead, 1991) was adopted to scope all supports available across community, acute, voluntary and statutory health and social care services within the area. This was expanded on further to develop the directory.

RESULTS: The directory provides details of 358 organisations, individuals and groups available to support older persons within a catchment area with a population of 13,853 older persons (CSO Census, 2016). Health services comprised 27% of these while community, HSE and GP health services made up 130. The remaining 201 were local and national NGOs and community groups ranging in service provision, a sample of which as follows: 39 provided some level of social/education engagement, three befriending, 18 counselling, five housing specific, 11 substance dependency, 12 supported persons to persons impacted by abuse. A further 20 national NGOs provided a local service or helpline with a focus on a particular health diagnosis.

Conclusion: This exercise shows the vast number of services available within just one small region, to support older persons to live well at home. The directory has been approved as a template for other networks in the CHO. It is being adapted into an online version by an interagency group. Using this template nationally has the potential to overcome gaps in health service resources, and support true integration, in line with the ICPOP (2016) 10 step framework.

THE USE OF A GROUP BASED UPPER LIMB PROGRAMME IN IMPROVING OUTCOME IN ACUTE STROKE REHABILITATION

Kerri Donnelly, Enya Mulcahy, Catherine Merrick, Orla Fitzgerald

BACKGROUND: After a stroke 85% of patients experience altered arm function. Current research demonstrates that increasing upper limb rehabilitation results in improved outcomes (Ward et al., 2019). The Graded Repetitive Arm Supplementary Programme (GRASP) group is an established adjunctive therapy in the stroke service. The group provides additional therapy for patients with upper extremity deficits. The group is run jointly by a physiotherapist and an occupational therapist. Patients attend twice weekly for a one hour period in addition to their regular therapy. The GRASP group consists of 3 levels of varying abilities and patients are categorised by their Fugl-Meyer scores.

METHODS: A prospective audit was completed in 2019 and data was collected using a word document and excel spread sheet. Standardised outcome measures were collected on admission and discharge to establish upper limb ability. The primary outcome measure was the Fugl-Meyer and the secondary outcome measures were the nine hole peg test and grip strength using the Dynamometer.

RESULTS: 12 patients attended the GRASP group over this period. 75% were males. The average age was 76 years with the age range from 48-95 years. 58% of patients experienced upper limb weakness in their non-dominant hand. Post intervention data was not obtained for 5 patients due to unforeseeable discharge from the acute setting. Preliminary data to date shows that our primary outcome measure improved in 86% of patients with increases ranging from 2-11 points on the Fugl-Meyer score (Minimally Clinical Important Difference =5points). Our secondary outcome measures demonstrated patients had no change (28%) or an improvement (72%) in grip strength and 100% of patients improved on the time taken to complete the nine hole peg test.

Conclusion: The GRASP group was found to be effective in improving upper limb outcome measures in an acute stroke inpatient hospital setting.
Pjs or hospital gowns. 45% of those deemed "Fit to Sit" were on a trolley. Patients 65 and older were more likely to be wearing Pjs (p = 0.03), but not more likely to be on a trolley (p = 0.23). Patients in ED for greater than 12 hours were also more likely to be in PJs (p = 0.001) and on a trolley (p = 0.057).

Conclusion: Our study suggests that a significant proportion of ED patients are lying on trolleys despite being deemed to be “Fit to Sit”. Introduction of an ED “Fit to Sit” programme may alleviate deconditioning and promote patient independence.

Audit on inappropriate prescribing of proton pump inhibitors amongst patients over 65 years in an acute rehabilitation hospital
Eimear O'Reilly1,2, Anqi Gao1,3, Lisa Cogan3
1Royal Hospital Derrynore, Dublin, Ireland
2University College Dublin, Dublin, Ireland
3Royal Hospital Derrynore, Dublin, Ireland

Background: Proton pump inhibitors (PPIs) are one of the most frequently prescribed drugs classes in the older person. Indications for PPI use are outlined in the NICE guidelines, however they are often prescribed without an appropriate indication resulting in increased healthcare costs and increased exposure to potential adverse clinical effects.

Methods: To determine the rate of inappropriate prescribing of PPIs, an audit was carried out to assess the incidence of inappropriate prescribing in an Acute Rehabilitation facility pre and post Education to Hospital Doctors. An audit was carried out, pre and post intervention, on patients over the age of 65 years admitted to an acute rehabilitation hospital between 2018 and 2019. Patient’s medical charts were reviewed and data was collected on PPI prescribing.

Results: Cycle 1: Pre Education; 83 people included in the audit. Mean age was 80.8 years [SD ± 9.4]. 43% of patients were on a PPI, all of which were prescribed the generic form. 83.4% of patients had no indication for PPI use. Of the 16.6%, indications included GORD, Barret’s oesophagus, PUD and PPI prophylaxis against NSAID’s, including aspirin. 77.7% were on therapeutic dose without any indication. 100% of patients were on PPI for longer than 6 weeks.

Cycle 2: Post education; 86 patients were included in re-audit. Mean age was 81.5 [SD ± 10]. 60.4% of patients were on an PPI. Of those, 55% had no indication for PPI. Of the 44% on PPI, indications were similar to those in Cycle 1. 83% of patients were on PPI longer than 6 weeks. 56.5% were on inappropriate dose of PPI.

Conclusion: This audit highlighted the inappropriate prescribing of PPIs in the older person. By providing education to Doctors about NICE PPI prescribing guidelines, overall rate of inappropriate prescribing of PPI decreased by 28.4% and accurate dosing of PPI improved by 21.2%.

User preferences for the design of wearable technology systems - a scoping review
Clliona O’Riordan1, Lorna Kenny1, Salvatore Tedesco2, Marco Sica2, Culum Crowe2, John Barton2, Suzanne Timmons1, Brendan OFynn2
1Centre for Gerontology and Rehabilitation, University College Cork, Cork, Ireland
2Tyndall National Institute, University College Cork, Cork, Ireland

Background: Wearable technology is a fast developing area. Often, the focus of research is on accuracy, while the practicalities of using the device may be overlooked, despite the fact that this greatly influences utility. This scoping review therefore explored the design and usability preferences of people for wearable technology for health monitoring.

Methods: A scoping review was conducted of literature evaluating user preferences for the design of wearable technology systems. The study objective was to synthesise empirical evidence, for people aged >50 years, with good health, or chronic disease.

Results: A search of relevant databases yielded 628 potential studies (after duplicates removed). Following title/abstract and then full text screening, 17 papers were included. The most commonly reported theme related to design and user interface (13 studies). Users wanted a small, unobtrusive and light device which doesn’t snag on clothing or affect activities of daily living, but yet it has a readable and easy-to-use interface, which may prove challenging for designers! Users were most happy to wear a device on the wrist and/or hip region, being considered the least obtrusive / most discrete. Users were open to the technology aspects of the device, but wanted specific training, or clear and readable instructions. Less commonly reported parameters included issues with privacy and ownership of data (two studies); cost (two studies); reliability and accuracy (three studies), including being accurate overnight and in the shower, etc.; and clinical usefulness, i.e. the data being effectively linked with other healthcare data. Where considered, participants didn’t want to wear a device by night (two studies). Safety of wearable devices was not a theme in any study.

Conclusion: Overall, user needs seem to be rarely considered in the design of wearable technology for health monitoring. However, the limited studies do highlight important user concerns, which should be considered by the technology designers and prescribers.

Role of a dietitian in a specialist memory assessment and support service - improving brain health
Emma Fox1,2, Sarah White1, Eimear Digan1, Sinead Feehan1, Cathy McHale1,5, Josh Doidge4,6, Sean Kennedy3,5
1Nutrition and Dietetic Department Tallaght University Hospital, Dublin, Ireland
2Dept of Age Related Healthcare, Tallaght University Hospital, Dublin, Ireland
3Department of Health and Nutritional Sciences, Institute of Technology, Tallaght, Ireland
4Nursing Dept, Age Related Healthcare, Tallaght University Hospital, Dublin, Ireland
5Memory Assessment and Support Service, Dept of Age Related Healthcare, Tallaght University Hospital, Dublin, Ireland
6Dept of Medical Gerontology, Trinity College, Dublin, Ireland

Background: Dementia cases are rising nationally due to our ageing population and is associated with a multitude of nutritional consequences. Both obesity and malnutrition are strongly implicated in the progression of cognitive decline. From diagnosis onwards, nutritional intervention is important to improve patient outcomes.

Methods: In order to highlight the important role of a dietitian, a retrospective analysis of 142 patients attending the tertiary memory assessment and support service from 2018 to 2019 was performed. Demographic, cognitive, anthropometric, and nutritional data was compiled from the case note review and biochemical laboratory results. This data was analysed using Microsoft Excel (2013) to study prevalence and relationships of variables in this cohort.

Results: A significant proportion of this population were overweight (41.2%) and obese (18.6%). Nearly half the population were at risk of malnutrition (44.1%) or malnourished (3.9%). In this cohort, 18.6% were characterised as frail. Only one individual had a severe clinical dementia rating score (CDR), 19.2% had a moderate and 28.2% had a mild CDR. Half (50.5%) of participants had some level of abnormal eating habits. Higher prevalence of malnutrition, frailty and higher CDR was associated with increased age. Up to 60% of those with normal nutritional status had a CDR of 0 or 0.5. As MNA score worsened, the incidence of robust individuals decreased linearly. Prevalence of frailty increased as CDR score increased. Of those with a mild CDR, 79% were overweight or obese. Those with high Cambridge Behavioural-Inventory (CBI-R) eating habit scores generally had lower CDRs.

Conclusion: Patients attending the memory service are experiencing a multitude of nutritional challenges such as disordered eating habits, overweight and obesity, malnutrition risk and frailty which are associated with cognitive decline and worse health outcomes. Nutritional support and dietary input as part of the post-diagnostic care-pathway is required to promote brain health and mitigate unnecessary decline.

The next steps: the development of dementia post-diagnostic psychoeducational support guidance
Matthew Gibb1, Dearbhlá O’Callery1, Cécile Craig1, Érner Begley2
1Dementia Services Information and Development Centre, Dublin, Ireland
2National Dementia Office, Tallaght, Ireland

Background: There is often a ‘care gap’ where people are given a clinical diagnosis of dementia but receive no useful support. (Foley, T. et al., 2019) However, the early stages of dementia are a crucial time for supportive interventions such as advice and strategies to cope with impairments and improve wellbeing and signposting through complex healthcare systems to access key supports and services. In February 2018 the National Dementia Office (NDO) commissioned the Dementia Services Information and Development Centre (DSIDC) to develop a guidance document to support health and social care professionals (HSCPs) establish, organise and facilitate evidence-based post-diagnostic psychoeducational interventions in the community.

Methods: The DSIDC undertook an extensive literature review examining the evidence for the various components of psychoeducational interventions. An experienced group of health and social care professionals provided additional material and expertise resulting in the development of the final guidance document. Members of the Irish Working Group of People with Dementia and the Dementia Carets Campaign Network also reviewed the document.

Results: The literature review found a growing evidence base for dyadic interventions. These interventions, directed at the person with dementia and their care partner, were diverse in their content, outcomes, the measures they used, their frequency and the professional who delivered. The literature review found a growing evidence base for dyadic interventions. These interventions, directed at the person with dementia and their care partner, were diverse in their content, outcomes, the measures they used, their frequency and the professional who delivered.

Conclusion: Dyadic interventions (and psychoeducational programmes in particular) have the potential to benefit both people with dementia and their care partners by decreasing depression and anxiety, increasing knowledge and coping skills and helping improve cognitive function. (Moon and Betts Adams, 2012) The practical guidance document developed from this review provides HSCPs with useful advice and information to facilitate the setting up and running of post-diagnostic psychoeducational support programmes.

Hospital discharges for acute stroke in Ireland: national data 2005-2017
Sarah Coveney1,2, John J McCabe1,2, Michael Marmane1,2, PJ Kelly1,2, Sean Murphy1,2
1SCN, T&L, Dublin, Ireland
2Stroke Service, Mater University Hospital and University College Dublin, Dublin, Ireland

Background: Acute stroke and its aftermath is the commonest cause of acquired disability amongst community dwelling adults.
Analysis of hospital discharge rates over time and the influence of patient age is important and may offer important insights on how best to configure stroke prevention and clinical services.

Here, we analyse hospital discharge data for Ireland for 2005-2017. 

Methods: A retrospective review of stroke discharges, with a primary diagnosis of stroke or subarachnoid haemorrhage, was performed.

Results: There has been a steady increase in the incidence of ischaemic stroke in those 50-64 years. The biggest decrease in strokes was seen in those 80 years.

Conclusion: Better understanding is needed of the risk factors underlying this worrying trend.

Clinical service providers will need to adapt to better deal with the challenges specific to stroke at younger age.

EVALUATION OF NUTRITION SERVICE PROVISION IN A DAY HOSPITAL SETTING

Eimear Digan1,2, Sarah White1, Emma Fox1,3, Sinead Feenham1, Audrey Cronin1, Sean Kennelly1

1Dept. of Nutrition and Dietetics, Tallaght University Hospital, Dublin, Ireland
2Dept. of Age-related Healthcare, Tallaght University Hospital, Dublin, Ireland
3Dept. of Health and Nutritional Sciences, Institute of Technology, Sligo, Ireland
4Dept. of Medical Gerontology, Trinity College, Dublin, Ireland

Background: Malnutrition, frailty and functional impairment adversely impact individuals and should be considered simultaneously in rehabilitation. Individuals in a Day Hospital (DH) setting require a multidisciplinary approach to rehabilitate and nutrition plays a fundamental role in improving patient outcomes. The aim of this study was to establish the nutritional profile of the patients attending the DH and to measure this against current dietary referral criteria.

Methods: A prospective quality improvement analysis of older adults attending the DH was conducted. Nutritional status, using the mini nutritional assessment short-form, biochemical and biochemical information was collected from nursing notes and the software Key. Frailty scores were assigned using Rockwood Clinical Frailty Scale. Nutrition service provision was evaluated in relation to the priority rating system for DH Patients.

Results: Nearly two-thirds of the 57 patients were malnourished (17.5%) or at risk (45.6%). 1 in 4 (26.3%) was obese. Most patients were frail (77.2%). 45.6% of patients had polypharmacy, ADEs and anticholinergic burden in the ≥65 population with rheumatic disease.

Conclusion: There is a high prevalence of polypharmacy in older adults with rheumatic disease. Increasing numbers of medications is statistically associated with increased number of PIMs, ADEs and increased anticholinergic burden.

A RE-AUDIT OF LIGNOCaine 5% MEDICATED PLASTER (VERSATIS®) PRESCRIBING IN AN OLDER ADULT INPATIENT POPULATION FOLLOWING CHANGES TO REIMBURSEMENT PROVISIONS

Deirdre McCar...2, Alison Poff, Stuart Lee, Alan Martin

Recommo...Dublin, Ireland

Background: Lignocaine 5% medicated plasters (Versatis®) are licensed only for treatment of postherpetic neuralgia. Our 2017 audit of Versatis® prescribing recorded a potential cost of €28,297/yr for just 26 patients, all off-label. We noted however the limited choice of alternatives in older adults due to co-morbid conditions such as CKD and frailty. The 2017 Medicines Management Programme (MMP) directive for label-only Versatis® prescribing aimed to reduce annual expenditure costs of €30 million noting 25,000 people had prescriptions under Community Drugs Schemes (CDS) in 2016.

Methods: We conducted a re-audit of Versatis® prescribing on five core geriatric medical, orthogeriatric and rehabilitation wards across three inpatient sites. Indication for, duration of and patient’s personal view of the plaster was recorded. Pharmacy provided medications costings. Cost per day and per length of stay were calculated. All other prescribed analgesics were recorded.

Results: Analgesics prescribed for 127 patients were recorded. Mean age was 81 years, 63% female. 4/127(5%) were prescribed Versatis® compared to 26/129(20%) in 2017, all off-label. Indications included osteoarthritis and spinal stenosis. Four patients were prescribed the plaster prior to admission. Cost per plaster was €3.46 compared to €2.58 in 2017. Cost of Versatis® for these 4 admissions was €346 for their combined 100 bed days. Total cost of co-prescribed paracetamol for these four patients was €45.90. Three patients noted little analgesic benefit, one felt the plaster a psychological support. Seventeen different analogics were prescribed across 127 kardexes.

Conclusion: No patient was newly prescribed Versatis® during their admission. The MMP directive for the prescribing of Versatis® influenced prescribing practice across our hospital sites. Opioid practice for prescribing off-label is still evident for chronic pain, reflecting the difficulty of pain control in older adults. The cost of individual plasters increased by 0.86€ since 2017.

AN EVALUATION OF POLYPHARMACY AND ADVERSE DRUG EVENTS IN OLDER ADULTS WITH RHEUMATIC DISEASE

Niamh Mooney1, Evelyn Hannan2, Mary Buckley1, Graninne Murphy3

1Department of Medicine, University College Cork, Cork, Ireland
2Department of Rheumatology, Cork University Hospital, Cork, Ireland

Background: Polypharmacy among older adults is a well-documented problem. The practice has been associated with potentially inappropriate medications (PIMs), adverse drug events (ADEs) and hospitalisation. This retrospective cohort study aims to evaluate polypharmacy, ADEs and anticholinergic burden in the ≥65 population with rheumatic disease.

Methods: All patients who were ≥65 and had a diagnosed rheumatic disease were included in this study. Patients’ medication lists, specific rheumatic disease, laboratory findings and associated comorbidities were obtained from their medical charts at rheumatology outpatient clinics. The data was screened for PIMs using the Screening Tool of Older Persons’ Medications (STOPP) criteria and probable ADEs using the WHO-UMC criteria.

Anticholinergic burden was determined using the ACB calculator. Polypharmacy in this project was defined as ≥4 regular prescription medications.

Results: 70 patients were studied. The prevalence of polypharmacy was 94%. The median (IQR) number of regular prescription medications was 7 (2-16). PIMs were recorded in 43 patients (61%). Increasing numbers of medications was a significant risk factor for PIMs (p<0.0007). ADEs were detected in 18 patients (26%). The ADE detection rate in PIM positive patients was 35% (15/43) and 11% (3/27) in PIM negative patients. A patient who was PIM positive had a statistically significant risk of having an ADE (p=0.047). Of the ADEs detected, 73% were due to a STOPP PIM.

Conclusion: There is a high prevalence of polypharmacy in older adults with rheumatic disease. Increasing numbers of medications is statistically associated with increased number of PIMs, ADEs and increased anticholinergic burden.

CLINICORADIOLOGICAL DIAGNOSIS OF CEREBRAL AMYLOID ANGIOPATHY-RELATED INFLAMMATION (CAA-RI) - A NON-INVASIVE APPROACH TO DIAGNOSIS AND MANAGEMENT

Deirdre McCartan1, David Williams2, Barry Maynihan2, Karl Boyle2

1Beaumont Hospital, Dublin, Ireland
2Beaumont Hospital, Dublin, Ireland

Background: Cerebral Amyloid Angiopathy (CAA) is an age-related disorder characterised by deposition of beta-amyloid protein in the walls of small and medium cerebral vessels leading to increased risk of intracranial bleeding. CAA-Related Inflammation (CAA-ri) is an under recognised subtype of CAA potentially responsive to immunosuppression and traditionally diagnosed by invasive brain biopsy.

Methods: Validated clinicoradiological diagnostic criteria for CAA-ri were applied to MRI T2 FLAIR and SWI sequences. CSF, APOE genotyping, EEG and cognitive testing were performed. Interdisciplinary perspectives were sought from Neurology, Neurosurgery and Infectious Diseases colleagues. Consensus opinion opposed brain biopsy on strength of imaging evidence and pulsed intravenous steroid treatment was initiated. MRI T2 FLAIR was used to avoid potential adverse inflammatory reaction in non-CAA-ri cases.

Results: MRI T2 FLAIR revealed an asymmetric multifocal distribution of cortico and subcortical white matter hyperintensities (WMH) with leptomeningeal enhancement while SWI showed extensive multifocal microhaemorrhages with confluent haemorrhage in the right frontal and temporal regions. EEG demonstrated right frontal theta slowing and absence of epileptiform activity. CSF analysis reported raised protein at 53mg/dl. Normal WCC. Formal cognitive testing with ACEII revealed a score of 79/100. EPOA was advised.

Conclusion: Clinicoradiological diagnosis of CAA-ri permits early initiation of immunosuppressive therapy and avoids invasive brain biopsy. In the absence of clinical suspicion and strong sensitive imaging sequences CAA-ri may be misdiagnosed as Acute Ischaemic Stroke or TIA where the addition of anti-inflammatory therapy could cause harm while early medical management offers potential reversibility.
THE EFFECTS OF ACQUIRED HEARING LOSS IN LATER LIFE - A PILOT STUDY
Amy Walden1, Amr El Refaie1, Anna Kingston2, Gernre O’Grady3, Siobhain Laide-Kemp1
1School of Clinical Therapies University College Cork, Cork, Ireland
2Community and Research Links, UCC, Cork, Ireland
3Cork Deaf Association, Cork, Ireland

Background: Acquired hearing loss (AHL) is defined as a hearing loss which is acquired after birth or at any other time in one’s life. In Ireland one in every twelve adults has a permanent hearing loss as a result of ageing or exposure to noise. Statistical findings are consistent with people identified with hearing loss in later life having a corresponding higher risk of cognitive decline. The pilot study aimed to investigate the experience of members of a deaf association who had been diagnosed with AHL in later life. This is the first time this particular group has been surveyed in Ireland.

Methods: A qualitative research design was used. The information was gathered using an open-ended questionnaire which was distributed to 30 participants. Rich data was extracted and analysed using thematic analysis (Braun and Clarke 2006).

Results: 12 members of the deaf association responded to the questionnaire. From these responses four themes were identified: emotional well-being, management strategies & rehabilitation, promoting awareness and alienation. This study indicated that AHL can have a detrimental effect on people in later life.

Conclusion: There is irrefutable evidence to suggest that the effect of AHL in later life exceeds the effect on hearing alone and extends to emotional and physical well-being as well as overall quality of life. The pilot study demonstrates the urgent need for a far-reaching study to evaluate the effect of AHL in later life on the Irish population, its impact on quality of life and cognitive decline while highlighting the need for community awareness and understanding.


DEPREScribing in frail older people transitioning to long-term care: A randomized controlled trial using STOPP/FRAIL criteria
Denis O’Mahony1, Emma Jennings2, Ruth Daunt3, Mary Randies4, Paul Gallagher1,2, Denis Curtis1,2, Anna Kingston2
1University College Cork, Cork, Ireland
2Cork University Hospital, Cork, Ireland
3Cork University Hospital, Cork, Ireland
4Mercy University Hospital, Cork, Ireland

Background: Older people with advanced frailty are among the highest consumers of prescription medications. When life expectancy is limited, the use of multiple medications may be unnecessary or burdensome. STOPP/FRAIL criteria were recently developed to assist clinicians with deprescribing decisions in frail older people approaching end-of-life. The aim of this study was to examine whether long-term medications could be safely discontinued in frail older people using STOPP/FRAIL criteria.

Methods: Retrospective analysis of adults aged ≥ 75 years with polypharmacy (> 5 long-term medications) that were transitioning to nursing home care. Participants were eligible if their Clinical Frailty Scale score was ≥ 7 and if their attending physician indicated that he/she “would not be surprised if the patient died in the next 12 months”. Patients were randomized to single time point pre-discharge STOPP/FRAIL-guided deprescribing or routine pharmaceutical care. The primary outcome was change in the number of regular medications at 3 months. Secondary outcomes included emergency hospital transfers, incident falls, fractures and mortality.

Results: Results are presented for the first 100 enrolled patients. The mean (±standard deviation [SD]) age of study participants was 85.1 (±5.7) and 61% were female. Interventions (n = 49) and control group (n = 51) participants were prescribed a mean of ±SD) of 11.5 (±3.0) and 10.9 (±3.5) regular medications, respectively, at baseline. The mean (±SD) change in the number of regular medications at 3 months was -2.7 (±2.8) in the intervention group and -0.6 (±2.6) in the control group (estimated difference 2.1 ±0.6; 95% confidence interval 0.8 -3.3, p=0.001). Ten intervention participants and 14 control participants died within 3 months of randomization (20.4% vs 27.4%, p=0.49). There was no significant difference between groups for emergency hospital transfers, incident falls or fractures.

Conclusion: STOPP/FRAIL-guided deprescribing significantly reduced medication burden in frail older people without adversely affecting clinical outcomes in the prospective 3 months.

ACUTE INCIDENCE OF DISEASE AT ELEVATED LEVELS OF FINE PARTICULATE MATTER (PM2.5) IN DUBLIN, IRELAND
Colm Byrne1, Kathleen Bennett1, Annie Hickey1, Paul Kavanagh1, Brian Broderick2, Margaret O’Mahony3, David Williams4
1Royal College of Surgeons in Ireland, Dublin, Ireland
2Tallaght University Hospital, Dublin, Ireland
3Trinity College Dublin, Dublin, Ireland
4NUI Maynooth, Maynooth, Ireland

Background: Fine particulate matter (PM2.5) has been associated with disease incidence worldwide. In Ireland this is mainly produced by residential heating systems, particularly peat, coal and wood. This study aimed to explore the relationship between short-term exposure to PM2.5 and hospital admissions due to stroke, atrial fibrillation, myocardial infarction, atrial fibrillation (AF), heart failure, chronic obstructive pulmonary disease (COPD), asthma, Parkinson’s disease, dementia and hip fracture in Dublin City and County between 2013 and 2017.

Methods: This was an ecological time series design utilising routine hospitalisation data collected from the national Health Service Executive (Hospital In-Patient Enquiry (HIPE)). Incidence of hospitalisation for each disease was identified by county of residence. Mean daily PM2.5 levels for Dublin were calculated using monitoring data from the Environmental Protection Agency’s four monitoring sites. Disease incidence was organised by mean PM2.5 levels into 10μg/m3 categories and analysed using Poisson regression models correction for minimum daily temperature at a lag of zero to five days.

Results: There was a significant increase in the short-term incidence of acute ischaemic stroke, AF, heart failure, Parkinson’s disease, dementia and COPD when PM2.5 levels were above 50μg/m3 compared to when levels were below 10μg/m3 at one day post exposure when controlling for minimum temperature.

Conclusion: Controls need to be brought in to ensure that PM2.5 does not exceed a 50μg/m3 level due to the increase in disease incidence associated with same. The urban burning of solid fuels should be severely restricted.

LIFE COURSE SOCIOECONOMIC POSITION AND ALLOSTATIC LOAD BURDEN
Snead Mclaughlin Cathal McGorry
The Irish Longitudinal Study on Ageing, Dublin, Ireland

Background: Allostatic load (AL) is a measure of cumulative physiological dysregulation that is posited to capture the ‘wear and tear’ on the body resulting from exposure to chronic stress. AL has been shown to predict disease, morbidity and mortality. Multiple studies have shown an inverse relationship between AL and SEP but few have examined the life course social patterning of AL.

Methods: Using baseline data from The Irish Longitudinal Study on Ageing (TILDA), an AL index was calculated by summing the number of biomarkers for which respondents fell within high risk quartiles. 17 biomarkers were examined, representing cardiovascular, immune, metabolic and parasympathetic nervous systems. SEP and life course trajectories were determined using father’s occupation (at age 14) and current occupation, which were aggregated to create four categories of social mobility: stable high, downwardly mobile, upwardly mobile and stable low. Negative binomial regression models were fitted for each of the life course models of critical period, accumulation and social mobility, to examine the associations between SEP and AL (n=3,282).

Results: Higher SEP was associated with lower AL. A significant association between origin SEP and later life remained after controlling for destination SEP. The ‘stable high’ across the life course had the lowest AL burden, the ‘stable low’ had the highest burden, and the mobile groups ranked intermediate.

Conclusion: Findings suggest childhood to be a sensitive period for the embedding of early life disadvantage. The accumulation hypothesis suggests that those who spend more time disadvantaged fare worse in terms of health. This study supports this hypothesis, as those who were stable low / stable high were in the worst / best health respectively.

NURSING HOME RESIDENTS IN ACUTE HOSPITAL - A TARGETED ANPC PROGRAM TO IMPROVE CARE
Claire Noonan1, Dan Ryan1, Tara Coughlan1, Senan Kennedy1,2
1Dept. of Age Related Healthcare Tallaght University Hospital, Dublin, Ireland
2Dept. of Medical Gerontology, Trinity College Dublin, Dublin, Ireland

Background: NHFR are the frailest group of older people and require a gerontologically attuned approach to combat multiple challenges presented to the practitioner. The in-reach ANPC liaison service aims to confront such challenges, by providing comprehensive gerontological input to all nursing home residents admitted to hospital under all specialties medical, geriatric, and surgical.

Methods: This service commenced in September of 2018, working 9-5 Monday to Friday with limited leave cross-cover. All nursing home residents are reviewed by a Gerontology advanced nurse practitioner. Each patient received comprehensive geriatric assessment (CGA) with recommendations for care. All had follow up 2 weeks after discharge in telephone review clinic.

Results: 118 nursing home residents were admitted for acute care in the study period; 96/118 (82%) were reviewed by the ANPC. 16/118 (14%) were discharged prior to review in telephone review clinic.

All assessed residents had > 1 recommendation for intervention to enhance care following CGA:

Interventions included 31% (30/96) undiagnosed delirium identified and management advice given. 21% (20/96) had recurrent falls work up and advice. 27% (26/96) had exacerbations and changes to admission medications. 37% (36/96) referred to other HSCP therapy disciplines for complete holistic care. 11% (11/96) had advanced care planning regarding future illnesses. 13% (13/96) had palliative care advice and referral to community palliative care.

Follow up telephone review clinics have further resulted in reduced re-admission rates through liaison with NH staff post-discharge.

Conclusion: The high complexity of this cohort of patients requires a timely, comprehensive gerontological approach in order to provide holistic care. They require a clearly defined approach to enhance care and minimise the need for unnecessary hospitalisations.
INTEGRATED CARE HUBS FOR OLDER PERSONS; RIGHT PERSON, RIGHT TIME

Niamh Phelan1, Margaret Bolger1, Emma Grant1, Catherine Murphy1, Suzanne Roche1, PJ Harnett1, George Pope1, Riona Mulcahy1, John Cooke1
1University Hospital Waterford, Waterford, Ireland
2Integrated Care Programme, Dublin, Ireland
3University Hospital Waterford, Waterford, Ireland

Background: The development of an Integrated Care Hub has resulted in a complete review of the triage system for older people referred to our service. Our aim was to develop a multidisciplinary triage process (MTP) to ensure patients are seen by the right person at the right time for a First Contact Assessment (FCA).

Methods: A quantitative retrospective analysis of referrals and frequency of multidisciplinary team input from January 2018 – June 2018, highlighted the majority of patients were seen by FCA by the staff nurse. This subsequent analysis was then reviewed and resulted in onward referrals to Allied Health Professionals within the ‘Hub’, and patients attended for multiple visits. A working group was formed to address these issues. This resulted in the development of the MTP where patients are triaged by the Multidisciplinary team (MDT) and allocated to the most appropriate team member based on the referring information. Following the introduction of this triage process, data analysed from November 2018 - April 2019 highlighted its impact on our service.

Results: In the first reference period the proportion of patients seen for FCA by each discipline was as follows; Staff nurse (SN) 53%, Clinical Nurse Specialist (CNS) 18%, Occupational Therapist (OT) 16% and Physiotherapist 9%. In the second reference period the proportions changed to the following; SN 12%, CNS 31%, OT 33%, Physiotherapist 20% and Dietitian 4%. It has reduced the number of patient visits to the ‘Hub’ and the waiting time to see the right person within the team.

Conclusion: Empowering supported MDT’s members to triage and the use of this new MTP has resulted in patients having rapid access to the most appropriate team member for FCA. It has resulted in a change in the distribution of the caseload to ensure patients are seen by the right person within the team, and at the right time for early patient centred intervention.

A NEW WAY OF MEMORY CARE IN AN INTEGRATED CARE HUB

Catherine Murphy1, John Cooke, Riona Mulcahy, George Pope, Maggie Bolger, Suzanne Roche, Mícheál Ó Gorman1, Jacinta Brennan, Niamh Phelan, Emma Grant, Marie Doyle
1WICOP University Hospital Waterford, Waterford, Ireland

Background: The Occupational Therapy (OT) service in the integrated care HUB team was established in January 2018. Prior to this, there was an established memory clinic, however with inconsistent access to OT. The streamlining and structuring of memory clinics further highlighted the need for pre-diagnostic support for example individual sessions focusing on memory education and practical strategies to enable independence in daily activities. The integration of OT enabled person-centred strategies to be provided to individuals experiencing memory loss.

Methods: A retrospective analysis was completed comparing the number of OT memory pathway contacts between January to June 2018 and November 2018 to April 2019 also reflecting the memory care pathway developed during this period. OT assessed all new patients experiencing memory difficulties that impacted on functional activities to initiate referral process. In April 2018, the Memory Technology Resource Room (MTRR) opened and the OT HUB using to facilitate patient contacts. The design/implementation of cognitive rehabilitation groups in May 2018 added another step to pathway. Dementia cafes were established in public cafes in the city and county area, sponsored by local care provider, also supported by HUB team. Feedback was gathered from surveys given to individuals, carers and HUB team in the Cafe and MTRR.

Results: From January to June 2018 there were 50 memory streamed patient contacts completed by the OT. From November 2018 to April 2019, 206 patient contacts were completed. These include both individual and group cognition focussed sessions. Positive qualitative feedback was retrieved from attendees to MTRR and Cafe all indicating at least one positive outcome from post-diagnostic supports and services.

Conclusion: A multi-domain cognitive OT service when initiated by an integrated care HUB proves to be an effective and acceptable memory care pathway. The development of this holistic pathway enabled the person to be seen in the right place, at the right stage of their journey with memory difficulties.

ADVANCE CARE PLANNING: PERSPECTIVES OF PEOPLE WITH DEMENTIA AND THEIR FAMILY MEMBERS

Diarmuid Ó Coimín1, Liz Ferguson1, Cliona Beaumont1, Sheighle Sheridan1, Lorraine Byrne1
1 Mater Misericordiae University Hospital, Dublin, Ireland
2University College Dublin, Dublin, Ireland

Background: Clear and effective communication is central to all aspects of healthcare. Discussions centred on advance care planning are vital to ensure the person with dementia receives the support and care they need in the future based on their will and preferences. The aim of this study was to ascertain from those provided with information on advance care planning if they perceived the support and care they needed.

Methods: This study centred on eliciting the views of older persons diagnosed with dementia and their carers on the provision of an information booklet titled ‘I have dementia ... How do I plan for the future’. Ethical approval was sought and provided to conduct this study. Participants presenting to an acute hospital day ward for older persons were identified and recruited through the medicine for older person’s team. 42 people consented to participate with 20 people returning questionnaires, a 48% response rate. Thematic analysis was applied to qualitative comments and descriptive statistical analysis was undertaken with quantitative data.

Results: The overwhelming majority (95%) of respondents found the provision of an information booklet on advance care planning helpful. Nearly two thirds (65%) spoke with someone about advance care planning thereafter. 60% of all respondents reporting that the booklet was either ‘easy’ or ‘very easy’ (40%) to understand. Participants strongly endorsed the provision of information on advance care planning and the benefits that it bestowed to them.

Conclusion: The study has confirmed the importance of communication and the provision of information on advance care planning for people with dementia and their carers in the day ward setting for older persons. Findings strongly endorse the information provided whilst also suggesting minor amendments to the booklet to improve future editions.

INTEGRATED DAY HOSPITAL FOR OLDER PERSONS IN A PRIMARY CARE CENTRE

Fiona McGrath1, Sarah Ranayne1, Karen MackHugh1, Mary McDonnell1, Eismari Mutaz1, Tom O’Malley1
1Mayo University Hospital, Castlebar, Ireland

Background: To progress with integrated care, for older persons, it was proposed to establish a Day Hospital in a Primary Care Centre. Population data for Co Mayo shows the percentage of those over 65 years, (17.6%), to be significantly higher than the national average In 2018 there were 39,092 attendances to the Emergency Department and approximately 500, per month, were over 75 years.

The aim was to develop a pathway from the Emergency Department to the Day Hospital for those 75 years and over who had experienced a fall. Additionally, this included an Early Supported Discharge for hip fracture patients.

Methods: The Day Hospital was operational 1 day per week with an allocation for a Consultant, Occupational Therapist and assigned Project Manager. Holter and Blood pressure monitoring equipment was purchased. The Home First Team were reassigned to the front door of the hospital and worked with a cANP and a Medical Registrar. A weekly multi-disciplinary forum, inclusive of all stakeholders, developed working relationships, built a shared vision and standardised the approach for the patient cohort.

Frailty training was provided specifically to Emergency Department staff.

Results: The Home First Team saw 541 patients (Jan-Apr 2019). 428 in collaboration with the Geriatrician streamed those suitable for management to primary care. The Integrated Day Hospital, 1 day per week (Jan-Apr 2019) delivered 55 new assessments plus follow-up appointments.

Conclusion: Creating a pathway for people in primary care is an innovative approach and shifts the focus of intervention from acute to primary care. The location is ideal due to a range of disciplines on site, PHN, Dietetics, Psychiatry. This is the initial phase, with some pathways in place, and the overall aim is to provide GP access to rapid assessment in Primary Care and thus ensure hospital avoidance where possible.

SWALLOWING/COMMUNICATION SCREENING IN OLDER ADULTS ATTENDING THE EMERGENCY DEPARTMENT AND ASSOCIATION WITH CLINICAL FRAILTY SCALE SCORES

Orla Boyle1,2, Louise Kelly1, Maeve Ryan1, Deirdre Brady1, Ruth Wade1, Catriona Wheleh1, Orishta Deherty1, Maeve Murphy1, Sarah Melia1, Paul McElwaine1, James Gray1, Sean Kennelly1, Derek Hayden1
1Department of Speech and Language Therapy, Tallaght University Hospital, Tallaght, Dublin 24, Ireland
2Department of Age Related Healthcare, Tallaght University Hospital, Tallaght, Dublin 24, Ireland
3Health and Social Care Professions Manager, Tallaght University Hospital, Tallaght, Dublin 24, Ireland
4Department of Emergency Medicine, Tallaght University Hospital, Tallaght, Dublin 24, Ireland

Background: Dysphagia, frailty and negative patient outcomes are interlinked. Changes in communication may result from the ageing process, chronic conditions, and/or neurologic conditions presenting in later years. However, unlike other cohorts, including stroke, frail older patients are not routinely screened for swallowing/communication difficulties in acute settings. We investigated the proportion of Speech and Language Therapy (SLT) referrals generated for older patients attending our Emergency Department (ED) following use of a swallowing/communication screening tool and their association with Clinical Frailty Scale (CFS) scores.

Methods: A retrospective analysis of data collected over a four week period was completed. Older patients presenting to ED were screened by the interdisciplinary gerontology ED team using a screening tool, including a locally developed swallow/communication screen. Statistical analyses were performed using STATA Version 12.

Results: Of 176 patients screened (mean age 81.8 years, SD 5.9 years), median CFS score was 5 (IQR 3.60). Thirty-seven percent (61/176) of patients were referred for SLT assessment following initial screen. SLT referrals were more commonly required in patients with a CFS
score of ≥4 (46.2% vs 19.3%, P=0.001) and likelihood of requiring SLT referral increased with greater GFS score (P<0.0001).

Conclusions: Results suggest that screening for swallowing and communication difficulties in older patients yields a high level of SLT referrals, with a higher frequency of SLT referrals observed with increasing frailty scores. Further research is required to determine the optimum swallowing/communication screening tool in the acute setting. Future research will focus on evaluating outcomes of SLT assessments completed and determining the prevalence of swallowing and/or communication difficulties in this cohort.

References:

Abstract

The introduction of in-house radiographers out of hours has led to a quicker transition of patients from the Emergency Department to the CT department thus reducing the median time spent in the Emergency Department times prior to CT imaging. To assess the impact of the introduction of in-house radiographers out of hours we compared door to CT times of FAST positive patients who presented to our Emergency Department. Stroke is a medical emergency where urgent assessment and treatment can lead to improved survival and reduced disability.

Methods: To assess the impact of the introduction of in-house radiographers out of hours we compared door to CT times of FAST positive patients who presented to ED out of hours pre and post the introduction of in-house radiographers. We took the first 30 FAST calls following the introduction of the in-house radiographers and compared those times to the last 30 FAST calls prior to their introduction.

Results: Preliminary results have shown that the introduction of in-house radiographers has reduced the median time spent in the Emergency Department times prior to CT imaging. Current median door to CT times prior to the introduction of in-house radiographers was 27 minutes, the median door to CT time post introduction of in-house radiographers is 21 minutes, however full results are still awaited.

Conclusion: The introduction of in-house radiographers out of hours has led to a quicker transition of patients from the Emergency Department to the CT department thus reducing door to CT times.

Abstract

Background: Stroke is a leading cause of death and disability in Ireland with up to 7,000 people hospitalised following a stroke annually (HHP/HSE 2016). Every minute in which a large vessel ischaemic stroke is left untreated equates to the average patient losing 1.9 million neurons (Saver, 2006). With the introduction of out of hours in-house radiographers our aim was to look at how this impacted on the service of care to FAST positive patients who present to our Emergency Department. Stroke is a medical emergency where urgent assessment and treatment can lead to improved survival and reduced disability.

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Conclusion: The introduction of in-house radiographers out of hours has led to a quicker transition of patients from the Emergency Department to the CT department thus reducing door to CT times.
Methods: This was a point prevalence observational study of patients aged >65 years residing in three HSE-run LTC facilities in Cork. Demographic characteristics, medical diagnoses and medication regimes at time of admission (TOA) to LTC, and time of data collection were recorded and reviewed using STOPP/PR and NORGEP-NH criteria.

Results: 98 patients met the inclusion criteria, with 66% being female. The median age was 83 years (IQR 77-88 years), and median length of stay was 31 months (IQR 14-53 months). The median number of medications per person on admission was 8 (IQR 6-11), which increased to 9 (IQR 7-11) at time of review (TOR) (p<0.001). PIP was found in 70 (84.3%) patients at TOA, and 79(80.6%) at TOR using STOPPP/PR, and was recorded as 81 (97.6%) at TOA, and 95(96.9%) at TOR using NORGEP-NH. Among the STOPP/PR criteria most commonly implicated were antipsychotics. The NORGEP criteria most commonly implicated were antipsychotics and antiparkinsonian agents. There was an increase in number of patients prescribed benzodiazepines, z-drugs, anti-depressants and anti-psychotics from TOA to TOR, while statins were prescribed less often at TOR (p<0.001).

Conclusion: Potentially inappropriate prescribing is highly prevalent in older residents of community hospitals using validated prescribing indicators. Criteria such as those used in this study could be used to highlight potentially inappropriate or futile medications in older, vulnerable patients. Regular medication review is recommended to facilitate deprescribing of such medications.

ADVANCE PHYSIOTHERAPY COMPETENCE IN DEMENTIA: A SERVICE DEVELOPMENT INITIATIVE

Claire Jones
Kerry Hospice, Dublin, Ireland

Background: Older adults are among the most frequent of health service users and often require physiotherapy input. Since the prevalence of dementia rises with age, physiotherapists regularly treat older adults with dementia in the acute setting. However, advancing competence in the area of dementia care represents a significant cultural shift for physiotherapists working. Physiotherapists are in a unique position to support the person with dementia in the acute care setting.

Methods: A learning needs analysis was conducted within a physiotherapy department in an acute, level three hospital. An educational programme was subsequently designed and delivered over six weeks. The programme aimed to equip physiotherapists with both the knowledge and skills to best support the person with dementia in the acute care setting.

Results: There was no difference in Pain scores between groups (P=0.98). 100% of respondents felt that undergraduate training did not sufficiently prepare them to work with adults with dementia. As a result of the educational programme, 100% of participants reported increased competence when treating adults with dementia and a subsequent positive impact on physiotherapy practice. 88% of respondents agreed that ongoing professional development in this area of dementia care would be beneficial and 100% reported that they would recommend the educational programme to a colleague.

Conclusion: The changing landscape of healthcare delivery has opened up new ways of working. Physiotherapists are in a unique position to support the person with dementia in the acute care setting. Participants of this educational programme demonstrated high motivation to advance their knowledge and skills in the area of person-centred dementia care.

THE IMPACT OF A PALLIATIVE CARE ECHO PROGRAMME ON SYMPTOM SEVERITY SCORES AND PHASES SCORE IN A NURSING HOME POPULATION

Claire Murphy1,2, Una Molloy2, Sarah McLean2, Daniel Ryan1
1 Tallaght University Hospital, Dublin, Ireland
2 St. Francis Hospice Raheny, Dublin, Ireland

Background: In Ireland most deaths occur in acute hospitals however 20% of deaths occur in residential facilities. Less than 30% receive specialist palliative care input. ECHO (extension for community healthcare outcomes) is a palliative care education programme consisting of a 10 part lecture series. Twenty nursing homes and 353 staff participated. A phases score is a 5-point rating scale classifying the status of a palliative care patient ranging from stable to bereaved.

Methods: Data collected by palliative care professionals from September 2017 to December 2018 was analysed. This included demographic features, a phases score and scores for pain, carer stress, spiritual and psychological need. Nursing homes that attended > 3 ECHO sessions were excluded. 15 participating nursing homes were included. Analysis performed was a univariate analysis comparing the phases scores and pain scores between TOA and TOR.

Results: There were 40 patients in the intervention group and 80 in the control group. Mean ages were 83yrs and 82yrs respectively. Palliative care referral numbers did not change significantly between the two groups (111 and 114). The Phases score was significantly reduced in the ECHO group compared to controls (P-=0.007). There was no significant reduction in the phases score in the phases scores in the ECHO group pre and post intervention (P=0.29).

Conclusion: The ECHO intervention led to a reduction in the overall phases score in participating nursing homes. This was not the result of increased palliative care referrals. We would infer it is a reflection of better control of symptoms overall. We did not find a significant reduction in individual symptoms. The phases score is an overall representation of a patient’s status. With the expansion of the ECHO programme on-going analysis will be performed.
SETTING BONES AND GETTING HOME: THE IMPACT OF A “I WANT TO BREAK FREE”: HARMING OLDER PATIENTS
ASSISTED DECISION MAKING (CAPACITY) ACT 2015:

We evaluated the integrated care team referral database as well as discharge letters from July to November 2018.

Results: Over 5 months, 45 out of approximately 90 referrals were deemed appropriate for the ICT. Almost half of referrals were unusable because of medical acuity or specific instructions such as being unable to weigh-beat. Over half of referrals came from the emergency department with no referrals from general surgery, orthopaedics or cardiology. During the time of review, the service was operating at <85% capacity. There is no specific registrar assigned to review ICT referrals. The service is expanding with 123 referrals in six months, compared to 54 in the same period the previous year.

Conclusion: The integrated care team helps older adults to avoid hospital admission, return home sooner and regain independence and is a much-appreciated service in the area. We identified shortcomings in the referral process, formal medical oversight and awareness of the service in areas where it could provide the most value. The ICT can expand as a key asset for frail older adults if supported by the necessary resources, staffing, consultative geriatrician leadership, referral criteria and pathways and is promoted and publicized in the clinical settings where it has the greatest potential for benefit.

METHODS: Data was prospectively collected on all hip fracture patients seen by the Orthogeriatric service from Aug 2018-Feb 2019 and was retrospectively compared with patients admitted with hip fractures from Aug 2017-Feb 2018. We examined KPIs including LOS on the orthopaedic ward, rehab admissions, rehab LOS, new nursing home (NH) admissions. We compared the proportions discharged directly home instead of to convalescence, and conducted a preliminary cost benefit analysis.

Results: Similar numbers of patients were seen in each time period (n=146 v n=139). Mean reduction in LOS on the orthopaedic ward was 3.5 days (15.5 days vs 19 days). The proportion of patients admitted to rehabilitation increased from 8.8% to 17.5% (p = 0.02). Patients got to rehabilitation faster and for those patients who availed of rehabilitation they had significantly shorter total length of stays (51.1 days v 71.6 days, p = 0.029). Fewer patients went to convalescence. Although not statistically significant there was a trend towards an increased proportion of patients discharged directly home (32.7% v 43.6%) and less new nursing home admissions (6.8% vs 8.4%). A cost benefit analysis incorporating shortened acute and rehab LOS and a reduction in spending on convalescence resulted in a projected saving of €480,390 over a six month period.

Conclusion: Introduction of OrthoGeriatric services has improved care for older people with hip fractures and has resulted in positive improvements to KPIs, resulting in mean- ingful improvements in clinical outcomes for patients in a cost effective manner. Monies saved should be redirected into further developing orthogeriatric services.


ASSISTED DECISION MAKING (CAPACITY) ACT 2015: EMBRACING THE PARADIGM SHIFT

Mary Walsh, Aiden Lawlor
Health Service Executive, Dublin North West, Ireland

Background: In a conference 2018, Senator Kelleher said she concurred with the statement describing ADMA “... as a paradigm shift. ... a major, major culture shift which has yet to work through our societal systems.”...1(1) In 2016, a senior and manager speech and language therapist (SLT) won the Dementia Innovation Award with the project “Empowering Persons with Dementia to Become More Active Participants in Decision Making Related to Their Present and Future Needs”. The IASLT Position Statement on the role of the speech and language therapist (SLT) in assessing Capacity and Facilitating Understanding to Support Decision Making for Adults with Communication Disabilities 2017 names training others in assisted decision making as a key SLT role. Talking Mats (TM) (2) may help address some training issues outlined. TM is discussed in NICE-Capacity and Decision Making Guidelines 2018. The Phase 1 project outlined recommends progression to Phase 2.

Methods: In 2018, the senior SLT trained SLTs working professionally with people with dementia across different service settings. They made a prior commitment to attend and complete course one and to trial TM with people with dementia.

Results: The Phase 1 report Dec 18 contains 16 brief case studies. Some initial findings:

• Facilitates strengths rather than deficits.
• Helpful for assisted decision-making when listeners are trained.
• Pictures help maintain attention and comprehension.
• Pictorial record of photographed TM viewed very positively, particularly for meetings.
• Video recording sessions, with consent, greatly enhances reflective practice.
• It helped address the unmet needs of one person with dementia who presented with reactive behaviour.

Conclusion: Talking Mats was strongly endorsed by all participants. Recommendations in Phase 1 report 2018 included progressing to Phase 2 i.e. training the six SLTs to become TM trainers and commence cascading through the system. We are currently awaiting funding approval.

References:

1. Law Society’s 16th Annual Rights Conference 2018
2. www.talkingmats.com

“FROM SIAD TO HAPPY”: A CASE OF EFFECTIVE USE OF Tolvaptan FOR HYponATREmia IN AN OLDER PERSON

Maria Costello1, Christine Newman1,2, Elaine Loughlin3, Michelle Canavan4, Marcia Bell1, Stephanie Robinson2
1 Centre for Diabetes, Endocrinology and Metabolism, University College Hospital Galway, Galway, Ireland
2 Department of Geriatric and Stroke Medicine University College Hospital Galway, Galway, Ireland

Background: Hyponatremia commonly affects the older person, leading to morbidity and mortality. Tolvaptan use is rare in this cohort, but may have benefit in select cases of syndrome of inappropriate antidiuresis (SIAD).

Methods: An 84-year-old gentleman presented with a history of increasing confusion, fatigue and lethargy attributed to symptomatic hyponatremia. He had background of a recent prolonged admission with small bowel obstruction, treated conservatively. That hospital course was complicated by hypovolaemic hyponatremia, sepsis and clostridium difficile colitis. On this admission, he had no clinical symptoms or signs of infection and his septic screen was negative. He had a Rockwood clinical frailty scale score of 7. His biochemical abnormality was a persistent hyponatraemia of 129 mmol/L. Clinically, he was euvoalaemic. Further biochemical work up revealed serum osmolality of 263 mmol/kg, serum urea of 6.3 umol/L, urine sodium 108 mmol/L and urine osmolality 541 mmol/kg. Thyroid function, cortisol, and HbA1c were normal. CT brain and chest x ray were unremarkable. A diagnosis of SIAD was made. Fluid restriction was ineffective and Tolvaptan (a selective non-peptide arginine vasopressin receptor antagonist) was commenced on consultation with Endocrinology.

Results: With initiation of Tolvaptan there was significant clinical improvement. Sodium normalised to 134 mmol/L. He became alert, less confused and more engaged with the multidisciplinary team. He was discharged home well, and on follow up four months later, his clinical frailty scale score was 4 with significant improvement in his mobility on continued Tolvaptan therapy. An underlying colonic neoplasm is the clinically suspected driver of his SIAD but he is declining further investigation at present.

Conclusion: This case reflects the positive benefits of careful selected use of Tolvaptan in the older population with refractory SIAD, resulting in improved functional status and quality of life.

I WANT TO BREAK FREE”: HARMING OLDER PATIENTS THROUGH RESTRAINT, ISOLATION AND TETHERING

Sarah Heywood, Donal Fitzpatrick, Kate Doyle, Ger Finn, Paul Gallagher
Cork University Hospital, Cork, Ireland

Background: The older inpatient population is a particularly frail cohort with high rates of delirium, falls and immobility. These patients require skilled gerontological nursing with high levels of supervision. Despite this, restraints such as bed rails continue to be common. Tethering through intravenous drips and urinary catheters are another form of restraint.

Methods: We performed a chart review and a bedside observation of patients aged ≥75 on medical wards admitted for ≥72 hours. We excluded patients who were critically unwell or imminently dying. We used the open source software package PSPP to complete the statistical analysis.

Results: We reviewed 100 patients, of whom 25 were restrained in some way (most commonly by bed rails 80%), 10 were tethered (through intravenous drips, oxygen tubing, urinary catheters and others), 7 were in isolation for infection control reasons. Restraint was associated with greater dependence in mobility and function, reduced time out of bed (Mann Whitney, P < 0.05), delirium and incontinence (chi square, p < 0.05). Isolation was associated with greater physical dependence (Mann Whitney, P ≤ 0.05), and tethering was associated with incontinence (chi square, p = 0.05). The relatively low number of isolated and tethered patients reduced the power of the study. 50% of patients with a urinary catheter did not have a clear indication and only 14% of catheterised patients had leg bags

Conclusion: Patients who are restrained are clearly frailter, more dependent, spend more time in bed, have higher rates of delirium and incontinence. These are particularly

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THROUGH RESTRAINT , ISOLATION AND TETHERING

Sarah Heywood, Donal Fitzpatrick, Kate Doyle, Ger Finn, Paul Gallagher
Cork University Hospital, Cork, Ireland

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AN AUDIT OF DOCUMENTATION OF RESUSCITATION STATUS IN A TEACHING HOSPITAL
Anna McDermough, Shane O’Hanlon
St. Columb’s Hospital, Dublin, Ireland

Background: The documentation of discussions about resuscitation status with patients and their relatives is an important part of medical care, but can be a time-consuming process. These discussions may be difficult, particularly for patients who have cognitive impairment and are acutely unwell. The National Consent Policy recommends that resuscitation decisions should be made with patients themselves, or with family members if the patient cannot participate. It also recommends decisions are made by the most senior decision maker with responsibility for the patient’s care and discussions should be carefully documented.

Methods: The charts of all 106 inpatients in our hospital were audited on a single day. Documentation of resuscitation status in the medical and nursing notes was reviewed.

Results: The average age of inpatients was 79.8 years. 25.5% of patients had a DNACPR order. Of these, 92% had their DNACPR status documented in the nursing notes. 100% had a DNACPR form in their medical notes but none were fully completed. 48% had not had the decision endorsed by the consultant in charge of the patient’s care. 74% had not been discussed with the patient or had not had a reason documented as to why the decision had not been discussed. 41% did not have any discussion documented in the medical notes.

Conclusion: The DNACPR form in use includes the details recommended by national guidelines but these forms are not being completed in their entirety. Discussions with patients themselves are possibly inappropriate at the time resuscitation status is being considered, but documentation of the reasons for this is still important. This, in particular, is an area which needs to be highlighted to medical staff in our hospital. Results of this audit will be incorporated into an education session, with a view to changing practice.


POINT PREVALENCE OF FRAILTY AND CONFUSION EXCEEDS THE CAPACITY OF A SINGLE WARD - SPECIALIST GERIATRIC WARD LEADS TO BEST PRACTICE
Desmond O’Donnell, Anne O’Mahony, Alice O’Donoghue, Claire McMahon, Marie Doyle, Mille O’Gorman, Riona Mulcahy, George Pope, John Cooke
University Hospital Waterford, Waterford, Ireland

Background: Our Model 4 Hospital will open a Specialist Geriatric Ward in the coming months. This ward will focus on the provision of evidence-based care to confused and frail older adults. Careful selection of patients who would most benefit from this care will be vital to ensure success. We aim to determine the prevalence of frailty and confusion in our inpatient cohort to determine expected demand on this new service and to inform admission criteria.

Methods: All adult inpatients were screened for frailty (pre-admission status >16 years of age), with the exclusion of obstetric, paediatric, critical care and psychiatric wards. Prevalence was calculated by measuring CFS scores on all adult inpatients of the current audit. The point prevalence of frailty (CFS Score ≥ 5) was 39.9%. The point prevalence of confusion (4AT score ≥ 24) was 24.4%.

Conclusion: Our data show that frailty and delirium are highly prevalent in hospital inpatients. It is not feasible for this number of frail and confused patients to be cohorted in a single specialist area. It is therefore important that each hospital determine admission criteria to identify those at greatest need. Clearly, given the prevalence outlined here, there will be a large number of patients likely to benefit from but unable to access a Specialist Geriatric Ward. These wards therefore need to also serve as exemplars of best practice so that evidence-based care for this vulnerable cohort can be disseminated within an institution.

DELIRIUM INCIDENCE IN HIP FRACTURE PATIENTS: AWARENESS ON THE ORTHOPAEDIC WARD
Rebecca Jeanne Bermingham, Paul McLaughlin, Helen O’Brien
Our Lady of Lourdes Hospital, Drogheda, Louth, Ireland

Background: Postoperative delirium is a serious neuropsychiatric condition that occurs in up to 65% of hip fracture patients(1). However, it remains poorly recognised as a postoperative surgical complication despite its association with increased mortality, longer length of stay (LOS), cognitive decline and increased risk of discharge institutionalisation.

Methods: As part of the delirium audit, all hip fracture patient notes were reviewed from Oct-Nov 2017 pre-implementation of an Orthogeriatric Service and Oct-Nov 2018 post-implementation. Documentation of delirium or use of the terms ‘new confusion, altered attention, change in behaviour’ in the orthopaedic, orthogeriatric and allied health professional notes were reviewed. The 4AT was used to routinely screen for delirium in the pre- and post-operative period by the Orthogeriatric team(1).

Results: The number of patients in 2017 group was 24, mean age 78, female 76% compared with 25 in the 2018 group, mean age 75.9, female 81%. In 2017, delirium was diagnosed in 4% of patients by the Orthopaedic surgeons and 37.5% by Allied Health Professionals. In 2018 delirium was diagnosed in 4% by the Orthopaedic surgeons, 40% by Allied Health Professionals and 44% by the Orthogeriatrics team in 2018. Pre-operative delirium occurred in 16% of patients and postoperative delirium occurred in 44% of patients in 2018. A clear delirium management plan was documented in 0% of charts in 2017 vs 100% in 2018. LOS in 2017 was 12.7 days vs 12.4 in 2018. However, discharge location varied greatly with 33.3% discharged to convalescence in 2017 versus 19% in 2018, 12.5% to Long term care in 2017 versus 4% in 2018, 20.8% to rehabilitation in 2017 vs 52% in 2018 and 16.7% home in 2017 vs 24% in 2018.

Conclusion: Prompt diagnosis and management of delirium is essential in optimising postoperative cognitive function and preserving independence. Our study highlights the need for routine delirium screening and improved awareness of delirium amongst all healthcare professionals.

A CLINICAL AUDIT OF DETECTION AND MANAGEMENT OF SARCOPENIA: REHABILITATION SERVICES IN AN ACADEMIC TEACHING HOSPITAL
Sarah O’Callaghan, Siobhán Quinn, Emer O’Dowd, Emma Fox, Rebecca Madden, Carina Sheridan, Patrick Hogan, Seán Kennedy,1,2 1Department of Age-Related Health Care, Tallaght University Hospital, Dublin, Ireland 2Department of Medical Gerontology, Trinity College Dublin, Dublin, Ireland

Background: Sarcopenia, characterised by progressive loss of muscle mass and strength, is associated with increased morbidity, mortality and poorer quality of life. International and European clinical practice guidelines on diagnosis and management of sarcopenia suggest the algorithm: Find Cases through screening, Assess Strength with validated outcome measures, Confirm Diagnosis with muscle quantity analysis and Determine Severity with validated physical performance measures (PPMs). Treatment recommendations include progressive resistance training (PRT) and a protein-rich diet. This audit aimed to investigate our specialist gerontological services’ adherence to these guidelines.

Methods: Using a custom-designed audit tool, patient medical records (PMRs) were reviewed in two inpatient rehabilitation wards and one Day Hospital (DH). Patients were included if under the care of a geriatrician and reviewed two or more times by a physiotherapist.

Results:Thirty PMRs were reviewed (18 DH, 12 inpatient). 0% of patients were screened for sarcopenia using a validated screening tool. 83.3% (n=15) of DH patients and 33.3% (n=4) of inpatients undertook a validated strength assessment. 0% of patients undertook muscle quantity analysis. 66.6% (n=12) of DH patients and 33.3% (n=4) of inpatients had valid PPMs performed. Probable sarcopenia was identified in 75% of DH and 100% of inpatients who had PPMs conducted. PRT was prescribed in 94% (n=17) and 50% (n=6) of DH patients and inpatients respectively. 16.6% (n=3) of DH patients and 75% (n=9) of inpatients were prescribed a high-protein-high-calorie diet.

Conclusion: This audit demonstrates limitations in identifying and managing sarcopenia as per the most recent international and European clinical practice guidelines. It is recognised that a multi-disciplinary approach is required to improve adherence to these guidelines. A multi-disciplinary sarcopenia management pathway is to be implemented to facilitate this. Re-audit is planned to ensure the effectiveness of this pathway.

ANTIPSYCHOTIC MEDICATION IN THE MANAGEMENT OF NON-COGNITIVE SYMPTOMS OF DEMENTIA: AN UPDATED EVIDENCE REVIEW
Siobhán Fox1, Ashling Murphy2, Aisling Jennings2, Kieran Murphy1, Suzanne Timmons1 1Centre for Gerontology and Rehabilitation, University College Cork, Cork, Ireland 2School of Nursing and Midwifery, University College Cork, Cork, Ireland

Background: Antipsychotic medications are commonly used in the management of non-cognitive symptoms of dementia (i.e., agitation, delusions, hallucinations, and aggression). This is despite increased recognition of adverse effects, including mortality, from these medications for people with dementia. The current aim was to review the most recent evidence for the efficacy and safety of antipsychotic medications in the management of non-cognitive symptoms of dementia.

Methods: Relevant studies published in English from March 2015 through to March 2018 were identified by searches of 5 databases: Medline, EBSCO, PsycINFO, Cochrane DARE, and Cochrane CENTRAL. Systematic reviews, meta-analyses, and controlled trials evaluating the safety of antipsychotic medication, or comparing antipsychotic medication with placebo, another antipsychotic medication, or non-pharmacological intervention, were included. Independent article review and data extraction was performed by two reviewers. Study quality was appraised using the Joanna Briggs Institute critical appraisal tools.
**Results:** Thirteen studies were included. Benefits and harms vary among antipsychotic medications for people with dementia; however overall efficacy of antipsychotics remains modest at best. A significant number of side effects are associated with antipsychotics, not least cerebrovascular events, sedation, gait disturbances, falls, fractures, uterine tract infections, cognitive worsening, and mortality. Atypical antipsychotics have a more favourable safety profile in some respects. People with certain dementias, notably Lewy Body Dementia, may experience more severe side effects.

**Conclusion:** The evidence reinforces caution when prescribing antipsychotic medications for people with dementia; these medications should only be considered when symptoms are severe or non-pharmacological interventions have failed. Clinicians should closely monitor people with dementia who are prescribed an antipsychotic for side effects, limiting use of these medications to short-term treatment if possible. The forthcoming national clinical guideline for appropriate prescribing of psychotropic medications for non-cognitive symptoms will support clinical decision-making in this regard.

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**Results:** Of 47 patients (33 female), average age was 79.8 years and median BMI was 25. Of 47 patients, 77% of patients drove before their stroke. 74% of these reported that they were advised not to drive post-stroke. Of these, 74% correctly identified all the risk factors they had been diagnosed with, including atrial fibrillation, hypertension, hypercholesterolaemia and carotid stenosis. 70% of patients reported receiving education in hospital post-stroke. Of these, 13% received written information. 30% of patients were shown their brain scan and the majority (89%) found it beneficial. 71% of those who did not see their scan would have liked to. 52% reported knowing which medications had been started post-stroke but only 23% of patients listed new medications correctly. 43% of patients felt they did not receive enough information about new medications and 27% reported either sometimes or frequently missing medications. 77% of patients drove before their stroke. 74% of those reported that they were advised not to drive post-stroke. Of these, 35% correctly identified how long they were advised not to drive for. Only 26% of those driving before their stroke had driving advice in their discharge letter.

**Conclusion:** These results illustrate areas in which we can improve education post-stroke, including ensuring patients receive individualised information about the aetiology of their stroke, risk factors and the importance of new medications. It also highlights the importance of ensuring advice regarding driving is clearly explained and documented.

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**Results:** Thirty consecutive patients attending stroke clinic completed a questionnaire, including questions regarding aetiology of their stroke, medications started, driving and education received as an inpatient.

**Conclusion:** The thirty patients were a median of 16 months post-stroke. One had a haemorrhagic stroke, all others ischaemic stroke. Only 53% correctly described the type of stroke they had. 50% correctly identified all the risk factors they had been diagnosed with, including atrial fibrillation, hypertension, hypercholesterolaemia and carotid stenosis. 70% of patients reported receiving education in hospital post-stroke. Of these, 13% received written information. 30% of patients were shown their brain scan and the majority (89%) found it beneficial. 71% of those who did not see their scan would have liked to. 52% reported knowing which medications had been started post-stroke but only 23% of patients listed new medications correctly. 43% of patients felt they did not receive enough information about new medications and 27% reported either sometimes or frequently missing medications. 77% of patients drove before their stroke. 74% of those reported that they were advised not to drive post-stroke. Of these, 35% correctly identified how long they were advised not to drive for. Only 26% of those driving before their stroke had driving advice in their discharge letter.

**Conclusion:** These results illustrate areas in which we can improve education post-stroke, including ensuring patients receive individualised information about the aetiology of their stroke, risk factors and the importance of new medications. It also highlights the importance of ensuring advice regarding driving is clearly explained and documented.

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**Results:** Of 79 consecutive admissions to an acute geriatric ward was carried out. Data was collected over a 3 week period in an Irish model 3 hospital. The following information was obtained from medical records: 1) Previous diagnosis of delirium/dementia 2) Documentation of a diagnosis of delirium 3) Features of delirium 4) Development of delirium as an inpatient 5) Formal screening for delirium 6) Cause and management of delirium 7) Length of stay.

**Conclusion:** This review showed delirium recognition, screening, prevention and management were overlooked to an alarming extent in our cohort of older patients. The next step is introduction of the 4AT screening tool and regular education sessions to increase the awareness of delirium amongst medical teams looking after older patients and improve care and outcomes.
**THE EXPERIENCE OF A DEMENTIA DIAGNOSIS: JOINT SUBMISSION FROM THE IRISH DEMENTIA WORKING GROUP AND THE DEMENTIA CARES CAMPAIGN NETWORK**

Codiagh Whelan, Kathy Ryan, Michelle Rawson

1. The Alzheimer Society of Ireland, Dublin, Ireland
2. The Irish Dementia Working Group, Cashel, Ireland
3. The Dementias Carers Campaign Network, Dublin, Ireland

**Background:** Members of the IDWG and the DCCN have differing experiences of receiving a dementia diagnosis. There is a disparity regarding how the diagnosis is communicated, follow up support and the approach of the clinician making the diagnosis.

**To improve practice members of both self advocacy groups supported by The Alzheimer Society of Ireland collaborated with a GP to create a video targeting health care professionals.**

**Results:** A member of the IDWG and the DCCN will present both the video and their experience of engaging with professionals on this matter.

**Conclusion:** This is the first campaign which the groups have undertaken together and the first which targets Health Care Professionals. As a member of the IDWG (living with dementia) says; ‘for us receiving a diagnosis is not the end of a journey it is the beginning and you can make a huge difference to how that journey begins. The audience at the IGS Conference is a critical one for the self-advocates and they would very much welcome the opportunity to present.’

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**PARTICIPANTS’ EXPERIENCE OF A NOVEL GROUP EXERCISE PROGRAM: RESULTS FROM THE DEFRAIL (Diet and Exercise for Frailty) STUDY PILOT**

Pádraig Bambrick, Niamh Phelan, Thomas Byrne, Clare McMahon, George Pope, Michael Harrison, Rína Burke, John Cooke

1. University of Limerick, Limerick, Ireland
2. University of Limerick, Waterford, Ireland
3. University of Limerick, Galway, Ireland

**Background:** DEFRAIL. (Diet and Exercise for Frailty) is a translational study examining the effect of a four-week multidisciplinary group exercise program and protein supplementation on frailty in older adults. At part of the development of this novel intervention, a four-week pilot was carried out to assess participants’ experience of the program, with a view to optimising the final format.

**Methods:** Inclusion in the DEFRAIL study requires a candidate to be deemed frail as per the Fried criteria. During the initial stage of recruitment for DEFRAIL, any individual who was identified as pre-frail was offered the opportunity to participate in the pilot trial (11 x 1 hour group sessions at a local sporting facility). Following its conclusion, a telephone interview using a standardised questionnaire was conducted on all participants to assess various aspects of their experience.

**Results:** Of 9 participants recruited for the pilot, 7 completed the four-week program (6 of these participants failed to attend any sessions due to difficulties with transport and 1 participant withdrew after the first week, reporting excessive fatigue as the main issue). Only 7 of the 9 participants who had completed the video assessments/assessments during admission 6 (13.2%) of these occurred within 6 hours of admission.

**Conclusion:** In summary while our hospital is succeeding in getting the vast majority of diagnosed strokes into our stroke unit we are not currently meeting the UK target for early swallowing screening. We aim to roll out an education and training programme targeting nurses and doctors in our stroke unit regarding early swallowing screening and re-audit this in 6-12 month’s time.

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**THE ELECTRONIC PATIENT RECORD AS AN ENABLER FOR FLEXIT: GERIATRIC MUSCLE ON THE ORTHOPEDIC WARD**

Clodagh Whelan, Robert Murphy, Aisling Derrys, Balthin Kissane, Ruari Waters, Colin Murphy, Ciara Egan, Shaun O’Keeffe, Eamon Mulkeen, Martin O’Donnell, Thomas Walsh, Fergal Byrne, Sinead Robinson, Michelle Caravan

1. Department of Geriatric Medicine, University Hospital Galway, Galway, Ireland
2. Department of Orthopaedics, University Hospital Galway, Galway, Ireland
3. Department of Physiotherapy, University Hospital Galway, Galway, Ireland

**Background:** Older patients post hip fracture benefit from specialist orthogeriatric care. Best practice tariffs incentivising compliance with the Irish Hip Fracture Standards (IHFSS) have been introduced in Ireland1. We compared levels of compliance to IHFSS before and after introduction of a dedicated orthogeriatric service in a tertiary referral hospital. We also hypothesized that improved continuity of care by regular orthogeriatric review would result in less general medical consultations to medical teams. We looked at the number of inpatient consultations sent for each time period and compared the number of general medical consultations sought by orthopaedic teams for similar time periods.

**Methods:** Data was prospectively collected on all hip fracture patients seen by the orthogeriatric service from Aug 2018-Feb 2019 and was retrospectively compared with patients admitted with hip fractures from Aug 2017-Feb 2018.

**Results:** Similar numbers of patients were seen in each time period (n=146 v n=139) with similar profiles (81.8% v 78.9% females). Improvements were seen in all of the six IHFSS. The most significant improvements were an increase from 31.2% to 96.5% in the proportion of patients seen by a Geriatrician, and an increase from 7.4% to 98.5% in those who had a formal falls assessment.

**Conclusion:** Introduction of an orthogeriatric service has substantially improved compliance with IHFSS. The reduction in the number of medical consultations requested by orthopaedic teams reflects the improved quality and continuity of care for these patients.
TRAINING AND USE OF THE 4AT BY A MULTI-DISCIPLINARY TEAM TO SCREEN FOR DELIRIUM IN THE FRAIL ADULT

Sobhian Ryan, Eamonn Cooney, Karen Sayers, Aine O'Reilly, Jennifer Maher; Karen Sayers, Brian Ó hAonáin, Christina Donnellan, Ivwen Clayle.
South Tipperary General Hospital, Clonmel, Tipperary, Ireland

Background: Delirium risk may improve outcomes. We assessed the prevalence of patients at risk of delirium assessed by a trained interdisciplinary team.

Methods: An interdisciplinary team: dietitian, physiotherapist and speech and language therapist, trained in the 4AT. Community dwelling patients, identified as frail during triage in a hospital emergency department, were assessed including a 4AT, over a 2 month period. Age, gender, Clinical Frailty Score (CFS), 4AT, Modified Barthel index (mBI), polypharmacy (as defined by 5 or more medications) and presence of hearing or visual impairment were entered onto Excel. Performance of the 4AT was at the discretion of the assessor.

Results: 150 consecutive patients were assessed. The mean(SD) age was 83.5(1). Female to male ratio was 1.2:1. Mean(SD) CFS was 5.6(1.2). 29(19%) patients did not have a 4AT performed. 63(42%) patients had a 4AT of 1-3, 16(11%) patients had a 4AT of 4 or greater. 42(28%) had a 4AT of zero. Patients with a 4AT 4 or greater were older, mean(SD) age 86.4(2.4) years. Polypharmacy was present in 10(60%) patients with 4AT 4 or greater and 60%(38%) with 4AT less than 4. 10(60%) patients with 4AT 4 or greater had had hearing and visual impairment. 16(15%) patients with a 4AT less than 4 had hearing and visual impairment. 10(60%) of patients with 4AT 4 or greater had a reduction in mBI. 35(31%) of patients with a 4AT less than 4 had a reduction in mBI.

Conclusion: Interdisciplinary teams can screen for delirium in ED. Frail patients at risk of delirium are older, have higher rates of polypharmacy, visual and hearing impairment and functional decline. It is possible to evaluate delirium in ED. Further work is needed to explore the relationship between the 4AT and frailty.

AN AUDIT OF PATIENT MEDICATION LISTS IN THE OUTPATIENT SETTING

Claire McAteer, Maeve D’Alton, Sarah Farrell, Elaine Dunn, Josephine Soh, Marie O’Connor, Eamon Delan, Siobhán Kennedy, Orla Donohoe, Ciara McGann, Anna Colthorpe.
Connolly Hospital, Dublin, Ireland

Background: Medication Reconciliation involves creating the most accurate list of medications that a patient is taking, with the patient/family member/caregiver being the first point of information. The main aim of this audit was to ascertain what proportion of patients attending outpatient appointments, brought an up-to-date list of their medications.

Methods: The audit was conducted using two anonymous, unlinked questionnaires, one completed by patients/caregivers, another completed by Doctors/Candidate Advanced Nurse Practitioners (cANP). Data was collected between 6/11/18 – 9/11/18 and incorporated Memory Clinics, General Geriatric Clinics and Hypertension/Stroke Clinics. 54 patient questionnaires and 53 Doctor/cANP questionnaires were completed.

Results: 67% of patients reported having an up-to-date list of medications. 62% of doctors/cANP felt the patient had an up-to-date list. The majority of patients were aged 71-80, on 5-10 medications and felt that their GP had the most up-to-date list of their medications. Only 17% of patients reported that they themselves had the most up-to-date list of their medications. Where patients did not have an up-to-date list, Doctors/cANPs compiled a list by phoning the Pharmacy in 50% of cases and referring to previous clinic letters in 38% of cases. 34% of patients had medications changed at their clinic visit.

Conclusion: This audit shows that roughly one third of patients do not bring up-to-date lists of medications to their outpatient appointments and only a small proportion of patients feel that they themselves have the most up-to-date list of their own medications. Suggested areas for improvement are: multidisciplinary patient education, reminder letters/exclusions to patients prior to their clinic appointments and the introduction of a Clinical Pharmacist to the outpatient setting.

INCORPORATING NEUROLINGUISTICS AND THE ROLE OF SPEECH AND LANGUAGE THERAPY IN A SPECIALIST CARE SETTING

Lisa Sheridan1,2, Cathy Mclaughlin1, Josh Doolhy2, Tara Coughlan1,3, Desmond O’Neill1,3, Renan Collins1,3, Dan Ryan1,2, Sean Kennedy1,3
1Speech and Language Therapy Department, Tallaght University Hospital, Dublin, Ireland
2Memory Assessment and Support Service, Age-Related Health Care, Tallaght University Hospital, Dublin, Ireland
3Dept. of Medical Gerontology, Trinity College Dublin, Dublin, Ireland

Background: Speech and Language Therapy (SLT) is recognised as having a unique role in contributing to the overall neuropsychological assessment of people living with dementia and cognitive impairment. The role of the SLT within a memory clinic has become more widely understood. It is now recognised that speech and language characteristics are reported to be amongst the most reliable behavioural markers for distinguishing amongst different dementia subtypes, and specific analysis of a language production and delivery facilitates timely and more accurate diagnosis.

Methods: Patients with a language predominant presentation or those with subjective complaints of speech/language difficulties were referred for SLT assessment through the tertiary memory assessment and support service from January 2018 – March 2019. Assessment of speech and language skills, and overall cognitive communications skills were reviewed, and this information was used to aid with differential diagnosis and contribute to the person’s overall cognitive profile. The SLT attends weekly memory service interdisciplinary consensus diagnosis conference. Data was collected on those patients to observe the profiles of those patients referred to SLT.

Results: 22 patients were seen for full SLT assessment during this period, 13 women, 9 men; mean age 69.5 (range 48-80). Diagnoses include: AD (32%), FTD behavioural variant (14%), Primary Progressive Aphasia (14%), Non-aminergic MCI (18%), Amnestic MCI (14%), Other neurological disorder (8%). 68% of these patients required ongoing SLT intervention for their cognitive communication difficulties following diagnosis.

Conclusion: SLTs fulfill an integral role in supporting both the diagnostic and post-diagnostic pathways of people living with dementia and cognitive impairment attending memory services. SLTs have a unique role and skillset in identifying the specific nature of language difficulties for a person with dementia or cognitive impairment and in reducing the impact of the communication difficulties for the person and for their family members.

AWARENESS OF ENDURING POWER OF ATTORNEY IN A FRAIL OLD POPULATION PRESENTING THROUGH THE EMERGENCY DEPARTMENT

South Tipperary General Hospital, Clonmel, Tipperary, Ireland

Background: Enduring Power of Attorney (EPA) is a simple legal document. A person can choose a specific individual(s) to take care of both personal and financial affairs in the event of losing mental capacity in the future. The objective of this study is to understand what proportion of frail older patients has either an EPA or an awareness of EPA.

Methods: Consecutive emergency department (ED) patients identified as Variable Indicative of Placement (1) positive at triage, were assessed using an interdisciplinary assessment tool (IAT) for 2 months (February 2019 to March 2019). Age, gender, Clinical Frailty Score (CFS) and awareness of EPA were recorded on an Excel database. Simple descriptive statistics were used.

Results: 150 patients with a mean (SD) age of 83.7(1.7) were assessed by the multidisciplinary team. The female to male ratio was 1.2:1. The mean (SD) CFS was 5.3(2.1). 56 patients were asked about EPA. 56 patients were not asked about EPA. 27% (n=14) patients had an EPA in place and one was in the process of making it. 41 patients neither had an EPA nor awareness of EPA. There was no gender difference between groups.

Conclusion: This is the first Irish and international study assessing the awareness of EPA in patients presenting to ED. In this small sample of frail older patients, a quarter of those asked had an EPA. A hospital admission represents an opportunity to discuss future care planning, including EPA. The majority of patients were not asked about EPA by the assessor, as it was felt to be inappropriate at the time. A patient centred approach to introducing these difficult but important discussions needs to be developed.


PATIENT AND CARERS EXPERIENCE OF AN ACUTE CARE AT HOME TEAM: A SERVICE EVALUATION

Deborah Toal1,2, Dr Patricia McCaffrey1
1Southern Health and Social Care Trust, Lurgan, Co Armagh, United Kingdom
2Queen’s University, Belfast, United Kingdom

Background: The Aim of the Acute Care at Home Team is to provide acute care to over 65’s in the patient’s own home, providing assessment and treatment of acute conditions such as pneumonia, urinary sepsis and heart failure. It is a multidisciplinary team that works together to streamline services to enable a patient to stay safely in their own home. A full comprehensive geriatric assessment is carried out in all patients to help improve patient outcomes. The patients have full access to in patient services such as scans, and x-rays. All
blood tests are treated as urgent to ensure the patient is in no way disadvantaged by being treated by acute care at home compared with hospital care.

The aims and objectives are to explore patient and family experiences and identify any areas for improvement. Methods: A service users and carers experience questionnaire (N=31) was used to gain insight into how satisfied the patient or family were with the service and what the experience was like having the team come into their home.

Results: Patient satisfaction with this Acute Care at Home Team was reported at 100%. Patients were happy with the care they received, 100% of patients were happy with staff's knowledge of their condition and treatment plan. All of the respondents stated they would recommend the service and use it again. The qualitative responses were in keeping with 100% satisfaction in that they were positive in nature.

Conclusion: This service evaluation has shown that patient and carer experience of this Acute Care at Home Team is a positive one, with 100% satisfaction levels. There are some small areas to be improved upon, however the results show this service is providing the over 65 population with a good experience of being treated at home as an alternative to hospital care when acutely unwell.

Background: The prevalence of dysphagia rises with age. It is associated with increased dependency and mortality (Smithard, 2016). The Irish Association of Speech & Language Therapists (IASLT) only supports swallowing screening by trained nursing staff post stroke in acute care settings. Further research is required to establish a role with other clinical populations (IASLT, 2016). This study was performed to evaluate the use of a swallowing screening tool by an interdisciplinary integrated team to identify frail older patients who require a clinical dysphagia assessment.

Methods: This was a prospective cohort study (N=177) of patients admitted through an acute hospital emergency department, between November 2018 and February 2019, 70 years or older, in an acute setting, who were identified as frail based on the Variable Indicative of Placement. The number of patients referred to SLT due to a positive swallow screen on CGA, conducted by a trained interdisciplinary team was compared with the number referred by the patient's primary team.

The criteria for dysphagia positive score was to answer yes to any of the swallow screen questions, which were based on risk factors for dysphagia.

Results: Of 177 patients, 47 (26%) screened positive for risk of dysphagia by the interdisciplinary team. Eight, who screened negative for risk of dysphagia, were referred by the patient's primary team. One out of eight who screened negative, required a diet modification based on an SLT assessment.

Conclusion: A trained interdisciplinary frailty team can reliably screen for and identify risk of dysphagia. This indicates a potential for use of more standardised swallow screening protocols beyond the post stroke population into a broader cohort of patients.

References:
1. Irish Association of Speech & Language Therapists (2016) IASLT Position Statement on Swallowing Screening.

Background: Frailty is associated with a prodromal stage called pre-frailty, a potentially reversible and highly prevalent condition before frailty becomes established. Despite this, there is no widely accepted definition of pre-frailty to support its early identification and management. This study applied an international consensus approach to define and better understand pre-frailty.

Methods: A modified electronic two-round Delphi Consensus study was conducted. In all, 23 experts from 12 countries with different backgrounds participated. The questionnaire was developed following a systematic literature review. An online consensus meeting was conducted with eight Delphi participants and two external experts. Qualitative and quantitative methods were employed for data analysis. An agreement level of 70% was applied for accepting statements.

Results: A total of 71 statements were circulated in Round 1. Of these, 52.8% were accepted. Fifty-one statements were re-circulated in Round 2, of which 92.1% were accepted. The online consensus meeting produced a consensus statement describing the concept, multi-factorial nature, and mechanism of pre-frailty as well as assessment, prevention and management approaches. All experts agreed that physical and non-physical factors such as psychological and social capacity are involved in the development of pre-frailty, potentially adversely affecting health and health-related quality of life outcomes. Practitioners should regard pre-frailty as a multi-factorial, multi-dimensional, and non-linear process that does not inevitably lead to frailty. It might be reversed or attenuated by targeted interventions. Brief, feasible and validated tools are recommended for opportunistic screening or case-finding followed by confirmation with multi-dimensional assessment.

Conclusion: It is difficult to establish consensus on one compact definition of pre-frailty, which is a multi-dimensional concept not only associated with physical impairment, but also with cognitive, nutritional, socioeconomic and other aspects of frailty. However, it may be too early to agree on an operational definition of pre-frailty since none yet exists for frailty.

Background: ExWell is a research evaluated, large scale, community-based chronic illness rehabilitation service. It is a collaborative project between local acute hospital, community organisation, local authority, and primary medicine specialists. The mission of ExWell is to transform the lives of people with chronic illness through Physical-activity based rehabilitation. Participants are medically prescribed to the ExWell program by hospital physicians or their GP.

Methods: Referral participants have a two-day induction which includes strength and fitness testing that are covered by key metrics - hip/waist ratio, BMI, grip strength (upper body strength), sit to stand time for 10 repetitions (lower body strength), 6 minute time trial and posterior chain flexibility. These metrics are tested in 3 and 6 month intervals to assess progress. Participants are instructed on exercise technique and class fundamentals. This comprise of 4 sections (1) strength/resistance training; (2) Aerobic conditioning; (3) Balance/core strengthening; and (4) Dynamic movement. The regular full class comprises of 10min warmup, 40minute exercise and 10min cooldown.

Results: Since its inception in May 2018, ExWell based in the local leisure centre has grown exponentially with classes having tripled to 6 pw, with a further 3 classes pw starting in May 2019. Over 660 referrals have been received in the first year, 85% of these were from hospital sources. Approximately 400,000 of referred participants were inducted into classes. Reasons for non-induction include diminished motivation, transport, work commitments. The average attendance each week is approximately 150 visits with an age range 27-92 years. (Average 68.3 years with 63.5% over the age of 65 and 16.7% over the age of 80).

Conclusion: ExWell demonstrates a scalable integrated partnership model for delivering sustainable exercise based programs to target chronic illness and frailty in community populations. Next steps include consolidating the ExWell program here and in two partner sites, with subsequent expansion to other areas.
INTRODUCING A ‘DO NOT ATTEMPT CPR’ AND ‘TREATMENT ESCALATION PLAN’ FORM TO IMPROVE PATIENT CARE AND DECISION MAKING

Hannah O’Keefe, Hannah Smyth, Nora Al-Shawee, Aya Tacheva, Mavee Bradley, Martin Murphy, Chywyn Lynch
Our Lady of Lourdes Hospital, Drogheda, Ireland

Background: The HSE National Consent Policy recommends health care professionals ‘develop specific mechanisms for the documentation and dissemination of decisions relating to resuscitation’. We also felt a need to move away from a unidimensional CPR focus more towards documentation of appropriate and inappropriate care for the individual patient.

Methods: In December 2018 we conducted a baseline study of the quality of documentation of patients’ resuscitation and escalation plans in our hospital. We reviewed the charts of patients on 4 wards on a single day.

Results: Of 80 patients, 19 had some documentation regarding a CPR discussion. Of those 19 one had been determined at time of an arrest call and one at the time of a deterioration. Only 1 had an advance decision regarding the decision. Only 5 had any documentation of the reasoning behind the decision.

Conclusion: Other hospitals in our hospital group had implemented a ‘Do Not Attempt CPR’ and Treatment Escalation Plan form in the last year. With their permission we used their form as a template to develop a form for use across our hospital. This form is to be readily accessible in an emergency and out of hours, and contains quality information regarding the goals of care for an individual patient. The form is a single page, easily identifiable with a red border and filed inside the front cover of the chart.

The form has is currently being printed and will be implemented in the coming weeks. We will be closely liaising with users and reviewing its use following implementation.

CLINICAL AUDIT ON TRANSIENT ISCHAEMIC ATTACK INVESTIGATIONS IN ACUTE MEDICAL UNIT

Syvia Karpinski, Orla Collins, Emer Kelly, Mary Therese Cooney, Emer McGrath
St Vincent’s University Hospital, Dublin, Ireland

Background: TIA (Transient Ischaemic Attack) is a transient episode of neurologic dysfunction. Patients with a TIA have a high early risk of recurrent stroke. These patients need urgent initial evaluation with brain imaging, neurovascular imaging and cardiac evaluation. We conducted retrospective audit in our Acute Medical Unit (AMU) to assess waiting time initial evaluation with brain imaging, neurovascular imaging and cardiac evaluation.

Methods: All consecutive admissions with suspected TIA’s were evaluated on length of stay, type of imaging tests obtained and how long they awaited for these tests. This was conducted retrospective audit in our Acute Medical Unit (AMU) to assess waiting time initial evaluation with brain imaging, neurovascular imaging and cardiac evaluation.

Results: Of 80 patients, 19 had some documentation regarding a CPR discussion. Of those 19 one had been determined at time of an arrest call and one at the time of a deterioration. Only 1 had an advance decision regarding the decision. Only 5 had any documentation of the reasoning behind the decision.

Conclusion: Other hospitals in our hospital group had implemented a ‘Do Not Attempt CPR’ and Treatment Escalation Plan form in the last year. With their permission we used their form as a template to develop a form for use across our hospital. This form is to be readily accessible in an emergency and out of hours, and contains quality information regarding the goals of care for an individual patient. The form is a single page, easily identifiable with a red border and filed inside the front cover of the chart.

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FROM CLINICAL CARE PROGRAMME TO FRAILTY PATHWAY; A MULTIDISCIPLINARY, INTERAGENCY JOURNEY

Amanda Casey, Che Wei Fan, Joseph Duggan
Water Matthewdale University Hospital, Dublin, Ireland

Background: The National Clinical Programme for Older Persons was introduced in the Model 4 Adult teaching hospital in 2012 with the development of a Specialist Geriatric Ward, supported by an existing Day Hospital and access to post acute rehabilitation in the local model 3 hospital. The continuing growth of the population over 70 years in the catchment area and the increasing awareness of the complex needs of this group of patients required a new way of thinking and working.

Methods: Using Lean methodology the group restructured the focus of the care pathway for older persons using evidence based practice and data collection. Workstreams have been identified and iterative project charters established to guide and empower staff to design and evaluate the supports they provide. Key internal and external stakeholders were identified and invited to participate in the ongoing steering group and the voice of the customer was used to underpin targeted improvements.

RESULTS: The hospital now has a structured framework for the delivery and evaluation of care provided to older persons attending our services. Overall governance is provided by a Frailty Steering Group with strong clinical leadership and is informed by agreed quality indicators and real-time data. Despite increases in numbers requiring admission, length of stay has decreased, readmission rates have remained stable and a greater proportion of our patients are accessing both offsite rehabilitation and home supports on discharge.

Conclusion: This is an ongoing project. Maximum and long term goals have been identified across all workstreams. The evidence and data gathered will inform service planning and resource allocation. A number of collaborative research projects are now being considered from across acute hospital and Community Healthcare Organisation.

A CASE STUDY OF RETINAL ARTERY OCCLUSION FOLLOWING MECHANICAL THROMBECTOMY VIA DIRECT CAROTID PUNCTURE

Brian Woods, Owen Thorpe, Karl Boyle
Beaumont Hospital, Dublin, Ireland

Background: This case study reviews the role of carotid puncture as arterial access in mechanical thrombectomy and an associated rare complication.

Methods: This case reviews the management of a 74-year-old gentleman who presented with a left MCA ischaemic stroke. On presentation NIHSS was 21 consistent with a left total anterior circulation stroke syndrome (TACS) with a very severe clinical deficit. He underwent IV thrombolysis and attempted mechanical thrombectomy via femoral puncture. However the intracranial middle cerebral artery (MCA) occlusion could not be reached with the balloon catheter at the internal carotid artery (ICA) origin or beyond. A carotid puncture was successfully attempted followed by mechanical thrombectomy with complete recanalization of occluded MCA. Despite carotid puncture occurring in the setting of IV thrombolysis there were no post procedure bleeding complications. On day 2 post procedure, the NIHSS score (residual facial droop) representing remarkable neurological recovery. On day 4 post-procedure, acute left eye vision loss developed with subsequent diagnosis of left retinal artery occlusion (CRAO). The mechanism of this retinal artery occlusion may have been a direct delayed complication of carotid artery puncture propagating clot into the ophthalmic artery, or may have been due to the underlying stroke mechanism such as new embolism from ICA origin or failure of collaterals.

Results: Persistent residual left eye blurred vision and right facial droop.

Conclusion: Proximal intracranial occlusion can effectively be treated with mechanical thrombectomy. Carotid puncture is a rarely used but effective alternative method of arterial access (11 out of 498 procedures between August 2016 and August 2018). Retinal artery occlusion is a possible complication from mechanical thrombectomy with carotid puncture.

THE ACUTE SPINE FRACTURE IN THE EMERGENCY DEPARTMENT; A RETROSPECTIVE REVIEW

Owen Thorpe, Avril Berme, Paul Fox, Aoife Nic Uidhir, Frances Dockrey
Department of Genitourinary Medicine, Beaumont hospital, Dublin, Ireland

Background: As to who should manage osteoporotic spine fractures presenting to Emergency departments (ED) is sometimes debated. We sought to review practice regarding their management in our institution that might inform a clinical pathway.

Methods: We conducted a search of radiology reports for a consecutive series of thoracic or lumbar spine fractures recorded in ED by a single radiologist. Patients presenting with vertebral fractures were identified and iterative project charters established to guide and empower staff to design and evaluate the supports they provide. Key internal and external stakeholders were identified and invited to participate in the ongoing steering group and the voice of the customer was used to underpin targeted improvements.

RESULTS: Over 7 months, there were 1,505 such reports; narrowed search and excluding duplicates yielded 168 patients of whom 84 had a fracture. We looked at the acute management of those >50yrs, excluding one metastatic fracture leaving n=64. Of these, 65% occurred following a fall, 14% on twisting/bending/coughing, 14% spontaneous, 7% unclear onset. ED first consulted orthopaedics for 10 cases, neurosurgeons for 2, physicians for 18. A total of 21 were discharged from ED (5 having specialty review pre-discharge). A further 11 were sent home from ED with fracture diagnosis made only when x-ray subsequently reported. Of those admitted, 28 went to physicians with consult to surgeons for 15. A total of 21 were discharged from ED (5 having specialty review pre-discharge). A further 11 were sent home from ED with fracture diagnosis made only when x-ray subsequently reported. Of those admitted, 28 went to physicians with consult to surgeons for 15. A total of 21 were discharged from ED (5 having specialty review pre-discharge). A further 11 were sent home from ED with fracture diagnosis made only when x-ray subsequently reported. Of those admitted, 28 went to physicians with consult to surgeons for 15. A total of 21 were discharged from ED (5 having specialty review pre-discharge).

Conclusion: Care of spine fractures presenting acutely varied; a high proportion managed by ED solely. Whether outcomes vary as a result is not answered by this audit but there is a need for a pathway to inform best practice. Osteoporosis is inadequately-addressed in this high risk group, highlighting need for fracture liaison services in post-acute management.

QUALITY IMPROVEMENT AUDIT ON STROKE HEALTH ASSESSMENT AND SECONDARY PREVENTION OF PATIENTS DISCHARGED FROM AN IN-PATIENT REHABILITATION UNIT POST FRACTURE

Pádraig Synnott, Michelle Brennan, Shaun O’Keefe, Michelle Carvan
Mater Misericordiae University Hospital, Dublin, Ireland

Background: The National Clinical Programme for Older Persons was introduced in the Model 4 Adult teaching hospital in 2012 with the development of a Specialist Geriatric Ward, supported by an existing Day Hospital and access to post acute rehabilitation in the local model 3 hospital. The continuing growth of the population over 70 years in the catchment area and the increasing awareness of the complex needs of this group of patients required a new way of thinking and working.

Methods: Using Lean methodology the group restructured the focus of the care pathway for older persons using evidence based practice and data collection. Workstreams have been identified and iterative project charters established to guide and empower staff to design and evaluate the supports they provide. Key internal and external stakeholders were identified and invited to participate in the ongoing steering group and the voice of the customer was used to underpin targeted improvements.

Results: The hospital now has a structured framework for the delivery and evaluation of care provided to older persons attending our services. Overall governance is provided by a Frailty Steering Group with strong clinical leadership and is informed by agreed quality indicators and real-time data. Despite increases in numbers requiring admission, length of stay has decreased, readmission rates have remained stable and a greater proportion of our patients are accessing both offsite rehabilitation and home supports on discharge.

Conclusion: This is an ongoing project. Maximum and long term goals have been identified across all workstreams. The evidence and data gathered will inform service planning and resource allocation. A number of collaborative research projects are now being considered from across acute hospital and Community Healthcare Organisation.
Background: Osteoporosis accounts for most disability-adjusted life years than many non-communicable diseases. Identification and treatment is important to reduce morbidity and mortality associated with further fracture.\(^\text{1}\) National Osteoporosis Guideline Group recommends all patients with a fragility fracture should undergo a bone health assessment and commencement pharmacological therapy if indicated.\(^\text{2}\)

**Methods:** Electronic discharge summaries of all patients with a diagnosis of fracture discharged from an off-site rehabilitation unit from 1\(^\text{st}\) January 2018 to 31\(^\text{st}\) December 2018 were reviewed.

Patient details, location and mechanism of fracture, bone health assessment and discharge prescription were assessed.

Following data collection, an education session directed at NCHDs was performed and a discharge checklist promoting bone health review and consideration of pharmacological therapy was introduced. A re-audit was performed in 4 months to assess change following this intervention.

**Results:** 74 patients had a diagnosis of fracture. 4 were excluded as fracture resulted from high impact trauma. 100\% had corrected calcium measured. 93\%(n=65) had Vitamin D(OH) measured. 91\%(n=64) had PTH measured. 55\%(n=39) were discharged on calcium/vitamin D(OH) supplementation. 33\%(n=23) were discharged on Vitamin D(OH) alone.

60\%(n=66) were discharged on antiresorptive therapy: 28\%(n=13) bisphosphonate, 67\%(n=31) denosumab, 4\% others. 33\%(n=23) were not prescribed any bone protection on discharge. 4 had advanced chronic kidney disease.

6\%(n=4) were discharged without calcium/Vitamin D or antiresorptive therapy. A re-audit from January to April 2019 of 15 patients post NCHD education has shown an increase in antiresorptive therapy prescription 86\%(n=13).

**Conclusion:** Bone health assessment and prescribing practices of antiresorptive therapy in patients undergoing rehabilitation post fracture is sub-optimal. Education of non-consultant hospital doctors can substantially improve rates of antiresorptive therapy prescription.

**References:**

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**COLLATERAL DAMAGE: THE COST OF FAILING TO TAKE A COMPREHENSIVE COLLATERAL HISTORY FOR OLDER ADULTS WITH COGNITIVE IMPAIRMENT**

Kate Doyle\(^1\), Donal Fitzpatrick\(^1\), Gerard Finn\(^1\), Paul Gallagher\(^1,2\)
\(^1\) Cork University Hospital Cork, Ireland
\(^2\) University College Cork, Cork, Ireland

**Background:** Age-related syndromes of cognitive impairment, including delirium and dementia, are becoming more prevalent in our hospitals. Patients with cognitive impairment are often unable to provide information relating to their pre-morbid cognition and function as well as their admission diagnosis. Such information is essential to correctly identify delirium and dementia, as well as making an accurate diagnosis and planning appropriate treatment. It is the standard of care recommended by both the Irish National Audit of Dementia 2014 and the UK National Audit of Dementia Care 2017 that a collateral history is obtained.

**Methods:** We reviewed the medical notes and conducted brief structured interviews with nursing staff for 100 medical inpatients aged ≥75.

**Results:** Only 44\% of patients with cognitive impairment had a collateral history. Half of patients described as having dementia did not have any further detail on the severity of dementia documented. 80\% of collateral histories were sourced by the admitting NCHD; if the collateral history was not obtained on admission, it was unlikely to be obtained at all. Among those for whom a collateral history was obtained, the level of detail regarding pre-morbid cognition, function, mobility and continence was sparse. The most common informant was the patient’s son or daughter (66\%), followed by spouse (16\%). Only 13\% of patients had formal cognitive testing.

**Conclusion:** Acute illness characteristically causes significant impairments in cognition and function in frail older patients. Identifying and reversing these impairments is impossible without a comprehensive collateral history. It is alarming that such an essential component of clinical assessment is so often disregarded and highlights the lack of awareness from clinicians of the importance of collateral history in the management of patients with dementia and delirium. This must be emphasised in both undergraduate and postgraduate training. An appropriate admission proforma would also promote competent collateral history taking.

**References:**

**Results:** 22 participants, 12 male and 10 females, age range 60-91 (mean 75.5 years), were analysed using Spearman’s Rho correlation (r=2). Results did not identify a strong correlation.

**Conclusion:** Dementia is commonly regarded as a disorder of memory. However, diagnosis is dependent on functional decline related to cognitive decline. The AMPS provides a formal assessment of functional skills, in terms of motor & process skills with cut off scores regarding safe independent living. The results of this study indicate that the AMPS is not associated with executive scores on formal cognitive assessments, highlighting the value of an extensive multi-component MDT approach (also incorporating history taking, imaging, bio marker testing etc.) in assessing and diagnosing a dementia.

**References:**

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**IMPROVING ADHERENCE TO IRISH HIP FRACTURE DATABASE STANDARDS 1 AND 2**

Siofra Hearne, Hannah Smyth, Pheadra Manohan, Hugh McGowan, Shirley Timmins, Paddy Hillary, Anant Mahapatra, Alan Walsh, Caron Conlon, Ethne Dunnill, Eleanor Campbell, Danielle Cardwell, Tommas Arvem, Helen O’Brien

**Background:** The Irish Hip Fracture Database (IHFD) National Report 2017 demonstrated poor performance across all six IHFD standards in our hospital. For the purpose of this study we focused on standards 1 and 2. IHFD standard 1: All patients with hip fracture

**Abstract**

Age and Ageing

**Background:** Benzodiazepine prescription is common among the Irish patient cohort: 23\% of medical card holders have been prescribed a benzodiazepine or Z-drug, with a third of these being for a period longer than three months. This is despite these drugs being associated with addiction, falls, cognitive and psychomotor impairment, mood disorder, sleep automatism and drug interactions. We performed an audit looking at the repeat prescriptions of patients attending a geriatric day hospital.

**Methods:** The repeat prescriptions of all patients currently enrolled at a day hospital were audited and benzodiazepines or Z-drugs prescribed. Medical records were then analysed to look for indication and whether these patients were currently attending psychiatric services. Subsequent to this, notices were placed in the patient consult room in direct line of sight of the registrar reminding them to consider weaning these drugs and detailing the negative side effects and guidelines for weaning from the Canadian National Pain Centre.

**Results:** 59 patients were enrolled at the day hospital when the audit was performed. 11 (19\%) had either a benzodiazepine or Z-drug as part of their repeat prescription (benzodiazepine-5, Z-drug-5, both-1). The most common benzodiazepines prescribed were diazepam and clonazepam (2 patients each on). Of those prescribed a benzodiazepine, none were currently being weaned. Of those on benzodiazepines, 4 of 6 had a documented psychiatric diagnosis, and 1 of 6 had documented that they were currently attending psychiatric services. A re-audit three months later showed no change in those prescribed benzodiazepines (5/59), and a non-significant increase in those on Z-drugs (9/59, p=0.26).

**Conclusion:** This audit showed a significant number of patients attending our day hospital are being prescribed long term benzodiazepines or Z-drugs, and highlights that this setting is an opportune time and place to establish a supported program to wean people off these medications.
Age and Ageing

should be admitted to an acute orthopaedic ward within 4 hours of ED presentation/ brought directly to theatre from ED within 4 hours, and IHFD standard 2: All patients with hip fracture who are medically fit should have surgery within 48 hours of admission and during normal working hours.

**Methods:** We examined IHFD standards 1 and 2 from August 2017-January 2018 and 2018-August 2018. 220 patients with hip fracture were medically fit and had surgery within 48 hours of admission and during normal working hours.

**Results:** From August to January 2017, 2.5% of patients were admitted to an orthopaedic ward within 4 hours versus 18.1% in 2017. IHFD Standard 2: in 2017, 64.8% underwent surgery within 48 hours during working hours, versus 65.3% in 2018. From February to April 2019, 32.1% of patients were admitted to an orthopaedic ward within 4 hours (IHFD 1) and 56.0% of patients underwent surgery within 48 hours and during normal working hours (IHFD 2).

**Conclusion:** Close collaboration between Emergency Medicine, Orthopaedic Surgery, Radiology, Nursing colleagues, Allied Health Professionals and Orthogeriatrics and Orthogeriatrics within 4 hours (IFHD 1) and 56.6% of patients underwent surgery within 48 hours and 64.8% underwent surgery within 48 hours during working hours, versus 65.3% in 2018. From February to April 2019, 32.1% of patients were admitted to an orthopaedic ward within 4 hours (IHFD 1) and 56.0% of patients underwent surgery within 48 hours and during normal working hours (IHFD 2).

**Results:** We examined IHFD standards 1 and 2 from August 2017-January 2018 and 2018-August 2018. 220 patients with hip fracture were medically fit and had surgery within 48 hours of admission and during normal working hours.

**Methods:** We reviewed the medical notes and medication charts of 20 patients with Parkinson’s Disease admitted through the Emergency Department. Medication charts were reviewed to assess for levodopa containing medications. We assessed whether medication dosing and timing was accurately recorded, if medications were administered on time, and if self-management of medication was considered if the patient was capable during the first 48 hours of admission. We measured our findings against standards from NICE guidelines and Parkinson’s UK.

**Results:** Of 20 cases there had the times and doses accurately documented on admission. An average of 2.7 doses/patient were missed or delayed in the 48 hour period. Of 152 total doses, 54 (35%) were missed or late. Only 3 out of 20 patients received all their medications on time. Only one out of 20 patients had a documented order to be allowed to self-manage their medication.

**Conclusion:** Medication errors and omissions during unplanned hospital admissions in patients with Parkinson’s Disease are unsurprisingly common. Many doctors are unaware of the need to provide alternative routes of delivering levodopa for patients with Parkinson’s Disease who are fasting or unable to swallow. Patients with Parkinson’s Disease are not being empowered to manage their own medication during hospital admission. Educating doctors on the importance of reducing these medication errors, and the existence of the OPTIMAL Calculator to convert the patients’ usual medications to alternative preparations, is imperative to improve inpatient management of patients with Parkinson’s Disease.

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**PREDICTORS AND OUTCOMES OF OLDER PERSONS ATTENDING THE EMERGENCY DEPARTMENT OF A LARGE ACUTE DUBLIN TEACHING HOSPITAL**

**Methods:** Consecutive ED attendees aged ≥70 years, and Manchester Triage System 3, 5, in a 6-month period, were eligible for inclusion. Participants underwent an interdisciplinary assessment by a Home FIR (Frailty Intervention & Response Team) member. Logistic regression analyses were performed to identify factors predictive of admission post ED index visit and unscheduled revisit. Predictive validity of frailty instruments were performed using receiver operating characteristic (ROC) curves.

**Results:** 1,156 ED attendances were included - 59% were female; median age was 80 years; 65% were discharged home poor index visit; 17.8% had an unscheduled ED revisit within 30 days. Age and sex did not predict hospital admission. Hospital admission post ED visit was imperfectly predicted by mild-moderate frailty: Clinical Frailty Scale 5-6 (AUC 0.57 (95% CI 0.50 – 0.64)), and 4 (OR 2.22 (95% CI 1.61 – 3.09)) and 4 (OR 2.32 (95% CI 1.16 – 4.63)), p=0.017. Paradoxically, higher frailty scores were not predictive of admission post ED index visit and unscheduled revisit. Predictive validity of frailty instruments were performed using receiver operating characteristic (ROC) curves.

**Conclusion:** Our study highlighted poor assessment of falls with only 3% patients being screened at admission. A 5% had a fall, described as mechanical. Following introduction of a falls screening questionnaire into the admission proforma, a re-audit of 17 admitted medical patients was then completed over the next 72 hours. Following the initial audit, a new proforma containing a falls screening questionnaire (as per best practice guidelines) was introduced and an information session provided on its use. A re-audit of 17 admitted medical patients was then completed over the next 72 hours.

**Results:** The initial audit highlighted poor assessment of falls with only 3% patients being screened at admission. A 5% had a fall, described as mechanical. Following introduction of a falls screening questionnaire into the admission proforma, a re-audit showed a significant increase, with 58% of admissions now being screened. Of these, 40% had fallen in the last year: 75% of falls were mechanical and 25% due to other causes.

**Conclusion:** This audit shows that falls in this patient population was largely unrecognized by medical professionals. Following implementation of a screening questionnaire, similarly predicted admission (OR 1.62 (95% CI 1.16 – 2.27), p=0.005), while delirium (AAT 3-4) was the strongest predictor of admission (OR 5.87 (95% CI 3.17 – 10.88), p<0.001). ROC-curves of both frailty scales showed moderate diagnostic accuracy for admission, but less so for unscheduled revisits.

**HEARING LOSS AS A POTENTIALLY MODIFIABLE RISK FACTOR IN PEOPLE WITH MILD COGNITIVE SYMPTOMS ATTENDING A SPECIALIST MEMORY SERVICE**

**Methods:** We performed a retrospective review of notes of patients seen in the Memory Assessment and Support Service (MASS) over a 6 month period (March 2019–August 2019). We recorded any history of hearing loss reported by the patients and any need for re-evaluation. The prevalence of hearing loss was compared against the normal population.

**Results:** A total of 150 patients were seen, of whom 10% reported a history of hearing loss. Of these, 65% reported difficulty hearing in 5/20 (25%). High frequency hearing loss was noted in 19/20 (95%).

**Conclusion:** The prevalence of hearing loss and difficulty hearing in 5/20 (25%). High frequency hearing loss was noted in 19/20 (95%).
significant improvements were made. This audit concludes that implementation of a falls screening questionnaire into the medical admissions proforma is an effective method in identifying falls in older patients admitted to hospital.

**Results:**

- Twenty OPIC clients received a feedback questionnaire following their final interaction with the OPIC service. Eighteen clients responded: 11 males and 9 females with mean age 81 years. Two male clients did not return the questionnaire (mean age 86 years). In terms of the treatment and advice provided by the team, all 18 clients agreed with statements that they were involved in decision making, treatment was explained in a way that they could understand and was effective and met their needs. All clients responding indicated that they were listened to, treated with dignity and had confidence and trust in the team. All 18 respondents would recommend the service to another older person.
- Respondents also provided individual comments which all indicated satisfaction with the service.

**Conclusion:**

Older people accessing integrated care delivered in their home reported a positive experience and can provide important information on further service development.

**THE IMPACT OF A FRAILTY TEAM LIAISON SERVICE ON NURSING HOME ATTENDANCES IN AN EMERGENCY DEPARTMENT**

Eamonn Cooney, Christina Donnellan, Brish Baburaj
South Tipperary General Hospital, Clonmel, Ireland

**Background:**

Up to 50% of referrals from nursing homes to emergency departments (ED) are considered inappropriate. Interventions such as the introduction of advanced practice registered nurses to nursing homes, and community matrons in other jurisdictions have reduced inappropriate referrals.

**Methods:**

A liaison service with nursing homes was initiated by a candidate Advanced Nurse Practitioner (cANP) supported by the frailty multidisciplinary team in January 2019. It focused on nursing home residents aged 70 years and older. A single point of contact was provided. ED presentations were assessed if possible, and telephone consultations were also available. A database was maintained and the data from the first 3 months of this service was analysed.

**Results:**

The service provided from 7th January and 31st March 2019 was studied. Referrals of patients aged 70 years and over from nursing homes to ED for this period in 2018 were 100. In 2019 it was 73, representing a 27% decrease in referrals. The total number of patients referred in 2019 was 51. Twenty one (41%) patients had an assessment by the cANP. Interventions by the cANP and team included rapid access to other specialties, medication reconciliation, and prescription of antibiotics, diagnostics and referral to the Community Intervention Team (CIT). Telephone liaison from nursing homes resulted in referrals to the palliative care service in 2 cases, prescription of antibiotic in another, rapid access comprehensive geriatric assessment in another case and rapid access to ED for catheter change in another, hence admission avoidance in all of these cases.

**Conclusion:**

The early experience of this service is that it facilitated more nursing home residents to receive care and support within their care setting. It contributed to reduced referrals of this vulnerable cohort of the population to ED, and also resulted in admission avoidance in some cases.

**PALLIATIVE CARE FOR OLDER PEOPLE IN RESIDENTIAL CARE: FROM THE INSIDE OUT**

Una Molloy1, Amanda Phelan2
1St Francis Hospice Raheny, Dublin, Ireland
2University College Dublin, Dublin, Ireland

**Background:**

To enhance the quality of care of older people living and dying in nursing homes, it has been suggested that palliative care should be integrated into this care. This study aims to explore what palliative care means in the context of older person residential care.

**Methods:**

Action research, using a co-operative inquiry (CI) approach was used. A total of 18 healthcare assistants (HCAs) and 16 registered nurses (RGNs) in two residential older person care units, participated. A reflection on deaths that occurred on the units over a six-month period N=23 took place. This facilitated reflection on care given to the residents and assisted in developing an understanding of how palliative care is understood and integrated into caring for residents.

**Results:**

A number of actions took place. A debriefing group, acknowledging the importance of relationships and a sense of loss experienced by staff on the death of a resident, a group reflection on recognising dying and how this might impact on care a resident receives, and a healthcare assistant group which contributed to developing an understanding of the unique role HCAs have in this context. Categories that evolved to describe palliative care included, communication, decision making, transitions in care, grief, relationships, existence and the importance of knowing a resident.

**Conclusion:**

This study has illustrated that palliative care in older person care, is often aligned with dying. In general, end of life care and person-centred care were more commonly used terms. It was suggested that palliative care is an inherent part of care. There is a need to value the expertise and experience of the nurses and healthcare assistants caring for older people living and dying in residential care. There is also a need to improve the interdisciplinary roles between older person care and specialist palliative care.
AUC 0.77 (95% CI 0.68 - 0.87) and 0.73 (95% CI 0.64 - 0.82), respectively. The GFI, CFS and PRISMA-2 had statistically similar, albeit lower scores. No instrument was accurate in predicting 30-day readmission after discharge (AUC < 0.7).

Conclusion: Short frailty screening instruments applied in ED have poor/modest predictive validity for important healthcare outcomes, particularly hospital re-admission. The RISCC score had the highest diagnostic accuracy for institutionalisation and death but this was fair at best, suggesting that instrument selection should be pragmatic with the expectation of identifying frailty.

297 RE-AUDIT OF SWALLOW ASSESSMENT IN ACUTE STROKE PATIENTS FOLLOWING INTRODUCTION OF A FULL-TIME SPEECH SPECIALIST

Emily Buckley, Maen Alalawi
Department of Medicine, Our Lady’s Hospital, Navan, Co. Meath, Ireland

Background: The National Clinical Guidelines and Recommendations for the Care of People with Stroke recommend that if an initial screen of a patient with an acute stroke indicates swallowing difficulties, the patient should have a specialist swallow assessment within 24 hours of admission and not more than 72 hours afterwards. The aim of this audit was to reassess the rate of specialist assessment in this patient group following the introduction of a full-time speech specialist in an acute hospital.

Methods: This was a clinical audit where all patients who presented with acute stroke, where initial swallowing screening indicated problems were reviewed. Data was collected from medical records over a twelve week period from January 2019-April 2019.

Results: Twenty patients presented with an acute stroke, with initial assessment indicating swallowing problems; 12 male, 8 female. Mean age was 72 years (ranging from 41 to 96). Eight of these were seen by a speech and language therapist (SALT) within 72 hours; 7 were assessed by SALT < 24 hours and 1 was assessed within the 48-72-hour window. Of those seen by SALT, 2 were placed on a normal diet, 2 by mouth (NPO), 4 were placed on a modified diet. Two patients were reassessed (3 and 2 times respectively). Of the patients assessed by SALT, 1 passed away and 7 were discharged home (2 referred to community SALT follow-up).

Conclusion: Introduction of a full-time speech and language specialist has increased the rates of swallow assessment in line with the national average. The overall rates of SALT interventions in dietary regimens highlights the need to overall general assessment rates in patients with acute stroke.

298 FALLS AND SYNCOPE IN OLDER PEOPLE IN THE EMERGENCY DEPARTMENT: PREVALENCE, CLINICAL CHARACTERISTICS AND OUTCOMES

Rabbe Bourke, Ciara Rice, Geraldine McMahon, Conal Cunningham, Rose Anne Kenny, Robert Briggs
St James’s Hospital, Dublin, Ireland

Background: Falls, syncope and presyncope comprise a large proportion of emergency department (ED) presentations among older people, however accurate data detailing this is limited. The aim of this study therefore was to ascertain the percentage of ED presentations in older people due to falls/syncope/presyncope, and examine admission rates, length of stay and likely underlying diagnosis.

Methods: Over 1,300 consecutive presentations of older people (aged ≥60 years) to the ED of a large urban university teaching hospital in March 2018 were examined (electronic and hard-copy notes) to ascertain the prevalence of falls/syncope/presyncope presentations. Data was collected for each presentation with fall/syncope/presyncope on demographics, and relevant clinical characteristics, including admission outcome and length of stay (LOS).

Results: Falls/syncope/presyncope comprised 19% (250/1,324) of presentations of older people to the ED, with a mean age of 75.3 ± 10.6 years. Almost 60% (158/250) presented during ‘normal’ working hours, i.e. Monday to Friday, 0800-1800. Almost half (121/250) had a Manchester Triage Score (MTS) of 3, indicating a need for urgent care, while one third (93/250) were categorized as requiring very urgent or immediate assessment (MTS 2 or 1 respectively). Over one third (97/250) presented with explained/accidental falls, while 26% (60/250) and 35% (87/250) presented with syncope and unexplained falls respectively. One in six (118/250) older people presenting with falls/syncope/presyncope were admitted to the acute hospital, and this rises to almost two thirds (82/135) of those ≥75 years. The median LOS was 15 (9.9 – 22.0) days.

Conclusion: Older people frequently present to the ED with falls/syncope/presyncope. The majority present during working hours and admission rates and LOS are relatively high. Falls/syncope/presyncope therefore represent an appropriate target for structured, multidisciplinary assessment at the ‘front door’ to provide early specialist assessment and management, and reduce complications associated with unnecessary admission to hospital.

299 A RETROSPECTIVE REVIEW OF UNSCHEDULED HOSPITAL ADMISSIONS OF NURSING HOME RESIDENTS OVER A TWO YEAR PERIOD

Aisling McKeever, Cliona Small, Susie Hyland, Jonathan O’Keeffe, Graham Hughes, Darmuid Ó hÓgáin

St Vincent’s University Hospital, Dublin, Ireland

Background: Older people living in Nursing Homes (NHs) represent a frail and vulnerable group. With multiple co-morbidities they are at increased risk of acute health deterioration prompting urgent hospital transfer. Our aim was to examine the outcomes for nursing home residents following unscheduled hospital attendances.

Methods: A prospective database was reviewed between 1 January 2016 and 31 December 2017. This record all emergency admissions of older people from NHs. The data was retrospectively analysed. Outcomes assessed included: length of stay (LOS), 30-day readmission rates, number of readmissions within one year and mortality. We compared these results to similar data collected in 2012-13.

Results: Over a two-year period, there were 1453 hospital admissions; a 7% increase from 1015 in 2012. 60% were female and 40% male with a mean age of 84.7 years. The average LOS was 9.58 days (vs 11.2 days in 2012-13). The 30-day readmission rate was 9.8% (vs 14% in 2012-13). 30% of patients went on to have 2 or more readmissions within one year, an increase from 21.1% in 2012-13. The total in-hospital mortality was 14%.

Conclusion: An increase in the number of NH residents presenting to an acute hospital over the past 5 years was observed. Despite this, we have seen reductions in average LOS and 30 day readmission rates. There is, however, an increasing number of recurrent admissions to the hospital within one year. These results highlight the importance of an integrated approach to patient care; from the primary care team, hospital team, palliative and community care services.

We believe the continued development of Nursing Home Outreach Programmes and community liaison services, combined with the evolving role of the in-hospital Geriatric ANP and liaison palliative care team, will help reduce inappropriate ED referrals and encourage advanced care planning.

301 OLDER FARMERS’ EXPERIENCES OF MUSCULOSKELETAL DISORDERS

John Cunningham1, Austin Kerin 1, Rose Galvin 2, 1
1 School of Allied Health, University of Limerick, Limerick, Ireland
2 Ageing Research Centre, Health Research Institute, University of Limerick, Limerick, Ireland

Background: Almost a third (n=41,000) of all Irish farm holders are aged 65 years or older. Older farmers are vulnerable to Musculoskeletal Disorders (MSD’s) both by virtue of the nature of their work and their age. MSD’s are a known risk factor for workplace accidents and farming is the highest risk occupation in Ireland.

This study aimed to explore older farmers’ experiences of living with and accessing healthcare for MSD’s.

Methods: A qualitative study design employing semi-structured interviews was employed. Nine Irish farmers aged 65 years and over with current or previous experience of MSD’s were recruited. All participants continued to farm on either a full-time or part-time basis. Data were analysed using thematic analysis.

Results: Four themes describing older farmers’ experiences of MSD’s and healthcare were identified; (1) acceptance of MSD’s as inevitable (2) biomechanical and biological beliefs about MSD’s (3) resilience and a commitment to continuing work in response to MSD’s (4) scepticism and avoidance of healthcare.

Conclusion: To the best of our knowledge this is the first qualitative study of older Irish farmers’ experiences of MSD’s. Findings reveal that older farmer’s experiences differ significantly from those reported by other occupational groups. Commitment to continue working permeated the findings of this study and shaped older farmers’ experiences and responses to MSD’s. Older farmers accept MSD’s and pain as inevitable consequences of farming, and they respond to MSD’s with stoicism. Lack of healthcare provider knowledge about MSD’s and their role is a contributor to older farmers’ negative healthcare experiences and avoidance of healthcare. Given the prevalence of MSD’s in this population future research should focus on developing and evaluating appropriate health promoting and patient-centered interventions to support continued safe farming for older Irish farmers.

302 VESTIBULAR ASSESSMENT AND REHABILITATION WITHIN A DAY HOSPITAL FALLS ASSESSMENT SERVICE: IS IT NECESSARY AND IS IT FEASIBLE?

Michael Mc Dermott1, Fiona McGrath2, Tom O’Malley1
1Mayo University Hospital, Castlebar, Ireland
2Mayo Integrated Day Hospital Service, Castlebar, Ireland

Background: Benign Paroxysmal Positional Vertigo (BPPV) and other vestibular disorders are very common and often missed in older populations and are a significant risk factor and cause of falls. Vestibular rehabilitation is increasingly recognised as an effective intervention for the management of vestibular dysfunction in all age groups. This review aimed to examine the prevalence of vestibular disorders in the cohort attending an integrated day hospital falls assessment service and the feasibility of delivering vestibular rehabilitation interventions as part of this service.

Methods: We retrospectively reviewed the charts of all the patients who attended a new ambulatory day hospital between Nov 2018 and April 2019. Inclusion criteria included a recent history of falls and aged over 75. All patients had received a comprehensive geriatric assessment which included screening for vestibular symptoms and on-site assessment (if indicated) by a physiotherapist with expertise in vestibular rehabilitation.

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Results: 40 patients (33 women, 7 men) with a mean age of 82 were seen in this period. All had suffered recent falls with 10 having suffered a fracture. 5 patients (12%) tested positive for Benign Paroxysmal Positional Vertigo and 2 others (5%) had evidence of both peripheral and central vestibular impairment. Vestibular rehabilitation interventions, including particle repositioning manoeuvres were delivered within the day hospital setting with review appointments offered to all patients.

Conclusion: This review highlights the high prevalence of vestibular disorders, especially BPPV (12%) in older fallers. It supports the feasibility of delivering vestibular assessments and rehabilitation as a component of the physiotherapy input within a day hospital falls service.

INTEGRATED CARE HUBS FOR THE OLDER PERSON: RIGHT TIME, RIGHT PLACE

Alicia O’Donoghue1, Claire MacMahon1, Margaret Bolger2, Suzanne Roche3, Niamh Reddan1, Catherine Murphy2, Emma Grant1, Desmond O’Donnell1, Anne O’Mahony1, Maged Henfi1, Millie O’Gorman1, Ruud Masambio1, Marie Doyle1, Píotr Hartnett2, Adriana O’Halloran2,3, George Pope4,5, Ríona Mulcahy2,6, John Cooke2,6
1 Department of Geriatric Medicine, University Hospital Waterford, Waterford, Ireland
2 Waterford Integrated Care of the Older Person, Waterford, Ireland
3 University College Cork, Cork, Ireland
4 University of Limerick, Limerick, Ireland
5 University of Limerick, Limerick, Ireland
6 University of Limerick, Limerick, Ireland

Background: Our Integrated Care Hub has been operating since mid-2017 providing patient-centred multidisciplinary team (MDT) care operating via a number of specialised care pathways. There has been an early emphasis on the response to crisis presentations and with the introduction of the Hub we now have an extensive and organised response to such presentations. We wanted to assess does this system result in earlier referral of the Crisis patient to an Integrated Care Hub.

Methods: We performed a retrospective quantitative analysis of data comparing two time-periods January to June 2018 with January to April 2019 (year-to-date). The number and type of MDT contacts were classified into 4 categories: Immediate Crisis (would present to the Emergency Department within 48 hrs if not reviewed), Emerging Crisis (would present to the Emergency Department within 2 weeks if not reviewed), Stable Situation (needs optimisation), Stable Situation (no intervention). Data were extracted from FileMaker Pro.

Results: There were 424 MDT contacts in January-June 2018 compared with 658 MDT contacts in the year-to-date 2019. The number of patients in these time-periods presenting in ‘Immediate Crisis’ was reduced in the year-to-date 2019 - 4.41% compared to the same time-period in 2018 - 11.79%. There was a similar reduction in ‘Emerging’ Crisis presentations in these time-periods: 15.65% in 2019 vs. 24.29% in 2018. While the patients attending that were classified as Stable Situation (needs optimisation) StableSituation (no intervention). Increased in 2019 compared to 2018 - 66.57% vs. 47.88.

Conclusion: We can see from our data that the creation of our Integrated Care Hub has resulted in an increased demand for our service, however, interestingly we have found that the crisis patient load has, in fact, decreased. This suggests that we are influencing referral patterns by both recognising and intervening at an earlier stage to manage, stabilise and reverse crisis in these patients in an organised manner within the MDT.

ED-FASU: A NOVEL ‘FRONT DOOR’ MULTIDISCIPLINARY SERVICE ASSESSING PATIENTS WITH FALLS AND SYNCOPE IN THE EMERGENCY DEPARTMENT

Robbie Bourke1, Ciara Rice1, Geraldine McNally1, Coral Cunningham1, Rose Anne Kenny1, Robert Briggs1
1 St James’s Hospital, Dublin, Ireland

Background: Patients with falls/syncope/presyncope frequently present to the emergency department (ED) and many that could be managed safely in an ambulatory care setting are admitted for extensive diagnostic work-up. A pilot intervention commenced in March 2019, with direct access to specialist assessment in the ED for patients presenting with falls/syncope/presyncope, aiming to provide appropriate testing and early diagnosis to reduce unnecessary hospitalisations.

This pilot study assessed the feasibility of embedding this service within the ED, as well as the effectiveness of the intervention in terms of admission avoidance.

Methods: The study was conducted between 25th March and 19th April 2019 in a large urban teaching hospital with a dedicated Falls & Syncope Unit and compared to similar data from March/April 2018.

The core ED-FASU team comprised a consultant geriatrician, specialist registrar in geriatric medicine and clinical nurse specialist. Inclusion criteria were those of all ages, presenting with falls/syncope/presyncope/dizziness between 0800-1800 Monday-Friday. Patients were reviewed directly from triage or after referral from the ED team.

Results: In total, 203 patients were assessed during the pilot, an average of 10 assessments per day. The median age of those seen was 63 (58-67) years. Almost one third (57/203) were aged >75 years.

After excluding those who were already admitted to the acute hospital and awaiting a bed when seen in the ED (n=29), 24% (41/174) of those seen were admitted to hospital. This compares to an admission rate of 33% (7/21) for the 2018 comparison group (p = 0.045).

Conclusion: This pilot study shows that it is feasible to embed specialist assessment for falls/syncope/presyncope in the ED.

Initial pilot data suggests a significant reduction in admission rates for those seen by this service but needs to be confirmed over a more prolonged assessment period and alongside data on readmission and length of stay.

THE CHANGING FACE OF STROKE IN THE DOAC ERA

Reece Davern1, Helena Hobbs1, Hannah Murugan1, Paul Cotter1
1 St. Luke’s Hospital, Kilkenny, Ireland
2 University of Limerick, Limerick, Ireland

Background: Patients prescribed oral anticoagulants (OAC) for atrial fibrillation (AF) can still present with stroke. The mechanism for stroke in these patients can be due to multiple factors including subtherapeutic dosing and non-compliance. With the increasing use of direct-acting OMs (DOAs) in favour of warfarin, it is unclear if the incidence of stroke in those already taking OAC has reduced.

Methods: Data was extracted from our unit’s stroke registry, a prospectively maintained database, for patients who presented with stroke while receiving OAC for AF from 2013 to 2017. Type of OAC, type of stroke, OAC dosing at time of event including non-compliance, stroke management and outcome were recorded.

Results: 67 patients were included for analysis, with 55 ischaemic and 12 haemorrhagic strokes. 52 patients were receiving warfarin at the time of their stroke vs. 15 receiving DOAs. 33/55 (60%) of ischaemic strokes occurred in patients taking warfarin with a sub-therapeutic INR. The OAC was held for a procedure in 6/55 cases (11%) the OAC had been stopped for another reason e.g. bleeding. 5/55 (7%) were due to non-compliance. 1 ischaemic stroke was due to under-dosing of a DOAC (dabigatran). 16 strokes were recorded in 2013 for patients prescribed OMC vs. 3 in 2017. Overall the number of ischaemic strokes due to subtherapeutic OMC decreased from 14 in 2013 to 1 in 2017 (p value 0.06).

Conclusion: The majority of strokes occurring in anticoagulated patients are related to warfarin use. We observed an almost significant reduction in the proportion of ischaemic stroke from 60% (60%) of ischaemic strokes occurred in patients taking warfarin with a sub-therapeutic INR. In 3/55 (5%) of ischaemic strokes, the OAC was held for a procedure while in 6/55 cases (11%) the OAC had been stopped for another reason e.g. bleeding, 5/55 (7%) were due to non-compliance. 1 ischaemic stroke was due to under-dosing of a DOAC (dabigatran). 16 strokes were recorded in 2013 for patients prescribed OMC vs. 3 in 2017. Overall the number of ischaemic strokes due to subtherapeutic OMC decreased from 14 in 2013 to 1 in 2017 (p value 0.06).

A SURVEY OF NUTRITIONAL STATUS OF OLDER PATIENTS ATTENDING MEDICINE FOR OLDER PERSON CLINICS

Kenielle Malamo1, Josephine Soh1, Eamon Dolan1, Marie O’Connor1
1 Conolly Hospital Blanchardstown, Dublin, Ireland

Background: Nutritional assessment is an important but frequently overlooked aspect of comprehensive geriatric assessment. Malnutrition is common and associated with clinical complications. Our study aimed to assess older patients’ perceptions of their nutritional status and to investigate clinical factors affecting it.

Methods: All patients attending our clinics over a 2 week period were invited to complete a self-administered questionnaire. Further clinical information including diagnosis and weight collected by review of medical notes.

Results: A total of 43 patients completed the questionnaire: median age 82.5 years (67-102). 69% of those, 68.8%(n=30) were female and 27.9% (n=12) lived alone. Majority reported good appetite (83.7%, n=36) and eating 3 meals a day (79.1%,n=34). 25.6%(n=11) prepared meals themselves and 34.9%(n=15) had received nutritional advise from healthcare professionals. 17 patients (39.5%) self-reported weight loss over the past year, and of these 76.5% (n=13) had objective weight loss documented. Only 2.3% (n=1) were concerned and seek advice from healthcare professionals. 50% (n=12) of the remaining 24 patients who self-reported no weight loss had objective weight loss in clinic. 26 (60.5%) patients had objective weight loss.

A higher proportion of the weight loss cohort lived alone (30.8% vs 23.5%), had no home care packages(HCP) (65.4% vs 47.1%), did not take nutritional supplement (76.9% vs 58.8%), had no dentures (42.5% vs 23.5%) and had no diagnosis of dementia (57.7% vs 47.1%).

Of those who lost weight, 54.6% (n=9) lost significant amount (>5% of weight, including 4 (15.4%) who lost >10%.

Conclusion: 2 out of 3 of our community dwelling, older patients lost weight, with one third having lost significant amount. Awareness is poor with 50% not recognising their weight loss and only one third ever sought nutritional advice. Patients who lost weight were more likely to be living alone with no formal community supports.

ASSOCIATION OF DIABETES AND FRAILTY WITH MORTALITY IN MIDDLE-AGED AND OLDER EUROPEANS

Mark O’Donnell1, Duong Seeg1, Aaron Liew1,2, Ráiní O’Caisimh1,3,4
1 Nádúr Leabharlann Teicniúil, Galway, Galway, Ireland
2 Department of Endocrinology, Forógraílzh University Hospital, Co Galway, Ireland
3 University College Cork, Cork, Ireland
4 Mercy University Hospital, Cork, Ireland

Background: Frailty is a common, multi-factorial, age-related syndrome commonly observed in people with diabetes. Although older diabetics are prone to adverse healthcare
outcomes and diabetes increases the risk of developing frailty, little is known about the effects of frailty on diabetes. This paper examines the association between diabetes, frailty, and mortality in Europeans aged ≥50 years.

**Methods:** Data were included from The Survey of Health, Ageing and Retirement in Europe (SHARE) waves one and six. A participant’s first interview was taken as the baseline and subsequent waves were used for mortality follow-up (time and cause). Frailty and prefrailty were measured using established cut-offs using the Physical Performance Test (SHARE-FI) and a 55-item Frailty Index (FI-55). Kaplan-Meier survival analysis was used to assess the relationship between frailty and mortality in people with diabetes and significance tested using log-rank test. Cox regression was used to adjust for potential confounders (age, sex, large vein pressure, socio-economic status, employment, alcohol use, smoking, hypertension, hypercholesterolaemia, myocardial infarction, stroke, metastatic cancer, chronic lung disease, polypharmacy, self-perceived health and depression).

**Results:** From the 20,131 diabetics aged ≥50 years included were 1,598 deaths (15.8%). According to the SHARE-FI, 1,971 (22.0%) were frail, 4,183 (46.7%) pre-frail and 2,800 (31.3%) robust. According to the Kaplan-Meier log-rank test survival varied significantly across frailty strata according to both indexes (p<0.001). At 10-year follow-up, adjusting for confounders SHARE-FI frailty and pre-frailty were significantly associated with mortality, adjusted Hazard Ratio (HR) 2.19, (95% CI:1.66-2.89), and 1.38 (95% CI:1.09-1.74), respectively. Results were similar using the FI-55, HR for frailty 1.66 (95% CI:1.09-2.54). Causes of mortality were significantly different according to frailty status (p<0.05).

**Conclusion:** Frailty and pre-frailty are independent risk factors for mortality in diabetics. The identification of frailty is important for the risk-stratification and management of middle aged and older patients with diabetes and should be included in the routine assessment of these high-risk individuals.

## IMPLEMENTATION OF A FORMALISED WEEKEND HOSPITAL HANDOVER PROCESS

Lucy Chapman, Oisin Hanigan, Grainne Courtney, Conal Cunningham, Declan Byrne
St James’s Hospital, Dublin, Ireland

**Background:** Patient handover has been described as “one of the most perilous procedures in medicine” (British Medical Association, 2004). The Irish Medical Council underlines the importance of high-quality, relevant clinical information communication at shift changes.

**Methods:** On Friday January 26th 2018, the weekend handover practice for medical inpatients requiring a medical registrar review was formalised in a large Dublin teaching hospital. Firstly, pertinent clinical information and the purpose of review were captured in an electronic order placed on the electronic patient record (EPR). A verbal handover meeting each Friday supported further discussion and patient handover. Data from the 26th of January to the 7th of July 2018 was analysed from the EPR. The purpose of weekend review was grouped under four categories - full clinical review, laboratory results review, review to facilitate discharge and patients who did not demand formal review but were handed over for information only.

**Results:** Over the 23 week period, 652 electronic orders for weekend review were placed on medical inpatients. This equated to an average of 27 reviews per weekend. The average age of patients reviewed was 63 years (SD 18.8 years). Median length of stay (LOS) was 4 days with a higher median LOS (6.7 days) observed for those aged 65 years and over. Over half (54%) of all weekend reviews required full clinical review whilst 27% of reviews were for laboratory results follow up only. Comparison between medical inpatients aged less than 65 and greater than 65 years noted little differences between the two cohorts in terms of the purpose of weekend review. Daily review was required for 73% of patients handed over to the medical registrar.

**Conclusion:** Weekend review of medical inpatients by medical registrars constitutes a significant workload. A formalised weekend handover practice complimented by an electronic process facilitates safer handover by improving the quality, transparency and accessibility of clinical information.

## CARE FOR OLDER PERSONS WITH DEMENTIA IN AN ACUTE MEDICAL CARE SETTING: AN EXPLORATION OF NURSES’ EXPERIENCES AND PERCEPTIONS

Kay Fitzmaurice1, Angela Flynn2
1 University Hospital Kerry, Tralee, Ireland
2 University College Cork, Cork, Ireland

**Background:** Presently in Ireland there are 55,000 people with dementia, with figures projected to rise to 130,000 by 2041. In acute hospitals, ensuring the provision of high standard, person-centred care for people with dementia is an essential part of policy and practice development. While nurses are key in implementing safe, effective and evidenced based care it is unclear at this moment what their experiences are, when caring for patients with dementia. It is twelve years since the last study was conducted in Ireland in a purpose-built unit for older patients so will not be reflective of an acute care setting. Therefore, it is timely to gather a current description of nurses’ experiences and perceptions in caring for patients with dementia in an acute care setting.

**Methods:** A purposeful sample of nine nurses working in an acute medical ward caring for patients with dementia participated in the study. Data was collected using semi-structured interviews, transcribed verbatim and analysed using content analysis.

**Results:** The findings are current and highlight that nurse’s display immense respect and empathy to patients with dementia and see beyond the dementia to the individuality of the person. This demonstrates positive attitudes towards these patients, despite organisational and environmental constraints. The findings further identify that staffing levels are inadequate and that nurses require specific education on dementia. Furthermore, the organisational culture and environmental design are not conducive for patients with dementia and changes need implementing in line with the Irish National Dementia Strategy and the Dementia Friendly Hospital Design Guideline.

**Conclusion:** These findings have provided a current view of nurses’ experiences and perceptions of caring for patients with dementia in an acute medical ward and support previous study findings. Strategies are now required to address these issues, with a focus on the six priority action areas from The Irish National Dementia Strategy.
AUDIT ON PRESCRIPTION LEGIBILITY IN AN IRISH UNIVERSITY TEACHING HOSPITAL

Christine E McCarthy, Salm Seboua, Kiran Sali, Elizabeth Murphy, Amrita Ray, Jason Hynes, Aiofe Leahy, Nur Ai'tikh Mohd Ase; Colin Quinn, Catherine Peters, Declan Lyons, Margaret O’Connor
University Hospital Limerick, Limerick, Ireland

Background: Illegible prescribing can lead to medication error and adverse drug reactions. The HSE Standards and Recommended Practices for Healthcare Records Management and the Practice Standards and Guidelines for Nurses for Prescriptive Authority have highlighted criteria which should be adhered to in relation to prescribing. We set out to audit compliance with these standards in relation to legibility of prescriptions in an Irish University Teaching Hospital.

Methods: Over a 48 hour period, drug kardexes were reviewed on 14 separate in-patient wards. Legibility was judged by a single assessor on each ward. A drug kardex was deemed legible if all of the following criteria were met:
1. The writing was clear and un-joined, in upper or lower case text.
2. Only approved abbreviations were used.
3. Doses were clear, with zero preceding decimal points, and appropriate measurement units used.
4. In cases where weight dependent medications were prescribed, the patient’s weight was clearly documented.

The chi squared test was used to determine the significance of the difference in proportions for categorical variables.

Results: 285 drug kardexes were reviewed over the 48 hour period. 41% were on surgical wards, 59% were on medical wards. The median patient age was 70 (IQR:55-78), and 56% were male. 48% of drug kardexes were deemed legible. A higher proportion were deemed legible on medical wards compared to surgical wards (68% vs 19% p<0.05). Upper case was used in 13% of kardexes, with similar proportions on medical and surgical wards.

Conclusion: Poor legibility of drug kardexes may increase risk of medication errors and adverse drug reactions. We plan to commence targeted prescribing education sessions to highlight these current deficiencies and improve current practice. Changes to kardex layout may also aid legibility. Long term planning for electronic prescribing would also help resolve issues in this area.

INCIDENCE OF COGNITIVE IMPAIRMENT AFTER STROKE: A RETROSPECTIVE COHORT OF REHABILITATION PATIENTS.

Sarah Gorey1, 2, Tim Cassidy1,3
1 Royal Hospital Donnybrook, Dublin, Ireland
2 St. Vincent's University Hospital, Dublin, Ireland
3 St. Vincent's University Hospital, Dublin, Ireland

Background: Pendlebury and Rochwell’s recent paper reports the incidence of cognitive impairment and dementia post stroke as 5% for TIA, 8% for minor stroke and 34% for severe stroke. We wanted to explore if these trends were reproducible in an Irish cohort.

Methods: We conducted a retrospective review of a random sample of 100 discharge records of all strokes discharged in 2017 from the National Rehabilitation Hospital, Dublin. Patients were included if they had a confirmed diagnosis of stroke, their discharge record was clear, and they were >18 years old.

Results: 285 drug kardexes were reviewed. No drug kardex was fully compliant with the 9 standards. The mean duration of monitoring using the external loop recorder was recorded. The time to first episode of atrial fibrillation was 34.2 hours.

Conclusion: External loop recorders present an opportunity for detection of paroxysmal atrial fibrillation in high risk individuals. Our study shows the feasibility and accuracy of a screening duration of seven days in the high risk post ischemic stroke population.

Methods: We examined the time of atrial fibrillation initial diagnosis in 50 patients with an original working diagnosis of cryptogenic stroke but later have atrial fibrillation confirmed on extended monitoring.

Conclusion: All patients were the external loop recorder from 1 day to 3 weeks’ duration. On return of the device, data from the external loop recorder was downloaded, and reviewed by a consultant cardiologist.

The total duration of monitoring using the external loop recorder was recorded. The time to first episode of algorithm detected atrial fibrillation was recorded.

Results: The mean duration of extended cardiac monitoring using the external loop recorder was 120.1 days.

OVER 75 YEARS OLD RESIDING IN LONG TERM CARE

Eimear O Reilly1, 2, Cormac Everard1, Lisa Cogan3
1 Royal Hospital Donnybrook, Dublin, Ireland
2 University College Dublin, Dublin, Ireland
3 Royal Hospital Donnybrook, Dublin, Ireland

Background: Patients residing in a long term care facility were reviewed and data was collected from ward medical notes and medication records in order to:
1. Quantify the proportion of patients on statins (therapy) (2) Review the indication for therapy (3) Investigate the inappropriate prescribing of statins in nursing home patients.

Results: 55 patients were included in the study. Of the 55 patients, 7 (12.7%) patients were on a statin. Average age of patients on a statin was 77.8 years (SD 9.4).

Conclusion: Firstly, this study highlights the incidence of inappropriate prescribing of statins in older patients in long term care. It also raises the question surrounding the indication of statin therapy in secondary prevention where
cholsterol level are within target range highlighting the need for further studies examining the benefit of statins in frail older patients in LTC.

**EFFECT OF REGULAR MULTIDISCIPLINARY PSYCHOTROPIC REVIEW MEETINGS ON ANTI-PsYCHOTIC PRESCRIBING PRACTICES IN A COMMUNITY NURSING UNIT**

**Barbara Giles**,1 Lesya Gamanova,1 Arlene Adaniz,1 Joy Gigace,1,2 Frances McCarthy,1,2,3

1 St. Mary’s Hospital, Dublin, Ireland
2 Mater Misericordiae University Hospital, Dublin, Ireland
3 University College Dublin, Dublin, Ireland

**Background:** The management of non cognitive symptoms of dementia can be challenging for people living with dementia and their carers. The risks and limited benefit of antipsychotics in this setting is well documented however despite this they are still often prescribed. A previous study at our facility in 2016 highlighted a high prevalence of antipsychotic prescribing at 35% (Bambrik et al, 2016). As a result of this, multidisciplinary psychotropic review meetings were established and are ongoing.

**Methods:** Two wards in our community nursing unit were selected. Inclusion criteria included residency > 6 months. The case notes, medication lists (admission and current prescriptions), and psychotropic review meeting notes were reviewed.

**Results:** 43 residents were included in the study. 72% (n=31) were female. The average age was 85 years. 74% (n=32) of residents had a documented dementia diagnosis. On admission, 7 residents were taking regular antipsychotics. 5 of these medications were subsequently either reduced or discontinued.

At the time of the study, 16% (n=7) were prescribed regular antipsychotics. There was a definite indication for 3 of these (schizoaffective disorder, psychosis, paranoid delusion). 1 resident had a traumatic brain injury with associated distressing symptoms with harm incidents. 3 had a dementia diagnosis with associated distressing symptoms. A further 14% (n=6) were prescribed antipsychotics on a PRN basis. 5 had a documented diagnosis of dementia with associated distressing symptoms. None of these residents received these medications in the 4 weeks prior to the study.

**Conclusion:** Significant improvements are noted since 2016 with the overall prevalence of antipsychotic prescribing decreasing from 35% to 16%, with the majority of these prescriptions having a clear indication. It is reassuring that residents are not receiving antipsychotics frequently. We await the national clinical guidance on ‘Appropriate Prescribing of Psychotropic Medication in People with Dementia’ to further guide our practice.

**EXPLORE THE COMPLEXITY OF DEMENTIA AND LONELINESS IN IRELAND**

**Irene Hartigan**,1 Nicola Connolly1,2 Tony Foley1, Suzanne Timmins1,2, Gyunghee Park1, Aisling Jennings1, Nicola Müller1

1 University College Cork, Cork, Ireland
2 Health Service Executive, Cork, Ireland

**Background:** Dementia and loneliness are both complex phenomenon’s that impact on both mental and physical health. Research has identified that loneliness can increase a person’s risk of mortality as much as smoking or alcohol consumption. People with dementia are at particular risk of loneliness and social isolation. This can negatively impact on a person with dementia’s health. To effectively address loneliness in dementia, we must first understand how people with dementia experience loneliness.

**Methods:** Interviews were conducted with people living with dementia. Participants comprised of eight community-dwelling individuals, aged 55 years and older (mean = 63.8; range = 55-77), who were each diagnosed with dementia at least one year prior to interview (range = 1.16 – > 5 years). Interviews were conducted in participants’ homes using a semi-structured format and lasted between 37-74 minutes.

**Results:** Three key themes emerged: the importance of maintaining meaningful relationships, maintaining independence and socio-cultural influences on individual perceptions of loneliness and dementia. The results emphasise the importance of maintaining both a sense of self and meaningful relationships with others post-diagnosis for individuals who identified themselves as ‘not lonely’. People living with dementia reported that the maintenance of social connection aids in fostering a sense of self-worth and self-management, which in turn mitigates feelings of loneliness. The majority of participants existing social connections with others was established prior to their diagnosis, although the maintenance of these relationships may have required an adjustment of their premorbid routines and method of social engagement.

**Conclusion:** Human contact and a meaningful relationship are superior in preventing loneliness. Individual feelings of loneliness or lack thereof are not directly correlated to the coping mechanisms most commonly employed by individuals with dementia. Further exploration is need to understand how people with dementia, who live at home, perceive or experience loneliness.

**GENERAL PRESCRIBING: WHERE ARE WE NOW? PRESCRIBING EDUCATION IS NOT ENOUGH**

**Aafie Leahy**, Jason Hyres, Kiran Safi, Christine E. McCarthy, Nur Atikah Mohd Arie, Amitra Roy, Elizabeth Murphy, Salim Seboua, Ahmed Garb, Muhammad Daniel Zulkifli, Basli Matti, Paul O’Hara, James Crotty, Colin Quinn, Catherine Peters, Declan Lyons, Margaret O’Connor

**Background:** Generic Prescribing is an essential component of prescribing, however it is often overlooked. Use of brand names can lead to poor recognition of the correct medications. It can also led to medication error. It is part of the policy of our hospital group that generic prescribing is used at all times. We performed a similar audit in 2018 and 79% of drug kardexes had brand names used. Prescribing education is an integral part of NCHD teaching. We wished to re-audit to determine rates of generic prescribing now.

**Methods:** We reviewed all drug kardexes in 14 wards both medical and surgical in a 48 hour period. Each drug was reviewed and if any prescription had brand names, the entire kardex was deemed non-compliant.

**Results:** 285 Drug kardexes were assessed across 14 separate wards. 41% were on surgical wards, 59% were on medical wards. 31 (11%) of kardexes had complete generic prescribing. Only 3 kardexes on the surgical ward had complete generic prescribing.

**Conclusion:** The low rates of generic prescribing remain an issue in our university teaching hospital. A similar audit was performed in 2018 with average rates of 20% of generic prescribing. This has decreased in the last year. The failure to generic prescribe puts patients at risk of medication error and also increases cost to the HSE. Education on prescribing is part of the NCHD induction, however, 9 months on there continues to be issues with compliance with generic prescribing. Education alone is not enough to improve current practice. The use of e prescribing offers the potential to alleviate this problem.

**THE IMPACT OF IMPLEMENTATION OF RECOMMENDATIONS FROM THE IFHD 2017 ANNUAL REPORT IN AN IRISH MODEL 3 HOSPITAL**


**Our Lady of Lourdes Hospital, Drogheda, Louth, Ireland**

**Background:** Hip fractures in the older person are associated with high mortality rates (NICE, 2011). Up to 40% of patients never regain their pre-fracture mobility, 10-20% never return to live at home. The Irish Hip Fracture Database (IFHD) National Report 2017 recommends appointment of an orthogeriatric consultant in this hospital to achieve IFHD standards 4 to 6.

**Methods:** We analysed a subset of HIPE data collected for the IFHD in patients over 60 years over a three month period from September – November 2017 and compare it to September – November 2018 after introduction of an orthogeriatric service. We looked at geriatrician review, bone health assessment, falls assessment, discharge destination, 30-day re-admission rate and mortality during admission.

**Results:** There were 45 hip fracture patients in each group. In the 2017 group, mean age was 79, female 64%; compared to mean age of 80, female 62.2% in 2018. In 2018, after the appointment of an orthogeriatrician, 96.5% of patients were seen by a geriatrician compared to 4.4% in 2017. In 2018, 97.7% received bone health assessment compared to 26.8% in 2017. In 2018 95.3% received specialist falls assessment, compared to 2.4% in 2017. Mean length of stay was 18 days in 2018 versus 13 days in 2017. 2.2% of patients were discharged to convalescence in 2018, 26.7% in 2017. 57.8% of patients were discharged to off-site rehabilitation in 2018 compared to 40% in 2017. 2.2% patients died during admission in 2018, 8.9% in 2017. In 2018, 6.7% of patients were readmitted within 30 days, 8.8% in 2017.

**Conclusion:** Provision of rapid Comprehensive Geriatric Assessment to all hip fracture patients, reduces falls and fracture risk. There is evidence of improvement in IFHD standards 4-6, mortality rate and 30-day readmission rate. Moreover, the orthogeriatric service has led to increased referral to rehabilitation services ensuring optimal functional recovery.

**AN INTEGRATED APPROACH TO FEAR OF FALLING**

**Eleanor Murphy**,1 Petra McLoughlin1, Fiona O’Sullivan1, Ciara Connellan1

1 Sligo University Hospital, Sligo, Ireland
2 St John’s Community Hospital, Sligo, Ireland

**Background:** Fear of falling (FOF) is a known risk factor for falls and subsequent activity restriction which has implications for quality of life and frailty level in older persons. The Integration Care Team for Older Persons in Sligo provides home-based rehabilitation for the acutely frail older adult. We noted that fear of falling was a commonly identified problem in our referral group following comprehensive geriatric assessment (CGA). Our study aims to characterise interventions required.

**Methods:** Descriptive study from CGA of acutely frail older adults with a FOF in all referrals to ICTOP from June to December 2018.

**Results:** Of the 52 patients studied, 67% reported a FOF with a higher incidence in females (81% vs 45%). Increasing age was associated with a greater likelihood of FOF with 0% reported at 70-74years (n=4) and 86% at 90-95 years (n=7). There was a 1.6 times increased risk of FOF associated with cerebral vascular disease and 1.26 with mental health issues.

The median Rockwood Clinical Frailty score was 6 with a median TUG of 28 seconds. Of those with a FOF, 100% received falls education, a home exercise program and advice on acquiring a pendant alarm. A mobility aid was provided in 63% and additional functional aids in 71%. Major housing adaption advice was given in 50% and additional equipment signposting and purchasing advice in 66%. Transport advice was provided in 49% of
cases and onward referrals to ophthalmology and orthodontics were provided in 9% and 11% respectively.

There were only 2 readmissions with a fall within 30 days.

Conclusion: A significant cohort of ICTOP referrals report a fear of falling. Specific physiotherapy and occupational therapy interventions aim to reduce the impact of this and our low rate of readmissions due to falls indicates the success of this program.


330 INSIGHTS INTO DEMENTIA- AN INTEGRATED CARE APPROACH TO FAMILY SUPPORT
Cathy McHale1,2, Martina McGovern1, Josephine Dewergifosse3, Maria Domsa4, Anna McPhail5, Fergus Timmonds4, Julie Greece6, Fiona Tobin7, Aine Bennett7, Myra Donnelly7, Tara Coughlan7, Desmond O’Neill7, Joshi Doolan7, Caroline Hyland3, Jean Scanlan8, Daniel Ryan1, Paul McElwaine7, Sean Kennedy7.

Methods: Staff from the Integrated Care Team, Specialist Memory Service and Primary Care were trained by the Alzheimer’s Society of Ireland to deliver a 6 week ‘Insights Into Dementia’ carers course. Tutors and dementia advisors from the Alzheimer’s Society of Ireland provided in-depth training prior to course delivery and feedback to the facilitators on a weekly basis. The course included advice and education on Dementia, Cognitive Changes, Relationships, Communication; Responding to changes in behaviour; Nutrition; Engaging in activities; Assisting with personal care and Safety in the home. Families gained advice regarding their self-care needs and learned how to access information and support. All services involved worked together to identify, refer and support families with dementia in the local area. The group took place in an accessible location at a time which accommodated families to attend. Each course attendee completed a questionnaire prior to and after commencement of the group.

Results: The group has delivered education and support to 48 families to date. Feedback from participants was very positive with self-reported increase in confidence, knowledge and awareness about dementia. Waiting time to access support has significantly decreased. Every course has led to a supported group who meet up on a regular basis in their community. Conclusion: This novel collaboration has become a key part of the integrated care pathway we have developed to support people living with dementia and their supportive others in our catchment area. The Integrated Care approach has served to enrich the programme and allow for timely upgooting to localised supports.

331 IMPLEMENTATION OF COMMUNITY BASED COMPREHENSIVE GERIATRIC ASSESSMENT AND INTERVENTION IN A RURAL IRISH SETTING
Peta McLaughlin1, Eleana Murphy4, Fiona O’Sullivan1, Ciara Conneally2.

1 Sligo General Hospital, Sligo, Ireland
2 St John’s Community Hospital, Sligo, Ireland

Background: The Integrated Care Team for Older People (ICTOP) in Sligo formed in 2018 to provide home based rehabilitation for acutely frail older adults to enable them to continue to live independently. It serves a predominantly rural catchment area with 14.5% aged >65 years versus the national average of 11%.

An in-home person-centred multidisciplinary approach is utilized based on the principles of comprehensive geriatric assessment (CGA). This observational study aims to describe the typical user of this service, interventions and outcomes to date.

Methods: An Excel database was compiled and analysed from CGA of consecutive referrals from June to December 2018.

Results: Of the 70 referrals studied, 69% resided in rural Sligo, two thirds were female and there was a mean age of 82.3 (range 68-95). The median Rockwood Clinical Frailty Scale level was 6 and the median Timed Up and Go was 28 seconds. Hospital in-patients accounted for 58% of referrals with functional deterioration (74%), mobility decline (72%) and cognitive decline (28%) the most frequent referral reasons. Gait imbalance was the most prevalent co-morbidity (77%). There was an average of 4.5 home visits per person.

Over 80% of referrals received combined physiotherapy and occupational therapy input, with Clinical Nurse Specialist (CNS) in Dementia involvement in 40%, speech and language therapy in 26% and social work in 15%. CGA identified additional clinical and social needs in 100%, and the team made 217 onward referrals to available community health and social supports. ICTOP referral decreased length of stay by 2.6 days and only one patient required long term care.

Conclusion: The use of a multidisciplinary team providing domiciliary assessments decreased hospital stay, facilitated maintenance of independent living and addressed both identified and un-identified needs in a frail older person’s population. Further evaluation over time is needed to indicate impact on readmission rate.


332 GEMS: GERIATRIC EMERGENCY SERVICE - OUTPUTS AND OUTCOMES FROM THE ACUTE FLOOR TEAM

Background: Frailty is now a key concept in healthcare planning and delivery and is driving vertical and horizontal integration. The positive narrative of Frailty is further emphasised by the growing scientific evidence in the prevention, reversal and modification of Frailty. Early identification of Frailty and early intervention with Comprehensive Geriatric Assessment (CGA) is fundamental. Older people with Frailty admitted to hospital who receive a CGA early are more likely to return home. Benefits are seen early and are sustained (Ellis et al 2011).

Methods: The aim of GEMS is to improve care, outcomes and the patient experience for older people living with Frailty. All people aged 75 years and older who attend as an emergency are screened on triage using the Variable Indicative of Placement Tool (VIP). Screening is automatic and mandatory. The GEMS Acute Floor Team respond early to those who screen positive by starting a CGA. The GEMS Home Team can manage those who are admitted.

Results: Over 2 years, 10,037 patients were triaged. The median time from arrival to VIP was 15 minutes. 43% screened positive for Frailty. 66% received a CGA. The median time from VIP to CGA was 1.7 hours. 84% identified at risk of polypharmacy, 27% at risk of malnutrition, 29% with delirium. 74% were admitted from home. 78% returned to pre-admission residence. 4% new admissions to NH care. Median length of stay was 7 days. The readmission rate within 30 days was 16%, 7% in hospital mortality.

Conclusion: The GEMS Team have developed and delivered a pioneering integrated care approach to the management of older persons at high risk of adverse outcomes attending the acute floor.

333 A TRANSCONTINENTAL EFFECTIVENESS-IMPLEMENTATION STUDY OF THE FAMILY CARER DECISION SUPPORT INTERVENTION TO IMPROVE END OF LIFE CARE IN LONG-TERM CARE
Irene Hartigan1, Kevin Braz1, Sharon Kasalainen2, Tamara Sussman3, Jenny Van Der Steen4, Martin Loucka5, Paola Di Giulio6, Nicola Cormally7.

1 University College Cork, Cork, Ireland
2 Queen’s University Belfast, Belfast, United Kingdom
3 McMaster University, Hamilton, Canada
4 McGill University, Montreal, Canada
5 Leiden University Medical Center, Leiden, Netherlands
6 Center for Palliative Care, Prague, Czech Republic
7 University of Turin, Turin, Italy

Background: The Family Carer Decision Support (FDCS) intervention has been designed to inform family carers about end of life care options available to a person living with advanced dementia. The FDCS intervention demonstrated a statistically significant impact in reducing family carer decision uncertainty on establishing goals of care at the end of life and, improved family carer satisfaction on quality of care in a study conducted in the United Kingdom.

Methods: The aim of this research is to adapt the application of the FDCS for use in different countries. Funding supported through the EU Joint Programme – Neurodegenerative Disease Research (JPND) project has supported the scaling up of the FDCS transnationally in the United Kingdom; Republic of Ireland; Netherlands; Canada; Czech Republic ; and, Italy. Launched in April 2019, this presentation will report on present activities including: a) description of the FDCS intervention; b) strategy for implementing the FDCS in care homes; c) study design employed for the evaluation of the FDCS; and d) work packages and that will be deployed to achieve intended outcomes.

Results: Expected project outcomes of this work will include a) develop guidelines to facilitate transnational use of the FDCS within care homes; b) staff education material including web learning resources; c) family carer informational material including web learning resources; d) measures and tools to evaluate the uptake and outcome of the FDCS intervention; e) establish a transnational FDCS community of practice across study care homes; f) estimated costs of providing the FDCS intervention; g) evidence of enhancing decision making among family members regarding resident care and satisfaction with care.
Conclusion: Recent research revealed that care home structures and staff play an important role in the successful implementation and adoption of innovations such as the FCDS intervention, this is further examined in this transnational study.

GEMS: GERIATRIC EMERGENCY SERVICE - ROCKWOOD'S CLINICAL FRAILTY SCALE AND OUTCOMES


Background: Rockwood's Clinical Frailty Scale (CFS), which uses clinical descriptors and pictographs, was developed to provide clinicians with an easily applicable tool to stratify older adults according to level of vulnerability. The CFS was validated in a sample of 2305 older participants from the Canadian Study of Health and Aging and was shown to be a strong predictor of institutionalisation and mortality (Rockwood K, 2005).

Methods: The aim of GEMS is to improve care, outcomes and the patient experience for older people living with Frailty. All people aged 75 years and older who attend as an emergency and screen positive for Frailty.

Results: 10,037 patients were triaged in the first two years of the service. 32% needed immediate care for older people living with Frailty. All people aged 75 years and older who attend an emergency and screen positive for Frailty.

Conclusion: The GEMS Home Team was planned and developed in December 2018 to case manage all those who are admitted.
THE IMPACT OF MEDICINE RECONCILIATION BY A CLINICAL PHARMACIST COMPARED TO STANDARD CARE FOR ELECTIVE ORTHOPAEDIC ADMISSIONS

Yvonne Connelly1, Sadhith N’ Cheallaigh1, Charles O’Connell1, Stephen Byrne2
1 Cappagh National Orthopaedic Hospital, Dublin, Ireland
2 School of Health and Social Care, University College Cork, Cork, Ireland

Background: Medicine reconciliation is defined as ‘The process of creating and maintaining the most accurate list possible of all medications a person is taking’. Medicine reconciliation (MR) is supported by various Irish governmental agencies such as the HSE, HIQA, PSI and the State Claims Agency. In addition, Irish GPs and community pharmacists are strongly in favour of expanding the role of hospital pharmacists in MR at all transitions in care. The aim of this study are to establish the appropriateness of the current MR service in elective surgical admissions in a Dublin based hospital.

Methods: This was a prospective interventional study that included 200 consecutive patients who met the inclusion criteria. The study was conducted between May and June 2018. All patients in the study received standard care in the control arm, followed by enhanced care in the interventional arm with errors noted and rectified after each process, this design allowed patients under standard care to act as a paired control group. Sub group analysis was performed on the following: (1) those > 65 years, (2) female patients, and (3) patients with a BMI > 30kg/m². Ethical approval was obtained for this project.

Results: We found to detect a statistically significant number of errors compared to standard care (p=0.039). In the sub-group analysis, those >65 years (p=0.0237) or female (p=0.001), were at statistically higher risk of experiencing a MR error, verses obese patients (p=0.389). The Cornish classification tool was used to assess severity of the MR errors; while 37.9% of patients experienced at least one MR error, only between 1.3% - 3.5% of errors were classified as Class 3 errors.

Conclusion: A full medicine reconciliation service could be of benefit to targeted patients including those aged over 65 years or female, experiencing polypharmacy, or those with communication difficulties.

THE PREVALENCE AND FACTORS ASSOCIATED WITH ANTI-PSYCHOTIC PRESCRIBING ON ADMISSION TO A DEMENTIA SPECIFIC NURSING HOME

Andrew Eustace, Elaine Murray, Kelley Daly
Highfield Healthcare, Dublin, Ireland

Background: The use of psychotropic medications and their adverse effects in frail adults has been debated extensively. However, it is unclear if antipsychotics are initiated in a nursing home or if the new resident arrives with the medication prescribed. The purpose of this study is to ascertain how many residents are already on antipsychotics and which factors, make them more likely to be on this medication.

Methods: All admission notes to the centre between 1st Jan 2018 and 31st Dec 2018 were reviewed. Inclusion criteria was any person admitted with a diagnosis of dementia. Exclusion criteria was anyone who had psychiatric diagnosis such as bipolar disorder or schizophrenia. We collected data on age, gender, referral pathway (hospital or community), MMSE, Barthel, Cohen Mansfield Agitation Inventory (CMAI) For comparisons of characteristics between the two groups (psychotropic drugs at admission: yes/no), the independent samples t-test (normally distributed data) or the Mann-Whitney U test (non-normally distributed data) was used for continuous variables and Fisher’s exact test was used for categorical variables.

Results: There was a statistically significant relationship between source of admission and whether or not the patient was receiving psychotropic drugs on admission (p=0.017). 88.0% of patients on psychotropic drugs on admission came from an acute hospital setting. In contrast, only 4.0% of patients receiving psychotropic drugs on admission came from home. Patients on psychotropic drugs at admission had higher CMAI scores compared to patients not on psychotropic drugs. Patients on psychotropic drugs at admission were younger (mean(SD): 76.28±7.7 years) than patients not of psychotropic drugs (mean(SD): 82.98±3).

Conclusion: Prevalence of prescribing antipsychotics outside of nursing homes is high with many residents being admitted already on these medications. Efforts should be put in place to admission to nursing homes to reduce and stop antipsychotics which have been initiated in the community and hospital setting.

THE ASSOCIATION BETWEEN BENZODIAZEPINE USE AND FALLS, AND THE IMPACT OF SLEEP QUALITY ON THIS ASSOCIATION: DATA FROM TILDA

Louise Marron1,2, Ricardo Seguroda3, Paul Claffey1, Rose Anne Kenny4, Triana McNicholas1,2,5
1 School of Public Health, Physiotherapy and Sports Science, University College Dublin, Dublin 4, Ireland
2 Department of Public Health, HSE East, Dublin, Ireland
3 School of Public Health, Physiotherapy and Sports Science, University College Dublin, Dublin, Ireland
4 Department of Medical Gerontology, Trinity College Dublin, Dublin, Ireland
5 The Irish Longitudinal Study on Ageing, Department of Medical Gerontology, Trinity College Dublin, Dublin, Ireland

Background: Benzodiazepines (BZD) are associated with adverse effects, particularly in older adults. Previous research has shown an association between BZDs and falls and BZDs have been shown to impact sleep quality. The aim of this study is to assess the association between BZD use and falls, and the impact of sleep quality on this association, in community dwelling adults aged over 50.

Methods: Data from the first wave of The Irish Longitudinal Study on Ageing were used. Participants were classed as BZD users or non-users and asked if they had fallen in the last year, and whether any of these falls were unexplained. Sleep quality was assessed via self-reported trouble falling asleep, daytime somnolence, and early-rising. Logistic regression assessed for an association between BZD use and falls, and the impact of sleep quality on this association was assessed by categorising based on BZD use and each sleep quality variable.

Results: Of 8,175 individuals, 302 (3.69%) reported taking BZDs. BZD use was associated with falls, controlling for co-founders (OR 1.41; 95% CI 0.95, 2.10; p-value 0.09), however a similar effect size to all falls was conducted with a purposive sample, and the corresponding prescribing physiotherapists, to achieve maximal variation in terms of HEP adherence, age and sex. The interviews were audio recorded, transcribed, and simple content analysis performed.

Conclusion: BZD use is associated with falls, with larger effect size in BZD users reporting poor sleep quality in community dwelling older adults. Appropriate prescription of and regular review of medications such as BZDs is an important public health issue.

HOW DO WE INCREASE ADOHERENCE TO HOME EXERCISE PROGRAMMES? INTERVIEWS WITH OLDER ADULTS AND PHYSIOTHERAPISTS

Siti Khalijah1, Suzanne Timmins2
1 AMWA Ltd Singapore, Singapore
2 Centre for Gerontology and Rehabilitation, School of Medicine, University College Cork, Cork, Ireland

Background: Regular exercise and physical activity can maintain function and cardiovascular health, and prevent cognitive decline, in older adults. However, studies show that there is often poor adherence to home exercise programmes (HEP). The purpose of this study was to explore how HEP are perceived by both older adults and physiotherapists.

Methods: A convenience sample of 28 older adults attending outpatient physiotherapy clinics were given an exercise journal to record their adherence to the HEP prescribed by their physiotherapists for six weeks. Subsequently, semi-structured interviews were conducted with a purposive sample, and the corresponding prescribing physiotherapists, to achieve maximal variation in terms of HEP adherence, age and sex. The interviews were audio recorded, transcribed, and simple content analysis performed.

Results: Fourteen participants returned their exercise journal. Median age was 80; half were female; median Berg Balance Score and Timed-up-and-Go-Test were 49 and 16 seconds respectively. Participants exercised a median 79.8% of the prescribed dose, or 5.6 days per week. Seven older adults were interviewed; about half had a positive attitude towards exercise. They were also moderately positive about their HEP (comments ranged from “double” and “nothing bad about it” to “enjoyable”). Barriers included time, mood, boredom, remembering to do the HEP and variable health status. Enablers included simple instructions and design, family encouragement, and sense of achievement. Physiotherapists (n=5) perceived that many older adults aren’t compliant with HEPs, but there was some therapeutic nihilism (“you can’t force them”). Their HEP instructions varied from verbal to written instructions/diagrams; one physiotherapist used individualised video content. Notably, participants with good adherence understood their HEP well in terms of content and purpose, although this may be cause or effect.

Conclusion: To improve compliance with HEP, healthcare professionals need to take time to motivate the recipient, simplify their instructions, and trouble-shoot potential barriers at the time of prescription.

NUMERACY PERFORMANCE AND THE RELATIONSHIP TO AGE AND RETIREMENT AMONG COMMUNITY-DWELLING ADULTS

Maureen Pickles1, Craig Carpenter2, Scott Loveridge1
1 Western Michigan University, Kalamazoo, USA
2 Texas A & M University, College Station, USA
3 Michigan State University, East Lansing, USA

Background: Remaining in the workforce in later life may be based on financial need, role fulfillment or opportunities for social participation. Employment can also provide intellectual stimulation, including the use of everyday math skills. Normal age-related decline in numeracy performance has been documented, but little is understood. This research uses population-based telephone surveys to analyze whether the interaction of age and retirement influences the ability of community-dwelling adults to calculate simple math problems.

Methods: Data was drawn from three independently sampled surveys in 2006 (n=991), 2010 (n=1,023) and 2014 (n=997). In addition to standard demographic questions, the survey measured individuals’ ability to perform basic computations. Three questions were...
asked regarding temporal (now or 5 years later) preferences about jobs, a community bond, and an inheritance payout. Respondents were then asked to calculate the amount needed to select the other option instead. Deficient numeracy performance was defined as either no response or an irrational choice (e.g. a lesser amount of inheritance with the alternative choice.)

Results: Approximately 30% of persons age 65+ chose not to perform the follow-up calculations for these questions. Moreover, a 1% increase in age decreased the likelihood of rationally calculating the discount rate by between 0.15 and 0.25 percentage points, depending on the scenario. A sharp decline in numeracy was observed starting at age 66 with the addition of an age x retirement interaction, even when controlling for key variables such as education and income.

Conclusion: Retirement may reduce the opportunity for intellectual challenges afforded in the workplace and consequently, the ability to perform math calculations may decline. Alternatively, decisions to retire may be due to declining health, including cognitive impairments. The timing of retirement has major implications for public policy. Future research more deeply exploring the causal influence of retirement on health and well-being is warranted.

**351 INTEGRATION OF AUDITORY AND VISUAL INFORMATION IS ASSOCIATED WITH AGEING, SEX AND COGNITIVE PERFORMANCE**

AnnaLisa Setti, Belinda Hernández, Rose Anne Kenny, Fiona N Newell

University College Cork, School of Applied Psychology, Cork, Ireland

Trinity College Dublin, TILDA, Dublin, Ireland

Trinity College Dublin, Institute of Neuroscience, Dublin, Ireland

Background: In ageing, multisensory integration, i.e. the ability to combine efficiently information from different sensory modalities, is emerging as a stand-alone contributor to explaining cognitive and functional deficits. Experimental evidence shows that inefficient multisensory integration is associated with cognitive impairment, falls and balance maintenance; however these findings need to be supported by large population representative studies. We utilised the Sound-induced flash illusion (SIFI) as test of multisensory efficiency; the test was conducted on a population representative sample from the Irish Longitudinal Study on Ageing (TILDA). We hypothesised that Susceptibility to the SIFI would increase with ageing and would be associated with poorer Montreal Cognitive Assessment (MoCA) scores.

Methods: Participants: 3,955 adults aged 50 years and over. Participants provided informed consent. Data were drawn from the third wave of the TILDA study, in which participants took part in a Computer Assisted Interview and a Health Assessment. The SIFI test was part of the Health Assessment; SIFI is a computer-based test in which participants see a series of white dots appearing quickly on the screen, which participants are required to count; the dots (flashes) can be paired with 0, 1 or 2 beeps; when one dot is paired with two beeps, there is the illusory perception that two dots are presented. A hierarchical Bayesian, ordinal-regression model was used to determine which variables predicted audio-visual integration (SIFI proportion of correct responses, i.e. no illusions). We controlled for a range of covariates.

Results: As predicted, higher susceptibility to the SIFI, indicating higher integration of audio-visual information, was associated with older age, and poorer scores at MoCA. Female sex was also associated with higher susceptibility, which represents a novel result in the literature.

Conclusion: The present study presents the first findings on multisensory integration in a large population representative study. They confirm that inefficient integration is associated with ageing, poorer cognition and, unexpectedly, being female.

**352 GREY AND WHITE MATTERS – DESIGNING AND IMPLEMENTING AN ACUTE STROKE PROGRAM IN A LEVEL 3 HOSPITAL**

Bart Daly, Richard Liston, Susan Griffin

University Hospital Kerry, Kerry, Ireland

Background: Following the publication of the National Stroke Audit in 2015 with below the national average rates of thrombolysis – 3.3% versus 11% - there has been a number of initiatives launched to improve stroke care in this hospital. In 2018 we enrolled in the National Quality Improvement Project for the care of Patients with Acute Ischaemic Stroke run by the RCSI. A stroke steering committee was established consisting of a multi-disciplinary group encompassing all areas of acute stroke care.

Methods: Acute stroke care practice and factors causing sub-optimal management were examined by the committee and compared with national standards.

A ‘3 jobs’ proforma for management and communication of Fast positive cases was designed to address the difficulties identified in stroke care and tailored to the resources available in this hospital. These simplified and standardised roles for all staff members involved, many of whom were unfamiliar with the practical delivery of thrombolysis and thrombectomy. Educational sessions were initiated for all those involved in acute stroke management.

The acute stroke program was implemented as a 6 month pilot before official launch in April 2019 with necessary changes assessed weekly by the stroke committee. Stroke data is continually audited with the National Stroke Register. Key Performance Indicators (KPIs) in the pilot were thrombolysis/thrombectomy rates and door to needle time.

Results: There were 164 patients admitted to the stroke unit in 2018. In 2018 prior to this initiative, the hospital had a 3% thrombolysis rate in 2018 and a 1% thrombectomy rate. Amongst FAST positive patients during the pilot period, 10/68 patients were thrombolysed (15%) and 6/68 thrombectomies (9%). Average door to needle time for patients was 96 minutes.

Conclusion: The redesigning of the acute stroke care program has led to significant improvements in the identified KPI’s although door to needle times remain below the national target of 30 minutes.
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