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Book of Abstracts

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PLATFORM PRESENTATION: MAJOR TRAUMA AND FALLS: WEDS 11.30-11.45

3115. Scientific Presentation - Falls, fracture and trauma

MAINTAINING INDEPENDENCE IN PEOPLE WITH DEMENTIA WHO HAVE HAD A FALL: A PILOT CLUSTER RANDOMISED CONTROLLED TRIAL (MAINTAIN)

L Allan[1,3]; L Greene[1]; B Whale[2]; J Connors[2]; A Sharma[1]; A Bingham[1]; A Hall[1]; C Hulme[1]; V Goodwin[1]; S Morgan-Trimmer[1] on behalf of the Maintain team

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Introduction: Falls are very common in dementia and lead to a loss of independence. Previous trials of interventions for falls in dementia have not aimed to maintain independence. This pilot cluster randomised controlled trial (RCT) examined the feasibility of a home-based rehabilitation intervention designed to enhance independence in people with dementia who had fallen, aiming to inform the design of a future definitive RCT.

Methods: This study used a mixed-methods design with an embedded process evaluation (reported separately) to assess the intervention's feasibility, fidelity, and acceptability. Participants over 50, diagnosed with dementia and a history of falls within the last 6 months, were recruited from six sites across the UK (randomised 1:1 by site to intervention or usual care). The intervention consisted of personalised rehabilitation sessions delivered by healthcare professionals, based on personal goals. Feasibility outcomes included recruitment, retention, adherence rates, and participant acceptability, with data collected through standardised measures.

Results: Thirty-one participants, with a mean age of 78 years (SD = 9.03), were recruited, (29 White British, 1 mixed race, 1 other). Of 54 individuals screened, 36 (66%) met eligibility criteria; among these, 36 were approached, and 31 (86%) of these consented to participate. 18 started the intervention and 13 started usual care. 27 underwent 3 month follow up and 25 underwent 6 month follow up. Among the intervention participants the mean initial assessment time was 2.05 hours, mean number of sessions was 15, range (6-25). Primary outcome data collection was 96.8% at baseline and 100% at the 6-month follow-up.

Conclusions: The Maintain intervention showed feasibility among people with dementia who had fallen, as evidenced by the trial processes for participants who entered the study. The progression criteria for going on to a definitive RCT to demonstrate the effectiveness and cost-effectiveness of the intervention were met.

PLATFORM PRESENTATION: MAJOR TRAUMA AND FALLS: WEDS 11.45-12.00

3114. Scientific Presentation - Neurology and Neuroscience

A REHABILITATION INTERVENTION TO IMPROVE RECOVERY AFTER AN EPISODE OF DELIRIUM IN ADULTS OVER 65 YEARS (RecoverED)

L Allan[1,3]; J Um[1]; A O'Connell[2]; J Connors[2]; A Laverick[1]; A Bingham[1]; K Chandler[1]; S Raghuraman[1]; L Goodwin[1]; L Clare[1,3] on behalf of the RecoverED team

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Introduction: Delirium, a common cognitive disorder in hospitalised older adults, prolongs stays and increases costs. However, research on post-discharge rehabilitation interventions is limited despite its importance. This study examined the feasibility of a home-based rehabilitation intervention designed to enhance recovery outcomes for older individuals after hospital discharge following delirium, aiming to inform the design of a future randomised controlled trial (RCT).

Methods: Mixed-methods design with an embedded process evaluation (reported separately) to assess the intervention's feasibility, fidelity, and acceptability. Participants over 65, diagnosed with delirium during hospitalisation, were recruited from six NHS hospitals across the UK. The intervention started within two weeks of discharge and consisted of personalised rehabilitation sessions delivered by healthcare professionals. Feasibility outcomes included recruitment, retention, adherence rates, and participant acceptability, with data collected through standardised measures.

Results: Nineteen participants, with a mean age of 84.98 years (SD = 6.49), were recruited, (all White British). Of 308 individuals with delirium, only 36 (11.7%) met eligibility criteria; among these, 24 were approached, and 19 (79%) of these consented to participate. Among those, 68% started the intervention, but only 53% completed at least six sessions, and 47% remained by the final follow-up. Initial assessments occurred an average of 18 days (SD = 13.01) post-discharge, with 77% completed within 14 days. Participants averaged eight sessions (SD = 2.9). Primary outcome data collection was 89.5% at baseline and 100% at the 6-month follow-up. The economic evaluation indicated a total cost of £1,249.29 per participant, covering assessments, intervention sessions, and training costs.

Conclusions: The RecoverED intervention showed feasibility among older adults recovering from delirium, as evidenced by the trial processes for participants who entered the study. However, recruitment challenges indicate a need for better strategies, and further research through a definitive RCT to demonstrate the effectiveness and cost-effectiveness of the intervention.

PLATFORM PRESENTATION: CLINICAL QUALITY SESSION: WEDS 14.30-14.45

3141. Clinical Quality - Improved Access to Service

QUALITY IMPROVEMENT: INTEGRATING SPEECH AND LANGUAGE THERAPY INTO A HOSPITAL AT HOME SERVICE FOR OLDER PEOPLE LIVING WITH FRAILTY

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Introduction: Oropharyngeal dysphagia (OD) affects up to 47% of older people with frailty (Tagliaferri et al., 2019). Community Speech and Language Therapy (SLT) services face challenges in identifying and addressing this need due to limited resources, poor awareness of SLT value, and workforce skill gaps.

This Quality Improvement (QI) project used an A3 improvement approach to understand SLT service needs of patients and explore benefits of integrating services with frailty on the caseload of a Hospital at Home (H@H) service.

Method: SLT provision for H@H is 0.2 WTE and excludes time for board rounds. Four PDSA cycles tested the impact of SLT attending board rounds twice weekly to offer direct support, improve service visibility, and initiate referrals. Referral numbers and staff feedback were monitored. Concurrently, PDSA cycles developed training sessions for community staff to improve dysphagia management and referral accuracy. Metrics included participation rates and feedback.

Results: Referrals increased by 500%, from 2 to 12 monthly. Staff feedback highlighted enhanced interdisciplinary collaboration, improved patient outcomes, and increased access to real-time advice. One H@H staff member shared, “readily available to ask advice and answer questions ensuring I have the correct information to work with and provide the right care for my patients.” Participation in SLT training rose from 0 to 21, with reported confidence improvements of 20–60%. However, SLT waiting times increased by 60% (55–88 days) due to higher referral volumes. Reliance on temporary staff underscored capacity constraints.

Conclusions: QI methodology can be used to integrate SLT and H@H services for older people with frailty. The project identified unmet SLT needs, improved referrals, and strengthened collaboration. SLT participation in board rounds proved most impactful. Sustaining this change requires further investment in integrated SLT services, expanded training, and streamlined workflows to enhance community care for older adults living with frailty.

PLATFORM PRESENTATION: CLINICAL QUALITY SESSION: WEDS 14.45-15.00

3127. Clinical Quality - Patient Centredness

IMPROVING PALLIATIVE DISCHARGES USING THE GREAT FRAMEWORK.

L Cunliffe

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Aims: 1. Improve the quality of discharge paperwork for fast-track discharges to transition to community care. 2. Improve advance care planning for patients in their last year of life.

Introduction: 30% of hospital inpatients are likely in their last year of life1 GREAT is an acronym for the 5 criteria required for good palliative discharge paperwork. 1) Gold Standard Framework database entry, 2) Record of what patient and family understand, 3) End of life medication review, 4) Advance care planning documentation, 5) Treatment escalation plan (TEP).

Method: A 3 cycle QIP auditing 'Gastro and Liver Unit' discharge summaries for a given month against the 5 GREAT discharge criteria. Inclusion criteria: fast-track discharges or patients meeting SPICT (Supportive and Palliative Care Indicator Tool) criteria. The first cycle occurred in December 2023 with subsequent cycles in March and May/June 2024 following each intervention. The first intervention introduced GREAT discharge posters to clinical areas, and the Palliative Care Team identifying patients who required GREAT discharge. The second intervention created a ward champion to give consistent education to nurses and doctors and highlight patients at board rounds to ensure GREAT discharge.

Results: Pre-intervention there was 0% compliance with GREAT discharges, in comparison to 100% compliance following interventions. After the third cycle 48% of patients meeting SPICT criteria had their TEP status documented in their discharge summary, compared with 5% in March 2024. However, only 1% of them had evidence of advance care planning.

Conclusion: Having a ward champion significantly increased the quality of discharge summaries for fast-track patients. The next step is to see if this change can be implemented across the hospital. Advance care planning for patients that meet SPICT remains poor. Ward champions have been allocated across 5 inpatient wards with a structured GREAT inter-departmental teaching program from December 2024.

PLATFORM PRESENTATION: MOVEMENT DISORDERS: WEDS 15.00-15.15

DISPARITIES IN PARKINSON'S SERVICE PROVISION FOR THOSE LIVING IN A RURAL AREA OF NORTH WEST ENGLAND

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Introduction: As part of an Idiopathic Parkinson's disease (IPD) prevalence study, electronic records were identified for 721 individuals living in North Cumbria under the care of the local specialist service. This study aimed to understand how individuals access services, with a view to identifying trends and barriers.

Methods: An electronic record search was performed to identify frequency of contact with a doctor and Parkinson's nurse specialist (PDNS). Contact within the last three, six or 12 months, and whether this was via telephone or face-to-face was detailed. We recorded contact with tertiary referral services for consideration of advanced therapies. Rural areas were defined as living in a settlement of less than 10,000 people, and most and least deprived areas, defined as the lowest five and highest five deciles of deprivation retrospectively.

Results: In total 93.1% had contact with a specialist within the last 12 months. The number receiving contact from a PDNS within the last six months was 194 (26.9%), lower than seen nationally. Only 23 (3.2%) of this population were receiving/considered for advanced therapies. There was no difference seen in service contact between rural and urban areas. Numbers in the most deprived areas were statistically significantly more likely to not have had service contact in the last 12 months compared to the least deprived areas, 37 (74.0%) (95% CI 61.8-86.2) compared to 13 (26.0%) (95% CI 13.8-38.2). There were statistically significantly fewer numbers with face-to-face PDNS contact in the most, compared to the least deprived areas, 48 (38.4%) (95% CI 29.9-46.90) compared to 77 (61.6%) (95% CI 53.1-77.1).

Conclusion: Greater disparities in service contact were seen between the most and least deprived areas, rather than living in the most remote or rural areas. It is hoped results will inform quality improvement work to improve equitable service provision throughout North Cumbria.

PLATFORM PRESENTATION: MOVEMENT DISORDERS: WEDS 15.15-15.30

3199. Scientific Presentation - Psychiatry and Mental Health

MEMORY FUNCTION AND POST-TRAUMATIC STRESS DISORDER RELATED TO CIVILIAN CONFLICT: FINDINGS FROM THE NICOLA STUDY

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Background: A link between post-traumatic stress disorder (PTSD) and deficits in memory has been reported but often in specialised cohorts of veterans, refugees or other trauma-exposed groups. The Northern Ireland (NI) population were exposed to a prolonged period of civilian conflict known as 'the Troubles' and this study aims to examine the association with PTSD and cognitive performance using data from the Northern Ireland COhort for the Longitudinal study of Ageing (NICOLA).

Methods: Seventeen NI Troubles related exposures were measured in addition to self-reported traumatic events. PTSD symptoms were measured using the PTSD Checklist Civilian version (PCL-C). Linear regression models were used to estimate the effect of PTSD on the objective continuous cognitive measures; immediate and delayed verbal recall, Mini Mental State Examination (MMSE), Montreal Cognitive Assessment (MOCA), Animal naming and Colour Trails test 2 for 2,142 participants that had complete data for key variables.

Results: Based on PTSD symptoms over the previous month, 247 (11.5%) met clinical criteria for current PTSD and nearly 60% of those reported the NI Troubles as their self-reported worst traumatic event exposure. Individuals with PTSD recalled approximately half a word less than those without PTSD on the tests of verbal recall (β -0.47, [-0.71, -0.22]) and scored lower on the global cognitive assessments MMSE (β -0.40, [-0.63, -0.17]) and MOCA (β -1.11, [-1.56, -0.65]), after accounting for sociodemographic characteristics. However, this effect was attenuated after further adjusting for health behaviours and current depression.

Conclusion: Findings demonstrate that NI continues to have high prevalence of PTSD and suggests an effect of trauma on cognitive function in older adults at a population level. Future research should explore the nature of this relationship over time and is an important public health question as those that lived throughout the worst years of the NI Troubles reach older age.

PLATFORM PRESENTATION: RESEARCH: THURS 11.30-11.45

3189. SP - Scientific Presentation - SP - BMR (Bone, Muscle, Rheumatology)

ISOMYOSAMINE FOR THE TREATMENT OF SARCOPENIA IN OLDER ADULTS

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TNF Pharmaceuticals Inc.

Introduction: Sarcopenia, a condition marked by the loss of muscle mass and function, significantly impacts older adults, contributing to frailty and decreased independence. Chronic inflammation is believed to play a key role in its progression. Isomyosamine, a small molecule derived from tobacco alkaloids, has the potential to regulate key inflammatory cytokines, including tumour necrosis factor-alpha (TNF-α), interleukin-6 (IL-6), and soluble TNF receptor 1 (sTNFR1), offering a therapeutic strategy for sarcopenia.

Method: In a Phase II clinical trial, older adults diagnosed with sarcopenia were administered once-daily oral doses of Isomyosamine (ranging from 600 mg to 1050 mg) for 28 days. Blood samples were collected at baseline and on Days 7, 14, 21, and 28 to measure inflammatory biomarkers. The pharmacokinetics (absorption and elimination) of the drug were also assessed. Safety and tolerability were evaluated by monitoring adverse events.

Results: Significant reductions in TNF-α levels were observed at both Day 7 ($p = 0.04$) and Day 14 ($p = 0.04$). IL-6 and sTNFR1 were also reduced after the first dose in most cohorts. No serious adverse events were reported, and the drug was well-tolerated. However, due to the rapid absorption and elimination of Isomyosamine, once-daily dosing may not be sufficient for therapeutic efficacy, suggesting a need for more frequent dosing in future trials.

Conclusion(s): Isomyosamine shows promise as a treatment for sarcopenia, significantly reducing inflammatory biomarkers in older adults. A new Phase II clinical trial will evaluate the effects of more frequent dosing on functional recovery in patients with sarcopenia who have suffered hip or femur fractures. This study, expected to begin in Q1 2025, will assess changes in mobility and inflammatory markers to further investigate the drug's potential in improving clinical outcomes.

PLATFORM PRESENTATION: RESEARCH: THURS 11.45-12.00

3134. Scientific Presentation - Other medical condition

EFFECTIVENESS OF THE SMARTJOURNAL DIGITAL INTERVENTION ON ORAL HYGIENE IN NURSING HOME RESIDENTS: A CLUSTER RANDOMISED TRIAL

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Introduction: The global trend of population ageing has led to a significant demographic transformation, with an increasing proportion of elderly individuals. This shift brings a heightened burden of disease, including oral cavity infections. Declining rates of edentulism and the rise of complex dental prostheses have emphasized the importance of maintaining oral health in older adults. Care-dependent individuals, particularly in institutional settings, rely on nursing staff for oral care; however, different barriers hinder the provision of adequate oral care. Poor oral health is linked to systemic diseases, and reduced quality of life, yet remains an overlooked concern in many institutions. In Norway, studies reveal widespread oral health neglect in nursing homes, highlighting the need for effective interventions to address this critical issue.

SmartJournal presents an interactive easy-to-use digital tool to assist nursing staff in preserving the oral health of nursing home residents. The app contains three components: Component 1, "registration of daily oral hygiene routines", component 2, "monthly oral health assessment", and component 3, "e-learning (knowledge base)".

Methods: The study was designed as a pragmatic, 12-week, parallel-group, three-arm blinded cluster-randomised trial (CRT) aiming to compare the effectiveness of SmartJournal use versus augmented care in improving oral hygiene among nursing home residents. It involved 12 nursing homes and 309 participants. The primary outcome measure was the mucosal-plaque score (MPS), which measures oral hygiene. The secondary outcome measure was the number of teeth.

Results: Preliminary results show a 10% improvement in oral hygiene scores in the intervention group. Further statistical analysis is ongoing.

Conclusion: Few clinical trials evaluate the effectiveness of preventive oral health care interventions for care-dependent older adults, making this study’s findings valuable for guiding future research and implementation of similar interventions.

PLATFORM PRESENTATION: THURS 14.50-15.05

3052. Scientific Presentation - Other medical condition

EFFICACY AND SAFETY OF DARIDOREXANT IN PATIENTS >65YEARS WITH INSOMNIA

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Introduction: Insomnia affects older adults more than younger adults, and comorbidities more prevalent in older populations can add to symptom burden and reduce therapeutic options. We report older subgroup analyses from a Phase-3 registration trial with daridorexant.

Methods: In this multi-centre, double-blind trial (NCT03545191), adults 18–64y and ≥65y with insomnia were randomised (1:1:1) to receive oral daridorexant 25mg, 50mg or placebo every evening for 3 months. Month 3 endpoints were: change from baseline in polysomnography-measured wake-after-sleep-onset (WASO) and latency-to-persistent-sleep (LPS) (both primary endpoints), subjective total sleep time (sTST), and daytime functioning (Insomnia Daytime Symptoms and Impacts Questionnaire [IDSIQ] – sleepiness domain. Safety endpoints included treatment emergent adverse events (TEAE), AEs of special interest (AESI) (and withdrawal effects upon treatment cessation.

Results: Of the 930 patients randomised, 364 (39.1%) were ≥65y: daridorexant 25mg (n=121), 50mg (n=121) and placebo (n=122). In this subgroup, at Month 3, the placebo-corrected change from baseline [95%CL] for daridorexant 25mg and 50mg were: WASO -17.0[-27.0,-7.0] and -19.6[-29.5,-9.7] mins; LPS -7.8[-15.2,-0.4] and -14.9[-22.3,-7.5] mins; sTST 18.7[4.1,33.2] and 30.6[16.1,45.2] mins; IDSIQ sleepiness domain -0.6[-2.2,0.9] and -2.6[-4.1,-1.0], respectively. TEAEs were reported in 32.2%, 35.3%, and 31.1% of patients ≥65y in the 25mg, 50mg and placebo groups, respectively. Falls (n=1,1,4 for 25mg, 50mg, placebo, respectively) and dizziness (n=4,1,1), were least frequent in the 50mg group. Compared to placebo, somnolence was as frequent for 50mg daridorexant (n=6,1,1) while fatigue was more frequent in both daridorexant groups (n=4,3,1); incidence did not appear dose-related. AESI, of mild intensity, were reported in 2 patients ≥65y (one in each daridorexant group). There was no evidence of withdrawal symptoms.

Conclusions: Daridorexant is efficacious in adults >65years for improvements in sleep and daytime functioning. No safety concerns in this vulnerable population were identified at either dose.

Support: Funded by Idorsia Pharmaceuticals Ltd.

PLATFORM PRESENTATION: THURS 15.05-15.20

3174. Scientific Presentation - Respiratory

AIR FILTRATION TO PREVENT SYMPTOMATIC WINTER RESPIRATORY INFECTIONS IN CARE HOMES: THE AFRI-C CLUSTER RANDOMISED CONTROLLED TRIAL

A D Hay[1]; R C Brierley[2]; N Turner[2]; J Thorn[2]; S Rees[2]; J Taylor[2]; T J Welsh[3,4,5]; E J Henderson[5]: J Sprackman[2]; G Morgan[6]; C Riddington[2]; L Campbell-Smith[2]; C Brown[7]; D Ready[8]; G Mazza[2]; E A Gidman[2]; R Kipping[9]

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Introduction: Respiratory tract infections are common in care home residents. Portable high-efficiency particulate air filtration units (HEPAFU) remove airborne microbial particles, but it is unclear if this is sufficient to reduce infections. We set out to investigate the effectiveness of portable HEPAFU to reduce the rate of respiratory infection episodes in care home residents.

Method: We conducted a two-arm randomised controlled trial, cluster randomised by care home over three winters from 1 September 2021 to 31 May 2024. Care homes were randomised to either HEPAFU in communal rooms and private bedrooms; or usual care. The primary outcome was number of symptomatic winter respiratory infection episodes recorded by care home staff for consented residents. Secondary outcomes included: rates of primary care consultation, antibiotic prescribing, hospitalisations and care home staff absenteeism.

Results: 91 care homes were randomised: 47 to intervention (569 residents with private room HEPAFU); 44 to usual care (589 control residents). There were 390 and 442 respiratory infection episodes in 95,235 and 102,579 consented intervention and control resident risk-days respectively. There was no difference in the number of respiratory infection episodes per private room resident per winter in intervention vs. control care homes: 0.99vs.1.04, adjusted incident rate ratio (aIRR) 0.92, 95%CI 0.64 to 1.33, p=0.67. A similar rate was observed in residents exposed to communal room HEPAFUs only. There were no differences seen in the rates of primary care consultation (1.77vs.1.57; aIRR 1.21; 0.91 to 1.62, p=0.20); antibiotic prescribing (1.55vs.1.47; aIRR 1.14; 0.85 to 1.53, p=0.36); hospitalisations (0.87vs.0.80; aIRR 1.15; 0.75 to 1.76; p=0.53) or staff absenteeism (5.04vs.5.76; aIRR 0.80; 0.55 to 1.16; p=0.24).

Conclusions: We found no evidence that HEPAFU reduced resident winter respiratory infection episodes. Care homes should continue adhering to nationally recommended infection prevention and control measures and not rely on HEPAFU to reduce respiratory infections.

PLATFORM PRESENTATION: RENAL AND TRANSPLANTS: FRI 12.00-12.15

3124. Scientific Presentation - HSR (Health Service Research)

REHABILITATION AFTER AN EPISODE OF DELIRIUM: MIXED METHODS PROCESS EVALUATION OF THE RECOVERED MULTI-SITE FEASIBILITY STUDY

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2. NIHR Applied Research Collaboration South West Peninsula, University of Exeter, Exeter, UK

Introduction: A process evaluation was conducted alongside a multi-site feasibility trial of RecoverED, a multicomponent delirium rehabilitation intervention for older people in post-acute settings. Up to 10 sessions of the home-based intervention is delivered by a multidisciplinary healthcare team. A modified Conceptual Model for Implementation Fidelity was used. Findings on implementation and acceptability are presented.

Design and Methods: A mixed-methods design was employed, and participants included older adults with delirium, their carers, and trained healthcare professionals (HCPs) from six NHS hospitals in the UK. Adherence to content, dose, and coverage, as well as moderating factors such as recruitment, context, participant responsiveness, delivery quality, and intervention complexity, were assessed. Data included in-depth interviews, focus groups, trial documentation, and training, and supervision logs. Mixed-methods findings were triangulated.

Results: Nineteen participant-carer pairs were recruited. Five older people, 9 carers, and 8 HCPs were interviewed post-intervention. Seven HCPs participated in two focus groups. Evaluating adherence to content was complex since the intervention is person-centred and personalized. Psychosocial support was delivered more frequently than planned for each individual, while physical rehabilitation and functional recovery activities were delivered less than planned. The value of participant-led goals was emphasised, with high satisfaction, engagement, and perceived value. Implementation was according to the theorised delivery approach, and participants expressed positive views on the quality of delivery. While HCPs found the training comprehensive, they preferred a more interactive and practical format. Teams need to be specifically staffed and co-located for effective coordination and supervision of RecoverED. Most withdrawals (N=10) were due to complex needs or impairments. No minority ethnic participants were recruited.

Conclusion: The RecoverED intervention was found to be acceptable; however, recruitment challenges suggest that acceptability and fidelity to dose and coverage should be interpreted with caution. Implementation fidelity to the delivery approach was high and well-perceived.

PLATFORM PRESENTATION: RENAL AND TRANSPLANTS: FRI 12.15-12.30

3190. Scientific Presentation - HSR (Health Service Research)

END-OF-LIFE DEMENTIA CARE: A QUALITATIVE STUDY OF THE EXPERIENCES AND PERCEPTIONS OF MINORITY ETHNIC AND ECONOMICALLY DISADVANTAGED COMMUNITIES

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Background: Dementia is a leading cause of death globally. However, people living with dementia are often underrepresented in specialist palliative care services. Existing research on palliative care for people with dementia frequently fails to include people from minority ethnic groups and those living in poverty.

Aims: This study explored the experiences and perceptions of end-of-life dementia care amongst underserved groups in England. The study also investigated how ethnicity, religion, and socioeconomic status influence these experiences.

Methods: Ten workshops were conducted, involving 29 Experts-by-Experience (EbE) with professional or personal experience of caring for people living with dementia from disadvantaged communities. Qualitative data from these workshops were analysed thematically.

Results: The findings highlight cultural, socioeconomic, and systemic barriers to accessing quality end-of-life care. Participants noted pervasive fear, stigma, and mistrust surrounding dementia and end-of-life care. Financial concerns were frequently described as major drivers of inequities in care.

Conclusions: This study reveals that individuals from minority ethnic and disadvantaged communities face significant challenges in accessing equitable, high-quality end-of-life dementia care. Future research should co-create culturally sensitive interventions with these communities to address disparities in care.

PRESIDENT ROUND

3054. Scientific Presentation - Falls, fracture and trauma

USE OF FALLS RISK INCREASING DRUGS IN OLDER PEOPLE, BEFORE AND AFTER HOSPITALISATION WITH A FALL

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Introduction: World Falls guidance [1] recommends medication review as part of multifactorial risk assessment for those at high risk of falling. Use of Falls Risk Increasing Drugs (FRIDs) [2], polypharmacy and anticholinergic burden are known to increase risk of falls in older people [3]. This prospective observational study was conducted to assess if polypharmacy, prescription of FRIDs and anticholinergic burden [4] improve after hospitalisation with a fall.

Method: Data gathered from electronic medication records, for patients aged ≥ 65 years, taking ≥4 medicines, at hospital admission with a fall, at discharge, and at 3 months after discharge included number of medications prescribed, number of Falls Risk Increasing Drugs (FRIDs) prescribed [2] and anticholinergic burden (ACB) score [4]

Results: Patients were included from March 2023 until May 2024. Mean age was 81±8.58 years and 80% of patients were female (n=90). The mean number of medicines per patient was 8.05±0.37(SE) at hospital admission, increasing by 32% to average 10.66±0.39, three months after discharge ($p<0.001$). The mean number of FRIDs per patient increased by 7.8% from 2.44±.16 at hospital admission to 2.63±.17 three months after discharge ($p =0.057$).

Most common FRIDs were bisoprolol, furosemide, codeine, amlodipine and amitriptyline. Codeine was the most common FRID started after discharge (n=13; 12% of patients).

ACB score increased by 18% to 2.40± 0.21 at 3 months following discharge compared to 2.04 at admission ($p =0.003$). Furosemide, codeine, amitriptyline, sertraline and diazepam were the top medicines with anticholinergic burden.

Conclusion: Three months after discharge from hospital following a fall, older people experience increased polypharmacy and anticholinergic burden and are prescribed more Falls Risk Increasing Drugs, compared to at the time of hospital admission.

PRESIDENT ROUND

3093. Scientific Presentation - Falls, fracture and trauma

BARRIERS AND FACILITATORS TO ENGAGEMENT IN FALL INTERVENTIONS AMONG OLDER ADULTS FROM ETHNIC BACKGROUNDS: A SYSTEMATIC REVIEW

S Ravithas; S J Meredith; M Jawad; A Lawal; S Lim

Southampton University; Dept of Academic Geriatric Medicine; University Hospitals Southampton; Hampshire City Council

Background: The incidence of falls is a major public health issue with one- third of older people falling annually. Consequently, there are many interventions available to prevent falls such as education and exercise training. However, their effectiveness at reducing fall prevalence is minimal due to low adherence, especially amongst ethnic minority groups. There is currently a paucity of research in this area particularly among older adults from ethnic minority groups.

Aims: This systematic review aims to identify the main facilitators and barriers to the uptake of fall prevention programs in older adults from ethnic minority groups.

Methods: The review was registered onto PROSPERO (CRD42024586433) before conducting a literature search on Medline, Embase and CINAHL databases using the PICO framework to extract relevant English language studies. Inclusion criteria included studies focusing on older adults aged 65 years and above and from ethnic minority groups. After removal of duplicates and full text screening, articles underwent quality assessment using the JBI tool. Data extraction took place, and key themes were categorised using the COM-B model.

Results: 12 studies were included in the final review: 9 qualitative and 3 mixed method studies. The review included 1176 participants including Hispanics, South Asians, Chinese and African American ethnic groups. Main themes included language barriers, cultural beliefs and inadequate support from healthcare professionals. Quantitative findings showed a statistically significant correlation between adherence and the following factors: living alone, low mood, level of education and culture.

Conclusion: This review has identified key barriers and facilitators to engage older adults from ethnic minority groups. Future interventions should consider these facilitators and barriers to enhance inclusivity and engagement.

PRESIDENT ROUND

3030. Scientific Presentation - SP - HSR (Health Service Research)

WHAT DO OLDER ADULTS VALUE ABOUT FAMILY PHYSICIAN ENCOUNTERS? INSIGHTS FROM A SYSTEMATIC REVIEW OF INTERNATIONAL EVIDENCE

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Introduction: Older adults (aged ≥65) frequently seek care from family physicians and often present with unique needs and preferences compared to patients of other age groups. We aimed to identify and synthesize the attributes of family physician encounters that older patients prioritize, spanning the time of accessing primary care to post-visit.

Method: We conducted a systematic search of three electronic databases (MEDLINE, Ovid Embase, Web of Science) to identify peer-reviewed research articles of any design. Seven reviewers screened and extracted information using a standardised template. We narratively synthesised findings across the included studies. Older adult patient partners provided strategic input throughout the key phases of this review, including developing the research question, literature screening and synthesis, and interpreting the findings to enhance relevance and applicability.

Results: We identified 28,461 articles for screening after duplicate removal. Title and abstract screening resulted in 463 retained articles, with 62 articles included for analysis after full-text screening. We identified six key attributes of family physician encounters which older adults value before, during, and after visits: trust in providers, feeling heard, effective information exchange, affective behaviours, continuity of care (longitudinal relationships), and foresight/future planning. Equitable access to family physicians and sufficient time for encounters emerged as enablers of the identified attributes.

Conclusions: Our findings synthesising international evidence highlight which attributes matter most to older primary care patients as they age and increasingly access family physicians. These attributes can guide primary care planning, organisation, and physician education/training to promote high-quality care for older adults.

PRESIDENT ROUND

3129. Scientific Presentation - HSR (Health Service Research)

ATTITUDES AND PERCEPTIONS OF CHINESE OLDER ADULTS TOWARD THE USE OF HOME-CARE ROBOTS

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Introduction: The exponential growth of the older population on a global scale, coupled with their escalating demand for care, has significantly exacerbated the existing shortage of qualified caregivers. This situation is particularly relevant in the Chinese context due to the weakening of the filial piety tradition, which places the responsibility of care for older adults (OA) on family members. Against this backdrop, there has been a growing development of smart technologies, such as care robots, designed to assist in long-term care for OA, which serves as a potential solution to challenges associated with caring for the older population. This study aimed to understand the attitudes and perceptions of OA toward the development and social implementation of home-care robots in Mainland China.

Method: 482 community-dwelling Chinese OA (age: 69.92 ± 6.94; male: 146, female 336) in Shanghai, China were interviewed through a structured questionnaire developed by our research team using a cross-sectional survey design.

Results: The results showed that most Chinese OA were open to using home-care robots (around 80%) and were willing to use them when receiving home-care services (around 64%). Gender difference was observed that male Chinese OA were more open and willing to use home-care robots than their female counterparts ($p < 0.05$). Moreover, the level of education also affected their openness and willingness. OA with tertiary education or above tended to be more receptive toward home-care robots than those with primary or secondary education ($p < 0.05$). Regarding the services provided by home-care robots, no significant difference was found in relation to gender and education levels.

Conclusions: Similar to the findings in our previous study among Western respondents, there were generally positive attitudes and perceptions of using home-care robots among Chinese OA.

PRESIDENT ROUND

3177. Scientific Presentation - HSR (Health Service Research)

SEX DIFFERENCES IN THE ASSOCIATIONS BETWEEN SOCIAL VULNERABILITY, FRAILTY, 5-YEAR SURVIVAL AND LONG-TERM CARE HOME ENTRY

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Introduction: Frailty and social vulnerability use deficit accumulation approaches to understand heterogeneity in older adult health outcomes. We examined sex differences in the effect of frailty and social vulnerability on 5-year mortality and long-term care home (LTCH) entry in Nova Scotia, Canada.

Methods: We followed community-dwelling older adults 65 years and over who were assessed for public home care supports from 2005 to 2018 using data from the Resident Assessment Instrument. We conducted sex-stratified and sex-disaggregated Cox proportional hazards analyses, adjusting for age, Cognitive Performance Scale and cohort year of entry.

Results: Of 5,520 home care clients, mean age was 80.5 (SD 7.5), frailty Index (FI) was 0.23 (SD 0.10) and Social Vulnerability Index (SVI) was 0.22 (SD 0.69). The cohort was 66.6% female who were significantly less frail, more socially vulnerable and more cognitively intact at baseline. At five years, 49.1% females and 63.0% males had died, and 36.3% females and 29.5% males required admission to LTCH. In sex-stratified models, higher SVI was associated with decreased 5-year mortality and increased LTCH entry; while higher FI was associated with increased 5-year mortality and LTCH entry. In sex-disaggregated analyses, higher SVI remained significantly associated with decreased 5-year mortality for females (aHR 0.92; CI: 0.86-0.99, p=0.02), but not for males (aHR 0.94; 0.86-1.02, p=0.11). There was a weaker association between FI and 5-year LTCH placement for males.

Conclusion: Greater frailty was associated with LTCH placement and mortality across sexes, as we hypothesized. However, in sex-disaggregated analyses, the association between frailty and LTCH entry was weaker for males and higher social vulnerability was associated with decreased mortality only in female models. This raises the importance of evaluating these populations separately, as well as the question of how current LTCH placement policies may be inadvertently perpetuating the sex (and gendered) differences of ageing.

PRESIDENT ROUND

3144. Scientific Presentation - Other medical condition

HEALTHY AGEING IN PLACE: PERSPECTIVES ON 'LOCAL' AND AGE-FRIENDLINESS IN THE BUILT ENVIRONMENT

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Introduction: Age friendly communities aim to create inclusive social and physical environments that facilitate older people to age actively, enjoy good health and continue participating fully in society. The built environment can profoundly influence older adults' health and wellbeing. This study aimed to explore mid-to-older adults' perceptions of the age-friendliness of their communities and how they defined localness.

Methods: Semi-structured interviews were conducted remotely and in-person between September 2023 and March 2024 with community-dwelling mid-to-older aged adults (n=22; 65.0 ± 5.5 years) from two communities with high levels of deprivation in Scotland, Renfrewshire and South Lanarkshire. Taking a systems-based approach, identified barriers and supports to the age-friendliness of communities were charted against the World Health Organization Age-Friendly Cities and the Place Standard frameworks, and perceptions of localness were explored.

Results: Physical influences on age-friendliness included the accessibility of transport modalities, the maintenance of public spaces and paths, the suitability of homes, and seasonal influences and environmental hazards. Social influences included access to places that facilitate social interactions such as churches or community centres, community cohesion, and employment and volunteering-related factors. Service influences included digital inclusion, ageist sentiments, and healthcare accessibility. Localness was defined by i) accessible and preferred modes of transport, with local areas shrinking as mobility declines; ii) the distance people needed to travel to access essential services like supermarkets and pharmacies; and iii) where they knew people, socialised with others, or visited family.

Conclusions: The gradual deterioration of communities has contributed to a decline in the age-friendliness of mid-to-older aged adults' local areas. The impact of declining mobility, individual- and area-level deprivation, and closure of essential facilities and social spaces on place attachment must be considered by policy makers to support older adults to age well in place.

PRESIDENT ROUND

3175. Scientific Presentation - Parkinson's Disease

SYMPTOM BURDEN AND IMPACT ON QUALITY OF LIFE FOR THOSE WITH ADVANCED PARKINSON'S IN A RURAL AREA

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Introduction: We recruited older adults with advanced Idiopathic Parkinson's disease (IPD) to better understand their symptom burden and its impact on quality of life (QoL) in the predominately rural area of North Cumbria.

Methods: Records were taken from an IPD prevalence study. Those identified with advanced IPD, defined by Hoehn and Yahr stage 4 or 5, were invited to participate, consultee was contacted for those unable to consent. Quantitative data were collected using validated questionnaires. These included the Movement Disorder Society Non-Motor Symptoms (NMS) Questionnaire and the Parkinson's Disease Questionnaire. Data were collected electronically with the participant, with assistance from a relative or carer if asked, or consultee as appropriate. Rural areas were defined as living in a settlement of less than 10,000 people.

Results: All 62 recruited participants experienced NMS, the number ranging between six and 17. Most frequently reported symptoms were sleep disturbance and physical fatigue. Physical fatigue was the most severely reported symptom. Mean NMS score for those living in a rural area (207.8 ±87.9) was higher than that for those living in an urban area (180.0 ±62.1), although this did not reach statistical significance (p=0.17). In rural areas, mental fatigue was the most frequently reported symptom, while those living in urban areas reported sleep disturbance most frequently. Mean NMS score was higher in males (198 ±85.5) than females (189 ±67.4), although this did not reach statistical significance (p=0.67). Mean PDQ-39 scores, an indicator of QoL, were similar in rural (40.6 ±10.9) and urban (39.4 ±10.4) areas and similar in males (39.6±10.1) and females (40.5 ±11.2).

Conclusion: Sleep disturbance and physical fatigue were frequently and severely reported NMS. Despite a higher NMS burden described in rural areas, QoL was similar between rural and urban areas. This could suggest possible protective factors improving QoL in rural areas.

PRESIDENT ROUND

3049. Scientific Presentation - Psychiatry and Mental Health

DELIRIUM PREVALENCE IN HOSPITALISED INPATIENTS ACROSS SPECIALITIES: A REVIEW OF A SINGLE HOSPITAL SITE

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Importance: Delirium effects up to 15% of hospitalised inpatients but prevenance rates vary by speciality. Outcomes for patients with delirium remain poor, but to improve care for patients having a full understanding of the burden of delirium within inpatients is an important first step.

Objective: To identify the prevenance of delirium on admission at a single hospital site across all specialities over a two-year period.

Design: A retrospective analysis of all non-elective admissions 4AT scores using Electronic Patient Records (EPR) data.

Setting: A 600-bed urban teaching hospital in the Northwest of England

Participants: All non-elective admissions in patients over 70 years old with a length of stay greater than 24 hours.

Main Outcome and Measures: Data was collected on 4AT scores, admission location based on admission speciality, and prevalence of delirium as defined by positive 4ATs scores as a percentage of total admissions.

Results: Out of 33,275, 16,059 4AT scores were completed and of these 4491 screened positive for Delirium representation a total prevalence of 14%. Breaking down by speciality, Acute Medicine had the highest prevalence of delirium at 17% and Neurosurgery had the highest prevalence amongst surgical specialities at 14%. Cardiology had the lowest prevalence of delirium at 3%.

Conclusions and Relevance: Out of 40 specialities studied, 28 had data on delirium screening however screening rates and prevalence varied significantly between specialities. Whilst overall prevalence was at 14% across the site, given the low overall rate of screening amongst specialties it is likely that this represented a significant under reporting of delirium rates and therefore this study highlights the need the for increased uptake of delirium screening across all specialities.

PRESIDENT ROUND

3153. Scientific Presentation - Psychiatry and Mental Health

COMPARISON OF FREE-COG WITH THE MINI-MENTAL STATE EXAMINATION AND LAWTON-BRODY FUNCTIONAL SCALES

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Introduction: The Free-Cog is a brief cognitive test designed to capture decline in both general cognition and executive function. The Free-Cog has been validated by comparison with the Mini-Addenbrooke Cognitive Examination in a UK secondary care setting. Here, we compare Free-Cog to the routinely-used Mini-Mental State Examination (MMSE) and the Lawton-Brody Instrumental Activities of Daily Living (IADL) and Physical Self-Maintenance Scales (PSMS).

Methods: Patients from three memory clinics were recruited (n=298 records). The Free-Cog, MMSE, IADL and PSMS were administered in-person (n=267), via telephone (n=17), or virtually using video conferencing (n=12). The four tests were compared using Pearson correlation and ability to predict dementia diagnosis using binary logistic regression and the area under receiver operator characteristic (AUROC) curves.

Preliminary results: In-person Free-Cog score correlations ranged from strong (MMSE; r=0.86, 95% Confidence Interval [CI]: [0.82-0.89], p<0.001), to moderate (IADL (r= 0.56, 95% CI: [0.46-0.64], p=<0.001) to weak with the PSMS (r=0.23, 95% CI: [0.10-0.35], p=<0.001). The Telephone Free-Cog only correlated significantly with MMSE (r=0.73, 95% CI: [0.39-0.90], p<0.001) and virtual Free-Cog with MMSE (r=0.92, 95% CI: [0.74-0.98], p<0.001) and IADL (r= 0.63, 95% CI: [0.09-0.88], p=0.03). Each 1-point increase in Free-Cog (Odds ratio [OR]: 0.84, 95% CI: [0.76-0.92], p<0.001) decreased the odds of being diagnosed with dementia, as the MMSE (OR: 0.79, 95%CI: [0.69-0.90], p<0.001), and IADL (OR: 0.73, 95% CI: [0.58-0.92], p<0.01). The Free-Cog (AUROC=0.79) best discriminated between dementia and diagnosed otherwise, followed by MMSE (AUROC=0.74), and IADL (AUROC=0.69), whereas the PSMS did not (AUROC=0.43).

Conclusion: The Free-Cog appears to be a free-of-cost, valid alternative to the routinely used MMSE, and supplements the IADL scale in capturing cognitive and functional changes associated with neurodegenerative diseases of cognition.

PRESIDENT ROUND

3170. Scientific Presentation - Stroke

FACTORS ASSOCIATED WITH HIGH ADHERENCE TO SECONDARY PREVENTATIVE MEDICATIONS 12 MONTHS AFTER A STROKE

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Introduction: Prior stroke is one of the biggest risk factors for future stroke events. Secondary prevention medications are key to reducing subsequent vascular events, and guidelines recommend use of antithrombotics, antihypertensives and lipid lowering drugs. We carried out a retrospective study of adherence to these medications in a post stroke population.

Methods: Consecutive patients admitted with acute stroke to a Dublin hospital between July 2022 and November 2023 were invited to participate. Participant interviews were carried out at 1 year post stroke to collect demographic and clinical information and evaluate care needs. Functional ability was graded using the Modified Rankin Scale (mRS). Adherence to three key categories of secondary preventative drugs was assessed using the 4-item Morisky Medication Adherence Scale, and participants were asked to show all current medications, which were compared to the discharge prescription.

Results: Interviews were conducted with 197 participants 1 year post stroke. Mean age was 68.8 years and 66% were male. Ethnicity was as follows: 79% white Irish, 11% other white, 5% African, 5% Arabic/Asian/others. Twelve (6%) were living in nursing homes while 68% were functionally independent with mRS 0-2. High adherence to all prescribed medicines was reported at 79% and was higher for antihypertensives and antithrombotics (87%) than for lipid-lowering drugs (78%). There were no statistically significant differences in self-reported adherence between gender or race subgroups. Adherence was better for participants who were functionally dependent by mRS (71% vs 97%, $p<0.0001$) and those who had an involved caregiver (69% vs 89%, $p<0.0001$).

Discussion: Self-reported adherence to medication was high in this cohort but one fifth were not adherent to important secondary prevention medications 1 year after a stroke. Adherence was higher for those who had more disabling strokes and an involved caregiver. No race or gender disparities in adherence were observed in our population.

POSTER

3135. Scientific Presentation - Falls, fracture and trauma

FACTORS INFLUENCING FALL PREVENTION PROGRAMMES: THE CHALLENGE OF IMPLEMENTING THE FaME PROGRAMME IN A COMPLEX LANDSCAPE

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Introduction: The occurrence of falls in adults 65+ years remains a common and costly issue worldwide. Exercise programmes that improve strength and challenge balance have been shown to be the most effective intervention for reducing falls in community-dwelling older adults, such as the 6-month Falls Management Exercise (FaME) programme. Despite the pre-existing evidence base, the adoption of the FaME programme has been limited. Perspectives of multiple key stakeholder groups and providers of the FaME programme could future inform more successful adoption and implementation of fall prevention programmes such as FaME.

Methods: Stakeholders and providers involved in local community fall prevention pathways were purposefully recruited from three geographical areas across England. Twenty-five semi-structured interviews were conducted to gain a broad understanding of factors affecting the adoption, implementation and spread of FaME. Data were analysed using an inductive thematic approach and mapped to the Consolidated Framework for Implementation Research (CFIR).

Results: Data from 25 participant interviews and document analysis revealed 11 themes organised within five CFIR domains – the innovation (3), outer setting (3), inner setting (1), characteristics of individuals (1) and process (2).

Conclusion(s): The adoption, implementation and spread of FaME into community settings is complex and faces multiple health system challenges. For adoption and implementation to be facilitated, FaME programmes must demonstrate effectiveness and fit the local needs of those receiving the intervention. For spread to occur, influential commissioners must support wider programme roll out, whilst also securing sufficient expert capacity to deliver the programme. Further monitoring of the programme is recommended to determine effectiveness of provision for older adults. The tailoring of future implementation strategies may help to increase the national availability of FaME classes across the UK for those at greatest risk of falls.

POSTER

3136. Scientific Presentation - HSR (Health Service Research)

IMPROVING PATIENT AND PUBLIC INVOLVEMENT (PPI) IN DEMENTIA RESEARCH: BUILDING CONDITIONS FOR IMPACT

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Introduction: Dementia is a major challenge to healthy ageing, and research into dementia is essential. Including people with lived experience of dementia in research leads to higher-quality, more impactful outcomes. But successful engagement can be complex and routine involvement practices may not always be inclusive for people with living with dementia. This project aimed to highlight what is needed to improve public involvement in dementia research and support researchers in engaging those with lived experience.

Method: We collaborated with experts by experience (people living with Dementia) and dementia researchers to explore current PPI activities within NIHR-funded dementia research. Mixed method data collection included an online questionnaire and structured conversations, supplemented with web searches. Data was organised in MAXQDA and visually mapped in MindGenius, identifying patterns and gaps.

Results: A diverse group of 38 participants, including researchers, healthcare professionals, funding panellists, and experts by experience, contributed. They emphasised that dementia affects individuals uniquely and involvement should be tailored to individual's abilities and preferences. They encouraged avoiding assumptions and a focus on positive change, particularly for underserved communities. Creative approaches were highlighted as effective for prompting discussions and enabling non-verbal individuals to express their experiences. Openness to learning from lived experiences and adaptability were key in shifting from task-oriented to relational approaches and deepen understanding. However, participants also identified that rigid funding processes, limited resources, and a lack of understanding of involvement can undermine these practices. They emphasised the need for funder guidelines, ethical working frameworks, and supportive spaces for shared learning.

Conclusion: Promoting good practice in Patient and Public Involvement for people with dementia is critical to enhancing both research and impact. This work seeks to highlight examples of relational approaches that foster co-learning and meaningful engagement, and addresses structural barriers, providing supportive frameworks to achieve impactful and inclusive dementia research.

POSTER

3053. Scientific Presentation - Other medical condition

EFFICACY AND SAFETY OF DARIDOREXANT IN PATIENTS WITH CHRONIC INSOMNIA DISORDER AND COMORBID NOCTURIA

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Introduction: Chronic insomnia and nocturia are frequently associated, particularly in older adults impacting sleep quality, daytime functioning and quality of life. This study evaluated the efficacy and safety of daridorexant in patients with insomnia and comorbid nocturia.

Methods: This double-blind, placebo-controlled, two-way cross-over study randomised 60 patients aged ≥55 years with chronic insomnia and self-reported nocturia to 4-weeks nightly treatment of daridorexant 50 mg or placebo. This was followed by a 14–21-day washout period, after which patients received the alternate 4-week treatment. The primary endpoint was change from baseline to Week 4 in self-reported total sleep time (sTST). Other insomnia endpoints included change from baseline in ISI score, sTST, depth of sleep and daytime functioning (Insomnia Daytime symptoms and Impacts Questionnaire [IDSIQ] total score. Nocturia endpoints, evaluated using the Minze diary Pod, included change from baseline in number and time to first nocturnal void. Safety endpoints included adverse events (AEs) and AEs of special interest (AESI: falls, urinary incontinence).

Results: Daridorexant (vs. placebo) significantly increased mean sTST (56.6 vs. 35.7 mins; p=0.002) at Week 4; significant improvements were seen from Week 1. Daridorexant (vs. placebo) significantly ($p<0.05$) decreased ISI scores (Weeks 2, 4) and significantly ($p<0.05$) improved depth of sleep (Weeks 1-4) and IDSIQ total score (Weeks 1, 3). Daridorexant (vs. placebo) reduced the number of nocturnal voids (Week 1: -1.5 vs. -1.0, $p<0.001$; Week 4: -1.6 vs. -1.3, p=0.09) and increased median time to first nocturnal void (difference to placebo, Week 1: +31 mins, p=0.0027; Week 4: +23 mins, p=0.2026). No serious AEs//AEs leading to discontinuation were reported in the study. No AESIs were reported during daridorexant administration.

Conclusion: In patients with insomnia and comorbid nocturia, daridorexant improves sleep, daytime functioning and nocturia symptoms, with no increased risk of falls or urinary incontinence.

Funding: Idorsia Pharmaceuticals Ltd

POSTER

3085. Scientific Presentation - Other medical condition

FUNCTIONALITY IN POST-COVID 19 OLDER ADULTS VS OLDER ADULTS WHO HAVE NOT SUFFERED FROM COVID 19 ATTENDING GERIATRIC OPD

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Introduction: Coronavirus disease 19 (COVID-19) has had lasting effects on the health of individuals, particularly older adults especially those with comorbidities, who are more vulnerable to severe and long-term illness. Studying the post-COVID 19 period in the older population is relevant for understanding the long-term effects of the disease. There have been conflicting results on functional decline in Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) in post COVID 19 older adults compared to their pre-infection baseline. This study aimed to compare functionality in older people who have survived COVID 19 infection vs those who have never tested positive for COVID 19.

Method: This study was a cross-sectional observational study. The primary objective was to compare functionality in the two groups, post COVID 19 and never tested positive for COVID 19. Both groups underwent detailed assessment via questionnaire which included socio-demographic details, functionality assessment, Comprehensive Geriatric Assessment (CGA) and details regarding COVID 19 infection in those who suffered from the infection.

Results: Analysis showed that both groups had no significant differences in median ADL (20 vs 20, p-value = 0.684) or IADL scores (5 vs 5, p-value = 0.181). The COVID 19 group had a higher prevalence of mild cases (70%). Between the two groups, the COVID 19 group had higher BMI (25.90 +4.45 vs 23.32 +3.62, p-value = 0.002) and education status (56% vs 20% graduate p-value = 0.001). There were no significant differences in the various domains on Geriatric assessment.

Conclusion: Functionality did not differ significantly in the COVID 19 survivors vs those who never suffered from COVID 19. Of all the variables, higher Body Mass Index (BMI) and higher education status were associated considerably with COVID 19 infection.

POSTER

3097. Scientific Presentation - Other medical condition

NURSES' VIEWS AND PERSPECTIVES OF PAIN ASSESSMENT AND MANAGEMENT IN RESIDENTS WITH ADVANCED DEMENTIA IN LONG-TERM CARE SETTINGS

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Introduction: There are limited evidence-based studies examining barriers and facilitators to pain assessment and management in residents with advanced dementia in long-term care settings, with no studies conducted to date in the long-term care setting in Northern Ireland.

Aims: We aimed to explore care home nurses' perspectives of facilitators of and barriers to providing optimum pain assessment and management to people with advanced dementia living in the nursing home setting in Northern Ireland.

Methods: One-to-one semi-structured interviews were conducted with nursing home nurses. Nurses who actively provided care to residents living with dementia, nursing home managers, regional managers, trainers who were registered nurses with the Nursing and Midwifery Council and who supported the provision of dementia care in a nursing home setting, and nursing home nurses who had completed their induction or preceptorship training were eligible to participate. Participants were recruited through the Queen's University Belfast Care Home Research Community of Practice. An interview guide was developed and piloted with three nurses who met the eligibility criteria. Interviews were conducted using Microsoft Teams, audio-recorded, transcribed verbatim, and analysed using reflexive thematic analysis. Ethical approval was obtained from the Faculty of Medicine, Health and Life Sciences Research Ethics Committee, Queens University Belfast.

Results: Interviews were conducted with 10 nurses between November 2023 and June 2024. Reflexive thematic analysis generated six themes: (1) the crucial role of the nurse, (2) recognising and assessing pain, (3) pharmacological and non-pharmacological approaches, (4) communication with families and healthcare professionals, (5) training and resources, and (6) barriers and challenges in pain assessment and management.

Discussion/Conclusion: Nursing homes should implement standardised policies and protocols, enhance nurse education on pain assessment tools and management strategies, and promote interdisciplinary collaboration to enhance recognition and management of pain and ultimately improve the quality of life for residents with advanced dementia.

POSTER

3102. Scientific Presentation - Other medical condition

PRACTITIONERS' PERSPECTIVES ON MEDICINE OPTIMISATION FOR OLDER PEOPLE FROM ETHNIC MINORITIES WITH POLYPHARMACY IN PRIMARY CARE

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Introduction: Medicine optimisation (MO) is a person-centred approach to support the safe, effective, and appropriate use of medications, aligned with patients' preferences and needs. MO in older people, particularly those from ethnic minority communities (EMCs), can be challenging due to cultural, communication, and systemic factors. These challenges are increased by polypharmacy, the use of multiple medications to manage multimorbidity, when medication errors, non-adherence, and adverse drug interactions are more likely.

This evaluation builds on a prior realist review that highlighted the complexities of MO for older people from EMCs. By exploring the perspectives of practitioners, this research aims to understand what works, for whom, why, and under what circumstances.

Methods: A realist evaluation was conducted using middle-range context-mechanism-outcome configurations (CMOCs) developed from a prior review. Semi-structured interviews were carried out with 15 purposively sampled primary care practitioners, including GPs and pharmacists. Interviews were audio-recorded, transcribed, and analysed using a realist framework.

Result: The earlier analysis revealed that older people from EMCs often faced barriers such as varying levels of health knowledge, language differences, and cultural stigmas, which limited their understanding of treatments and engagement in MO. These contexts triggered mechanisms of mistrust and disengagement.

However, when older people from EMCs encountered practitioners who demonstrated cultural understanding and adapted communication to their needs, mechanisms such as trust, understanding, sense of empowerment, and active participation were activated. This improved their confidence and adherence to medications. Systemic constraints, such as short consultation and reliance on remote tools, often disrupted continuity of care, leaving older people feeling unsupported.

The involvement of family members and interpreters helped bridge communication gaps, but inconsistencies in understanding or engagement sometimes introduced confusion, undermining trust, and clarity.

Conclusion: MO works best when tailored to the contexts of older people from EMCs, activating mechanisms such as trust, understanding, and empowerment.

POSTER

3143. Scientific Presentation - Other medical condition

ACTIVE AND CONNECTED: PLACE UTILISATION TO ENHANCE PHYSICAL AND SOCIAL ACTIVITY IN MID-TO-OLDER ADULTS

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Introduction: Physical activity and social connectedness play an important role in healthy ageing. Access to facilities such as libraries, parks, and community centres can facilitate physical activity, social interaction, and community building. Little is known about how older adults use places for physical or social activities. This study aimed to explore the places mid-to-older adults go to, and why they choose to engage or not engage in physical and/or social activities in particular places.

Methods: Semi-structured interviews were conducted with community-dwelling adults aged 55-75 years (n=22; 65.0 ± 5.5 years) from two communities with high levels of deprivation in Scotland, Renfrewshire and South Lanarkshire between September 2023 and March 2024. Taking a systems-based approach, we explored place utilisation among mid-to-older adults to support physical and social activity. Maps of participant's local community populated from Ordnance Survey data, such as depicting parks, were used to guide the interviews.

Results: Participants varied according to levels of physical activity, frailty, and loneliness. Places for physical and social activities included community centres, green spaces, gyms, clubs, religious buildings, shops and places for eating and drinking. Social enablers to place utilisation included having inclusive, well-advertised activities in multi-purpose spaces like community centres to foster intergenerational connections, community cohesion, and social engagement. Physical enablers included the importance of accessibility and convenience, mobility-friendly design, and diverse transport options. Barriers to place utilisation included activities that perpetuated ageist sentiments, the rising costs of physical and social activities, and seasonal barriers such as poor weather and reduced daylight.

Conclusions: It is essential to provide affordable and engaging activities, as well as versatile spaces that combine recreation, learning, and social interaction to foster intergenerational and social connections for older adults. Additionally, infrastructure and transportation should prioritise accessibility, while communities should promote respect, inclusion, and active participation in society.

POSTER

3196. Scientific Presentation - Other medical condition

PROXY INDICATORS TO SUPPORT INDEPENDENT AGEING-IN-PLACE IN OLDER PEOPLE WITH FRAILTY: A DELPHI-STYLE EXPERT CONSULTATION SURVEY

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Introduction: In the context of frailty, there is a call to reframe the goal from "managing the condition" to "living well with the condition". Older people with or at risk of frailty who live at home can still lead fulfilling lives, engage with their community, and maintain a good quality of life, that is, age in place well. We need reliable and valid measures capturing the various ageing-in-place experiences of older people with frailty in the community to support them better. This expert consultation survey aimed to identify potential ageing-in-place indicators for community-dwelling older people with frailty.

Methods: We used a modified Delphi approach to build consensus on ageing-in-place indicators for older people with frailty using two survey rounds. Eighty-nine indicators were extracted from a rapid literature review and grouped into five themes: "Personal Characteristics of Older People," "Place," "Social Networks," "Support," and "Technology." Twenty experts rated indicators on a 1–5 scale for importance for ageing-in-place and feasibility of routine measurement. Consensus was defined as mean importance and feasibility ratings of ≥4.0, suggesting indicators were extremely or very important and feasible to routinely measure.

Results: Only four indicators met the criteria for consensus: physical performance and mobility, multimorbidity, sensory function, and pressure ulcers (all "Personal Characteristics"). Thirty indicators were rated extremely or very important for ageing-in-place (20 related to "Personal Characteristics", four to "Social Networks", and three to "Place" and "Support" each). Only five indicators were considered extremely or very feasible to routinely measure: multimorbidity, pressure ulcers, physical performance and mobility, polypharmacy, and sensory function.

Conclusions: Future directions include: (1) using these indicators to stratify risk in older people with frailty to implement targeted policies and personalised interventions; (2) understanding challenges in routinely assessing non-clinical indicators; and (3) understanding where in care pathways these indicators can be feasibly measured.

POSTER

3162. Scientific Presentation - Parkinson's Disease

RELIABILITY AND REPEATABILITY OF A PORTABLE BIO-IMPEDANCE MEASUREMENT DEVICE IN EARLY PARKINSON'S DISEASE

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Introduction: Parkinson's disease (PD) is an age-related neurological condition characterized by bradykinesia, tremor, and postural instability. Weight loss within the first year of diagnosis is associated with poor prognosis. Studies suggest that if older adults lose skeletal muscle, their risk of falls and related injuries increases. Therefore, measures of body composition (e.g. muscle, fat) are important in PD, where the risk of falls is high. Established body composition analysis equipment is bulky and only used in research settings. We tested the reliability of a portable SECA mBCA 525 device that has not been validated in PD.

Method: We recruited 19 participants from Movement Disorder Clinics, with 11 household controls. Participants consented to body composition analysis using a SECA mBCA 525 device. It passes a mild electrical current between adhesive electrodes on the hands and feet to determine tissue impedance. Proprietary algorithms then use the impedance and manually collected data (weight, height, waist circumference and reported activity level) to estimate fat, lean, and water mass (kilograms). We performed this process at two visits a month apart to determine test-retest reliability.

Results: We collected data from 24 participants: 10/11 control and 14/19 PD participants.
All five PD participants with SECA data collection 'failures' had rest tremor. However, tremor amplitude was the same as the whole group average (mean 1.6, standard deviation 1.9 vs mean 1.6, standard deviation 1.2 for the whole group).

There were no significant differences between estimates of lean- and fat mass between trials 1 and 2 (Bland-Altman plot and linear regression, $p>0.05$).

Conclusions: The SECA mBCA 525 portable bio-impedance analysis device had good test-retest reliability for assessing lean- and fat mass in subjects with and without PD. However, data collection 'failures', which may be due to limb tremor, limit its usefulness in studies of people with PD.

POSTER

3125. Scientific Presentation - Psychiatry and Mental Health

A LONGITUDINAL OBSERVATIONAL STUDY ON OLDER ADULTS WITH INCREASED-RISK ALCOHOL USE AND THEIR NUTRITIONAL STATUS

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Introduction: In people over 65, 1 in 6 drinks at increased-risk levels and an estimated 1 million are malnourished. However, little is known about alcohol's harmful effect on older adults' nutritional status. Therefore, we measured the nutrient intakes and outcomes of older adults, scoring ≥4 on the AUDIT, at index hospital admission and at 3 to 6 months afterwards.

Methods: This mixed-methods project investigated the nutritional status at baseline and follow-up. Nutrient intakes were measured by 24-hour dietary recalls and compared against the UK Government Reference Nutrient Intakes (RNI). Clinical characteristics were measured by the Alcohol Use Disorder Identification Test (AUDIT), Hospital Anxiety and Depression Scale (HADS-A, HADS-D), Six-Item Cognitive Impairment Test (6-CIT) and a health service use analysis. Exploratory analysis, and descriptive statistics are presented.

Results: At baseline (n=30, 70% male, median age 71yrs (IQR=60-91)), the median nutrient intakes of 19/32 (59.38%) nutrients did not meet the RNI. The median intake (as a percentage of the RNI) for energy (kcal) was 62.77% (IQR=7.14-124.76%), for protein was 134.82% (IQR=10.30-215.33%), for fat was 65.83% (IQR=8.72-130.43%), for carbohydrates was 53.42% (IQR=6.07-201.51%), and for fibres was 32.67% (IQR=0.00-156.03%). At follow-up (n=15), this increased to 22/32 (68.75%) nutrients that did not meet the RNI. At baseline (n=30), 80% (24/30) scored ≥8 on the AUDIT, 43.3% (13/30) experienced anxiety, 50% (15/30) experienced depression and 53.3% (16/30) were cognitively impaired. At follow-up, the proportion with harmful alcohol use and anxiety decreased while depression and cognitive impairment remained constant. Polypharmacy (≥5 medications prescribed) was 93% (27/29), multimorbidity was 100% (30/30) and the mortality rate was 20% (6/30).

Conclusion: Older adults' profound susceptibility to alcohol-related harms and malnutrition are reflected by the notable morbidity and mortality observed. Overall, this study's findings highlight the complex clinical and sociodemographic status of older adults drinking at increasing risk or dependent levels.

POSTER

3147. Scientific Presentation - Planned and ongoing trials

HORIZON SCANNING FOR THE IDENTIFICATION OF INTERVENTIONS FOR PREVENTION, DELAY, AND TREATMENT OF SARCOPENIA

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Background: Sarcopenia is the age-related loss of muscle strength and mass. It affects 10% to 27% of individuals aged over 60 and increases the risk of falls, hospital admissions, and early mortality. It costs the UK around £2.5 billion annually in healthcare. Currently, no approved pharmacological treatments exist—this horizon scan aimed to identify early-stage trials testing potential interventions to prevent, delay, or treat sarcopenia.

Methods: Five databases were searched: PubMed, MedRxiv, BioRxiv, ClinicalTrials.gov, and UK Research Funding Successes. We included studies reporting pharmaceutical, nutraceutical, or technology-based interventions for preventing, delaying, or treating sarcopenia, as well as those targeting muscle strength or mass.

We focused on early-stage preclinical studies, including animal models, laboratory studies, and first-in-human trials, published or ongoing within the last five years (2018-2023). "Early stage" refers to interventions not yet in Phase II or advanced trials.

Records were screened by individual researchers, with team discussions held for uncertain cases. Ten per cent of records were also double-checked for quality and accuracy.

Results: The search yielded 3,835 publications. After screening, 235 met the inclusion criteria, of which 111 focused on nutraceuticals, 91 centred on licensed pharmaceuticals, and 14 examined technology-based therapies. Out of the 235 records, 138 were animal studies, with all but two being rodent-based. Ninety-seven studies were clinical trials.

The human studies varied in size, with populations ranging from 6 to 630 participants. Fifty-one of these studies included individuals with sarcopenia. Other populations studied comprised healthy older adults, patients at risk of developing sarcopenia, cirrhotic and hemodialysis patients, osteoporotic women, and malnourished or sedentary individuals.

Conclusions: This horizon scan has generated a comprehensive list of potential interventions for sarcopenia and established a robust pipeline for clinical trials. Utilising a reliable intervention selection tool will aid in selecting the most promising interventions for testing.

POSTER

3010. Clinical Quality - Clinical Effectiveness

IMPROVING THE ASSESSMENT AND MANAGEMENT OF BONE HEALTH ON AN ACUTE FRAILTY UNIT

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Introduction: Fragility fractures are a significant cause of morbidity and mortality in the UK. An estimated 549,000 fragility fractures occur each year, with a significant financial and social cost. By identifying and treating those at risk we can reduce the incidence of fragility fractures. We wished to assess how we could optimise management of bone health in those presenting to our acute frailty unit (AFU).

Method: We conducted a retrospective review of patients admitted to AFU with falls on a background of frailty. 2 PDSA (plan, do, study and act) cycles were undertaken in 2023 and 2024 respectively. We audited if patients had a full assessment of bone health (calcium, Vitamin D levels and FRAX score) and if they had been started on appropriate treatment.

Interventions included multiple educational sessions for members of the elderly medicine team, updated guidelines for primary and secondary prevention and concise poster guidelines visible on all elderly care wards.

Results: Over two cycles, we noted an improvement in bone health assessments amongst those admitted. By the end of our cycles, 48% had appropriate bone health bloods compared to 13% prior and 30% had a FRAX score calculated compared to 7% before. 33% of the patients had a clearly defined treatment plan for bone health compared to 0% at the start of the cycle.

Conclusions: 1. Education proved a moderately successful tool for increasing the awareness of bone health in frail patients admitted to AFU and also in increasing appropriate assessment and management of these patients.

2. Despite this, the majority of patient's did not receive an assessment. Possible factors limiting this included time, clinical acuity and uncertainty about best management option.

3. This QIP has demonstrated the need for the development of a fracture liaison service to provide robust assessment and management in the frail population.

POSTER

3022. Clinical Quality - Clinical Effectiveness

USING THE IRISH HIP FRACTURE DATABASE TO DRIVE IMPROVEMENT IN OLDER ADULT CARE

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Introduction: The Irish Hip Fracture Database (IHFD) is a national clinical audit managed by the National Office of Clinical Audit, that measures the quality of care and outcomes of hip fracture patients aged over 60 years. Annually there are 4000 hip fractures, the median age of a patient is 81 and 66% are female. 84% are admitted from home, 12% from a nursing home and 95% are caused by a low trauma fall.

Method: Data is collected through the Hospital In-patient Enquiry (HIPE) system. Care is measured against 7 clinical standards and two data quality standards and since the IHFD 2018 this have been linked to a Best Practice Tariff payment. The hospital with the highest compliance in the standards is awarded the 'Golden Hip Award'.

Results: To date the IHFD has reported on 11 years of data. There have been statistically significant improvements in all standards between 2013-2023. In 2023 the data showed that 29% were admitted through ED within 4 hours, 75% had surgery within 48 hours, 4% developed a pressure injury, 83% were seen by geriatrician or Advanced Nurse Practitioner, 87% had bone health assessment, 83% specialist falls assessment and 87% were mobilised on the day after surgery (87%).

Other data shows that 82% get a pre-op nerve block, 71% have a nutritional screen, 49% had a delirium screen day 1, 24% achieved independent mobility, 25% were discharged home directly, 38% went to rehabilitation and the median length of stay was 12 days.

Conclusion: This data has led to the development of a national hip fracture bypass pathway, orthogeriatric services in each hospital and quality improvement is embedded in each hospital through their hip fracture governance committee. The IHFD is an exemplar of how to get care right for older adults.

POSTER

3033. Clinical Quality - Clinical Effectiveness

DELIRIUM EPIDEMIOLOGY AND OUTCOMES – IS THERE VALUE IN A DELIRIUM BEST PRACTICE TARIFF?

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Introduction: Delirium complicates 10% of admissions. A delay in diagnosis can lead to permanent cognitive decline, care home placement and death.

Watford General Hospital's (WGH) delirium liaison service receives fewer referrals than expected from areas with vulnerable patients such as ITU. This audit sought to understand why and what effect this might have on outcomes.

Method: The audit team reviewed notes for all >75-years-old in WGH on a single day, looking for delirium risk factors, evidence of delirium and, if present, a diagnosis and management plan.

Outcomes were reviewed at 90 days.

Results: Of 216 patients, 44% had evidence of delirium. 40% were missed, with only half of those diagnosed having a delirium-centred plan.

Pareto analysis revealed 50% of >75-yr-olds on only four of twenty wards and 50% of delirium present on those same four wards.

90-day outcomes revealed:
- Delirium is associated with higher mortality (OR 2.28)
- Longer length of stay (LOS) (+3 days).
- LOS was longer if delirium was missed (average 28.5 days)
- Frailty is a predictor of delirium (OR 3.26) and mortality (OR 2.5)

Subgroup analysis showed that, even when compared to other geriatrician led CGA based care, orthogeriatric patients with delirium had significantly higher rates of diagnosis (100% vs 53%), management (100% vs 35%), lower mortality (OR 0.55), comparable LOS, and fewer than half as many readmissions.

Conclusions: Delirium is concentrated on a small number of medical and orthopaedic wards. Orthogeriatric patients have significantly higher rates of diagnosis, delirium-focused plans, lower mortality and readmission rates. This data suggests that a best practice pathway, akin to that for hip fractures, mandating delirium screening for at-risk, especially frail, patients on high-risk medical wards may improve outcomes. This data has allowed us to develop a focused improvement plan based on a time-critical pathway.

POSTER

3036. Clinical Quality - Clinical Effectiveness

EVALUATION OF A NEW REGIONAL PATHWAY FOR MEDICINES OPTIMISATION IN OLDER PEOPLE (MOOP) MEDICINES ADHERENCE PHARMACIST OPTIMISING

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Introduction: The Regional Medicines Optimisation in Older People (MOOP) Medicines Adherence Pharmacy team review medicines for older people at home across Northern Ireland (NI). Northern Ireland Ambulance Service (NIAS) are often first responders to older people at home requiring medical attention, and identify medicines adherence issues, which may lead to Emergency Department presentation and hospitalisation if not addressed.

Method: In July 2023, Belfast HSC Trust MOOP pharmacy team led a new regional pathway pilot to enable NIAS first responders to refer older people for medicines adherence review.
Inclusion Criteria:

- Age ≥65 years
- Medicines adherence issues
- Patient consents

Pharmacist Interventions were graded using Eadon grading scale(1), & ScHARR cost avoidance estimates(2,3) which defines costs related to Adverse Drug Events (ADEs) were applied.

Results: n=12 patients: Reason for referral by NIAS included people with multiple unused medicine compliance aids, suboptimal pain management, or confused about their medicines.
Time spent by pharmacist ranged from 60 to 400 minutes (average 170 minutes per patient). Clinical pharmacist interventions (n=62) included blood pressure measurement, deprescribing of inappropriate medicines, optimising pain management, & supply of adherence aids. 97% of clinical interventions were potentially significant at Eadon grade 4 (n=60).
Total cost avoidance due to pharmacist interventions was £5678 to £12867, with Invest to Save £6.40 to £14.52 for every pound invested.

Conclusion: A collaborative pathway between medicines optimisation in older people pharmacy service and the Northern Ireland Ambulance Service, led to cost effective improvements in medicines optimisation for older people.

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POSTER

3059. Clinical Quality - Clinical Effectiveness

COLLABORATIVE REVIEWS OF ANTICHOLINERGIC BURDEN (ACB)SCORES IN PRIMARY CARE FOLLOWING DISCHARGE FROM SECONDARY CARE AFTER A FALL

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Background: Older adults with multimorbidity are prescribed medicines to manage chronic conditions. Some of these cause anticholinergic side effects which can lead to falls.

Introduction: This work originated from the West Yorkshire ACB Task and Finish Group and involved pharmacists in secondary and primary care working collaboratively.
The aims were:
To raise awareness of ACB across all sectors.
To calculate the ACB scores for patients admitted with falls on acute elderly admission wards in two hospitals and refer to primary care for review on discharge if the score is 3 or more (clinically significant).

Method: On admission, the pharmacist calculated the ACB score using an online ACB calculator. Medicines contributing to ACB were reviewed throughout the hospital stay reducing doses and stopping medicines where appropriate following discussion with patients and carers.
Any ACB score still ≥ 3 on discharge was documented in the discharge letter with a request to review and deprescribe anticholinergic medicines in primary care. Consent to access SystmOne was obtained so patient records could be checked in secondary care 6 weeks post discharge.

Results: Over one hundred ACB scores were calculated during the 4-week data collection period. After reduction of ACB scores in secondary care, 15 patients still scored 3 or more on discharge and were referred to primary care for review.
66.67% (10/15) of patients referred received a primary care review.
70% (7/10) of primary care reviews resulted in reduced ACB scores.

Conclusion: Awareness of ACB in secondary care was raised through routine calculation of ACB scores on admission.
A high proportion of referrals were actioned in primary care.
By reducing ACB scores patients were subjected to less side effects and a potentially reduced falls risk.

This project was identified by NHSE in a national scoping exercise and analysed in a medicine safety scoping review.

POSTER

3068. Clinical Quality - Clinical Effectiveness

PROMOTING THE REDUCTION OF SEDATIVE USE IN OLDER ADULTS WITH DELIRIUM – A QI PROJECT

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Introduction: Non-pharmacological de-escalation techniques are effective in managing agitated patients with delirium yet are often overlooked in favour of pharmacological management. Sedatives are prescribed despite increased falls and extrapyramidal side effects. We used quality improvement methodology with the aim of reducing sedative use in older adults with delirium in an acute UK hospital.

Methods: Utilising inpatient electronic prescribing records, we collected data on all patients aged ≥65 prescribed a sedative acutely during May 2022 in a 575-bedded acute district general hospital. Based on best-practice guidelines, formulated standards were: <10 cases of sedatives prescribed monthly, and in individuals with sedatives prescribed 100% screened for delirium, 90% have non-pharmacological delirium management methods trialled first, 100% have rationale for sedative prescription documented, and 100% of sedative prescriptions reviewed within 24 hours. Of cases prescribed a benzodiazepine, 100% should have contraindication to haloperidol documented. We conducted one Plan-Do-Study-Act (PDSA) cycle, focussing on hospital-wide education and the implementation of aide-memoires, and repeated our audit in May 2024.

Results: Total sedatives prescribed declined significantly at re-audit (42 vs 72), with 28 individuals meeting inclusion criteria (vs 36 at baseline). Rates of delirium screening remained static (93%) while documentation of non-pharmacological methods improved by 16%. Where sedatives were used, 21% of prescriptions lacked documentation of rationale (vs 14% at baseline), no instances of contraindication to haloperidol were recorded (vs 6%), and only 68% of prescriptions were reviewed within 24 hours (vs 75%). Sedation for a scan reduced by the largest margin (18% of prescriptions vs 34%).

Conclusions: The total number of sedatives prescribed decreased through education initiatives. Where prescribed, fewer standards were met, including fewer documentations of rationale and medication reviews. Future work will be to implement an electronic prescribing sedative care plan to encourage non-pharmacological de-escalation techniques prior to consideration of appropriate, time-limited sedative prescriptions.

POSTER

3082. Clinical Quality - Clinical Effectiveness

GET IT ON TIME: IN-PATIENT ADMINISTRATION OF PARKINSON'S DISEASE MEDICATIONS IN SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST

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Introduction: The timely administration of Parkinson's Disease (PD) medications is essential for better motor symptom control, leading to improved patient outcomes. The NICE Guidelines and Parkinson's UK recommend all hospital in-patients with PD should get their PD medications on time – within 30 minutes of their prescribed administration time. This audit aimed to assess the adherence of timely administration of PD medications amongst in-patients at South Tyneside and Sunderland NHS Foundation Trust, and to compare this pre- and post-interventions.

Methods: A two-cycle retrospective audit was conducted in November 2023 (pre-intervention) and July 2024 data (post-intervention). Data on all doses of PD medications administered in the trust, and whether they were given on time, was collected via our trust's data warehouse application. On analysis, the percentage of PD medication doses given on time was calculated according to location. From this, six lower-performing wards were identified, and interventions for them (surveys, education and training) were carried out in April-May 2024.

Results: In November 2023, the trust-wide percentage of PD medications given on time was 83.46% (n=2920), increasing to 88.32% (n=4024) in July 2024. Pre-intervention, the percentage of PD medications given on time across in-patient locations within the trust was varied, ranging from 0-100%. Post-intervention, there was more consistency – ranging from 50-100%, this evidenced improved performance achieved trust-wide. All wards where interventions took place showed improved results, seeing 7.5-95.4% increases from their previous rates. New lower-performing wards which would benefit from interventions in future cycles of this audit were also identified.

Conclusions: Over the two cycles, South Tyneside and Sunderland NHS Foundation Trust showed improvement in the percentage of in-patients receiving their PD medications on time. The post-intervention data also illustrates the positive impact of our interventions. Our work has been recognised as a best practice case study by Parkinson's UK.

POSTER

3084. Clinical Quality - Clinical Effectiveness

A QUALITY IMPROVEMENT PROJECT ASSESSING THE DELIVERY OF MUSIC THERAPY ON A CARE OF THE ELDERLY WARD AND ITS IMPACT ON PATIENTS WITH BEHAVIOURAL AND PSYCHIATRIC SYMPTOMS OF DEMENTIA

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Introduction: Music therapy (MT) can alleviate the behavioural and psychiatric symptoms of dementia (BPSD) but it is not a standard intervention. NICE recommends MT to improve wellbeing in patients with dementia.

On our Care of the Elderly (COE) wards, MT is carried out by a qualified music therapist once a week, in groups, individual sessions, or both.

This quality improvement project (QIP) aimed to establish what, if any impact, MT, as it was currently provided, had on BPSD, in the setting of a general district hospital ward, thereby also potentially setting new standards which could be used to further optimise the provision of MT to patients.

Method: Patients with either a diagnosis of dementia or delirium were identified at the start of the day. MT was delivered in groups, individually, as well as both in some cases. Patients were interviewed by the music therapist both before and after MT, using the Neuropsychiatric Inventory Questionnaire (NPIQ), which was introduced and edited for this project. Patients' engagement with MT was observed by the therapist and recorded as routinely done, unbeknown to the therapist to later be included in the project. Data was collected on a weekly basis.

Results: Over the course of 9 Mondays, 37 patients were scored on the NPIQ pre and post MT. Nine had a score of 0 both pre and post intervention. From the remaining 28 participants, 20, i.e. 71% had an improvement in their NPIQ score. Engagement levels were extracted from the therapist's narrative on the day and 94 % (32/34) were positively engaged. One patient had five sessions of MT. In his case, MT reduced the need for anti-psychotics.

Conclusions: Music therapy improves the wellbeing of patients with dementia and delirium and should therefore be a standard resource on a COE ward.

POSTER

3094. Clinical Quality - Clinical Effectiveness

DELIRIUM ASSESSMENT AND MANAGEMENT IN HEALTH CARE FOR OLDER PEOPLE WARDS AT GOOD HOPE HOSPITAL: A QUALITY IMPROVEMENT PROJECT

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Introduction: Delirium is a common presentation in geriatric medicine. Improvement in delirium assessment and management should improve identification of these patients and improve their outcomes. This Quality Improvement Project, completed by a group of Health Care for Older People (HCOP) resident doctors, aimed to improve delirium assessment and management for patients admitted to the five HCOP wards at Good Hope Hospital, Sutton Coldfield.

Methods: Patients with documented confusion were selected and delirium assessment/management was compared to current NICE Guidance. This included whether delirium screening was done, which screening tool was used, and how delirium was managed. Data was collected retrospectively from electronic patient records, anonymised, and recorded using an online form. Data from 85 randomly selected patients admitted to HCOP wards in Good Hope Hospital during September 2024 was collected.

Interventions of departmental teaching for all HCOP doctors and informative posters in common areas were implemented.

Data collection was then repeated with 77 patients admitted during November 2024.

Results: Screening for delirium increased from 55.3% to 71.4% (+16.1%). Use of the NICE recommended 4AT tool increased from 30% to 43.9% (+13.9%). Implementation of non-pharmacological techniques (such as re-orientation) rose from 2.4% to 16.9% (+14.5%), and treating an identified cause rose from 75.6% to 94.8% (+19.2%).

Conclusion: Departmental teaching and educational posters were successful in improving delirium assessment and management. The largest improvements were in using a screening tool and treating an identified cause, which are largely undertaken by doctors. To improve further, educational efforts could be extended to the entire multi-disciplinary team. This may have resulted in more frequent use of non-pharmacological interventions. To implement long-lasting change, the posters have been provided to the department and delirium will continue to be taught in departmental teaching for future rotations of resident doctors.

POSTER

3111. Clinical Quality - Clinical Effectiveness

EVALUATION OF PRESCRIBING PATTERNS IN SEVERELY FRAIL OLDER ADULTS IN AN ACUTE GERIATRIC WARD ACCORDING TO THE STOPPFrail CRITERIA

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Introduction: Polypharmacy, multimorbidity, and frailty are closely interlinked. The STOPPFrail (Screening Tool of Older Person's Prescriptions) criteria offer a structured approach to identifying potentially inappropriate medications (PIMs) in very frail older adults with limited life expectancy. This study evaluates the application of these criteria before and after admission to a specialist geriatric ward in a tertiary care hospital.

Method: Medications were assessed against the STOPPFrail (Version 2) criteria before and after admission. Patients aged ≥65 years were included if they met all three STOPPFrail criteria: dependency in activities of daily living and/or severe chronic disease or terminal illness, severe irreversible frailty, and a clinical expectation of survival of less than 12 months. Data, including demographics, Clinical Frailty Scale (CFS) scores, medical history, and medication lists, were collected prospectively over three months.

Results: Of 120 patients admitted, 30 met the STOPPFrail criteria (57% female, median age 89.5 years, median CFS 6, median Charlson Comorbidity Index 7). All patients were prescribed one or more PIMs before admission, and 96.7% remained on at least one PIM after admission. Lipid-lowering medications decreased from 36.7% to 16.7%, while antihypertensives were fully discontinued (23.3% to 0%). Vitamin D and calcium supplements decreased from 60% to 43.3%, antipsychotic use increased slightly (10% to 13.3%), and proton pump inhibitor (PPI) use remained unchanged at 30%. Despite deprescribing efforts, the median number of medications increased from 8.5 to 9.5.

Conclusion: PIMs are prevalent in frail older adults. While deprescribing was focused on lipid-lowering and antihypertensive medications, gaps remain for PPIs and antipsychotics. Structured medication reviews, clinician education, improved documentation, and greater pharmacy involvement are essential to optimize prescribing. Identifying very frail older adults for whom STOPPFrail criteria are appropriate is vital to ensure a person-centred approach to medication management, enhancing safety and appropriateness for this vulnerable population.

POSTER

3130. Clinical Quality - Clinical Effectiveness

ONWARDS AND UPWARDS: THE SUCCESS OF A MOBILISATION STANDARD FOR IRISH HIP FRACTURES

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On behalf of The Irish Hip Fracture Database National Governance Committee

Introduction: The Irish Hip Fracture Database (IHFD) is a national clinical audit that measures standards of care for hip fracture patients across trauma sites in Ireland. Early mobilisation is considered one of the most influential modifiable factors for improving outcomes post hip fracture in older adults. The development of a mobility standard within the IHFD has provided a framework for physiotherapists to provide early mobilisation for hip fracture patients nationally.

Method: Each of the sixteen trauma sites in Ireland enter data into the IHFD. The data is analysed by NOCA and published in annual reports. 2018 saw the commencement of reporting mobilisation post-operatively as part of the IHFD. In 2022, a formal clinical standard for mobilisation, titled Irish Hip Fracture Standard seven (IHFS 7) was introduced. The standard requires patients to complete a stand on the day of or day after surgery by a physiotherapist. Functional measures including the Cumulative Ambulatory Score (CAS) and the New Mobility Score (NMS), are also recorded to guide goal-orientated rehabilitation and quality care for this cohort. IHFS 7 has also led to the formation of a physiotherapy network, designed to encourage shared learning and knowledge for therapists.

Results: Mobility rates have increased from 7% in 2018 to 87% in 2023 on day one post-surgery. Weekend physiotherapy service provision have also increased based on organisational surveys completed nationally. The majority of Irish hip fracture patients demonstrate low functional ability pre-fracture (52%), as graded by the NMS, with only 24% achieving independent mobility by day of discharge.

Conclusion: The introduction of IHFS 7 has been successful in supporting early mobilisation. Work needs to continue in enhancing completion rates for our functional outcome measures and evaluating barriers to mobility in the early post-operative phase.

POSTER

3137. Clinical Quality - Clinical Effectiveness

FEASIBILITY AND BENEFITS OF AN ONLINE PSYCHOSOCIAL GROUP FOR FAMILY CARERS OF PEOPLE WITH LEWY BODY DEMENTIA

R Thompson; R Webb

1. The Lewy Body Society; 2. Dementia UK

Introduction: Family carers of people with Lewy body dementia (LBD) often experience poor mental and physical health, reduced quality of life and high levels of strain/burden. Effective carer interventions include psychoeducational or psychotherapeutic tailored to individual needs, with group interventions evaluated as the most effective. However, dementia carer interventions rarely address the symptoms of LBD, despite some evidence indicating specific group interventions can enhance understanding and reduce social isolation.

Method: The Lewy body dementia Admiral Nurse service is a UK based dementia specialist nurse model. Referrals via a national helpline are offered individualised, multicomponent interventions including psychoeducation and coping strategies. Support is delivered remotely through telephone or online video calls. In 2021 the service developed on online psychosocial group programme for family carers at earlier stages of their caring. This included 6 x 2-hour sessions aimed at supporting understanding of LBD, coping strategies, addressing emotional impact of caring and planning for the future. Mutual support and self -care was facilitated via small group sizes. Carers were assessed prior to attending to ensure suitability. Feedback was gathered via an anonymised survey and wellbeing measured using Warwick Edinburgh Mental Wellbeing Scale.

Results: The programme has been offered to 4 separate groups (4-6 participants). Survey feedback (n= 15) indicated a positive difference to understanding of the condition, increased confidence in coping, development of new skills and feeling supported / connected with others across all respondents. Wellbeing scores improved overall on average, by approximately 6 points (43.3 – 49.1).

Conclusion: Initial feedback and outcomes indicate this intervention was acceptable and made a positive difference to coping and wellbeing for those who took part. Further research is required to fully evaluate the impact and benefits of online psychoeducational groups for family carers of people with Lewy body dementia at different stages of their role.

POSTER

3188. Clinical Quality - Clinical Effectiveness

IMPROVED DISCHARGE SUMMARIES FOR OLDER PATIENTS: A STEP TOWARD BETTER CONTINUITY OF CARE WITH COMPREHENSIVE GERIATRIC ASSESSMENT

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Introduction: Effective communication between primary and secondary care teams is essential for providing continuity of care in the community for older people with frailty. Discharge summaries often lack information captured in a comprehensive geriatric assessment (CGA). Junior members of the team, tasked with writing discharge letters, have not been formally taught in this area. This project aimed to incorporate key CGA domains into discharge summaries.

Methods: The geriatric medicine department at Broomfield Hospital and community mid virtual frailty team identified 7 core CGA domains for discharge summaries: main diagnosis, DNAR (Do Not Attempt Resuscitation) status, clinical frailty score (CFS), mobility/functional assessment, cognition, psychological concerns, and medications review. The project was piloted on a 26-bed ward, with data collected from patients over 65 years discharged. Audits were conducted across three cycles between October 2023 and November 2024. A total of 42 patients in cycle 1 and 2, and 50 patients in cycle 3 were included, excluding deaths. Initial interventions involved delivering an educational session and placing a poster. For the third cycle, additional measures were introduced: appointing two resident doctors as project champions and displaying an example discharge summary template. Weekly review of discharge summaries for 7 weeks, with weekly feedback was also implemented.

Results: Baseline audit showed low compliance with CGA in discharge summaries. By cycle 3, significant improvements were observed: main diagnosis and medications review were fully documented (100%), CFS documentation increased to 75%, and mobility/functional assessment (37%), cognition (38%), and psychological concerns (38%) showed notable progress. However, DNAR status documentation decreased from 81% to 75%. Feedback from doctors was positive, with the new template considered straightforward.

Conclusion: The project successfully improved CGA documentation in discharge summaries. Future proposals include expanding the initiative to other wards and integrating a modified template into the electronic discharge system for easier access.

POSTER

3204. Clinical Quality - Clinical Effectiveness

BONE HEALTH ASSESSMENT IN STROKE REHABILITATION

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Background: The National Clinical Guideline for Stroke recommends bone health assessment for patients at higher risk of falls. Following stroke, patients have reduced bone mineral density, correlated with functional deficit. Stroke can result in reduced mobility, asymmetric weight bearing, poor nutrition and impaired Vitamin D stores. This results in higher risk of fragility fracture. However, bone health is often overlooked. An initial review on a stroke rehabilitation unit in March 2024 found no bone health assessment process.

Objectives: Patients with stroke and high risk of fragility fracture should undergo bone health assessment and timely treatment or onward referral if indicated.

Method: Patients undergoing stroke rehabilitation were identified as high-risk for fragility fracture based on age, gender, falls history, cognition, visual impairment and post-stroke seizures. Patients with life expectancy <1 year or predicted to be bedbound longer term were excluded. Data was collected over two cycles for 1 month (September 2024, November 2024). If high-risk, records were reviewed for serum calcium and Vitamin D measurement, FRAX score and treatment initiation and/or onward referral.

Results: Local guidelines were developed with input from orthogeriatric and stroke physicians. Following initial analysis, 3/32 eligible inpatients (11.1%) had recorded FRAX scores with none initiated on therapy. Prompts were added to patient records and departmental teaching delivered. Significant improvement was seen in the following cycle: 43.8% (n=14) of eligible patients had bone health assessment. Serum Vitamin D measurement increased from 41% to 56% and all below threshold started replacement. Five patients were referred for bone densitometry and a further five were prescribed bisphosphonate therapy.

Conclusion: Patients with stroke are at higher risk of fragility fractures. Increased awareness and assessment in the rehabilitation setting are required. Further improvements include displaying posters of the treatment flowchart, induction education for rotating doctors and additional electronic record prompts to increase engagement.

POSTER

3212. Clinical Quality - Clinical Effectiveness

COLLABORATIVE CARE IN FRAILTY: EVALUATING THE CLINICAL EFFECTIVENESS OF NURSE-PHARMACIST PARTNERSHIPS

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Introduction: Frailty presents significant challenges to healthcare systems, particularly in Thurrock, Essex, where 14% of residents are aged 65 or older. This demographic shift, combined with socioeconomic factors, highlights the need for clinically effective, tailored healthcare services.

Aim: To improve the clinical effectiveness of frailty management for elderly patients in Thurrock by integrating pharmacist support within a nurse-led frailty service. The initiative focuses on improving medication management, alleviating workload pressures, and providing holistic care to enhance patient outcomes and reduce hospital admissions.

Method: A 12-week pilot involved patients aged 65+ undergoing joint reviews with a frailty nurse and pharmacist. Participants had a Rockwood Frailty Score of 5-7 and at least one long-term condition. The reviews included evaluations of medication, functional and falls risks, nutritional status, fracture risk, and blood tests. The management phase focused on deprescribing, dose adjustments, and addressing health metrics such as postural hypotension, bone protection, and falls risk. Regular follow-ups ensured coordinated care between the nurse and pharmacist.

Results: From April 4 to June 28, 2024, 37 patients (mean age: 84) participated. Comprehensive assessments led to 155 interventions (averaging 4.07 per patient). Medication management improved significantly, with 88 drugs deprescribed, including 55 Falls Risk Increasing Drugs (FRIDs), resulting in a 14.39% reduction in FRIDs and a 23.03% reduction in polypharmacy. These changes resulted in £6,252.18 in annual drug savings and a 974.09kg reduction in CO_2 emissions. Key outcomes included 57 health and social interventions and 38 new medications prescribed. Financial analysis suggested savings of £63,450 from preventable hospital admissions, with a return on investment (ROI) of 1655.4%.

Conclusion: The pilot demonstrated the clinical effectiveness of pharmacist-nurse collaboration in improving medication management, chronic condition control, reducing falls risk, and preventing hospital admissions. It underscores the value of skill mixing between professions for enhanced clinical outcomes.

POSTER

3225. Clinical Quality - Clinical Effectiveness

DELIRIUM ASSESSMENTS IN AN ACUTE FRAILTY WARD: AN AUDIT OF CURRENT PRACTICE

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St George's University Hospitals NHS Foundation Trust

Introduction: Delirium is a common, reversible condition with significant morbidity. Guidelines facilitate diagnosis and management (NICE Delirium Guidelines [CG103]). Previous audits in an acute frailty ward identified areas for improvement in assessment of delirium. In this cycle, a novel admission proforma was implemented to promote adherence to current guidelines.

Methods: This is a continuation of a previous quality improvement project representing cycles three and four. An admission proforma was co-developed with patients and the multidisciplinary team (MDT), primarily to prompt staff to complete delirium assessments. Adherence was audited and the proforma was modified based on feedback. An equivalent audit was then conducted on the updated proforma. The audit period occurred over several resident doctor changeovers. Primary outcomes; completion of delirium assessments, positive diagnosis of delirium and use of the new proforma. Secondary outcomes; completion of resuscitation and clinical frailty score (CFS) forms and the relationship between length of stay (LOS) and delirium or CFS.

Results: The initial admission proforma was used in 86% of admissions. After its introduction, 53% of patients had completed delirium assessments and the prevalence of delirium was 25%. Resuscitation forms were completed in 86% of patients, 60% of patients had completed CFS. Diagnoses of delirium were associated with increased LOS. CFS of 6/7 was associated with an increased LOS and a diagnosis of delirium.

The modified proforma was used in 94% of admissions. Completion of delirium assessments improved to 79% and diagnoses of delirium to 43%. Completion of resuscitation forms and CFS improved to 93% and 79% respectively. The difference in LOS between patients with and without delirium was statistically significant.

Conclusion: This study shows the efficacy of an admission proforma, as low-cost MDT-based intervention, improving and sustaining adherence to guidelines and improving documentation and assessment of other elements of a comprehensive geriatric assessment.

POSTER

3088. Clinical Quality - Efficiency and Value for Money

CAN THE LENGTH OF STAY ON INTERMEDIATE CARE UNITS (ICUS) BE REDUCED FOR NON-WEIGHT BEARING PATIENTS?

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Introduction: Fragility Fractures can lead to immediate complications, decline in health status, increase in hospital stay, increased care needs and reduction in the quality of life (Court-Brown C Clement N, Duckworth A, The Bone and Joint Journal, 2014 96-B(3) 366-372). However, the National Osteoporosis Society (2017) reported 80% of non-hip fractures were not offered strength or balance exercises It is estimated that fragility fractures cost the UK £4.4 billion which includes £1.1 billion for social care (Office for Health Improvement & Disparities, 2022).
At Sussex Community NHS Foundation Trust, non-weight bearing (NWB) patients have prolonged bed-based stays. Complex patients cannot be discharged home when NWB as there is no commissioned social care pathway. These patients are seen as low priority for rehabilitation.
The aim of the project was to reduce the length of stay for NWB orthopaedic patients.

Method: Baseline data of 10 inpatients from the Sussex Community NHS Foundation Trust ICU, discharged in April 24 was scrutinised. The team articulated the issues for NWB in a fishbone diagram, and a tailored programme of resistance strengthening and balance exercises was introduced for 8 NWB patients in May and June 2024, as a PDSA cycle. This included leg ankle weights and dumbbells to carry out chair and standing exercises (when appropriate), in addition to routine group physiotherapy sessions. All patients were seen 2-3 times a week.

Results: The average length of stay for NWB patients reduced by 14 days. The number of therapy contact sessions reduced to 2.1 post orthopaedic review and patients were weight bearing again.

Conclusion: Providing a tailored strengthening exercise programme that focuses on the non-weight bearing phase of the patient's orthopaedic rehabilitation journey reduced the length of stay on the intermediate care unit, and the physiotherapy interventions once weight bearing.

POSTER

3095. Clinical Quality - Efficiency and Value for Money

REDUCTION IN THE USE OF NURSING ENHANCED OBSERVATION WITHIN ACUTE CARE

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NHS Forth Valley, acute services identified an increase of over 122% demand on the request for patients to receive enhanced observations during 2023-2024. In March 2024 a project was undertaken to understand the cause of the increase. This highlighted patients were not appropriately risk assessed or regularly reviewed and there was also a lack of evidence that the least restrictive options had been explored. The sample review also demonstrated patients were not engaged in meaningful activity, cognitive rehabilitation or stimulation, which therefore provided an absence of evidence of the benefit to patient, highlighted a risk of a prolonged length of stay, risk of exacerbating stress and distress and potential increase of physical harm. In addition, enhanced observation has a significant financial impact due to the requirement of supplementary staffing. Improvement interventions with education and adapting electronic systems has led an 86% reduction of patient identified as requiring enhanced obs. In addition this has seen a 94% reduction in supplementary hours used and supplementary staffing requests through the staff bank. NHS Forth Valley have seen no themes in adverse events or complaints which related to the reduction in use of enhanced observations.

POSTER

3149. Clinical Quality - Efficiency and Value for Money

MEASURING VITAMIN D POST HIP FRACTURE – SHOULD WE TEST OR JUST TREAT? LESSONS LEARNT FROM AN ORTHO-GERIATRIC REHAB UNIT

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Introduction: Plasma 25(OH)D is commonly tested following hip fracture. The National Osteoporosis Society recommends against routine testing in these patients as vitamin D is often co-prescribed with anti-resorptive agents, making vitamin D testing unnecessary.

Our median reporting time for plasma 25(OH)D is 11.5 days, costing around £7/unit. High dose, rapid vitamin D loading costs £1.34. So, is vitamin D testing in these patients cost-effective and does it add to our clinical decision-making?

Method: Records of 72 discharges from our ortho-geriatric unit over 3 months were reviewed for admission serum calcium, creatinine clearance, PTH and vitamin D. Vitamin D prescription regimes were reviewed.

Results: 100% of patients had plasma 25(OH)D checked. Mean plasma 25(OH)D was 44.8 (range <5 - 106.6). 23 patients were vitamin D deficient (32%), 23 insufficient (32%) and 26 replete (36%).

100% of patients with vitamin D deficiency and 91.3% with insufficiency received rapid high dose vitamin D loading regime (150,000-200,000 units over 1-7 days).

53.8% of vitamin D replete patients were prescribed a high dose vitamin D regime (n = 14) but 3 were switched to low dose when levels returned as normal. 12 patients with an early normal plasma 25(OH)D were prescribed Adcal D3 or low dose colecalciferol.

Conclusions: 58 patients (80.5%) were prescribed rapid high dose vitamin D regimes, the majority of whom were vitamin D deficient or insufficient. Only 3 patients were switched and a further 12 started on low dose vitamin D based on a normal plasma 25(OH)D result.

Plasma 25(OH)D resulted in a change in vitamin D regime in only 20.8% of patients. When comparing the cost of the test to that of the treatment regime, we would argue that serum calcium/PTH are more cost-effective and stronger predictors of who requires a lower dose vitamin D dose regime (e.g. in hyperparathyroidism) than plasma 25(OH)D.

POSTER

3197. Clinical Quality - Efficiency and Value for Money

COLLABORATIVE CARE: ENHANCING FRAILTY MANAGEMENT THROUGH NURSE-PHARMACIST PARTNERSHIPS

J Sharma

North East London Foundation Trust, Community Frailty Team Thurrock Essex

Introduction: Frailty poses significant challenges to healthcare systems, particularly in Thurrock, Essex, where 14% of residents are aged 65 or older. This demographic shift, combined with socioeconomic factors, underscores the need for tailored healthcare services.

Aim: To enhance frailty management for elderly patients in Thurrock by integrating pharmacist support within a nurse-led frailty service. The initiative focuses on improving medication management, alleviating workload pressures, and providing holistic care to enhance patient outcomes and reduce hospital admissions.

Method: A 12-week pilot involved patients aged 65+ referred by frailty nurses for pharmacist review, with a Rockwood Frailty Score of 5-7 and at least one long-term condition. The process included screening using the Rockwood Frailty Score, followed by evaluations on medication, functional risk, falls risk, nutritional status, fracture risk, and blood tests. The management phase focused on deprescribing, dose adjustments, and addressing health metrics such as postural hypotension, bone protection and falls risk. Regular follow-ups ensured coordinated care.

Results: April 4th to June 28th, 2024, 37 patients participated (mean age: 84). Comprehensive assessments resulted in 155 interventions (averaging 4.07 per patient). Medication management improved significantly, with 88 drugs deprescribed, 55 Falls Risk Increasing Drugs (FRIDs) deprescribed, leading to a 14.39% reduction in FRIDs and a 23.03% reduction in polypharmacy. This intervention generated an annual drug savings of £6,252.18 and reduced CO_2 emissions by 974.09 kg. Key outcomes also included 57 health and social interventions and the prescribing of 38 new medications. Financial analysis indicated potential savings of £63,450 from preventable hospital admissions with a return on investment (ROI) of 1655.4%.

Conclusion: The pilot demonstrated the effectiveness of pharmacist-nurse collaboration in improving medication management, chronic condition control, reducing falls risk and preventing hospital admissions for frail older adults. It highlights the value of skill mixing and potential for expansion to other services and settings.

POSTER

2937. Clinical Quality - Improved Access to Service

FROM MOBILITY AND BEYOND

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1. Frailty assessment unit; 2. Department of Elderly Care; Musgrave Park Hospital; Belfast Health and Social Care Trust

Introduction: Frailty is a clinically recognized condition characterised by increased vulnerability due to age-related decline across various physiological systems, leading to reduced ability to cope with daily and acute stressors. Managing frailty requires a person-centred approach, involving patients, families, and caregivers, and utilising evidence-based practices such as Comprehensive Geriatric Assessment (CGA), delivered by specialist multidisciplinary (MDT) teams. Research indicates that older individuals receiving CGA are more likely to be alive and living independently at home six months after an acute illness.

To support the development of Older People's Services, a review of the service model was conducted to deliver a rapid access service for patients referred by general practitioners (GPs). This service aims to avoid emergency department (ED) visits while providing necessary CGA assessments.

Method: The initiative involved creating a direct referral option within the GP's electronic referral system (Clinical Commissioning Group), developing a standard operating procedure for the triage process, establishing an education process for staff to clarify roles and responsibilities including data collection, and scheduling MDT members for triage support.

Results: Following the implementation of the agreed procedures, there was a notable improvement in scheduling urgent GP referrals within three days. A daily referral system with live triaging was established, along with daily post-clinic MDT meetings. The backlog of urgent GP referrals was cleared. This successful system was replicated using Plan-Do-Study-Act (PDSA) cycles to integrate ED referrals.

Conclusion: Collaborating with a team whose values aligned with Health and Social Care (HSC) principles—working together, striving for excellence, openness, honesty, and compassion—was a rewarding experience. The project provided valuable learning opportunities in team-building and service development. The success of the GP referral system was also leveraged to expand the service to other areas, such as ED referrals, demonstrating effective duplication of successful strategies.

POSTER

2999. Clinical Quality - Improved Access to Service

AN AUDIT OF THE IMPACT OF BONE HEALTH ASSESSMENT IN RESIDENTIAL HOME PATIENTS

S Evans

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Introduction: There are approximately 549,000 new fragility fractures each year in the UK and the prevalence of both osteoporosis and risk of falling increases with age. Care home residents are three times more likely to fall and have a 3- to 4-fold higher incidence of fractures than people of the same age living in the community. These older, frailer and multimorbid patients often have the highest fracture risk and therefore the most to gain from anti-osteoporosis treatments to reduce this risk.

Method: Retrospective audit of residents who were reviewed by the newly started Enhanced Health in Care Homes (EHCH) team within the 5 residential homes for an initial comprehensive geriatric assessment (CGA) between March 2022-June 2024.

These initial CGAs were reviewed to determine if a FRAX assessment had been completed and subsequent sub-analysis of those with high/very high FRAX scores to determine whether they were on appropriate bone protection.

Results: 100% of residents (183) had a bone health assessment including a FRAX score (age-adjusted if appropriate). Prior to CGA, 37% patients with a high/very high FRAX score were on appropriate bone protection, having excluded patients who were not suitable for any treatment for reasons including poor renal function or not clinically appropriate. Following EHCH initial CGA and management plan, this average improved to 85% across the residential homes. The most significant improvement in one residential home was from 0% to 83% post bone health assessment.

Conclusion: There has been a considerable improvement from 37% to 85% in the number of residents at high and very high risk of fractures who are on appropriate bone health protection following an initial bone health assessment and subsequent management plan initiated by the Enhanced Health in Care Home team.

POSTER

3013. Clinical Quality - Improved Access to Service

A NEW COMMUNITY-BASED APPROACH TO THE CARE OF ACUTE DELIRIUM

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Background: Current practice for acute delirium presentation is hospital admission whilst the delirium resolves, often including multiple transfers with poor outcomes. This project challenges this practice and allows people to recover at home with a maximum of 6 calls a day and night with carers trained in delirium.

Results: From a previous audit of Pathway 2 beds patients with delirium had poor outcomes, high levels of placement in permanent care and long lengths of stay (21 days).

There have been 192 episodes of care through the Delirium Pathway. 80% were from hospital wards and 20% stepped up from community settings.

In 2023, 42% had no ongoing social care support needs and 21% had only the requirement of ongoing domiciliary care needs at home. 2.6% entered long term care with the re-admission rate remaining within the local rate for this cohort of 20-30%. There has been low demand for night care. The average LoS is 15 days.

Delirium symptoms significantly improved at discharge and stayed improved; pre-discharge the median 4AT score was 7, at first pathway assessment (generally within 24 hours of arrival home), the median 4AT score was 2 and at exit of pathway the median 4AT score was 1.

Patients and carers reported that the discharge home felt safe and that home was the best place for recovery: 89% of patients and 76% of carers felt it was safe to return home; 94% of patients; and 93% of carers felt that home was the best place for recovery.

Conclusion: This pathway has demonstrated that discharging patients with an acute delirium with supportive home care is safe, effective, and reduces admissions to long term care.

POSTER

3023. Clinical Quality - Improved Access to Service

OLDER ADULTS ARE NOW THE FACE OF MAJOR TRAUMA IN IRELAND

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1. National Office of Clinical Audit; 2. Cork University Hospital; 3. St. Vincent's University Hospital

Background: The Major Trauma Audit is a national clinical audit managed by the National Office of Clinical Audit (NOCA), that captures data of patients with life threatening or life changing injuries. It has been publishing annual reports since 2014.

Methods: Originally established using the Trauma Audit Research Network (TARN) method, now entitled National Major Trauma Registry in the UK.

Results: In 2024 a focused report from 2017-2021 on older adults was published as this is the largest group of patients in the major trauma population (51%, n=11,145). 56% of patients were female, the median age was 79 and 74% had pre-existing comorbidities. Low falls, of less than 2 metres, were the leading mechanism of injury (82%) and home was the main location of injury (70%). The most common injuries were limbs (27%) & head (25%). One third were allocated to the most severe injury category (injury severity score >15). Older adults are less likely than <65's to be pre-alerted (9% vs. 22%), received by a trauma team (6% vs. 15%), have longer hospital stays (12 vs 7 days), 22% of older adults were discharged to a nursing home and 44% went home. Mortality was 7%.

Conclusion: In light of recently published clinical guidance for the care of older adults with major trauma published by the Health Service Executive this data shows that significant improvement is required to create an age friendly healthcare system with prompt and effective care for older adults. Data from the MTA is being used to redesign the trauma system in Ireland into two networks with major trauma centres and trauma units so that the right patient can be brought to the right hospital at the right time.

POSTER

3044. Clinical Quality - Improved Access to Service

AN OVERVIEW OF THE DEMENTIA UK CONSULTANT ADMIRAL NURSE SERVICE SUPPORTING FAMILIES AFFECTED BY FRAILTY AND DEMENTIA

K Lyons

Dementia UK

Introduction: Emerging and increasing frailty often goes unidentified, and families living with dementia and frailty are missing vital opportunities to receive the right support at the right time. People living with frailty are less able to adapt to stress factors such as acute illness, injury, or changes in their environment, personal or social circumstances, leading to adverse health outcomes and an earlier loss of independence.

Method: We developed a unique and innovative frailty Consultant Admiral Nurse role and service to address this concern. This service was created alongside a recognition of the need for equal access to better national awareness, knowledge, resources, and support around the management of frailty and dementia. The service provides professional leadership, consultancy, education, and expert clinical practice to families.

Results: The service has been operational for 12 months, with excellent quantitative and qualitative outcomes. To date, 536 people have received specialist frailty and dementia training. Clinical interventions equated to 2862 activities directly delivered to support families. From carers surveyed, 100% stated that the service helped them manage symptoms of frailty alongside dementia, understand frailty, and cope with the challenges posed by frailty and dementia.

Conclusion(s): The Dementia UK Frailty Consultant Admiral Nurse service has demonstrated significant positive impacts on families living with dementia and frailty. The service focuses on reducing barriers to care and support, ensuring equality in service provision. The involvement of Lived Experience partners in service planning and delivery has been crucial. The service aims to expand further, building on the successful outcomes of its first year.

POSTER

3092. Clinical Quality - Improved Access to Service

NURSING HOME NURSES' EXPERIENCE IN AN ACUTE TELECONSULTATION SERVICE: A QUALITATIVE STUDY

C Y Ong[1]; Y Q R Koh[2]; H Xu[3]; J J A Ng[1]; H H S Teo[1]; M H J Lee[1]

1. Sengkang General Hospital Singapore; 2. Singapore Management University; 3. Duke University Durham

Introduction: An acute hospital-regional nursing home service (EAGLEcare ACT) were established with an aim to reduce preventable emergency department visit and inpatient hospitalisations of nursing home residents. We aim to explore the experiences of nursing home nurses using the service.

Method: Ten focus group discussions were conducted in seven partnering nursing homes. A total of 57 nursing home nurses with an average of 4.9 years of working experience participated in the discussions. Transcripts were analysed using qualitative interview analysis.

Results: Three main themes emerged: empowerment, feasibility of use, and needs unmet. The EAGLEcare ACT service provided by an acute hospital were welcomed to supplement the unavailability of resident general practitioner. It promotes capability building among partnering nursing home nurses and provides assurance to the next-of-kin of ill residents. The processes and teleconsultations were found to be convenient, and the service was responsive. Medication ordering to administration time, and laboratory investigation ordering to collection and dispatch time were identified as areas for service improvement.

Conclusion: Teleconsultation service partnership between an acute hospital with nursing homes were generally well received and perceived as helpful and scalable collaboration.

POSTER

3118. Clinical Quality - Improved Access to Service

NOGG GUIDELINES AND APPLICATION IN PRACTICE: ANALYSIS OF 3 YEARS OF NHFD DATA AND BONE HEALTH SERVICE PROVISION AT ROYAL ALBERT

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Introduction: National Osteoporosis Guideline Group (NOGG) guidelines published in 2022 significantly changed practice in orthogeriatric setting with recommendation for early treatment to address “imminent fracture risk” and recommendation for greater use of injectable therapies for those at “very high fracture risk”. Intravenous zolendronate is now considered first line treatment, particularly post hip fracture but additional services for provision of injectable therapies have not been created to address this. The aim of this work was to analyse treatment choices for patients entered on National Hip Fracture Database (NHFD) for bone protection and assess current service provision against ongoing need.

Method: Data was collected retrospectively, using NHFD dataset for Royal Albert Edward Infirmary over 3 year period (2022 – 2024). Details of treatment choice were analysed across the 3 years and service provision for continuation of injectable therapies assessed against patient need.

Results: There were a total of 420 in 2022, 432 in 2023 and 381 in 2024 patients who were entered on the NHFD locally. In 2022, 192 patients (45%) of patients were discharged on oral bisphosphonate, whereas this number went down to 174 (40%) in 2023 and only 22 in 2024 (6%). Meanwhile, use of zolendronate nearly tripled from 56 (13%) in 2022 to 149 (39%) in 2024. Denosumab use also increased from 75 (18%) in 2022 to 107 (28%) in 2024. Overall, more than two thirds of patients were discharged home on injectable antiresorptive therapy in 2024 following a hip fracture.

Conclusions: Updated guidelines on optimal bone protection after hip fracture advise greater use of injectable antiresorptive drugs. National initiatives should focus on ensuring equitable access to these treatments both via hospital day case unit provision but also via delivery of injectable therapies for osteoporosis in community, as we aim to deliver more healthcare outside of hospital environments.

POSTER

3131. Clinical Quality - Improved Access to Service

FOLLOW UP OF HOUSEBOUND AND CARE HOME PATIENTS WITH PARKINSON'S DISEASE

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Introduction: There are approximately 600 patients in the Pembrokeshire Movement disorder service, of whom, around 10% are either housebound or live in placements. There is concern these patients struggle to access follow up due to difficulties in attending face to face clinics. NICE and Parkinson's UK recommend that people with Parkinson's should be seen by a specialist healthcare professional every 6 to 12 months.

Method: A retrospective case note analysis was carried out for 55 patients that were identified as being either housebound or living in residential or nursing homes. Data were collected on time since last clinic visit and last letter, hospital admissions in the past 2 years, number of prescribed medications and DNACPR status on Welsh Clinical Portal.

Results: The mean time since last clinic visit was 15.3 months, with the longest 81 months. Housebound patients had a mean time since last clinic visit of 15.5 months and those in placements had a mean time of 15.3 months. The time since last letter was lower, however those patients still in their own homes had a longer interval than those in placement. 53% of patients had a DNACPR decision recorded on Welsh Clinical Portal. When isolating housebound patients this dropped to 29%. 72% of those in placements had a DNACPR decision.

Conclusions: The requirement to see patients with Parkinson's every 6 to 12 months is not being met. This is likely due to practical difficulties of attending face to face clinics. It is proposed to create a regular virtual clinic to discuss these patients, in combination with their relatives or carers and patient reported outcome measure questionnaires. This will be brought to the health board Parkinson's meeting in order to facilitate change. Once the change has been implemented data can be recollected to establish the effect of the change.

POSTER

3132. Clinical Quality - Improved Access to Service

QUALITY IMPROVEMENT PROJECT: CLINICAL FRAILTY ASSESSMENT DURING CLERKING FOR THE OLDER PATIENT

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Introduction: The Commissioning for Quality and Innovation (CQUIN) framework sets a 10% minimum and an ideal goal of 30% of acutely presenting patients over the age of 65 to receive frailty assessment scores. Early recognition of frailty helps mitigate risks such as deconditioning. This project aims to assess and improve the adoption of this standard in medical emergency admissions of a Birmingham district general hospital by working with medical admissions teams and frailty services and observing for associated outcome measures.

Method: PDSA methodology was used. Data was retrospectively collected for patients aged 65 and above from the electronic patient records (EPR) over a week's interval from the acute medical take. Collected data included prevalence of CFS scoring and social history, escalation discussions and mortality. Interventions were delivered via an educational presentation to resident doctors and displayed posters in key areas. The data was examined for improvements in CFS prevalence and its relationship with onwards referral, escalation discussions or mortality.

Results: Pre-intervention only 3.31% (8/242 patients) had a recorded CFS score. Post-intervention, 19.10% (34/178) patients had a CFS score documented. Post-intervention, 82.35% of those with CFS scores were referred to the frailty therapy service, as opposed to 17.36% of those without CFS scoring. Escalation discussions were had with 41.17% of those with CFS scoring and 29.17% of patients without. Mortality was 5.88% in the CFS scored patients and 9.72% in the patients with no CFS score.

Conclusion: After focused interventions, the CFS prevalence was above the 10% minimum requirement and closer to the 30% goal set by the CQUIN 05. Patients with a CFS score saw higher rates of onwards referrals to older person services, and higher rates of escalation discussions. In forwards application, CFS could be discussed in induction, incorporated into IT clerking systems

POSTER

3152. Clinical Quality - Improved Access to Service

INTRODUCING AN ONCO-GERIATRICS REFERRAL PATHWAY FOR FRAIL OLDER ADULTS LIVING WITH CANCER

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Introduction: The Royal College of Physicians (RCP) introduced guidance on implementing frailty assessment and management in oncology services in November 2023. Frailty-informed care has been demonstrated to improve outcomes. The RCP suggests that where the management of frailty is beyond the skillset of the oncology team, links should be built with local geriatric teams to ensure holistic care, responding to individual needs.

Method: We set up a referral pathway within an existing geriatric clinic at a district general hospital, facilitating referrals initially from oncology colleagues, then expanding to haematology. This was complemented by drop-in sessions and multi-disciplinary teaching sessions on frailty and comprehensive geriatric assessment.

Results: There were 23 referrals between January and November 2024. The median frailty score was 5. Cancer sites included rectal, urological, upper GI, lung and haematological malignancies.

The majority of referrals were for polypharmacy (6), pre-treatment optimisation (6) and poor mobility (6). Other categories included falls and advance care planning. Patients waited between 2 and 21 days for an appointment. Outcomes for patients seen included rationalising medications (8); onward specialty team referral and investigations (7); multidisciplinary involvement (4) and advance care planning (2).

Through our interventions, assessment of frailty score improved from 0 to 96% of patients in this sample.

Conclusion and next steps: We have demonstrated the feasibility of integrating an onco-geriatrics pathway into an existing geriatrics service and nurturing links between departments through regular teaching sessions. As well as improving access to services for older adults, this provides training opportunities to resident doctors.

Patient survey data is currently being collected to look at the impact of this service on patient experience. Whilst outside the scope of the initial project, future work could look into whether the positive impact of this service translates into a reduction in re-admissions in this cohort of patients.

POSTER

3154. Clinical Quality - Improved Access to Service

LUMBAR PUNCTURE TO DIAGNOSE ALZHEIMER'S DISEASE WITHIN A GERIATRICIAN-LED MEMORY SERVICE IS WELL-TOLERATED

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Introduction: With the emergence of disease modifying treatments for Alzheimer's disease (AD), there is an increasing emphasis on the earlier detection and diagnosis of AD. Cerebrospinal fluid (CSF) sampled using lumbar puncture (LP) can be used to establish a biological diagnosis of AD. One potential obstacle to the widespread adoption of CSF biomarkers for AD diagnosis has been a perceived association with poor patient tolerability and safety of LP. LPs have been undertaken within our Geriatrician-Led Memory Service since May 2022. Patients are provided with a written information sheet prior to LP.

Method: A survey was developed in-house by the clinical team. A service evaluation initiative was registered within the local trust. All patients attending for LP since May 2022 were posted a feedback form with an enclosed pen and stamped addressed return envelope on 5th August 2024. Questions included: what the patient's understanding was of why they were having a LP, whether the written information sheet provided sufficient information, their overall experience of the LP and whether there were any concerns about the procedure.

Results: Of the 36 feedback forms posted, 17 (47%) were returned. Of the 17 responses received, 12/17 (71%) patients strongly agreed and 4 (24%) patients agreed that they understood why they were having a LP, what a LP involved before attending and that the leaflet provided sufficient information about a LP procedure. All 17 patients agreed that they were satisfied with their overall experience of the LP procedure. 5/17 (29%) patients stated they had concerns during or after the procedure; these included length of time taken for results to become available.

Conclusion: This survey of patients attending a Geriatrician-Led Memory Service for LP found obtaining CSF biomarkers for AD to be a well-tolerated procedure with high overall patient satisfaction.

POSTER

3178. Clinical Quality - Improved Access to Service

VARIATION IN MISSED OPPORTUNITIES FOR SECONDARY FRACTURE PREVENTION

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Introduction: Despite clear national guidelines and government support for Fracture Liaison Services, the osteoporosis treatment gap remains significant. The Fracture Liaison Service Database (FLS-DB), a national audit run by the Royal College of Physicians (RCP), has recently expanded its reporting to highlight this issue.

Method: Previously the FLS-DB benchmarked data from those trusts submitting data to the audit. From January 2025, an extra column has been added to show 'Missed Opportunities' that includes data from sites not participating in the FLS-DB. Using local hip fracture data for 2022 from the National Hip Fracture Database (NHFD) figures, the predicted local FLS caseload was determined by multiplying the number of hip fractures by 5. Expecting 80% of the predicted caseload to be identified, at least 50% of those to be recommended treatment (accounting for mortality, severe comorbidities etc.) and 80% of those initiating and staying on treatment up to 12 months gives the expected on treatment population. This was compared with the data from the FLS-DB and NHFD KPI set to generate the number with a missed opportunity.

Results: 77 FLS are participating with the FLS-DB with 82 NHFD sites not covered by an FLS. While 80,767 records were submitted in 2022, the missed opportunity count was estimated to be 56,550 patients (48,214 in England and 6,180 in Wales) per annum. When the missed opportunity estimate was analysed in 36 ICSs, there was an over 100-fold difference in the estimate.

Conclusions: Despite clear guidelines and prioritisation of FLSs, over 50,000 patients are not on osteoporosis treatment when they should be. By making this data visible at the local hospital and ICS / Health board level, care providers can better judge the level of resources required for FLS locally, and the data provides support for ICSs in FLS implementation.

POSTER

3180. Clinical Quality - Improved Access to Service

A REVIEW OF INJECTABLE BONE HEALTH MEDICATION FIRST DOSE ADMINISTRATION FOLLOWING A HIP FRACTURE

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Introduction: At Wrightington, Wigan and Leigh 381 patients were admitted with hip fracture diagnoses in 2024. As part of the orthogeriatric review, bone health medications zoledronic acid and denosumab were utilised in this cohort of patients, where appropriate, to address the significant risk of "imminent fracture" in line with NOGG guidelines. The aim was to review January to June of 2024; 118 patients were evaluated, reviewing delays in initiation of these treatments to improve services and patient care.

Method: Utilising hospital electronic records, a sample of patients were selected from those admitted in 2024 (118 patients). These were split into treatment choices zoledronic acid (59 patients) and denosumab (59 patients) to better evaluate the pathways for each treatment. An intervention to consent and initiate treatments before discharge in patients presenting with a hip fracture was implemented at WWL in September 2023. The results reviewed the number of patients receiving treatments before discharge, the date range variation between first doses and why these were so varied.

Results: The average length of time for first dose denosumab was 62 days, improved greatly since 2022 (187 days) and 2023 (76 days). The average length of time for first dose zoledronate was 72 days with no comparative data. Further analysis shows how zoledronate delays in 91% of patients was due to the practice of not administering bisphosphonate medications within 14 days of surgery, a practice that has now changed. Furthermore, 64% of denosumab patients and 75% of zoledronate patients were delayed due to replacement of vitamin D.

Conclusion(s): Implementation of inpatient consent has been shown to expediate first dose denosumab greatly. Analysis of data will be required to review the first dose administration of zoledronate; stopping limitations such an administering within the 14 days of surgery should reduce delays further.

POSTER

3184. Clinical Quality - Improved Access to Service

IV ZOLEDRONIC ACID POST-DISCHARGE CARE FOR PATIENTS IN THE TRAUMA WARD, CRAIGAVON AREA HOSPITAL

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Introduction: Following the publication of 'Call to action: A Five nations consensus on the use of intravenous zoledronate after hip fracture,' Craigavon Area Hospital began offering IV Zoledronic acid (IV Zol) to patients with a fragility neck of femur (NOF) fracture. However, the administration of IV Zol is based on the bone health assessment, vitamin D level, and requires ongoing post-discharge care. An oral bisphosphonate should be started one year after IV Zol administration. This study aimed to analyse whether discharges from Craigavon Area Hospital following a NOF fracture had clear instructions for post-discharge care.

Method: The discharge letters of patients with a NOF fracture from the Trauma Ward over six weeks were assessed and subdivided into three groups. A (Bone health, IV Zoledronic acid and post-discharge instructions), B (Bone health and IV Zoledronic acid mentioned but no post-discharge instructions given) and C (Bone health, IV Zoledronic acid and post-discharge instructions not mentioned). These groups were then analysed for potential interventions to improve future discharge letters.

Discussion: Only 38% (16) of the 42 discharge letters were included in group A and 37.5% contained ambiguous instructions. There were 13 discharge letters in groups B and C of which 15% and 38% were discharged outside of normal working hours respectively. The evidence suggests that standardised wording for discharge letters in patients with fragility NOF fractures and visible posters by the doctor's computers may increase the proportion of patients in group A and thus improve patient care.

Conclusion: This study has highlighted the importance of adequate post-discharge care for patients who have received IV Zol. Unfortunately, many discharges did not mention the necessary information for GPs so proposals were made to improve ongoing care. This will be reassessed in March 2025.

POSTER

3185. Clinical Quality - Improved Access to Service

PROACTIVE AGEING WELL SCREENING AT A COMMUNITY MUSCULOSKELETAL PHYSIOTHERAPY EVENT IN LAMBETH: LESSONS LEARNT

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Background: The NHS Long Term plan calls for change to deliver proactive community frailty care1. Proactive frailty case-finding outside traditional healthcare settings should be explored2. Aims: To pilot test proactive frailty screening at a community event.

Methods: GSTT Musculoskeletal Physiotherapy department hosted a community day in a deprived area of Lambeth, London. Waiting list residents were invited for a café-style assessment. Stalls were available to meet wider needs including finances, wellbeing, Ageing Well and others. Ageing Well (Consultant Geriatrician and Geriatrics trainee) completed frailty screening using a 1-page screening tool with follow on assessment/interventions.

Accessibility evaluated by characteristics of attendees. Feasibility and acceptability evaluated by participation and assessment completion. Appropriateness by prevalence of frailty needs, number of interventions arranged.

Results: 137 residents accepted, 26 (19%) were 65+ years old. 14 residents were reviewed by Ageing Well. Mean age 67 years (57-80), mean 4 comorbidities, 72% from ethnic minority groups, mean Clinical Frailty Scale (CFS) 4 (range 2-5). 43% were digitally excluded (unable to use internet or phone). All 14 residents participated freely in an open setting suggesting acceptability including sensitive topics e.g. continence/mental health. The Frailty screening tool identified significant needs: pain (93%), fatigue (64%), falls (50%), mental health concerns (64%), medication management (50%), bladder concerns (50%), difficulties with activities of daily living (57%), financial concerns (43%). 43% attended ED in the last year. Only 1 was known to social services but 43% had informal help from friends/family. Personalised care plans included bone health interventions, medication changes, continence management, strength/balance exercises programme access, equipment provision, social services access, self-management advice/information .

Conclusions: Ageing Well screening and assessments appeared feasible, acceptable, accessible and appropriate to managing frailty needs proactively in ambulant vulnerable-mildly frail residents. This proactive outreach approach should be explored at alternative outreach events.

POSTER

3201. Clinical Quality - Improved Access to Service

EVALUATION OF A NEW FRAILTY ON-CALL SHIFT FOR GERIATRIC SPRS AT ST THOMAS' HOSPITAL (STH)

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Introduction: Frailty-attuned acute hospital care is a vital component of integrated services for older people. The NHS Long Term Plan requires hospitals with major emergency departments to deliver 70 hours of acute frailty services each week. Workforce limitations often prevent services from meeting this target and expanding. Geriatric specialist registrars (SpRs) must gain experience in acute frailty so that the consultant workforce of the future can meet patient needs effectively. St Thomas' Hospital (STH) Acute Frailty Service expanded hours of operation through the introduction of a frailty twilight SpR. The aim was to increase patients seen by the frailty service, enhance access to Comprehensive Geriatric Assessment (CGA) and provide learning opportunities in acute frailty.

Method: The twilight frailty SpR was introduced in October 2024 by re-allocating existing on-call resources, without using additional staffing. Retrospective data from April to November 2024 were analysed to compare patient numbers and service performance before and after implementation. Feedback was collected from SpRs on the learning opportunities and challenges encountered.

Results: Following introduction of the twilight frailty SpR, the average number of patients seen by the acute frailty team increased by 28.3%, from an average of 129 per month (April–September) to 166 per month (October–November). A survey of SpRs revealed that the majority felt twilight frailty shifts provided valuable learning experiences. Key benefits included increased autonomy and enhanced experience in CGA in an acute setting. Challenges included difficulties in discharging patients on the same day due to limited therapy support and the need for additional social care.

Conclusion: The introduction of a twilight frailty SpR extended acute frailty service hours and increased the number of patients receiving a CGA at the front door. SpRs have gained valuable experience in acute frailty management which is key in developing the consultant workforce of the future.

POSTER

3207. Clinical Quality - Improved Access to Service

UTILISING DIGITAL QUESTIONNAIRES TO IDENTIFY FRAILTY IN OLDER PATIENTS ON THE ELECTIVE GENERAL SURGERY WAITING LISTS

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Introduction: Frailty is associated with an increased risk of perioperative complications, prolonged hospital stay, and functional decline after surgery. Despite the potential advantages of early detection, frailty screening of surgical patients is not standard practice across the UK. Digital questionnaires may offer an effective tool for screening large patient populations; however, there is concern that this is biased when used in frail or elderly patients. The primary aim of this study was to evaluate the effectiveness of digital screening in patients aged 65 and over who are awaiting elective general surgery.

Method: We distributed digital questionnaires to 738 patients via text message. Participants were eligible if aged 65 or older and on the waiting list for elective general surgery. Participants had a 7-day period to complete the questionnaire, with a reminder sent 5 weeks later to non-responders. Participants self-assessed frailty using a modified Clinical Frailty Scale (CFS), those who scored above 3 were also asked to complete the Comprehensive Risk Assessment and Needs Evaluation and EQ-5D-3L questionnaire. We analysed response rate, frailty and age.

Results: 187 (25.34%) patients responded within the initial period. A further 156 (21.14%) responded following the reminder. The overall response rate was 46.48%. The average age of responders was 72. Our data showed that frailer patients were able to complete digital questionnaires either themselves or with support.

Conclusion: Early screening can help identify frail patients who would benefit from peri-operative planning and optimisation, including a geriatric review. Our findings suggest that digital questionnaires could be an effective tool for screening older adults and that frail patients are able to participate. This may be due to various factors, including caregivers support. Previous studies have documented response rates ranging from 30% to 50%, which provides a valuable benchmark for the interpretation of our findings.

POSTER

3209. Clinical Quality - Improved Access to Service

ROUTE TO A STREAMLINE TRANSIENT ISCHEMIC ATTACK PATHWAY: A QUALITY IMPROVEMENT INITIATIVE

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Background: Specialist, hyperacute management of a transient ischemic attack (TIA) is necessary to decrease subsequent stroke. As part of a local Quality Improvement (QI) initiative, we implemented a new TIA pathway in our hospital to maximise efficiency, encourage an ambulatory approach, and improve global TIA management in line with the 2023 UK and Ireland Clinical Guidelines for Stroke.

Method: We completed a retrospective cohort study of patients who attended our hospital between April 1, 2024, and June 30, 2024. Patients with a primary diagnosis of TIA were identified through the Hospital In-Patient Enquiry (HIPE). Each diagnosis was verified with electronic records review, with exploration of key investigations and management parameters.

Result: 28 patients were coded as TIA. 28.5% were seen directly via Acute Medical Unit (AMU), increased from 10.1% pre-TIA pathway, with the rest attending ED initially. The median length of Stay (LoS) in hospital was 0.65 days, down from 1.08 days pre-TIA pathway for those managed directly in AMU. 35.7% were managed within 24 hours, vs 28.2% prior to new pathway initiation. Most patients were admitted under the AMU (35% vs 33% pre-pathway) or Stroke service (42.9% vs 26% pre-pathway), with a shorter LoS if the patient was admitted under these services. 27 (96.4%) patients underwent neuroimaging; 89.3% underwent CT Brain vs 94.8% pre-pathway, 75% underwent MRI Brain without preceding CT in keeping with National Clinical Guideline for Stroke for the UK and Ireland recommendations. 96.4% were reviewed by a stroke specialist vs 82.1% pre-pathway. Utilisation of inpatient echocardiograms and 24-hour holter monitors were reduced to 35.7% and 21.4% respectively, down from 42.9% pre-pathway.

Conclusion: This re-audit has shown improved neuroimaging utilisation, increased numbers of patients being reviewed by stroke specialist clinicians, increased use of ambulatory services, and reduced length of stay.

POSTER

2935. Clinical Quality - Patient Centredness

IMPROVING DELIRIUM ASSESSMENTS IN ACUTE SENIOR HEALTH: A QUALITY IMPROVEMENT PROJECT FOR CARE OF THE OLDER PERSON

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Introduction: Delirium is a common and reversible neurobehavioral condition with significant morbidity and mortality ramifications for older patients. Consequentially, clear guidelines exist pertaining to its swift identification and management. However, studies suggest that adherence to these guidelines are poor. This audit aimed to evaluate compliance to the National Institute for Health and Care Excellence's (NICE) delirium guidelines in an Acute Senior Health Unit (ASHU) and to present a single centre experience of a low-cost ward-based intervention for improving delirium guideline adherence.

Methods: A retrospective observational audit was conducted on patients admitted to ASHU between 01/07/2023 and 30/07/2023. Data on delirium assessments, diagnoses and causes of delirium were obtained through retrospective database searches. Posters and education based multidisciplinary team (MDT) interventions were designed and initiated following grounded thematic literature analysis and ward discussion. A methodically equivalent audit was then conducted between 01/09/2023 and 30/09/23. Data was anonymised and blinded and analysis was performed on SPSS V12.0.

Results: A total of 128 patients were included in the study. Initial audit revealed suboptimal compliance with NICE recommendations. Chi-square test of independence found that patients were statistically more likely to receive a full delirium assessment (1.9% vs. 56.6%, p=0.001) and formal diagnosis (5.8% vs. 27.6%, p=0.002) after the ward-based intervention.

Conclusion: This study provides limited evidence in favour of low-cost MDT based interventions for improving adherence to NICE delirium guidelines and provides a 5-step framework for future studies. This study also explores the potential patient implications of these interventions. A repeat audit should be conducted to ensure lasting and sustainable change is achieved.

Trial registration/clinical trial number: AUDI003614

POSTER

2998. Clinical Quality - Patient Centredness

A REVIEW OF THE IMPACT OF A MEDICATION REVIEW ON POLYPHARMACY AND ANTI-CHOLINERGIC BURDEN IN RESIDENTIAL HOME PATIENTS

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Introduction: Care home residents are often multi-morbid with both physical and cognitive impairments. An average care home resident takes 7.2 medications per day. Older people are more likely to experience adverse effects from polypharmacy due to pharmacokinetic and pharmacodynamic changes associated with age. Polypharmacy and anti-cholinergic burden (ACB) not only increase the risk of adverse drug reactions but also can increase the number of falls, hospital admissions and mortality.

Method: Retrospective analysis in October 2024 of all patients at a residential home who had an initial Comprehensive Geriatric Assessment (CGA) which included a medication review since Enhanced Health in Care Home (EHCH) team started in March 2022 up until September 2024. The number of medications a patient was on at initial CGA alongside their ACB burden was analysed pre and post CGA.

Results: 65 residents had an initial CGA within this time period with an average of 6 medications and ACB score of 2. Post CGA, the average number of medications per resident was reduced to 5 with an ACB score of 1. 68% of patients had polypharmacy (≥5 medications) prior to initial CGA and this was reduced to 58% post. 12% had ≥10 medications (excessive polypharmacy) prior to CGA and 8% (5) post. Pre CGA, 26% of residents had a high ACB score ≥3 which reduced to 15% post. There were 59 medications prescribed with an anti-cholinergic score of ≥1 which were reduced overall by 24% following the CGAs.

Conclusion: The overall degree of polypharmacy and anti-cholinergic burden in care home residents can be reduced through a medication review as part of a CGA

POSTER

3202. CQ - Clinical Quality - CQ - Patient Centredness

PROMOTING PATIENT-CENTRED INPATIENT CARE FOR PARKINSON'S DISEASE BY UPSKILLING KNOWLEDGE AND CONFIDENCE OF WARD STAFF

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Introduction: 1 in 37 adults in the UK are diagnosed with Parkinson's Disease (PD). The varied nature and specific symptom management of the condition requires a person-centred multi-disciplinary approach to care.

Methods: On a care-of-the-elderly ward at Bristol Royal Infirmary, 3 cycles of a quality improvement project were conducted to upskill knowledge and confidence of the staff caring for PD patients. In cycle 1, baseline knowledge and confidence of staff were gathered using a data collection survey. 5 teaching sessions were organised addressing topics in PD such as medication, palliative care and communication. The survey was then repeated. In cycle 2, another 3 teaching sessions were run on swallowing, physiotherapy and occupational therapy in PD. An easy-to-read information board on PD was also created on the ward. After a month, the staff were re-surveyed. In cycle 3, information was gathered from PD patients and their carers on what topics they thought were important and 3 further teaching sessions were run on physiotherapy, medication and an overview of PD. A final data collection survey was distributed after 6 months of the initial baseline survey being conducted

Results: Within the knowledge questions there was a 5 out of 8 higher correct answer rate across most parameters except medications, after the teaching sessions. This was also mirrored in the confidence questions with higher confidence rankings in 4 out 5 parameters being questioned.

Conclusion: To continue the teaching programme with a wider range of care providers and having repeat teaching sessions on topics highlighted by PD patients and their carers. There should be a focus on further medication teaching, which has also been widely requested by staff members. Additionally, this teaching could be recorded for staff who cannot attend in person.

POSTER

3027. Clinical Quality - Patient Centredness

IDENTIFYING AND CODING PATIENTS APPROPRIATE FOR THE GOLD STANDARD FRAMEWORK ON DISCHARGE FROM AN INPATIENT GASTROENTEROLOGY WARD

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Background: A third of hospital inpatients may be in their last year of life and over the past 25 years there has been evidence to show the Gold standard Framework (GSF) reduces hospitalisation and allows more people to live and die in their preferred place of care. Teams undertaking GSF find admissions and lengths of stay are significantly reduced. Our inpatient ward did not have processes to identify those appropriate for the GSF.

Aim: To identify and code patients appropriate for the gold standard framework on the inpatient gastroenterology ward at Salford Royal

Methods: Baseline data was collected, standards were set and data was collected from March 2024 to July 2024 by retrospectively reviewing documentation. Using the PDSA cycle format; the first intervention carried out was an education session. The second intervention was a poster and flow diagram. Other data collected was valuable such as whether the hospital palliative inpatient team had been involved, if advanced care planning discussions had been had and whether community palliative care were informed on discharge.

Results: Of the 36 patients admitted in the first 2-week period the 11 patients who had a GSF eligible diagnosis were not identified or coded. Following the first and second interventions made 21 further patients were identified as eligible for diagnosis on data collection but no GSF coding was carried out or documentation on the discharge letter.

Conclusion: The two interventions received positive feedback and engagement however it did not lead to patients being coded. The patients who were reviewed in the Specialist liver disease palliative care MDT (SILP) had referrals placed to the community palliative care team and advanced care planning initiated. Our recommendation was to consider implementing a bundle that suggests referral to the SILP and within the bundle asks for the GSF to be coded.

POSTER

3029. Clinical Quality - Patient Centredness

ANALGESIA IN THE ELDERLY: IMPROVING PRESCRIBING PRACTICES IN PATIENTS FOLLOWING A FALL – A QIP

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Introduction: Observations of the acute medical take suggested that patients who sustained a fall were affected by long delays and wait times to see both A+E and medical doctors. We felt that analgesia prescribing in these patients, many of whom sustained injury, was done poorly and some were being left without any analgesia leading to a negatively perceived patient journey. Our aim was to assess analgesia prescribing practices for patients following a fall with a view to improving experience.

Method: We completed three rounds of data collection, with 20 patients in each. We included patients coded as having a fall on admission and excluded patients under 70. We manually reviewed the case notes to see if patients had a pain assessment on admission and whether they were prescribed analgesia by the A+E team, the medical admissions team or on the post-take ward round.

Our intervention was a presentation and education session to the acute medicine and geriatrics departments following each cycle, with the aim of involving both junior and senior decision makers with prescribing privileges.

Results: We reviewed 68 patients across all three data cycles and found that 40% of patients were not prescribed any analgesia by the A+E team. We found that the number of patients with regular or PRN analgesia prescribed rose to 70% once the medical and post-take had seen them. The proportion of patients that had no regular/PRN/stat analgesia prescribed throughout their entire acute patient journey fell from 28% to 16%.

Conclusion: Despite intervention, prescribing practices remained static. 1/3rd of patients did not receive regular or PRN analgesia following their admission injury despite seeing multiple clinicians. There was a modest reduction in patients who never received any analgesia at all following intervention.

POSTER

3037. Clinical Quality - Patient Centredness

TESTING A MODEL OF ANTICIPATORY CARE FOR PEOPLE LIVING IN A RESIDENTIAL CARE HOME SETTING, THE MOOP (PHARMACY) CONTRIBUTION

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Introduction: In winter 23/24, the NHSCT tested an anticipatory care model in residential care homes. The model included a pharmacist medication review and pharmacy education element.

Method: Across four residential homes the lead care homes pharmacist completed patient-centred, medication optimisation reviews, and carried out education sessions for senior carers. The number of recommendations/interventions made by the pharmacist was calculated. The number of recommendations/interventions relating to falls prevention, was also calculated. The clinical significance of each medicine optimisation recommendation/intervention made by the pharmacist was graded using the Eadon1 criteria. Eadon graded interventions were then assigned a monetary value using The Sheffield Centre for Health and Related Research (Sheffield University) Economic Model (ScHARR)2. Additionally, a qualitative review of the service was carried out via questionnaires.

Results: In total 92 residents had their medications reviewed. A total of 322 recommendations/ interventions were made, an average of 3.5 per resident. Of the 322 recommendations/ interventions 115 (36%) were in relation to falls prevention, an average of 1.3 per resident. Interventions of note included antihypertensives being stopped or dose reduced for 20 residents (22%), and bone protection being reviewed, commenced or altered for 31 residents (34%). The views of a capable residents, next of kins and senior carers were sought via questionnaire. Responses were all positive.

Conclusion: Results demonstrate the positive impact and value of medicines optimisation in the residential care home setting.
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POSTER

3062. Clinical Quality - Patient Centredness

SUPPORTIVE CARE AND COGNITIVE REHABILITATION AT HOME IN THE MANAGEMENT OF EARLY NEUROCOGNITIVE DISORDERS IN GENERAL PRACTICE

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Introduction: The implementation of cognitive rehabilitation sessions (CRS) in the management of individuals with neurodegenerative diseases has increased. To identify the barriers to the implementation of CRS at home from the perspective of the primary caregiver.

Method: This is a multicentric, quantitative, descriptive, observational, cross-sectional study. We distributed questionnaires from May to November 2023 to the primary caregivers of patients being followed for mild to moderate cognitive disorders and who had received a prescription for CRS. Comparisons of variables were made using the Kruskal-Wallis test. We collected 150 questionnaires. Our population had an average age of 81 years, predominantly female (55%), and mainly followed in memory clinics (61%) for Alzheimer's disease (58%). The primary caregiver was mainly a spouse (74%), with 40% being female. The patients mostly received home nursing care (SSIAD) (47%) and physiotherapy (34%), with 54% of the patients receiving the personalized autonomy allowance (APA). 69% of CRS prescriptions were made by a geriatrician, and 19% by a general practitioner.

Results: The time to prescription of CRS differed according to the place of follow-up (15 months day hospital vs. 26 months general practitioner vs. 20 months memory clinic ($p = 0.03$)). The average time between prescription and implementation of CRS was 3 months. Regarding the opinions of the primary caregivers: 98% of the primary caregivers considered them beneficial but insufficient in quantity (67%); 22% did not accept the presence of a team at home, and 21% found the home unsuitable for sessions.

Conclusion: The sessions should be started as early as possible in the management of cognitive disorders to prevent the progression of the pathology. Our study showed that patients managed in a day hospital had a quicker prescription of sessions compared to patients followed by a general practitioner or in a memory clinic.

POSTER

3067. Clinical Quality - Patient Centredness

VENOUS THROMBOEMBOLISM PROPHYLAXIS: PRESCRIBING AND DEPRESCRIBING IN FRAILTY PATIENTS

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Introduction: Venous thromboembolism (VTE) prophylaxis is commonly administered to patients across many hospital settings; however, it can be more challenging to address in frailty patients. These patients are more likely to have contraindications to anticoagulation and be "delayed discharges" (medically fit for discharge and at baseline mobility), at which point VTE prophylaxis may not be indicated.

Method: This quality improvement project was carried out in the acute geriatric ward at St John's Hospital. With the aim to improve VTE prophylaxis (appropriately prescribed and deprescribed when delayed discharge) in frailty inpatients by December 2024, through education of medical staff and by creating a Trak proforma.

Teaching was provided to ward medical staff and a new delayed discharge Trak proforma was created. This prompted a review of VTE prophylaxis deprescribing when patients were medically fit for discharge. A simultaneous QI project created an admissions proforma which prompted a review of VTE prophylaxis prescribing when a patient was first admitted to the ward.

Results: Before the intervention, only 58% of patients in Ward 8 had VTE prophylaxis correctly prescribed on admission. Many patients (40%) remained on VTE prophylaxis despite being delayed discharges. A staff survey revealed a higher confidence level around prescribing VTE prophylaxis than deprescribing. Only 44% of staff regularly considered stopping VTE prophylaxis once a patient was a delayed discharge.

After the intervention, an increased number of patients (74%) had correct VTE prescriptions on Ward 8 admission (28% improvement). Only 16% of delayed discharge patients remained on VTE prophylaxis (60% improvement).

Conclusion: This project improved rates of VTE prescribing in patients admitted to an acute frailty ward and deprescription rates in patients where VTE prophylaxis was no longer indicated by prompting regular reviews of these prescriptions. This intervention could be utilised in other departments.

POSTER

3072. Clinical Quality - Patient Centredness

QUALITY IMPROVEMENT: ENHANCING IPC APPLICATION IN STROKE CARE

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Introduction: DVT is a common complication post stroke. Clinically evident DVT can occur in 2-10% after an acute stroke. DVT can develop as early as Day 2 after acute stroke; Risk peaks between Days 2 and 7. Untreated proximal DVT has a 6-15% mortality risk. Intermittent pneumatic compression (IPC) of the legs is recommended to reduce the risk of DVT in non-ambulatory stroke patients.

Methods: Criteria = All new stroke admissions to Stroke ward should have IPC applied by the time they were seen by the consultant on the post-take ward round - unless contraindicated.

Initial Audit = 100 admissions from June-July 2024. Intervention = Posters placed in doctors' offices and nursing bases (three locations) to remind both nursing and medical staff to prescribe and apply IPC on time. Post-intervention Audit = 100 admissions from August-September 2024.

Results: Initial Audit = 21.6% of patients did not have their IPC applied on time. Post- intervention audit = 18.1% of patients did not have IPC applied on time, reflecting a 3.5% improvement. Patients not receiving IPC by Post-take ward round reduced by 3.5% post-intervention. The reduction was mainly due to more timely IPC prescriptions by medical staff (improved by 5.9%) but compliance in IPC application by nursing staff worsened (by 2.2%).

Conclusion: The intervention successfully improved timely IPC prescription rates but did not fully address the delay in application by nursing staff. Targeted reminders can improve compliance, but additional strategies may be necessary for sustainability. Second cycle being planned to include: More targeted posters. Larger pool of patients to be audited (150). Request for ideas for interventions from nursing staff/resident doctors. Data will be collected on incidence of VTE in affected patient group.

POSTER

3120. Clinical Quality - Patient Centredness

PERIOPERATIVE MANAGEMENT OF PATIENTS WITH PARKINSON'S DISEASE: A REVIEW OF DISEASE MANAGEMENT

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Introduction: Parkinson's disease (PD) is a progressive neurological condition which affects more than 150, 000 people in the UK. Classically involving a triad of bradykinesia, rigidity and tremor alongside other non-motor conditions. Delayed medication can result in significant motor and non-motor fluctuations. Poor management of patient medications contribute to longer hospital stays, delayed recovery and worse patient outcomes. Patients with Parkinson's have a higher risk of peri-operative complications.

Method: This QIP collected a second cycle of data following up a project completed in 2019 to review perioperative care in patients with PD. The 2019 project resulted in the trust implementing new guidance within the existing standard operating procedure for the surgical and perioperative management of acute patients with PD. The aim of this QIP is to analyse the changes that have taken place and consider if areas for further improvement exist.

Data was requested and analysed for PD patients who had a surgical procedure over a 12-month period ending June 2023. 328 patients were identified initially, and these were each reviewed. Of these 260 were excluded from the study with the most common reason for exclusion being day case procedures not requiring admission. 68 PD patients were identified for further analysis.

Results: 68 patients analysed
26% (18) were first on the surgical list.
56% (38) PD medications within 30 minutes of administration time compared to 17% (10) in 2019
38% (26) compared to 18% (10) in 2019 had cognitive testing via the 4AT
47% (32 patients) were seen by the PD nurse specialist compared to 3.5% (2 patients) in 2019

Conclusion: Results demonstrated a significant improvement. However, there is significant scope for improvement. Increased education for surgical teams and increased awareness of the guidance and help available to support PD patients in the perioperative period have been identified to support this improvement.

POSTER

3159. Clinical Quality - Patient Centredness

IMPROVING MULTIDISCIPLINARY TEAM WORKING: A MULTIPRONGED QUALITY IMPROVEMENT PROJECT IN A TERTIARY CARE UNIVERSITY HOSPITAL

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Introduction: In geriatric medicine department of a large tertiary care university hospital, it was observed that multidisciplinary team (MDT) working was not standardised, morning huddles were inefficient, there was a lack of inclusion of all members in MDT meetings and the meetings were too medical focused. The aim of this project was to address these concerns through a multipronged approach.

Methods: An initial survey was carried out with 34 participants from all disciplines of MDT. Areas needing improvement were identified from the survey and through discussions among doctors, nurses and therapists. A pilot of changes was introduced in the largest ward of the department. A post change survey was carried out, demonstrating improvement across multiple domains.

Result:
Changes implemented:
-Structured daily morning board round with all MDT disciplines using a new pro forma
-MDT meetings led by flow-coordinator via a structured format making them more holistic, person-centred and inclusive
-Publishing of handbook to improve understanding & purpose of MDT's and terminologies used in meetings.

Post change survey showed:
-66% said meetings now more structured; easier to share their views
-75% felt more valued
-76% thought meetings now were more person-centred
-Improved attendance & efficiency of morning huddle (mean time reduced to 10 from 30 minutes).

These findings were presented and shared in departmental monthly meeting

Conclusion: The true essence of MDT working lies in all professions coming together to achieve patient-centred care. This can only be achieved if all professions understand and respect each other's role and responsibilities. Through best practices, we can achieve more holistic care and prevent harm. It results in resources being used more efficiently through reduced duplication, greater productivity and preventative care approaches. Through a series of changes we demonstrated these in one ward and plan to replicate and implement these changes across the whole department.

POSTER

3173. Clinical Quality - Patient Centredness

STANDARDISED ADMISSIONS PROFORMA IMPROVES PATIENT FOCUSED CARE AND REDUCES LENGTH OF STAY

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Introduction: Our district general hospital utilises an unselected medical receiving model where generic admission clerk-ins often miss salient information vital for comprehensive geriatric assessment (CGA). Recent Healthcare Improvement Scotland guidelines outlined people living with frailty that are admitted to an acute hospital are at risk of adverse outcomes. A standardised proforma for admissions to our medicine of the elderly (MOE) ward (clinical frailty score over five required for admission) would ensure critical information was collated for more effective CGA, decision making and discharge planning. The aim was by November 2024, 90% of inpatients within our acute MOE ward would have had complete admission proformas documented.

Method: We analysed information from generic medical admission notes and identified key items often omitted such as escalation status, medication review and discharge planning goals. We created a standardised MOE admission proforma which was piloted (cycle 1) and then incorporated into the electronic patient record (cycle 2). The outcome measure was the percentage of MOE patients with complete admission proformas. We also reviewed average length of stay data and sought feedback from ward staff.

Results: Baseline data revealed 57.2% of MOE patients had key CGA information documented on admission. Cycle one (July 2024) illustrated an increase to 74.1% meanwhile cycle two (November 2024) increased to 90.8%. There was a 25% reduction in average length of stay from 12.8 days to 9.6 days. Feedback from users of the standardised proforma was universally positive.

Conclusion: This proforma established a standardised patient-centred methodology for initial MOE patient assessment by ensuring medication reconciliation, improved comprehensiveness of clinical documentation and streamlining multidisciplinary team assessment to provide effective continuity of care and discharge planning. This was well received by users and resulted in patients returning home sooner. This proforma will be re-audited in 4 months and applied to other MOE wards.

POSTER

3191. Clinical Quality - Patient Centredness

EVALUATING A FRAILTY SAME DAY EMERGENCY CARE SERVICE: PATIENT AND FAMILY PERSPECTIVES

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Introduction: Frailty is a growing concern, particularly for older adults attending Emergency Departments (EDs). Frailty accounts for 5-10% of all ED visits and up to 30% of acute admissions. The NHS mandates that hospitals with Type 1 EDs provide a minimum of 70 hours of Acute Frailty Services per week to address this challenge. At Salford Royal Foundation Trust (SRFT), a Frailty Same Day Emergency Care (SDEC) service was introduced to deliver rapid assessment and care for frail older adults, aiming to reduce hospital admissions and improve patient outcomes. This service operates five days per week and is staffed by a multidisciplinary team.

Methods: A mixed-methods approach was used to evaluate the Frailty SDEC service. Data was collected through paper surveys distributed to patients aged 65 years or older with a Clinical Frailty Score (CFS) >5 and their relatives or carers during their admission to the SDEC service. The survey included both closed-ended and open-ended questions. Quantitative data was analysed using descriptive statistics and qualitative data was analysed using thematic analysis.

Results: A total of 32 responses were collected over a two-month period in 2024. The results showed high levels of patient and family satisfaction (97%) with the Frailty SDEC service. Participants particularly valued the compassionate and personalized care, clear and professional communication, and the efficient and timely service delivery. Areas for improvement included upgrading the physical environment and providing clearer communication about waiting times and procedures.

Conclusion: The Frailty SDEC service at SRFT demonstrates high levels of patient satisfaction and effectiveness in delivering care for frail older adults. This evaluation provides valuable insights for enhancing patient-centred care and highlights the importance of further research to explore long-term outcomes and compare different models of SDEC services for older adults.

POSTER

3194. Clinical Quality - Patient Centredness

ASSESSING THE IMPACT OF ALONE'S COMMUNITY-BASED SERVICES FOR OLDER PEOPLE

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Introduction: Ireland's population aged 65 and older increased by 40% in the last decade. ALONE is a national organisation that enables older people at age at home. The ALONE model is being delivered within the Enhanced Community Care (ECC) programme, which aims to ensure health services work in an integrated way to meet population needs. This presentation, designed using the RE-AIM Framework, presents preliminary effectiveness results from ALONE's national service evaluation.

Methods: Phone-based surveys using validated measures (Shortened Warwick-Edinburgh Mental Wellbeing Scale, EQ-5D-3L, UCLA Loneliness Scale-3) were conducted with participants at baseline and three months into service. These measures were selected and piloted by the project team, which includes older people and volunteers.

Results: 272 participants completed the first survey (62.5% were female, 51.5% aged 75-85). Almost all (97%) had at least one chronic illness, 98% identified as white and 95% were not working. Participants had higher levels of loneliness (M= 5.7; SD = 2.2), lower wellbeing (M= 23.81; SD = 4.3), and lower health-related quality of life (M = 59.6, SD =23.6) compared to national studies. Preliminary analysis of data from 212 older people who participated in Time 2 indicated incremental improvements in loneliness (M T1=5.7; M T2=5.5) and self-reported health (M T1= 59.6; M T2 = 64.7). There were some changes in the percentage of people reporting no pain (T1=19.3%; T2 =21.2%) and not feeling anxious or depressed (T1=38.7%; T2=40.1%). Moreover, the average number of GP consultations (T1M = 2.32; T2M=1.93), A&E calls/attendance (T1M=.24; T2M=.09/T1M=.43; T2M=.17), planned (T1M=.30; T2M=.12) and unplanned (T1M=.58; T2M=.24) hospital stays per participant decreased.

Discussion: These early findings demonstrate modest improvements across several areas within three months of ALONE support. This provides important evidence supporting the effectiveness of community-centred care coordination as part of the wider system.

POSTER

3198. Clinical Quality - Patient Centredness

BETTER UPDATES, BETTER CARE: IMPROVING THE COMMUNICATION WITH RELATIVES IN GERIATRIC SURGICAL PATIENTS

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Introduction: According to the GMC's Good Medical Practice, medical professionals have a responsibility to be considerate and compassionate to those close to a patient through giving support and information. For those lacking capacity, clinicians can assume that patients would want those close to them to be kept up to date with their condition. NHS digital data last year showed that 17.1% of written complaints are linked with communication. The primary aim of this project was to increase the percentage of surgical patients aged 65 or over receiving a next of kin (NOK) update. The secondary aim was to decrease the time to NOK update for this patient group to under 48 hours.

Method: QI methodology and 2 PDSA cycle loops were used. Using the electronic patient record surgical patients aged 65 years or over on two surgical wards were identified. Medical records were checked for documentation of a NOK update. Where a NOK update was documented, time to update from surgical team decision to admit was noted. In those without a documented NOK update, time from clerking was recorded. The percentage of patients receiving an update and mean time to update was calculated. Following the implementation of posters prompting NOK updates, data was recollected. Following a teaching session a third data analysis was undertaken.

Results: Following the initial intervention the time to NOK update decreased by 78% from 232 hours to 50 hours. The data post second intervention saw an increase in the percentage of NOK updates from 62% pre-interventions to 70% and time to update decreased by a further 5% to 40 hours.

Conclusion: Implementation of a poster prompt and undertaking a teaching session, highlighting the importance of communication with NOKs, demonstrated improvement in percentage and mean time to NOK updates for our patient cohort on surgical wards.

POSTER

3215. Clinical Quality - Patient Centredness

REDUCING ANTICHOLINERGIC BURDEN (ACB) WITHIN THE HEALTHCARE FOR OLDER PEOPLE'S (HCOP) WARDS

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Introduction: Medications with anticholinergic properties can have significant adverse effects, particularly in older adults. An Anticholinergic Burden (ACB) score of ≥3 is associated with increased risks of falls, cognitive impairment, and mortality. Additionally, side effects such as urinary retention, visual disturbances, and constipation are frequent contributors to delirium.

Aim: To assess whether raising awareness of ACB within the Healthcare of Older People (HCOP) department can lead to a reduction in ACB scores.

Methods: Over four months, a teaching session and a poster was disseminated on ACB. Retrospective data were collected from three separate weeks, one before any intervention, one after the teaching session and one after the poster for patients discharged from the HCOP department. Admission and discharge ACB scores were calculated using the ACB Calculator (www.acbcalc.com). Patients on end-of-life medications were excluded.

Results: Cycle 1: Of 40 patients, 13 had an ACB score ≥3 on discharge. Seven patients retained their admission ACB scores ≥3 at discharge, while eight patients showed a reduction. A lack of awareness of ACB was identified, prompting a teaching session.

Cycle 2: Of 33 patients, eight had an ACB score ≥3 on discharge, and 11 showed a reduction in scores. A poster campaign was launched across HCOP doctors' offices.

Cycle 3: Among 39 patients, 17 had an ACB score ≥3 on discharge. However, this cycle achieved the highest number of score reductions, with 12 patients showing improvement.

A side analysis revealed that lansoprazole was the most commonly prescribed medication with anticholinergic properties, affecting 33 patients across the three cycles.

Conclusion: Raising awareness of ACB scores has successfully reduced ACB scores. Sustained efforts, including regular reminders and medication reviews, are essential to mitigate risks for older patients. Ongoing discussions with the pharmacy team aim to implement an automated ACB score calculation in the online noting system.

POSTER

3216. Clinical Quality - Patient Centredness

PATIENT-CENTRED COLLABORATIVE CARE: ENHANCING FRAILTY MANAGEMENT THROUGH NURSE-PHARMACIST PARTNERSHIPS

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Introduction: Frailty presents significant challenges to healthcare systems, particularly in Thurrock, Essex, where 14% of residents are aged 65 or older. This demographic shift, combined with socioeconomic factors, underscores the need for patient-centred, clinically effective, and tailored healthcare services.

Aim: To improve the clinical effectiveness of frailty management for elderly patients in Thurrock by integrating pharmacist support within a nurse-led frailty service. The initiative focuses on enhancing medication management, reducing workload pressures, and providing holistic, patient-centred care to improve outcomes and reduce hospital admissions.

Method: A 12-week pilot involved patients aged 65+ undergoing joint reviews with a frailty nurse and pharmacist. Participants had a Rockwood Frailty Score of 5-7 and at least one long-term condition. Reviews included evaluations of medication, functional and falls risks, nutritional status, fracture risk, and blood tests. The management phase emphasized deprescribing, dose adjustments, and addressing health metrics such as postural hypotension, bone protection, and falls risk. Regular follow-ups ensured coordinated care with a focus on patient-centred outcomes. Results: From April 4 to June 28, 2024, 37 patients (mean age: 84) participated. Comprehensive assessments led to 155 interventions (averaging 4.07 per patient). Medication management improved significantly, with 88 drugs deprescribed, including 55 Falls Risk Increasing Drugs (FRIDs), resulting in a 14.39% reduction in FRIDs and a 23.03% reduction in polypharmacy. These interventions led to £6,252.18 in annual drug savings and a 974.09 kg reduction in CO2 emissions. Key outcomes included 57 health and social interventions. Financial analysis suggested savings of £63,450 from preventable hospital admissions, with a return on investment (ROI) of 1655.4%.

Conclusion: The pilot demonstrated the clinical effectiveness of pharmacist-nurse collaboration in improving medication management, chronic condition control, reducing falls risk, and preventing hospital admissions. It highlights the importance of patient-centred care and the value of skill mixing between professions to improve clinical outcomes.

POSTER

3083. Clinical Quality - Patient Safety

IMPROVING POST-FALL CARE FOR INPATIENTS AT NORTH MIDDLESEX UNIVERSITY HOSPITAL

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Aim: We aimed to improve the assessment, documentation, and management of inpatient falls by introducing a memorable CARE poster and promoting the use of a digital falls proforma for both nurses and doctors. This initiative aims to standardise practices and enhance patient safety.

Method: Cycle 1: Initial data revealed poor documentation of falls, with missing elements such as Clinical Frailty Scale (CFS) scoring, medication review, pain management, and lying/standing blood pressure (LSBP) measurement. These critical aspects were incorporated into the CARE poster. Cycle 2: The CARE poster and digital falls proforma were launched, accompanied by brief training sessions on the geriatric ward. These sessions encouraged resident doctors to prescribe analgesia and supported comprehensive documentation. We audited falls documentation before and after the intervention to evaluate improvements in recording relevant data.

For the next cycle, we aim to engage a broader audience, including all medical and surgical teams, by conducting face-to-face campaigns and distributing email reminders. The focus will be on ensuring doctors and nurses complete every section of the proforma.

Conclusion: The CARE poster and digital falls proforma have significantly improved falls documentation, ensuring the inclusion of critical elements like LSBP, blood sugar checks, and thorough physical examinations. It also highlights key management steps, such as requesting investigations, prescribing analgesia, and reducing polypharmacy.

Our project demonstrated a 40% improvement in LSBP documentation and medication review. However, analgesia care improved by only 2%, despite 85% of post-fall patients sustaining injuries. Further education for doctors and nurses is needed to address this gap.

Currently in its third cycle, this QIP continues to evolve, with ongoing implementation and a planned audit. We are optimistic that it will enhance clinical practice and uphold our trust's core value: putting the patient first.

POSTER

3086. Clinical Quality - Patient Safety

HELLO ISSiT ME (YOU'RE LOOKING FOR): IN-SITU SIMULATION FOR THE MULTIDISCIPLINARY TEAM IN CARE OF THE ELDERLY WARDS

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Introduction: In-situ simulation has been shown to improve professional skills, team working and clinical care via social learning theories, benefiting all of the wider multi-disciplinary team - including nursing, physician associate and administrative colleagues - in addition to medical staff, by building camaraderie and a sense of belonging. Thus, a novel in-situ simulation training programme was created within the Department of Medicine for the Elderly at Broomfield Hospital; additionally forming part of an ongoing quality improvement project in medical education.

Method: Cycle 1: 30-minutes long sessions held on frailty ward on ad-hoc basis.

Cycle 2: 30-minutes long sessions held on base ward of doctors on an ad-hoc basis, with select equipment provided.

Pre- and post-teaching questionnaires were circulated to participants, with data scored via Likert scales assessing pre- and post-teaching confidence in reviewing an acutely unwell patient, familiarity with ward staff and equipment, and confidence in escalating patients, and handover. Each cycle ran over 4 months, with new participants per cycle.

Results: Significant improvements in key metrics were noted following attendance at a simulation session.

Following the first cycle (n=20), 75% of participants were confident above neutral midpoint in reviewing an acutely unwell patient post-attendance, compared to 20% pre-teaching. Confidence in escalation of unwell patients rose from 65% to 95%, and confidence in handovers increased from 45% to 85%.

Following the second cycle (n=23), confidence above neutral midpoint in reviewing an acutely unwell patient rose from 13% to 69%. Confidence in escalation of unwell patients increased from 52% to 65%, and confidence in handover rose from 30% to 65%.

Conclusion: The implementation of in-situ simulation has been shown to improve confidence in reviewing an acutely unwell patient, along with other metrics related to patient care and communication, highlighting the need for high fidelity simulation in medical education within hospital settings.

POSTER

3087. Clinical Quality - Patient Safety

A QUALITY IMPROVEMENT PROJECT ASSESSING THE TIMELY ADMINISTRATION OF ANTI-PARKINSONIAN MEDICATIONS FOLLOWING AN ACUTE ADMISSION

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Introduction: This quality improvement project (QIP) aimed to determine whether the acute admission of patients with Parkinson's Disease (PD) is meeting the current NICE guidelines in the appropriate prescription and timely administration of anti-parkinsonian medications (APM). The project evaluated the accuracy of prescriptions, quantified delays in medication administration, and established the causative factors for delays.

Methods: This QIP was a retrospective study with two cycles analysed over a one-year period. Following consent and approval, notes for eligible patients meeting the inclusion criteria of a PD diagnosis being treated with APM's, were retrieved. The records were analysed and reviewed against a data collection tool. Two criteria were established with a targeted compliance of 100% without exception: the first outlined that patients should have their APM's administered on time without a delay of more than 30 minutes (criteria 1); the second appraised the accuracy of the prescription on drug charts (criteria 2).

Results: The combined cycles included sixty-five patients which were analysed based on the QIP objectives. In the first cycle, the compliance of criteria 1 was 21%, and criteria 2 was 58.6%. Following these results, key interventions were implemented in the trust: regular teaching on APM's, commencement of mandatory PD training, posters created and displayed, stocks of APM's kept in the emergency department, new guidelines for PD management published, and 'Give it on Time' stickers clearly placed on patient notes with a diagnosis of PD. Following the intervention, the second cycle's compliance of criteria 1 improved to 65% and criteria 2 increased to 88.5%. Notably, after interventions, more patients (36%) were empowered to self-administer their medications.

Conclusions: Overall, this QIP identified a low compliance with the standards set by NICE guidelines in the first cycle. Following the key interventions, the compliance improved significantly and this subsequently enhanced patient safety and outcomes.

POSTER

3163. Clinical Quality - Patient Safety

REDUCING THE ANTICHOLINERGIC BURDEN OF PATIENTS IN THE INPATIENT AND OUTPATIENT SETTING

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Introduction: Anticholinergic medications are associated with cognitive decline and increased risk of falls. This link is dose dependent and has been shown to decrease with medication discontinuation, therefore reducing the anticholinergic burden of patients represents an opportunity to prevent patient harm and improve quality of life. This project aims to improve patients' anticholinergic burden (ACB) scores following admission to Meadowlands Care of the Elderly Unit and presentation to the Frailty Assessment Unit.

Methods: We began by conducting two simultaneous audits in the inpatient and outpatient setting. We audited ACB scores on presentation and on discharge from the inpatient ward or following clinic review as appropriate. We then completed two PDSA cycles. Our first intervention involved a teaching session for doctors on the risks associated with anticholinergic medication and the benefits of reducing ACB scores. Our second intervention was a poster directing staff to the ACB calculator and raising awareness of the risks of anticholinergic medications for our patients.

Results: In both the inpatient and outpatient setting, and regardless of intervention, the average ACB score improved following admission or outpatient review. In the inpatient setting the average reduction was 0.57, and in the outpatient setting the average reduction was 0.35. However, there was no clear improvement in the reduction of ACB scores associated with any of our interventions.

Conclusion: While it was encouraging to see that following admission under the Care of the Elderly Team or after review at the Frailty Assessment Unit there was a reduction in patients' anticholinergic burden, this reduction is small and could potentially be improved. Unfortunately, our interventions did not bring about this improvement. There are multiple possible reasons for this, including the rotational nature of trainee medical staff and the lack of pharmacist involvement.

POSTER

3221. Clinical Quality - Patient Safety

COLLABORATIVE CARE: ENHANCING FRAILTY MANAGEMENT AND PATIENT SAFETY THROUGH NURSE-PHARMACIST PARTNERSHIPS

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Introduction: Frailty presents significant challenges to healthcare systems, particularly in Thurrock, Essex, where 14% of residents are aged 65 or older. This demographic shift, combined with socioeconomic factors, underscores the need for patient-centred, clinically effective, and tailored healthcare services that prioritize patient safety.

Aim: To improve frailty management for elderly patients in Thurrock by integrating pharmacist support within a nurse-led service, focusing on medication management, reducing workload pressures, providing holistic, patient-centred care, and ensuring patient safety to enhance outcomes and reduce hospital admissions.

Method: A 12-week pilot involved patients aged 65+ undergoing joint reviews with a frailty nurse and pharmacist. Participants had a Rockwood Frailty Score of 5-7 and at least one long-term condition. Reviews included evaluations of medication, functional and falls risks, nutritional status, fracture risk, and blood tests. The management phase focused on deprescribing, dose adjustments, and addressing health metrics such as postural hypotension, bone protection, and falls risk. Regular follow-ups ensured coordinated care with a focus on patient-centred outcomes and patient safety.

Results: From April 4 to June 28, 2024, 37 patients (mean age: 84) participated. Comprehensive assessments led to 155 interventions (averaging 4.07 per patient). Medication management improved significantly, with 88 drugs deprescribed, including 55 Falls Risk Increasing Drugs (FRIDs), resulting in a 14.39% reduction in FRIDs and a 23.03% reduction in polypharmacy. These interventions led to £6,252.18 in annual drug savings and a 974.09 kg reduction in CO_2 emissions. Key outcomes included 57 health and social interventions. Financial analysis suggested savings of £63,450 from preventable hospital admissions, with a return on investment (ROI) of 1655.4%.

Conclusion: The pilot demonstrated the clinical effectiveness of pharmacist-nurse collaboration in improving medication management, chronic condition control, reducing falls risk, and preventing hospital admissions. It emphasises the importance of patient-centred care, safety, and skill mixing to enhance clinical outcomes.

POSTER

3167. Scientific Presentation - Big Data

THE IMPACT OF LIFESTYLE AND POLYPHARMACY ON THE PROGRESSION OF MULTIMORBIDITY IN COMMUNITY-DWELLING OLDER ADULTS

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Introduction: Globally, about one-third of community-dwelling older adults suffer from complex multimorbidity. Complex multimorbidity (three or more chronic diseases and affecting three or more different body systems) have worse outcomes than multimorbidity, such as more frequent hospitalizations, and premature mortality. The effect of sociodemographic factors in the progression of multimorbidity has been found, but the lifestyle and polypharmacy remain unclear. This study aims to explore impact of lifestyle and polypharmacy on the progression of multimorbidity among community-dwelling older adults.

Methods: The study used data from the health examination records of older adults residing in Southern China in 2017 and 2020 (n=3647). The outcome was occurrence of the status of the older adults changed from multimorbidity to complex multimorbidity after 3 years. Logistic regression model was used to analyse the influence of lifestyle (diet, physical activity, smoking and drinking) and polypharmacy of baseline on the progression of multimorbidity. Demographic variables were also included in the model as confounding variables.

Results: Totally 13.5% (n=491) of older adults with multimorbidity had developed into complex multimorbidity. The proportion of complex multimorbidity increased from 32.1% to 45.6%. The logistic regression analysis indicated that, compared with who exercise daily, those who don't exercise (OR=1.561, 95%CI:1.233-1.976, p<0.001) and those exercise occasionally (OR=1.670, 95%CI:1.328-2.100, p<0.001) are more possibly to have complex multimorbidity. The smokers have a higher risk than non-smokers (OR=1.636, 95%CI:1.137-2.353, p<0.01). Those widowed are more likely to developing complex multimorbidity than those married (OR=1.532, 95%CI:1.221-1.923, p<0.001). Diet, drinking and polypharmacy had no significant effect on the progression of multimorbidity.

Conclusions: Lack of exercise, smoking and loss of spouse can significantly increase risk of the progression of multimorbidity and developing into complex multimorbidity among community-dwelling older adults with multimorbidity. Future research could focus on developing and implementing exercise-based interventions to delay the progression of multimorbidity.

POSTER

3203. Scientific Presentation - Big Data

SOCIOECONOMIC STATUS, DEPRESSIVE SYMPTOMS AND POOR SLEEP ASSOCIATED WITH WORSE COGNITIVE PERFORMANCE: FINDINGS FROM NICOLA

C Potter[1]; C Marr[1]; L O'Hara[1]; C Neville[1]; M McAlinden[1,2]; C Hill[1]; L Smyth[1]; E Cunningham[1]; A J McKnight[1]; F Kee[1]; B McGuinness[1]

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Background: Up to 45% of future dementia cases could potentially be prevented if 14 risk factors were eliminated. Northern Ireland Cohort for the Longitudinal study of Ageing (NICOLA), a cohort of 8,283 adults aged 50+ includes cognitive assessments and interviews on socioeconomic status, health conditions, and behaviours.

Methods: Six measures of cognitive performance were tested including objective measures the Mini- Mental State Examination (MMSE), Montreal Cognitive Assessment (MoCA), tests of episodic memory (immediate and delayed recall), verbal fluency and executive function. Hierarchical linear regression analysis assessed association with score in these cognitive measures and selected covariates. Mild cognitive impairment (MCI) or possible dementia was defined following agreed clinical consensus with combination of scores on MMSE or MoCA, functional status and absence of current depression.

Results: Worse cognitive performance assessed separately using scores for all 7 included cognitive assessments, was associated ($p<0.05$) with being older, not married, having lower educational attainment, more social deprivation, poorer self-reported memory, physical health, mental health, hearing and vision, not being physically active, sleeping less than 6 hours and having more health problems, social isolation and polypharmacy. For the fully adjusted models including all covariates listed, significant associations remained for age, gender and current depressive symptoms and MMSE score (β -0.01 [95% CI -0.02, -0.01]) and for word recall (both immediate and delayed) and age, gender and sleep duration less than 6 hours (β-0.42 [95% CI -0.66, -0.18]) remained significant Only 0.3% (n=13) met the criteria for dementia and 5.8% (n=218) met criteria for MCI.

Conclusion: Depression continues to be a significant risk factor for poor cognitive performance in older age. With episodic memory appearing sensitive to poor sleep duration. Longitudinal follow up will allow robust assessments of causal mechanisms between risk factors and future cognitive decline.

POSTER

3213. Scientific Presentation - Big Data

DNA METHYLATION IN THE NORTHERN IRELAND COHORT FOR THE LONGITUDINAL STUDY OF AGEING (NICOLA) – RECRUITMENT AND CHARACTERISTICS

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Introduction: Epigenetic modifications including DNA methylation (DNAm) are proposed mechanisms by which social or environmental exposures may influence health and behaviours as we age. The Northern Ireland Cohort for the Longitudinal Study of Ageing (NICOLA) DNAm cohort, established 2013, is one of several worldwide, nationally representative prospective studies of ageing with biological samples from participants who consented for multi-omic analysis.

Methods: NICOLA recruited 8,478 participants (8,283 aged 50 years or older and 195 spouse or partners at the same address aged under 50 years). Computer assisted personal interviews (CAPI), self-completion questionnaires (SCQ) and detailed health assessments (HA) were completed. Of the 3,471 (44.1%) participants that attended the health assessment in Wave 1, which included venous blood sampling, 2,000 were identified for the DNAm cohort. Following technical and data quality control checks, DNAm data is currently available for n = 1,870.

Results: There was no significant difference based on age, self-reported gender, education, employment, smoking or alcohol status and subjective health reports between the DNAm cohort and other health assessment attendees. Participants were more likely to be in the DNAm group if they lived with one other person (OR 1.26, CI 1.07, 1.49). The DNAm group had a lower proportion of depressed participants and those meeting criteria for post-traumatic stress disorder (11.7% and 4.4% versus 13.5% and 4.5% respectively) categorised by objective assessment tools but this was not significant (OR 0.84 CI 0.69-1.02 and OR 0.87 CI 0.64-1.19).

Conclusion: The deeply phenotyped DNAm cohort in NICOLA with planned prospective follow up and additional multi-omic data releases will increase the cohort's utility for research into ageing. The genomic and epigenetic data for the DNAm cohort will be deposited on the European Genome-Phenome Archive (EGA), increasing the profile of this cohort and data availability to researchers.

POSTER

3217. Scientific Presentation - Big Data

VOLUNTEERING, INFORMAL SUPPORT, AND BIOLOGICAL AGEING: INTERNATIONAL EPIGENETIC EFFECTS OF HELPING BEHAVIOURS ON AGEING

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Introduction: Helping behaviours, such as formal volunteering and informal helping, have been linked to health and well-being across cultures. This study investigates their differential impacts on epigenetic age acceleration in culturally distinct populations from the United States and Ireland.

Methods: Using data from the U.S. Health and Retirement Study (HRS, N=3,919) and the Northern Ireland COhort for the Longitudinal Study of Ageing (NICOLA, N=1,830), we examined self-reported frequency of helping behaviours and the five DNA methylation (DNAm) measures. Formal volunteering, characterized by unpaid activities that help religious, educational, health-related or other charitable organizations; and informal helping, characterized by unpaid activities that help friends, neighbours, or relatives, were assessed for their unique associations with epigenetic clocks: Horvath, Hannum, PhenoAge, GrimAge, and DunedinPACE.

Results: In Northern Ireland, both formal volunteering and informal helping at 1-4 hours per week are associated with decelerated GrimAge. There were no significant associations for other DNAm measures. In the U.S., results indicate the moderate engagement (1-99 hours annually) in both formal and informal helping is generally associated with decelerated epigenetic ageing, particularly for PhenoAge, GrimAge, and DunedinPACE. However, high levels of informal helping (200+ hours per year) were linked to accelerated biological ageing, potentially reflecting stress or role strain. Formal volunteering consistently demonstrated protective effects against biological ageing, even at higher frequencies. Cultural variations emerged as well: Americans were more likely to engage in formal volunteering while Northern Irish participants engaged more often in informal helping.

Conclusion: The findings underscore the importance of cultural context as a critical backdrop in which helping behaviours shape health outcomes. By integrating biological and cultural perspectives, this study contributes to understanding the complex interplay between social behaviours and ageing.

POSTER

3073. Scientific Presentation - BMR (Bone, Muscle, Rheumatology)

REVIEW OF THE EFFECTIVENESS OF TRANSDERMAL LIDOCAINE FOR OSTEOARTHRITIC PAIN

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Introduction: About 73% of people living with osteoarthritis are older than 55 years. Osteoarthritis can greatly reduce the quality of life. While surgical interventions (including joint replacement) present one approach to advanced and disabling osteoarthritis, non-surgical interventions help people living with the condition to manage pain and maintain optimal levels of functioning. Pharmacological options should be used in combination with non-pharmacological measures at the lowest effective dose for the shortest period of time possible.

Lidocaine 5% plasters are used off license in clinical practice to treat chronic pain, and pain from osteoarthritis. The lidocaine contained in the medicated plaster diffuses continuously into the skin, providing a local analgesic effect. The low systemic exposure to lidocaine following use of the lidocaine patch 5% is particularly beneficial for patients with polypharmacy, or for patients who have low tolerance for systemic analgesics.

The aim of this review was to examine the current evidence for using transdermal lidocaine patch in managing pain from osteoarthritis.

Method: A comprehensive literature search was performed using electronic databases to identify studies that assessed the effectiveness of transdermal lidocaine in osteoarthritis. Reference lists of included studies were also reviewed.

Results: 6 studies were included in the review, with a total of 359 patients. 3 studies used the Western Ontario and McMaster Universities (WOMAC) Osteoarthritis Index and showed significant improvement from baseline with use of 5% lidocaine patch in WOMAC pain scores($p<0.01$), and 1 study showed significant improvement all 4 Neuropathic Pain Scale composite measures($p<0.001$).

3 studies were included in a meta-analysis. This showed a significant improvement across pain, stiffness and physical function on WOMAC Osteoarthritis Index.

Conclusion: Although these studies included small numbers, they have shown a positive effect. Geriatric patients are more likely to have co-morbidities, frailty and polypharmacy which would prevent surgical/systemic pharmacological interventions. Further trials in this area would be beneficial.

POSTER

3099. Scientific Presentation - BMR (Bone, Muscle, Rheumatology)

CORRELATION OF INFLAMMATORY BIOMARKERS IN GERIATRIC PATIENTS WITH SARCOPENIA - A CASE CONTROL STUDY

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Introduction: Chronic inflammation has a significant role in the pathogenesis of sarcopenia. The aim of our study was to evaluate the correlation of inflammatory biomarkers (CRP, IL-6, TNF-α, IGF-1) with sarcopenia in elderly.

Method: We conducted a hospital-based case control study in patients aged more than/equal to 60 years visiting the Geriatric Medicine outpatient clinic. After obtaining informed consent, subjects were screened using SARC-F tool and diagnosis confirmed as per Asian Working Group for Sarcopenia (AWGS) criteria. Biomarker quantification (CRP, IL-6, TNF-α, IGF-1) was done from serum samples using enzyme-linked immunosorbent assay (ELISA) in 30 patients with sarcopenia and 30 patients without sarcopenia. These biomarkers (CRP, IL-6, TNF-α, IGF-1) were then correlated with sarcopenia using appropriate statistical tools.

Result: Mean age of cases (n=30) was 67.6 ±7.5 years and of controls was 66.1 ± 6.2 years out of which 56.7% of cases and 46.7% of controls were females. Mean serum albumin in cases were significantly low in cases as compared to controls. Among the four biomarkers assessed, mean CRP among cases (5.58 ± 2.47mg/l) and controls (2.98 ± 3.0mg/l) (P=0.001) and mean TNFα among cases (176.66 ± 163.1pg/ml) and controls (45.1 ± 89.14pg/ml) (P=0.000) differed significantly statistically. No significant differences were observed for levels of IL-6 and IGF-1 in cases and control.

Conclusions: Sarcopenia in elderly is associated with increased levels of inflammatory markers TNF-α and CRP. These may be potential biomarkers and further study is warranted to determine the physiological role of immune aging in the pathogenesis of sarcopenia.

POSTER

2505. Scientific Presentation - Education / Training

BARRIERS PERCEIVED BY MEDICAL STUDENTS WHEN CONSIDERING A CAREER IN GERIATRIC MEDICINE

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

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

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

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

POSTER

3060. Scientific Presentation - Education / Training

CANADIAN GERIATRICS SOCIETY: THE AGEING CARE 5Ms COMPETENCIES FOR GRADUATING MEDICAL STUDENTS

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Background/purpose: To prepare future physicians to care for a growing aging population, the Canadian Geriatrics Society (CGS) Education Committee formed a working group in 2019 to update the 2009 Core Competencies in the Care of Older Persons for Canadian Medical Students. The goal is to assist medical educators with developing relevant undergraduate medical curriculum.

Methods: The working group chose 5Ms model and canMEDs framework to develop the competencies. A modified Delphi process was used. National participants were recruited and three rounds of Delphi surveys were conducted via survey monkey. A 7-point Likert scale was used for each competency statement.

Results: The first round was conducted in October 2019, n=72, identifying the importance and skill level of the components of the competencies under three headings; knowledge, skills and attitudes. The second round was conducted in September 2020, n=54, with proposed competencies under seven headings; aging, caring for older adults, (5Ms): mind, mobility, medications, multi-complexity and matters the most with > 70 % agreement for all. Based on the strength of the agreement and comments, minor revisions were made and the final survey was conducted in June 2021. The agreement level for competencies varied from 85 - 98 %. Thirty-three core geriatric competencies were developed under 7 headings. The CGS education committee approved the competencies in Dec 2021.

Conclusion: The 2021 Aging Care 5M Competencies framework integrates new concepts and knowledge that inform current practice in the field of geriatrics.

Thirty-three core geriatric competencies for the graduating undergraduate medical student were developed and classified under 7 headings. The framework was distributed to the accreditation and examination bodies and Canadian medical schools and was published in Academic medicine. 2024 Feb 1;99(2):198-207. doi: 10.1097/ACM.0000000000005475. Epub 2023 Nov 19. Currently we are working on implementation of the competencies.

POSTER

3079. Scientific Presentation - Education / Training

SIMULATING ADVANCE CARE PLANNING DISCUSSIONS FOR HEALTHCARE PROFESSIONALS AND ITS IMPACT ON PATIENTS AND LEARNERS

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Introduction: Simulation based education can be used to train healthcare professionals in communication skills used in Advance Care Planning (ACP) and End of Life (EOL) care discussions. We used a scoping review to determine what is known about simulating ACP discussions for healthcare professionals and its impact on patients and learners.

Methods: We applied Arksey and O'Malley's framework to identify relevant studies which met the inclusion criteria for our scoping review question. Three databases (MEDLINE, Embase and Web of Science) were searched with the keywords simulation-based education, advance care planning and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR). This resulted in 84 citations. There were 18 studies meeting criteria for inclusion.

Results: Five (28%) studies included more than two healthcare disciplines in their research. Seventeen (94%) studies used healthcare professionals from various stages of training. All studies used face-to-face simulation with a simulated or standardised patient. Seventeen (94%) studies found improvements in confidence and communication skills with regards to ACP and EOL. Two (11%) studies found improvements in attitudes towards ACP and EOL care with one (6%) study finding no improvement in patient reported communication skills in these discussions. Two (11%) studies reported efforts to ensure psychological safety for learners, screening for emotional distress and offering psychological support.

Conclusion: The use of simulation-based education as an educational modality for ACP training has been proven to be effective in improving confidence and communication skills amongst healthcare professionals. There is scope to develop it further to include a greater breadth of interdisciplinary learning, to examine the effect of cultural context and spiritual care on learning, and to determine the lasting effects this learning has on learners and on the care of their patients. It is also effective when used alongside other teaching techniques as part of a wider educational programme.

POSTER

3171. Scientific Presentation - Education / Training

BETTER MEALTIMES FOR PEOPLE LIVING WITH DEMENTIA IN CARE HOMES: A FEASIBILITY STUDY

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Introduction: Some people living with dementia have difficulties at mealtimes, with significant implications for physical and mental health (Abdelhamid et al., 2016). Care home staff provide direct care at mealtimes (Skills for Care, 2015), but there is a shortage of high-quality dementia care training focusing on mealtimes (Fetherstonhaugh et al., 2019). This study tested the feasibility and acceptability of an evidence-based training programme promoting better mealtime care for people living with dementia (Faraday et al., 2022).

Method: The study comprised a before-and-after design using multiple methods of data collection and analysis. The qualitative arm of the study is reported here. The training programme was delivered in three care homes in the UK, chosen for differences in context, size and ownership. Trainees were recruited from a range of different roles across the homes, including care staff, kitchen staff and management staff. After training, participants attended focus groups to elicit views on their experience of the training and suggestions for improvement. Data from the focus groups were analysed using reflexive thematic analysis (Braun & Clarke, 2022).

Results: Analysis to date has generated five themes: Need a mix of experience in the room; More dementia-specific content; Make the most of group discussions; Scenarios should be nuanced and complex; One-day delivery is easiest; Facilitator experience and skill outweighs profession. These themes will inform modification of the training programme's content and format, to increase its acceptability and usefulness to care home staff, prior to wider roll-out and evaluation. At the same time, a short animation has been co-produced with experts by experience to convey key messages from the training as accessibly as possible (https://vimeo.com/1009856313).

Conclusion(s): This study has reduced uncertainty about the training programme's acceptability, so that it is more likely to become embedded in practice and improve mealtime care for people living with dementia.

POSTER

3172. Scientific Presentation - Education / Training

RISING STUDENT NUMBERS – USING A COMPREHENSIVE GERIATRIC ASSESSMENT EXERCISE TO EDUCATE SURPLUS STUDENTS?

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1. Glasgow Royal Infirmary; 2 University of Glasgow; 3. Older People's Services NHS GGC

Introduction: As medical student numbers rise, clinicians are under increasing pressure to provide high quality teaching. To increase Geriatric medicine representation within the undergraduate curriculum, fourth-year students from the University of Glasgow attending Glasgow Royal Infirmary (GRI) are given the opportunity to participate in an 'Older People's Services Float (OPS) week'.

Clinical Teaching Fellows (CTFs) and Clinical Development Fellows (CDFs) support students to undertake a condensed version of Comprehensive Geriatric Assessment (CGA). Students assess patients from the perspective of various Multidisciplinary Team (MDT) members. The 'CGA' is then presented in a simulated 'MDT meeting'. This promotes self-directed learning and teamwork while alleviating pressure on clinical teams to deliver teaching.

Methods: The 'OPS Float week' was integrated into the medical student timetable over 15 weeks, with 3 students rotating each week. Anonymised quantitative and qualitative feedback was collected using a questionnaire. This included a combination of Likert scales and free text boxes.

Results: Data was collected from twenty-eight students. Overall, the feedback was positive. Seventy-five percent (75%) of students reported that they 'strongly agree' the exercise improved their knowledge of how to undertake a CGA. Eighty-two percent (82%) reported that they strongly agree the exercise has improved their understanding of the different roles within the MDT. An example of the qualitative data collected includes: "Really good…Definitely made me think more holistically about the patient and identify areas in a patient's life that could make a real difference to their care".

Conclusion: The introduction of the 'OPS Float week' has successfully enhanced the learning experience of medical students by offering valuable insights into Older People's Services, the CGA process and working within an MDT. The model also presents a practical approach to addressing the challenges of increasing student numbers while continuing to provide high quality medical education.

POSTER

3187. Scientific Presentation - Education / Training

WOULD YOU BE A GERIATRICIAN? THE EVOLUTION OF MEDICAL STUDENT PERCEPTIONS OF GERIATRIC MEDICINE FROM 2010 TO 2024

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Introduction: Quality education in ageing at medical school can positively influence students' attitudes towards older people. The 'Medicine in the Community Module' integrates 2-weeks of clinical placement in geriatrics into a 6-week mandatory teaching module in the final 18-months of student training. In 2010, we found an association between module completion and interest in pursuing a career in geriatric medicine.

Method: We administered an 18-item survey on career interests to medical students before and after the 2024 module. Results were analysed within the cohort to assess impact of the current module, and post-module results were compared to 2010.

Results: Overall, 49% (143/291) of students completed the pre-module survey and 35% (101/291) completed the post-module survey. Prior to commencing the module in 2024, 29% (41/143) of responders indicated they would favourably consider a career in geriatric medicine, which improved to 44% (44/101) post-module ($p<0.02$). These proportions were higher than 2010 (20.6% pre-module, 31% post-module; $p=0.02$). In the 2024 post-module survey, 42.6% (43/101) of responders felt career decisions are made in medical school, with 23% (14/61) indicating a preference for medical specialities, 19.6% (12/61) surgery and 14.6% (9/61) paediatrics. The perceived most important factors influencing speciality choice in both cohorts were: interesting specialty, variety, and working hours. Students also placed importance on potential future income in 2024 76% (2010=47%). The availability of research opportunities was consistently rated as the least important factor influencing student preference (2024= 42%, 2010=35%).

Conclusion: This study indicates that students are positively impacted by dedicated geriatric medicine exposure in medical school, highlighting the importance of core speciality exposure. Priorities students place on different aspects of a career choice appear largely similar to those from a 2010 study, except that students today more often report income as important.

POSTER

3047. Scientific Presentation - Epidemiology

A TIME-SERIES ANALYSIS TO EXAMINE THE IMPACT OF COVID-19 ON PSYCHOTROPIC MEDICATION USE BY CARE HOME RESIDENTS WITH DEMENTIA

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Introduction: Evidence is contradictory on the impact of the COVID-19 pandemic and imposed restrictions on psychotropic medication use among people with dementia. This study examined prescribing trends of psychotropic medications (antipsychotics, antidepressants, hypnotics and anxiolytics, antiepileptics) before and after pandemic onset, among care home residents with dementia in Northern Ireland.

Methods: Medication data from a population-wide prescribing database were linked with demographic and care home data from administrative records. Participants included individuals living in a care home categorised as providing dementia care to whom a medication indicated for dementia management was dispensed. Monthly prescription uptake was examined over two phases (pre-pandemic: January 2018-February 2020; during the pandemic: March 2020-December 2022). Time series autoregressive integrated moving average (ARIMA) analysis was performed in R; expected monthly values were compared with actual values, stratified by resident and care home characteristics.

Results: The study included 7,544 participants; the majority were female (n=4,967, 65.8%) and aged ≥75 years (n=6,659, 88.2%). Over the study period, 70.5% of participants were in receipt of a psychotropic medication pre-pandemic, increasing to 72.4% during the pandemic. Antipsychotic medication uptake followed an upward trend during the pandemic. It was statistically significantly higher than expected forecast values in January, March, and December 2021, and uptake was higher than expected amongst males, those aged ≥85 years, and those living in care homes located in rural areas. Antidepressant medication uptake was lower than expected in females, those aged 65-74 and ≥85 years, and those living in care homes located in urban areas and in residential homes. Uptake of hypnotic, anxiolytic and antiepileptic medications were largely unchanged during the study period.

Conclusion: These findings highlight changes in the use of psychotropic medications among RwD during the pandemic, notably antipsychotics and antidepressants. Regular monitoring and review of psychotropic medications is warranted to reduce medication-related harm.

POSTER

3090. Scientific Presentation - Epidemiology

IDENTIFYING AND VISUALISING MULTIMORBIDITY PATTERNS AND NETWORK AMONG OLDER ADULTS IN SOUTHERN CHINA

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Background: Multimorbidity poses major healthcare challenges which contributes to a decline in quality of life and an increased mortality risk. There exists heterogeneity on the internal associations within multimorbidity. We aimed to explore multimorbidity patterns and construct networks, delving into the relationships among diseases.

Methods: The data from the health examination records of adults residing in Southern China in 2020 were utilised. Individuals aged 65 and above were included. Fifteen diseases were extracted. Hierarchical cluster analysis was performed. The multimorbidity matrix was calculated and a heatmap was drawn by Python. Gephi was used to visualise the multimorbidity network. Subgroup analysis was performed based on the clustering results and gender.

Results: This study included 54,829 individuals, with 30,872 females (56.3%). The average age was 75.9±7.1, and the prevalence of multimorbidity was 45.5%. The heatmap revealed the closest relationship between gout and osteoarthritis, with a correlation coefficient of 0.6. The cluster analysis revealed three multimorbidity patterns: the CAD-hypertension-cardiac failure cluster, the bronchical diseases-COPD-asthma cluster, the arrhymia-hyperlipidemia-osteoporosis cluster. The network analysis confirmed the strongest connection between gout and osteoarthritis, with a weight of 1.1. Subgroup analysis based on the clustering results indicated that within the arrhymia-hyperlipidemia-osteoporosis cluster, the relationship between hyperlipidemia and osteoporosis was the most tightly linked, with a weight of 0.1. In the bronchical diseases-COPD-asthma cluster, the connection between bronchial diseases and COPD was the closest, with a weight of 0.5. In the CAD-hypertension-cardiac failure cluster, the relationship between CAD and hypertension was the strongest, with a weight of 0.4. Gender-based subgroup analysis revealed that network density among females was higher at 0.83 compared to males at 0.78.

Conclusions: Multimorbidity is prevalent, and females exhibited greater complexity in their multimorbidity patterns. These can facilitate clinicians in identifying core diseases and providing targeted interventions to lower the risks of multimorbidity.

POSTER

3126. Scientific Presentation - Epidemiology

ANTIDEPRESSANT AND ANXIOLYTIC USE AND MORTALITY RISK IN PEOPLE WITH DEMENTIA IN NORTHERN IRELAND: A NESTED CASE-CONTROL STUDY

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Introduction: Limited evidence exists to support the use of antidepressant and anxiolytic medications in people with dementia; these medications may contribute to potentially inappropriate prescribing and be associated with mortality. This study aimed to investigate trends in prescribing of these medications and the association between exposure to antidepressants and anxiolytics and mortality risk among people with dementia.

Method: A nested case-control study was conducted using record linkage of five administrative population-based data sources in Northern Ireland between 2010 and 2020. Dementia cases (identified if a medication indicated for dementia management was prescribed from 2012) were matched to one control (based on age and sex). Exposure to antidepressants and anxiolytics was assessed from prescribing records two years prior to dementia diagnosis until six months prior to death or end of study. Odds ratios (ORs) and 95% confidence intervals (CIs) were calculated using conditional logistic regression after adjusting for demographic factors and comorbidities. Sensitivity analyses were undertaken assessing exposure period and number of prescriptions.

Results: In total, 14,420 dementia cases and 14,361 controls were included. A greater proportion of study participants were prescribed antidepressants (59.2% of cases, 54.7% of controls) than anxiolytics (44.8% of cases, 36.0% of controls). There was evidence of an increased risk of mortality in people with dementia who were prescribed antidepressants (fully adjusted OR = 1.08; 95% CI 1.02-1.14) and in those prescribed anxiolytics (fully adjusted OR = 1.26; 95% CI 1.19-1.33) compared to nonusers. Sensitivity analyses demonstrated neither exposure period nor number of prescriptions had a significant impact on mortality risk.

Conclusion: In this large population-based study, the use of antidepressants and anxiolytics in people with dementia was high. The use of antidepressants was associated with a slightly increased risk of mortality whilst the use of anxiolytics was more strongly associated with mortality. Further studies are warranted to support these findings.

POSTER

3150. Scientific Presentation - Epidemiology

THE IMPACT OF INFECTIONS ON TELOMERE DYNAMICS: INSIGHTS FROM A SYSTEMATIC REVIEW

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Introduction: Infections are linked to an increased risk of age-related diseases like cardiovascular disease and dementia. Accelerated immunological ageing, which can be measured by telomere length, could be a potential underlying mechanism. However, the extent to which different infections influence telomere length or its attrition is not fully understood. Clarifying these relationships could guide preventive strategies to reduce age-related disease risk.

Methods: We conducted a systematic review searching six major databases (MEDLINE, EMBASE, Web of Science, Scopus, Global Health, Cochrane Library) on 31 August 2023. Two reviewers independently screened and selected studies, extracted data, and assessed risk of bias using the ROBINS-E tool. High inter-study heterogeneity meant meta-analysis was not feasible, so we performed a narrative synthesis. Studies were categorised by infection type, telomere measurement method, cell type used for telomere length measurement, and statistical analysis approach.

Results: From 8,670 identified studies, 63 met inclusion criteria. Most studies (50) were cross-sectional and conducted after 2000, with the earliest from 1996. The USA was the most frequent study location (15 studies). HIV was the most studied infection (30 studies), followed by COVID-19 (8 studies), and then Cytomegalovirus and H.pylori (6 studies each). Eighty percent (20) of HIV studies (of those without overlapping samples) reported evidence of an association between HIV and shorter telomere length or increased telomere attrition. Findings for other infections were more variable. Differences in infection types, telomere measurement methods, cell types analysed, and statistical approaches, complicated cross-study comparisons. Furthermore, risk of bias was high in most studies, mainly due to risk of unmeasured confounding.

Conclusion(s): There is evidence to suggest that HIV infection is linked to telomere attrition, while findings for other infections are not conclusive. Future research should prioritise longitudinal studies with standardized telomere measurement methods and rigorous control of confounding to better understand relationships between infections and telomere dynamics.

POSTER

3206. Scientific Presentation - Epidemiology

OLDER ADULTS LIVING IN RURAL AREAS OF NORTHERN IRELAND REPORT BETTER HEALTH, HEALTH BEHAVIOURS AND NEIGHBOURHOOD SUPPORT

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Introduction: Our lived environment can impact our health and wellbeing as we age. In Northern Ireland (NI) some of the highest levels of social deprivation are found in large urban areas and yet rural living may bring its own challenges resulting in health disparity. This study aimed to examine the perception of health and wellbeing based on where you lived.

Methods: Wave 1 participants of the Northern Ireland Cohort for the Longitudinal study of Ageing (NICOLA), a population representative cohort over 50-year-olds were included in this analysis. As part of the initial computer assisted personal interview (CAPI), participants were asked detailed questions on their health including self-reported health status, health behaviours and questions on neighbourhood cohesion. Urban area was defined according to the NI statistics and research agency's (NISRA) settlement criteria of any small town with >4,500 residents or greater.

Results: Of the 8,478 NICOLA Wave 1 participants 69.6% have been living in their current home for over 20 years and 3,563 (42%) live in a rural area. When age and gender were matched, those living in a rural area were 64% less likely to report poor physical or mental health (OR 0.46, p <0.001), were less likely to be current smokers (OR 0.59 p <0.01), drink alcohol excessively (OR 0.37, p <0.001) and more likely to be physically active regularly (OR 1.32 p <0.001). When asked about their neighbourhood, those living in a rural area were 56% less likely to say their neighbours wouldn't help them (OR 0.44 p <0.001).

Conclusion: Those living in rural areas self-report better health, health behaviours and neighbourhood support than age matched urban counterparts. Further analysis examining different social determinants of health could identify some of the reasons behind the difference and is possible within the deeply pheno-typed NICOLA cohort

POSTER

3218. Scientific Presentation - Epidemiology

DIRECTLY GENOTYPED APOLIPOPROTEIN (APOE) ALLELE STATUS ASSOCIATED WITH WORSE COGNITIVE PERFORMANCE IN THE NICOLA STUDY

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Introduction: The APOE gene (encoding apolipoprotein E) accounts for much of the measurable genetic contribution to late onset Alzheimer's disease (LOAD). There are three polymorphic forms of APOE, ε2, ε3 and ε4. In those of European ancestry, one copy of APOE ε4 is associated with a 3-fold increase in a diagnosis of LOAD, while two copies of APOE ε4 increases the risk by about 12-fold; conversely, APOE ε2 has lower LOAD risk. Missense variants, rs429358 and rs7412, are two independent variants for APOE that are consistently associated with large effects on LOAD risk, and together define the ε2/ε3/ε4 alleles. A significant limitation with APOE testing in large cohort studies to date has been their reliance on imputation for APOE genotyping rather than direct measurement.

Methods: NICOLA Wave 1 participants who attended the health assessment and consented to venepuncture and genetic analysis were directly genotyped for APOE rs429358 and rs7412 to generate allele status. Linear association with allele status, key demographics and cognitive performance were measured including Mini Mental State Examination (MMSE), Montreal Cognitive Assessment (MoCA) and animal naming.

Results: Of the 3,741 Wave 1 participants that attended the health assessment, 2,978 had APOE status generated from direct genotyping. 2109 participants (71.6%) are not ε4 carriers, 766 (26.0%) are heterozygotes and 72 (2.4%) have two ε4 alleles. For MMSE and MoCA, having two ε4 alleles was significantly ($p<0.05$) associated with worse cognitive performance, including after age adjustment.

Conclusion: APOE continues to represent a significant portion of the genetic risk of LOAD. Direct genotyping, alongside other multiomic methodologies, in a large representative study of community dwelling over 50-year-olds deeply phenotyped for a wide range of health and cognitive measures will allow complex questions of the genetic and environmental interplay between ageing outcomes including LOAD to be explored.

POSTER

2917. Scientific Presentation - Falls, fracture and trauma

ANTICHOLINERGIC BURDEN, FALLS AND MORTALITY IN A DIVERSE ELDERLY POPULATION IN KUALA LUMPUR

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Introduction: Falls are a significant cause of morbidity and mortality throughout the world. This burden is greatest in elderly populations. Malaysia is experiencing a rapid demographic shift towards an ageing population, it has a low incidence of falling, but a high mortality to fall ratio. Identifying risk factors may guide future practice and prevent harm. Anticholinergic medication is associated with cognitive decline, mortality and falling.

Methods: Data were used from the Malaysian Elders Longitudinal Research study (MELoR), an ongoing study to assess geriatric health in Malaysia, to assess anticholinergic burden, falls, and mortality, from which 1472 participants were identified. The Anticholinergic Cognitive Burden (ACB) scale was used and participants were assigned positive (ACB≥1) or negative (ACB=0) ACB scores. Data analysis used bivariate and regression analysis to adjust for multicollinearity.

Results: A positive ACB score was identified in 300 (20.4%) participants. Cardiovascular medication accounted for around half the anticholinergic burden. A positive ACB score was a significant predictor for falling and mortality at five years after adjusting for age, sex and ethnicity. Incontinence and hearing loss remained the only significant predictors for both outcomes after regression analysis.

Conclusion: The impact of anticholinergic burden cannot be fully accounted for by comorbidities. Incontinence and hearing problems are both modifiable risk factors for falls and mortality. Further research into the diagnosis and management of these comorbidities in this population is recommended.

POSTER

3034. Scientific Presentation - Falls, fracture and trauma

EXPLORING THE USE OF BEDRAILS WHEN USED TO SUPPORT ADULTS: A SCOPING REVIEW

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Introduction: In the UK, concerns regarding the safe use of bedrails, especially in nursing homes and a person's own home, prompted a National Patient Safety Alert in August 2023. A scoping review was conducted to identify and map the literature relating to bedrail use in hospital and community settings and identify future areas of research.

Methods: The scoping review was performed in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines. The search was conducted using MEDLINE, EMBASE, EMCARE, COCHRANE, BASE, CINAHL, and Google Scholar. Two reviewers independently contributed to screening. Data extraction included reason and prevalence of use, causes of harm and alternatives to bedrails. Findings were reported narratively.

Results: A total of 33 papers were included. Bedrails were widely used across hospital settings and nursing homes. No studies examined bed rail use in a person's own home. Bed rails were primarily prescribed as a falls prevention device, despite the absence of empirical evidence supporting their effectiveness. In the UK, bedrail use appeared to be influenced by local culture and practice rather than policy. Self-reported use of bedrails as patient restraints in the UK, perhaps indicates inadequate legal literacy among equipment prescribers. Bedrails were found to be safe when used appropriately. There is concern that bedrail use is increasing with increasing patient dependency and advances in bed technology but authors express apprehension that it may be ethically impossible to design a randomised controlled trial to address patient safety concerns.

Conclusion: Empirical data supporting bedrails as a falls prevention device is lacking. Additionally, there is a dearth of evidence reporting the opinions of users or inquiries regarding bedrails in a person's own home. Therefore, clinicians are advised to consider bedrail prescriptions with a sense of responsibility and inquisitive inquiry to support both ethical and lawful use.

POSTER

3051. Scientific Presentation - Falls, fracture and trauma

GAITKEEPER: REVOLUTIONISING STANDARDISED GAIT SPEED MEASUREMENT WITH AI-ENABLED MOBILE TECHNOLOGY

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Introduction: Gait speed, often referred to as the 'sixth vital sign,' is an important health indicator in older adults, predicting morbidity and functional status. This study evaluated GaitKeeper, a novel artificial intelligence (AI)-enabled mobile technology that integrates augmented reality (AR). GaitKeeper is designed to standardise the measurement of gait speed and address inconsistencies commonly encountered in traditional clinical settings due to varied assessment techniques.

Methods: This study was conducted in two phases to validate GaitKeeper against Vicon and GaitRite, two established gait analysis systems. Phase One involved thirty-five healthy volunteers from a university setting, comparing gait speed, stride length and step length between GaitKeeper and Vicon. Phase Two tested GaitKeeper in a clinical environment with thirty participants diagnosed with mild cognitive impairment to assess the comparative accuracy and reliability of GaitKeeper and GaitRite in recording gait dynamics.

Results: In Phase One, GaitKeeper demonstrated high external consistency with the Vicon system, showing less than 2% variance in measurements of gait speed and stride length. Spearman correlation coefficients were 0.947 for gait speed and 0.989 for stride length, both statistically significant ($p<0.0001$). Phase Two established GaitKeeper's reliability in clinical assessments, exhibiting a strong Pearson correlation coefficient of 0.71 for stride length with GaitRite - also highly significant ($p<0.0001$). The Spearman correlation coefficient for gait speed was 0.918 ($p=0.000$) indicating a high degree of consistency between the two systems.

Conclusion: GaitKeeper has been validated as a reliable and precise tool, providing standardised measurements of gait speed in a timely manner. Additionally, GaitKeeper supports longitudinal monitoring, crucial for managing chronic conditions and rehabilitation programmes. Its versatility allows for deployment in a variety of settings, from traditional hospital environments to home-based rehabilitation where routine gait speed assessments can be challenging. This adaptability positions GaitKeeper to revolutionise gait analysis across diverse healthcare contexts.

POSTER

3055. Scientific Presentation - Falls, fracture and trauma

IS APPETITE RELATED TO THE OCCURRENCE OF FUTURE FALLS IN OLDER ADULTS WITH UPPER LIMB FRACTURE?

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Introduction: Older people can commonly experience reduced appetite and it can be assessed very simply by questionnaires such as the Simplified Nutritional Appetite Questionnaire (SNAQ). Decreased appetite is associated with sarcopenia and frailty, which in turn are related to falls. The aim is to assess if screening for poor appetite might aid in predicting risk of future falls by exploring association between appetite score and falls at three and six months in older people with upper limb fracture.

Methods: A secondary data analysis. Baseline appetite was assessed using the SNAQ, with score <14/20 defining poor appetite. Descriptive statistics summarised characteristics associated with poor appetite. Association between baseline characteristics and the presence of falls at 3 and 6 months were measured using logistic regression.

Results: 100 participants (80% females and 20% males, median age 73 years (IQR 9.75)). 9% had poor appetite. Sarcopenia (SARC-F score ≥4), frailty (FRIED phenotype) and a higher number of comorbidities and medications were more prevalent in individuals with poor appetite. Appetite at baseline was not related to occurrence of falls at 3 and 6 months (P = 0.627, P = 0.698 respectively). Sarcopenia, number of comorbidities, EQ5D5L mobility, EQ5D5L self-care and EQ5D5L activities were associated with occurrence of falls at 3 months. There was no relationship between baseline variables and falls at 6 months. In multivariate analysis, the association between EQ5D5L activities and the presence of falls at 3-months remained (OR 3.485 (95% CI 1.463, 8.302), P= 0.005).

Conclusion: In this study population, poor appetite was related to higher prevalence of sarcopenia and frailty but was not predictive of future falls. Sarcopenia, comorbidities, EQ5D5L mobility and self-care were associated with falls at 3 months. Identifying individuals with sarcopenia and difficulty in performing routine activities continues to be imperative to minimise the risk of future falls.

POSTER

3140. Scientific Presentation - Falls, fracture and trauma

MAINTAINING INDEPENDENCE IN PEOPLE WITH DEMENTIA WHO HAVE HAD A FALL: A PILOT CLUSTER RANDOMISED CONTROLLED TRIAL (MAINTAIN)

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Background: Falls in people with dementia often result in physical and psychological impacts, reducing independence and increasing healthcare costs. Falls place a significant economic burden on the healthcare system. Although individuals with dementia face a heightened risk of falling, there is limited evidence supporting effective home-based interventions for this population.

Methods: A mixed-methods process evaluation was embedded within a pilot cluster randomised controlled trial, guided by a realist framework. The evaluation was conducted across six UK sites (three intervention, three control). It included fidelity checks of routine data collection, observation of intervention sessions, multidisciplinary team (MDT) meetings, and therapist supervision. Semi-structured interviews were conducted with people with dementia, caregivers, and therapists.

Results: High fidelity was achieved in home assessments and intervention delivery, with participants completing an average of 15 out of 22 planned sessions. Regular home visits enhanced engagement and motivation, while MDT support boosted therapist confidence in managing complex cases. Most participants met their functional goals and reported improved confidence. However, challenges included geographical and capacity variability in service delivery and inconsistent referral pathways. Therapists' attitudes toward advanced dementia influenced intervention delivery. The dyadic approach supported activity engagement but occasionally increased caregiver responsibilities.

Conclusions: The Maintain intervention was feasible and acceptable, with preliminary evidence of improved daily living activities and quality of life. A future trial should focus on standardising MDT support, addressing falls-related anxiety, and developing sustainable post-intervention strategies. Protocol adaptations, such as video consultations, demonstrated potential to mitigate workforce challenges.

POSTER

3195. Scientific Presentation - Gastroenterology

DETERMINANTS OF SURVIVAL OF ELDERLY PATIENTS WITH COLORECTAL ADENOCARCINOMA: A POPULATION-BASED ANALYSIS OF 191,417 PATIENTS

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Introduction: Colorectal adenocarcinoma (CA) is the second most common cause of cancer mortality in the United States (US) and the United Kingdom (UK). The median age of diagnosis is 70-72 years old. This study aims to explore the factors associated with survival in elderly patients with CA.

Methods: 191,417 patients with CA diagnosed between 2011 and 2021 who are aged 65 years or older were extracted from the US Surveillance, Epidemiology, and End Results (SEER) Database. Univariable and Multivariable Cox regression was performed to explore the factors associated with survival in this group of patients. Kaplan Meier plots for overall survival (OS) were generated.

Results: Most patients were aged 65-75 (45.9%) were males (50.8%) and of white race (70.5%). The most common household income category was 55,000-75,000 USD (34.2%). Mean tumour size was 47 mm with a mean number of positive lymph nodes of 1.1. Most tumours were right sided (40.6%). The commonest stage was stage 2 (25.1%) and the commonest grade was grade 1 (63.3%). The most common metastasis organ was the liver (87.6%). 74.1% had surgical resection, 30.9% had chemotherapy and 10.4% had radiotherapy.

Five-year OS was 46.8%. Multivariable cox regression showed that survival is worse with advanced age, larger tumour size, worse grade, left colon, male sex, lower income, not receiving chemotherapy, not undergoing surgical resection, advanced stage and having metastases.

Conclusion: Poor survival in elderly patients with CA is associated with advanced age, advanced stage/grade, left colon site, larger tumour lower income and not receiving surgical or chemotherapy. Future research is needed to individualize and tailor therapy and approach in this age group. Limitations include data inaccuracy and missingness in SEER especially treatment variables and the lack of quality of life and performance status data.

POSTER

3138. Scientific Presentation - HSR (Health Service Research)

OLDER PATIENTS' AND CAREGIVERS' PERCEPTIONS OF AND ATTITUDES TO DE-PRESCRIBING IN SAUDI ARABIA: A CROSS-SECTIONAL STUDY

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Introduction: Development of effective deprescribing interventions requires thorough understanding of attitudes of relevant stakeholders involved in the medication decision-making process. This study aimed to examine older patients; and caregivers; perspectives on deprescribing in Saudi Arabian hospitals and explored factors influencing their attitudes.

Method: A survey study was conducted using the Revised Patients' Attitudes Towards Deprescribing (rPATD) questionnaire (Arabic version), which was administered to older patients and caregivers recruited from two hospitals in southern Saudi Arabia through convenience sampling. Participants provided written informed consent and ethical approval was obtained. Descriptive analyses (frequencies and proportions) summarised beliefs about medication inappropriateness, burden, discontinuation concerns, involvement and two global questions. Bivariate analyses examined links between participant characteristics and questionnaire responses.

Results: Questionnaires were completed by 253 participants (126 older patients and 127 caregivers; response rate 87%). Most patients were aged 65-69 years (53.2%), married (65.1%), and taking 5-8 medications (57.2%). Almost two-thirds (65.9%) were satisfied with medications, and 88.1% were willing to have them deprescribed. Patients taking 5-8 medications showed significantly greater willingness for deprescribing compared to those taking ≥9 medications ($p<0.001$). Married patients were more involved in medication decision-making than non-married patients ($p<0.05$). Most caregivers were aged 25–34 years (38.5%) and married (75%). Their care recipients were primarily ≥80 years, with 67.7% taking 5-8 medications. Most caregivers (60%) were satisfied with care recipients; medications, and 82.6% were willing to have these deprescribed. Caregivers of care recipients taking ≥9 medications reported greater burden associated with managing medications ($p<0.001$).

Conclusion: Characteristics such as the number of prescribed medications influenced patients' and caregivers' perceptions of medication burden and willingness to have medications deprescribed, while marital status influenced involvement in medication decision-making among patients. These insights may be used to help guide hospital deprescribing interventions.

POSTER

3046. Scientific Presentation - Neurology and Neuroscience

UNSEEN SPINE: A CASE OF INFECTIVE DISCITIS MASKED BY DIVERTICULITIS IN ELDERLY CARE PATIENT

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Introduction: Spinal infections include vertebral osteomyelitis, septic discitis, facet joint septic arthritis, and spinal epidural abscesses. The common presentation usually involves back pain, fever, and elevated inflammatory markers, with signs of neurological deficits implying presence of spinal epidural abscess. Spinal infections are infrequent (0.2–3.7 per 100,000 hospital admissions for spondylodiscitis), with relatively higher incidence in elderly patients.

Case presentation: We present a case of an 80-year-old female patient with a complex past medical history, including chronic back pain, osteoarthritis, bladder cancer, breast cancer, and lymphedema. She presented to the emergency department with a 3-day-history of lower back pain radiating to the abdomen. There was no history of trauma. Examination revealed no signs of intra-abdominal infection. There was a significant elevation of white blood cell count and C-reactive protein (CRP). The initial CT scan identified acute, uncomplicated sigmoid colonic diverticulitis, which was treated under the surgical team conservatively with antibiotics, following which the patient was discharged.

Thirteen days later, the patient represented again with the same symptoms with additional pain radiation to the right leg affecting mobility. There was lumbar spinal process tenderness on examination with persistently high inflammatory markers in blood. Blood cultures resulted positive for Streptococcus agalactiae. An MRI spine revealed infective discitis with a right paravertebral abscess, causing thecal sac compression evident on CT scan also with bilateral psoas abscess. Following starting an appropriate antibiotic course guided by the cultures, and CT-guided drainage of the abscess, the patient improved symptomatically and clinically.

Conclusion: Spinal infections are uncommon, yet significant aetiology of back pain. They should be considered a differential diagnosis in anyone with new or increasing back pain. The investigation and treatment approach must be guided by history taking and clinical examination.

POSTER

3050. Scientific Presentation - Neurology and Neuroscience

THE PREVALENCE AND IMPACT OF MEDICATION-RELATED HARM IN PEOPLE LIVING WITH DEMENTIA – A SYSTEMATIC REVIEW

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Introduction: People living with dementia (PLWD) take five more medications on average than those without dementia. This can increase the risk of medication-related harm, defined as any negative outcome, harm or injury caused by taking a medication. The aim of this systematic review was to identify studies that reported the prevalence of medication-related harm in PLWD and to assess its impact by evaluating various outcomes.

Methods: Twelve databases were searched from date of inception to April 2023. Papers published in English, reporting on the prevalence and/or adverse outcomes of medication-related harm in PLWD using any study design were eligible for inclusion. Methodological quality was assessed using the Cochrane Risk of Bias 2 tool for randomised controlled trials (RCTs) or the Risk of Bias in Non-randomised Studies of Exposures for non-randomised studies. A meta-analysis was conducted to determine combined hazard ratios (HRs) and 95% confidence intervals (CIs) on studies with similar harm-related outcomes using Review Manager software.

Results: Ninety-seven studies were included in the review; 93 were non-randomised studies and four were RCTs. Quality assessments found all four RCTs and the majority of non-randomised studies (n=58) to be at a low risk of bias. Adverse health outcomes, including hospitalisations and mortality, were most frequently reported (n=45 studies), with psychoactive medications (such as antipsychotic medications) being the most implicated class of medicines (n=54 studies). Analysis showed that the use of antipsychotics was associated with a significantly increased mortality risk in six studies (n=25,715 participants; HR=1.42; 95% CI 1.10-1.84; p=0.008).

Conclusion: This systematic review is the first to report the impact of medication-related harm among PLWD, with evidence to suggest that antipsychotic medication use is associated with mortality. However, the included studies had high heterogeneity, which made it difficult to draw comparisons between studies.

POSTER

3113. Scientific Presentation - Neurology and Neuroscience

THE INCREASING NUMBER OF DEATHS RELATED TO ALZHEIMER'S (AD) OVER THE LAST DECADE

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Introduction: Despite the growing evidence from North America and Europe suggesting a decreasing trend in the incidence of dementia globally, the number of people affected by dementia is estimated to have increased by 117% (The Lancet Public Health, e105 - e125, 2019). This can be attributed to an ageing population, increased longevity, increased duration of the disease, and improved diagnosis. The aim of our study was to identify the mortality trend in AD over the last 10 years.

Methods: Data was collected from the Office of the National Statistics (England and Wales). The number of deaths from 2013 to 2023 was extracted using the code G.30 which included all types of AD.

Results: The number of deaths due to AD was 9787 in 2013, and it gradually increased year by year; to 11,298, 14323, 15,795, 17,984, 19,864, 20,400, 23,657, 21,495, 23,474 and 24,522 by 2023.

Discussion: The number of deaths due to AD has more than doubled over the last decade. The increase was gradual and affected both males and females. The dip seen in 2021 was also seen in other neurodegenerative conditions like Parkinson's disease; this was probably due to Covid-19, when people were advised to shield and Covid-19 was given precedence as the cause on the death certificates.

The increasing number of deaths due to AD is likely primarily due to people with AD living longer, leading to an increased prevalence and duration of the condition. It is important to recognise the increasing burden and we should convince decision makers to invest in resources to improve the care of people with AD.

POSTER

3151. Scientific Presentation - Neurology and Neuroscience

EFFECTIVENESS OF A BRIEF VIDEO-BASED INTERVENTION ON THE INTENTION TO BOOK FUTURE VISION AND HEARING ASSESSMENTS

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Introduction: Hearing and vision impairment are associated with cognitive impairment and dementia in older adults. There is limited public understanding that modifying these risk factors can reduce the risk of dementia. In previous studies 36% of older adults have not had a vision assessment and hearing aids are thought to be underused.

This study aimed to increase the understanding of patients attending a memory service of the link between cognition, vision and hearing impairment and encourage participants to have future eye and hearing assessments.

Method: A video was developed with patient and public involvement explaining the link between eyesight, hearing and cognitive impairment and the importance of regular vision and hearing assessments (https://vimeo.com/948705659 Password EMSAMS). All patients attending a memory clinic between 16/09/24 and 05/11/24 were asked to watch this short animated video. A questionnaire was performed after the video asking about previous hearing and vision assessments and whether it was more likely for participants to book a hearing or vision assessment after the video.

Results: 18 patients participated. 72% had a vision assessment in the past 2 years and 94% recalled at least 1 vision assessment. 66% of participants felt that this video made it more likely they would book a vision assessment in future.

33% of participants had a hearing assessment in the last 2 years. 44% felt that this video would make it more likely that they would book a hearing assessment in future.

Free text comments about the video stated that the link between hearing, eyesight and memory was interesting and that the video was easy to understand.

Conclusions: This study shows that a video shown to patients at memory clinic explaining the link between hearing and vision impairment, and cognitive impairment and dementia can motivate patients to book future hearing and vision assessments.

POSTER

3128. Scientific Presentation - Other medical condition

PATIENTS PRESENTING WITH SIGNS AND SYMPTOMS OF DELIRIUM/DEMENTIA: WHEN TO SUSPECT CJD

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Background: Prion disease/Transmissible spongiform encephalopathies consists of a family of rare, progressive neurodegenerative disorders which have long incubation periods, are rapidly progressive and always fatal. CJD is caused by prions, which are abnormal pathogenic agents that induce abnormal folding of specific normal cellular proteins. This leads to brain damage and the characteristic signs and symptoms of the disease.

There are 4 recognised forms – sporadic, genetic, iatrogenic and variant CJD.

Review of 4 cases admitted to our acute ward for the elderly who were all ultimately diagnosed with CJD.
Case 1: 56 M with 4-month history of dizziness and memory decline. Collateral History revealed development of slow speech, expressive dysphasia and rapid progression. MRI Head showed widespread FLAIR high signal and diffusion restriction. CSF analysis was diagnostic for CJD.

Case 2: 75 F with few weeks' history of worsening confusion, short-term memory decline, change in personality, hallucinations and increasing dependence. MRI Head showed abnormal diffusion and cortical diffusion high signal within the insular cortices bilaterally. CSF sample was normal. A clinical diagnosis of CJD was made.

Case 3: 68F with 2-4 weeks' history of decorticate posturing, issues with lexical fluency, verbal apraxia, fluctuations in behaviour and visual hallucinations. MRI Head showed new restricted diffusion in left middle frontal gyrus cortex and the right cerebral hemisphere. Lumbar Puncture was negative. Diagnosed as Sporadic CJD.

Case 4: 79 F with 2-3 months' history of struggling with personal care, with acute decline over 3 weeks. Collateral history noted rapid progression of symptoms which included increasing ataxia, emotional lability and word finding difficulty. CSF analysis was diagnostic for CJD.

Conclusion: These cases highlight the importance of obtaining a detailed collateral history and consideration of alternative diagnoses to dementia or delirium in patients who present with cognitive decline as part of rapidly progressive neurodegenerative disease.

POSTER

3139. Scientific Presentation - Other medical condition

DO PREOPERATIVE ECG ABNORMALITY AT PRE-ASSESSMENT PREDICT CARDIAC COMPLICATIONS IN PATIENTS UNDERGOING MAJOR NON-CARDIAC SURGERY

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Background: Cardiovascular complications are one of the most common causes of morbidity and mortality perioperatively during non-cardiac surgery. This risk is significantly increased in those ≥65 and those who are frail. NICE and ESC both recommend that all patients ≥65 have a pre-operative ECG to assess each patient's risk of perioperative cardiovascular complications before any intermediate or high-risk surgery. This study aims to assess the risk of perioperative cardiovascular complications in those ≥65 with abnormal ECGs.

Methods: We analysed data from patients attending our combined Geriatrician and Anaesthetist run pre-operative assessment clinic for elective colorectal cancer resections between 23/09/2021 - 11/09/2023. All patients were aged ≥65, those who then underwent surgery had their pre-operative ECGs assessed for abnormalities including; New AF, LBBB, RBBB, LAD, Heart block, ectopics, ST depression, and T wave Inversion. There were no patients with episodes of non-sustained VT or long QT intervals, two categories ordinarily considered higher risk for complications. The discharge letters, operation notes, and any post-operative cardiology letters were then assessed for any perioperative/post-operative cardiac complications including myocardial infarction, cardiac arrest, acute heart failure, and established new arrhythmias.

Results: 140 patients between 23/09/2021 and 11/09/2023 underwent elective colorectal resection. 56 of these patients had abnormal pre-operative ECGs (40%) with; New AF (2), LBBB (3), RBBB (16), LAD (15), Heart block (6), Ectopics (7), ST depression (3), and T-wave Inversion (4). On assessment, none of these patients had any perioperative or postoperative cardiac complications.

Conclusion: Our study suggests pre-operative ECGs alone were not predictive of perioperative/ post-operative cardiac complications in patients undergoing elective colorectal resection for cancer. All of the patients were managed by perioperative Geriatricians without the need of further onward referrals to Cardiology, suggesting a perioperative cost saving.

POSTER

3123. Scientific Presentation - Parkinson's Disease

DAILY FLUID INTAKE IS REDUCED IN PEOPLE WITH EARLY PARKINSON'S DISEASE COMPARED WITH CONTROLS

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Background: Parkinson's disease (PD) is an age-related neurodegenerative condition with a range of motor and non-motor symptoms. Early non-motor symptoms include constipation and orthostatic hypotension, while dysphagia is common in established PD. Previous work by our group showed that many people lose weight within a year of diagnosis. This study explored if fluid intake was also reduced in people with newly diagnosed PD.

Materials and methods: We invited people with newly diagnosed PD (within six months of a diagnosis or longer if not requiring treatment) to join the study. Controls were household members of the participants with Parkinson's disease. Participants undertook a number of assessments, including a 24-hour dietary recall, a video-recorded swallowing assessment, and grading of stool sample consistency using the Bristol Stool Chart.

Results: We recruited 30 participants, 19 with newly diagnosed PD and 11 household controls. People living with PD reported significantly lower fluid intake from drinks (control median = 1799 mL, PD median = 1124 mL, p=0.005 for difference in medians). The difference was not compensated for by fluid intake from elsewhere in the diet. People with PD drank fluid slightly slower than the controls, 6.0 mL/second vs 7.5 mL/second, but this did not reach statistical significance. Participants with PD had significantly harder stools than controls, with a mean Bristol Stool Chart number of 3.2 vs 4.6 for controls (p=0.01).

Conclusion: Newly diagnosed PD is associated with significantly reduced intake of fluids from beverages, which may contribute to constipation and orthostatic hypotension.

POSTER

3205. Scientific Presentation - Pharmacology

POLYPHARMACY AND QUALITY OF LIFE IN OLDER PEOPLE: WHERE DO WE STAND? A NARRATIVE REVIEW

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Introduction: Health affects older people's quality of life (QoL). Those experiencing health decline often require multiple medications (polypharmacy). This narrative review aims to explore the effect polypharmacy has on QoL and health-related QoL (HRQoL). We also wished to determine the QoL/HRQoL measurement tools employed and polypharmacy definitions used in included studies.

Method: Searches were carried out primarily in MEDLINE and EMBASE. Publication databases for The Irish Longitudinal Study on Ageing (TILDA) and the English Longitudinal Study of Ageing (ELSA) were also searched. Search terms such as "polypharmacy", "older person", "health-related quality of life" and "quality of life" were used. Primary or secondary research articles investigating the association between polypharmacy and QoL/HRQoL, including qualitative studies, QoL/HRQOL tool development studies, and randomised controlled trials investigating the number of medications and QoL/HRQoL as outcomes were included. Screening and data extraction were undertaken by one reviewer and a narrative synthesis conducted.

Results: In total, 55 articles were included. The key finding of this review was the heterogeneity of the effect of polypharmacy on QoL/HRQoL, ranging from no association to a significant negative clinical association. Considerable variation was seen in the number of QoL/HRQoL measurement tools and polypharmacy definitions used. Qualitative studies highlighted factors which were perceived to impact QoL/HRQoL, including the relationship between patients and healthcare providers, clear benefit of medication and commitment to everyday medication management. These findings highlight the difficulty in interpreting the true impact of polypharmacy on QoL/HRQoL.

Conclusion(s): In qualitative research, patients highlight the negative impact of polypharmacy on QoL; however, this isn't always reflected in quantitative research. The range of differing associations could be due to the responsiveness of the tools used, populations studied, or the nature of the relationship between polypharmacy and QoL, which is likely intertwined bidirectionally with many contributing and confounding factors.

POSTER

3169. Scientific Presentation - Psychiatry and Mental Health

PRIORITIES FOR IRISH RESEARCH INTO LONELINESS AMONG OLDER PEOPLE: RESULTS OF A ROUNDTABLE DISCUSSION

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Background: Ireland has the highest rates of loneliness among EU countries, with those aged 80+ particularly vulnerable. Loneliness is a significant risk factor for various negative health outcomes. To address this, the Loneliness Research Network (LTRN) was established in November 2022 to ensure policy recommendations from Ireland's national Loneliness Taskforce are informed by robust research. The LTRN's first initiative aimed to identify research priorities, particularly in gerontology, to guide the future of loneliness research in Ireland.

Method: The study was conducted in two phases. Phase 1 involved a roundtable event in April 2024, attended by approximately 50 stakeholders, including NGOs, health professionals, individuals with lived experience, academics, private sector representatives, and government officials. Discussions at seven tables covered various loneliness research topics, with two tables focusing on loneliness in older adults. In Phase 2, LTRN members ranked 5–12 research priorities across different topics.

Results: The roundtable revealed diverse priorities, with limited overlap between outputs. Older adults were identified as a key group for research. Priorities included:

- Exploring the impacts of financial challenges in later life (e.g., rising living costs, housing insecurity) on loneliness.
- Developing a "universal toolkit" or service directory based on evidence of effective loneliness interventions.
- Understanding emotional or existential loneliness that persists despite social engagement improvements.

Conclusion: This study underscores loneliness as a critical issue in Ireland, highlighting the need for targeted research across demographics and contexts. The findings will inform the National Loneliness Taskforce's efforts to develop, fund, and implement a cross-Government national strategy to reduce loneliness.

POSTER

3142. Scientific Presentation - Planned and ongoing trials

DEVELOPMENT OF TOOLS AND CRITERIA TO SELECT AND PRIORITISE CANDIDATE INTERVENTIONS FOR EARLY-PHASE SARCOPENIA CLINICAL TRIALS

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Background: Recent advances in skeletal muscle biology have identified multiple potential candidate therapeutic interventions for sarcopenia. A systematic approach is needed to prioritise the most promising interventions for early-phase clinical studies.

Methods: A multidisciplinary team with expertise in sarcopenia, early-phase clinical trials, and geriatric medicine sought to identify target product profile (TPP) and intervention selection tools for neuromuscular conditions. As none were identified for sarcopenia, the group then developed a sarcopenia TPP. An algorithm was created to select interventions most suitable for early-phase trials, combining "stop/go" criteria and traffic-light ratings. The tool was tested by evaluating outputs from a recent horizon scan and was adapted iteratively based on the findings.

Results: Key characteristics of an effective intervention for sarcopenia, as outlined by the Therapeutic Product Profile (TPP), include:

- Improving strength and/or physical performance.
- Safety for adults aged 65 and over.
- Mild, reversible, infrequent, and/or transient side effects only.
- Oral or intranasal administration twice a day or less; injectable forms once a month or less.
- Minimal or no laboratory monitoring required.
- No need for cold chain storage.

The selection algorithm starts with two questions: “Is the drug contraindicated for older adults?” and “Is there already a Phase 2/3 clinical trial evaluating this or similar agents for sarcopenia?” The assessment considers evidence strength, mechanism of action, effective dose, safety in older adults, administration route and frequency, side effects, patent status, and availability. Examples of interventions include Alverine citrate (deprioritised as it is contraindicated in older adults), melatonin (prioritised for its safety and plausible mechanism), and angiotensin-receptor blockers (deprioritised due to previous Phase II testing).

Conclusions: The TPP and intervention selection tool show promise in enabling systematic evaluation of candidate sarcopenia interventions. They will now be used to select and prioritise interventions for future trials.

AUTHORS' INDEX