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Improving healthcare for older people

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Book of Abstracts

Contents

1091. OLDER PERSONS ASSESSMENT SERVICE (OPAS): DELIVERING COMPREHENSIVE GERIATRIC ASSESSMENT (CGA) IN THE EMERGENCY DEPARTMENT (ED) 3

A. BURGESS; E.A.DAVIES; D.J BURBERRY; C.J.BEYNON HOWELLS; P.QUINN; L.JAMES;C.HOPKINS; D.CLEE; A. MDHLONGWA; D.A.DAVIES 3

1106. Effect of COVID-19 on hip fracture care in Wales – an analysis of how organisation of services affected hospital length of stay 5

Abigail Probert 5

1105. Introduction of a Surgical Older Persons Assessment Service (SOPAS) in a large regional centre 6

A Venkatesh; A Burgess; DJ Burberry; EA Davies 6

1099. CWTCH in the community - Improving education to reduce adverse outcomes for patients who fall in Nursing Homes (NH). 7

A.J. Burgess 1; D Clee 1; E.A. Davies 1; D.J. Burberry 1; L. Keen 2 7

1108. Communication, Connection and Care: Cardiff Community Resource Team (CRT) Remote-Working Experience during the Covid-19 Pandemic 9

JE Lewis1; A Probert1; A Ferris1; S White2 and J Butler1,3 9

1096. Multimorbidity, Frailty and Cardio Pulmonary Resuscitation Outcomes in the Covid era 11

ELIN HELEDD THOMAS; ALED RHYS LLOYD; JULIA SCAIFE; NICKY LEOPOLD 11

1097. A QI project looking at the prescription of osteoporosis secondary prevention medications following a hip fracture 13

G Davies; S Gerrie 13

1098. Improving the Recognition of Frailty at the Front Door 15

N Thompson1; E De Rosa1; J Boylan1; R Marsh1 15

1101. Evaluation of frailty documentation pre and during the COVID-19 pandemic in a large regional centre 17

A Venkatesh; DJ Burberry; EA Davies; A Ansar, S Aye, E Mwendwa 17

1102 An Evaluation of a Geriatrician-Led Acute Medical Admission Unit at Morriston Hospital, Swansea 19

A Yusoff; E A Davies; D J Burberry; N Jones; C Walters; C Beynon Howells; D Davies; P Quinn 19

1107. Admission avoidance in the frail population - use of an urgent clinic 21

D Allen1; A Probert1; D Gyimah2 21

1109. Chronic Kidney Disease ; Audit of NICE guideline compliance in medical inpatients in a DGH 22

K James ; A James ; C Roberts ; A Young 22

CQ - Clinical Quality - CQ - Efficiency and Value for Money
[Platform Presentation]

1091. OLDER PERSONS ASSESSMENT SERVICE (OPAS): DELIVERING COMPREHENSIVE GERIATRIC ASSESSMENT (CGA) IN THE EMERGENCY DEPARTMENT (ED)

A. BURGESS; E.A.DAVIES; D.J BURBERRY; C.J.BEYNON HOWELLS; P.QUINN; L.JAMES;C.HOPKINS; D.CLEE; A. MDHLONGWA; D.A.DAVIES

Older Persons Assessment Service , Morriston Hospital, Swansea Bay University Health Board.

Method
Phase 1
In 2018, the Older Persons Assessment Service began a liaison service to ED, taking referrals from medical and ED teams for patients who presented with frailty syndromes (falls, cognitive impairment, care dependence, polypharmacy). The service saw 437 patients April - August 2018. 76% of the patients assessed were discharged by utilising available community services, rapid access outpatient follow up and inpatient reablement off the acute site. The service was estimated to avoid 50-80 admissions per month to medicine and was commissioned as a permanent service.

Phase 2
In 2020, a dedicated unit within ED was allocated to OPAS, enabling the acceptance of patients directly from triage and from the Ambulance Service. This provided rapid access to specialist assessment, continued access to Elderly Care services, avoided exposure to coronavirus related admissions and the risks of nosocomial infection associated with admission. The service operated from 8am-4pm on weekdays.

Results
Between June 2020 - December 2021, the service saw 1302 patients (950 presenting with falls). 1087 patients (83.4%) were discharged from Morriston on the day of assessment. The average age of an OPAS patient was 83yrs and had a CFS > 5. Readmission rate at 14 days was 5% (55).

Conclusion
This service demonstrates the ability of services that provide CGA in ED to avoid hospital admissions and readmissions. The team has secured investment and functions 7am-7pm on weekdays, with plans for future weekend working.

OLDER PERSON'S ASSESSMENT SERVICE (OPAS): DELIVERING COMPREHENSIVE GERIATRIC ASSESSMENT (CGA) IN THE EMERGENCY DEPARTMENT (ED)

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

A.J. Burgess; E.A. Davies; C.J Beynon-Howells; P. Quinn; D.J. Burberry; L. James; C. Hopkins; A. Mdhlongwa; D.A. Davies; D. Clee.
Morriston Hospital, Swansea Bay University Health Board

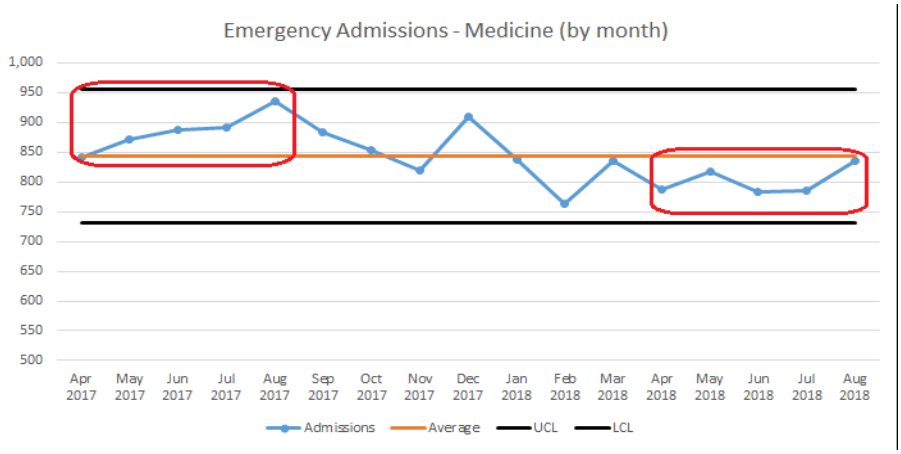
Introduction

Innovative models of service delivery are required to provide Comprehensive Geriatric Assessment for older patients presenting to the Emergency Department (ED) with frailty syndromes. Out of 139,636 attendances to ED at Morriston Hospital Swansea in 2020-2021, 3906 were due to falls in patients > 65yrs. In patients >80yrs 41.64% of these converted to admission 2018-20, readmissions to ED occurred in 24%.

Intervention

Phase 1- In 2018, OAPS began a liaison service to the ED, taking referrals from the medical and ED teams for patients who presented with frailty syndromes (falls, cognitive impairment, care dependence, polypharmacy). The OPAS team consisted of a physio, Clinical Nurse Specialist (CNS) and Advanced Nurse Practitioner (ANP) linking with the existing ED Occupational Therapy (OT) service and with a consultant Geriatrician. The service saw 437 patients April - August 2018. 76% of the patients assessed were discharged by utilising available community services, rapid access OP follow up and inpatient re-ablement off the acute site. The service was estimated to avoid 50-80 admissions per month to medicine Image 1 & Table 1 (saving 17- 23 beds a year) and was commissioned as a permanent service.

Phase 2 -A dedicated unit on the ED footprint was allocated. In 2020, a dedicated unit within ED was allocated to OPAS, enabling the acceptance of patients directly from either triage and from the Ambulance Service. This provided rapid access to specialist assessment, continued access to Elderly Care services, avoided exposure to coronavirus related admissions and the risks of nosocomial infection associated with admission. The service operated from 8am-4pm on weekdays. The OPAS team consisted of a physio, OT, CNS and ANP with a consultant Geriatrician.



Results

Between June 2020 and December 2021, the service saw 1302 new patients (950 presenting with falls). 1087 patients (83.4%) were discharged off the acute site on the day of assessment. 69 (5.29%) patients were admitted to other facilities run by the Health Board (e.g. Inpatient Re-ablement). The average age of an OPAS patient was 83yrs and had a CFS > 5. Readmission rate at 14 days was 5% (55). Of the 284 patients who were admitted to an inpatient setting, 12.3% (35) contracted nosocomial Covid-19. Since 2021, the conversion to admission via A&E has fallen to 37.68% (41.38% in 2017 pre OPAS).

	Apr	May	Jun	Jul	Aug
Admissions - 2017	842	871	887	892	936
Admissions - 2018	788	817	784	786	835
Dif +/-	-54	-54	-103	-106	-101
OPAS Admission Avoidance	16	51	49	84	54

Conclusion

This service demonstrates the ability of consultant-led MDT services that provide comprehensive geriatric assessment in the Emergency Department to avoid hospital admissions and readmissions. This study has been able to demonstrate a greater measurable impact on these service metrics than has been previously published[1-3]. The team has secured investment and now functions 7am-7pm on weekdays, with plans for future weekend working. The team has expanded with a ENP, Frailty CNS and from August 2022, will have a Research SCF.

References
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2.Conroy SP, Ansari K, Williams M, et al. A controlled evaluation of comprehensive geriatric assessment in the emergency department: The Emergency Frailty Unit. Age and Ageing. 2014;43(1):109-114.
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1106. Effect of COVID-19 on hip fracture care in Wales – an analysis of how organisation of services affected hospital length of stay

Abigail Probert

University Hospital of Wales

Introduction
The National Hip Fracture Database (NHFD) report that length of stay (LOS) fell (from 19.7 to 16.9 days) in the first year of the COVID-19 pandemic, as patients, families, cares, and staff in health and social care responded to this challenge. This analysis examines trends in Wales where LOS can be profiled very completely as it predominantly remains within a single health board.

Methods
We used data from the NHFD www.nhfd.co.uk to define pre-pandemic LOS (in the year to 1st March 2020) and compare this with the following 18 months. We set figures for all 12 hospitals in Wales against the changes in service organisation which each reported to the NHFD's 2020 Facilities Survey, and against the local incidence of COVID-19 among their hip fracture patients.

Results
Monthly LOS fell markedly at the pandemic's onset; the national figure falling 8.3 days (from 31.2 – 22.9 days) between February and June 2020. Overall LOS in Wales fell by 1.6 days across the year as a whole, but this ranged from a fall of 6.3 days in one hospital to a rise of 4.5 days in another. Five hospitals reported a rise in LOS. These hospitals had either never had orthogeriatric support, or lost this to COVID-19 duties, they did not achieve the initial fall in LOS in response to the pandemic, and they reported pressures with ‘outliers’ after the first wave. Unlike other units in Wales they cited problems with workload, particularly in terms of physiotherapy.

Discussion
NHFD data provide a detailed picture of hospitals’ response to the COVID-19 pandemic, and allow us to examine service factors underpinning their resilience in the face of this challenge. More detailed work should be carried out for the 150 hospitals in England using the same sources of data.

1105. Introduction of a Surgical Older Persons Assessment Service (SOPAS) in a large regional centre

A Venkatesh; A Burgess; DJ Burberry; EA Davies

Morriston Hospital

Introduction
The number of older people undergoing surgery is increasing.[Fowler;BritishJournalofSurgery;2019; 1012–1018] Frailty in this group is associated with higher risk of postoperative morbidity and mortality.[Parmar;AnnalsofSurgery;2021;709–718] Inspired by Shipway's liaison service at North Bristol, we have introduced a Surgical Older Persons Assessment Service (SOPAS) at Morriston.[Shipway;2018;Future Healthcare Journal;108–116]

Method
Prior to the introduction of SOPAS, frailty was not recorded in our surgical population and Clinical Frailty Scale (CFS) was introduced to improve this. SOPAS was developed using QI methodology over multiple PDSA cycles. The service started in April 2021 and accepts electronic referrals from general surgery, vascular, urology, and also proactively screens admissions and at board rounds. We used a bespoke software tool based on the Hospital Frailty Risk Score to analyse general surgical patients for mortality, re-admission rate, and length of stay since SOPAS' introduction.[Gilbert;Lancet;2018; 1775-1782] Those with Covid-19 were excluded.

Results
SOPAS has seen over 300 patients till date. Of these, 203 general surgical patients were identified through the SBUHB Digital Intelligence tool which covered April 2021 to January 2022. This has shown a reduction in mortality of 2.59% and a mean length of stay reduction of 2.83 days compared to April 2020 to January 2021. This equates to a saving of approximately 574 bed days or £109,153.

Conclusions
Introduction of SOPAS at Morriston has led to reductions in mortality and length of stay amongst general surgical patients. This is consistent with previous similar studies and has confirmed a significant cost saving. This data and experience will be used to further develop the service.

CQ - Clinical Quality - CQ - Improved Access to Service [Platform Presentation]

1099. CWTCH in the community - Improving education to reduce adverse outcomes for patients who fall in Nursing Homes (NH).

A.J. Burgess 1; D Clee 1; E.A. Davies 1; D.J. Burberry 1; L. Keen 2

1. Older Person's Assessment Service (OPAS), Morriston Hospital, Swansea Bay University Health Board (SBUHB) 2. Welsh Ambulance Service NHS Trust (WAST).

INTRODUCTION
Falls have significant morbidity and mortality and cause significant harm in NH residents (1). We have proposed that an educational intervention offered to NH will reduce the number of 999 calls and reduce adverse outcomes.

METHODS
Phase 1 WAST calls between 01/01/2020-30/01/2022 from NH in SBUHB concerning Falls and ?Falls (Haemorrhage/lacerations, Unconscious/fainting, traumatic injuries, sick person, convulsions/fitting) were included. A survey was sent out to all SBUHB NH to investigate how staff treated falls. Phase 2 Education was provided to NH about CWTCH (Can we move them?, Will it harm them? (neck pain, back pain), Treat them – pain relief, dressing wounds, Can – eat & drink, Help – when to call 999). We surveyed staff to assess confidence and whether this would change practice.

RESULTS
Phase 1 Out of 4709 calls, 825 were falls (17.52%) and 988 ?Falls (20.98%), 60.49% conveyed to hospital. The survey revealed 47% of NH do not have falls guidelines and 100% patients are Nil by Mouth and 88.24% are not moved. Emergency services were always contacted to attend a fall by 88.24% of respondents. Phase 2 Education was delivered to 7 NH (39 staff). Feedback showed 100% feel more confident in giving food and drink, analgesia and moving patients and found the session helpful with 69.23% less likely to contact 999 with 89.74% having not received prior training.

CONCLUSIONS
Falls remain a significant burden on WAST and the Emergency Department. A rapid falls intervention would be expected to improve care as 39.51% patients remained at scene. Future directions include offering this education package to all NH in SBUHB. From March 2022, OPAS will offer same day assessment for NH residents (and others) via the Acute Primary Care Service and WAST. 1.

CWTCH in the community - Improving education to reduce adverse outcomes for patients who fall in Nursing Homes (NH).

GIG CYMRU NHS WALES
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1. Older Person's Assessment Service (OPAS), Morriston Hospital, Swansea Bay University Health Board (SBUHB)
2. Welsh Ambulance Service NHS Trust (WAST).

Introduction

Falls have significant morbidity and mortality and these are more common and more likely to cause significant harm in Nursing home (NH) residents (1). We have proposed that by improving education to NH staff, we can reduce the amount of 999 calls and reduce adverse patient outcomes. NH residents are also more at risk of further falls as interventions and risk factor modification is more difficult.

Intervention

Phase 1

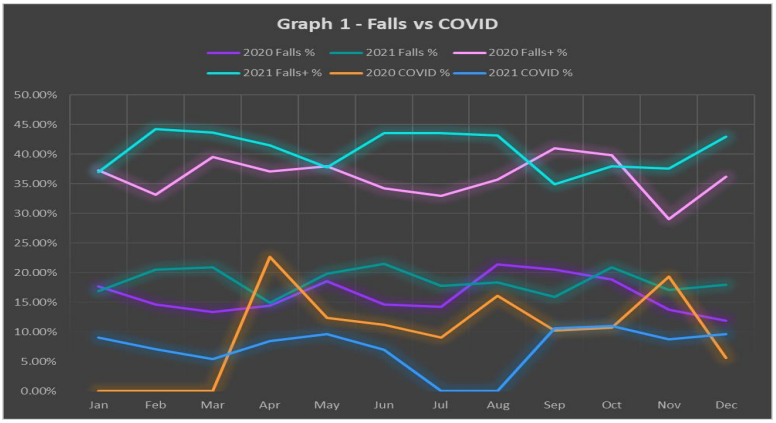
We looked at the NH in Swansea Bay Health Board (Swansea and Neath) and all 999 calls between 1st Jan 2020 to 30th Jan 2022 where an Emergency Ambulance vehicle attended the scene. We looked at all calls coded as Falls and those that could be related to Falls (Sick person, Haemorrhage/lacerations, Unconscious/fainting, trauma injuries, convulsions/fitting). A survey was sent out to all SBUHB NH to see how the staff treated falls.

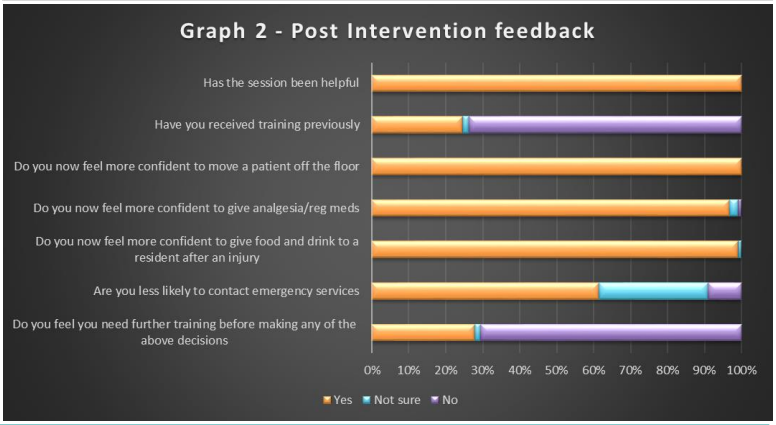
Phase 2

The team prepared an education package delivered to all NH managers and other staff members encouraging staff to consider **CWTCH**

- **C**an we move them
- **W**ill it harm them? (neck pain, back pain),
- **T**reat them – pain relief, dressing wounds
- **C**an – eat & drink
- **H**elp – when to call 999).

A survey was then performed showing whether staff felt more confident post intervention and whether this would change their practice moving forward. The teaching was delivered by an Emergency Nurse Practitioner (ENP) and Specialist Registrar.





Results

Phase 1

In total 4709 calls were made, 825 were coded as falls (17.52%), 988 were potential falls (20.98%). Even over the COVID-19 pandemic the calls for falls were consistently higher than those for COVID-19 (See Graph 1). Of all calls, 60.49% were conveyed to hospital, 13.59% treated at scene, 16.79% referred to GP or alternative services. The survey showed that 47% of NH do not have any guidelines for falls and that patients are often kept Nil by Mouth (53% yes, 47% sometimes) and that 88.24% of fallers are not moved. Emergency services are contacted 88.24% of the time.

Phase 2

Education was delivered to Education was delivered to all NH in Swansea (122 staff). One NH declined any education due to staff shortages. Feedback showed 100% feel more confident in giving food and drink, moving patients and all found the session helpful with 90.98% less likely to contact 999. There is a clear educational need as 75.40% had not received prior training on how to manage residents who fall. Feedback around analgesia shows that 96.72 % feel more confident in giving analgesia but comments from staff felt that this was a potential issue and something that could be improved upon especially regarding PRN analgesia.

Conclusion

Falls remain a significant burden on WAST and the Emergency Department, with opportunity to reduce morbidity and mortality. NH do not have adequate procedures and a rapid falls intervention could have an impact as 39.51% patients remained at scene. Future directions include delivering the education package to all NH in SBUHB.

From March 2022, OPAS at Morriston Hospital will offer same day assessment for NH residents via the Acute Primary Care Service and is collaborating with WAST to provide a rapid response for falls and minor injuries in the community. We are working with local GP's about providing PRN analgesia e.g. PENTHROX for fallers.

1 - Robertson K, Logan P, Ward M, Pollard J, Gordon A, Williams W, et al. Thinking falls – taking action: a falls prevention tool for care homes. British Journal of Community Nursing 2012; 17:5, 206-209

CQ - Clinical Quality - CQ - Patient Centredness [Poster]

1108. Communication, Connection and Care: Cardiff Community Resource Team (CRT) Remote-Working Experience during the Covid-19 Pandemic

JE Lewis1; A Probert1; A Ferris1; S White2 and J Butler1,3

1 Geriatric Medicine, University Hospital of Wales, Cardiff; 2 Geriatric Medicine, University Hospital Llandough, Llandough; 3 Community Resource Team, Whitchurch Hospital, Cardiff

The Covid19 pandemic represents an unprecedented challenge to global health and care services and necessitated a rapid shift towards healthcare being provided remotely.1 A quality improvement project was conducted in Cardiff CRT to improve staff confidence in relation to remote-working to optimise the care of older patients in the community. Objectives: To integrate the use of technology in intermediate care in Cardiff CRT Method A survey was sent to Cardiff CRT staff in May 2020. The plan-do-study-act (PDSA) model was used to implement improvement interventions whilst allowing continuous service delivery.

These included investment in hardware, updated software, a daily team huddle, increased transparency throughout the Multidisciplinary Team and stricter referral criteria. A follow-up survey was conducted in February 2022.

Results
Three key areas for improvement were identified: i) access to resources ii) team communication and iii) access to information. The majority of respondents (62%) had no experience of remote-working prior to the Covid19 pandemic. Now, telephone consultation (50%), video consultation (19%), email (23%) and other technology (8%) are regularly employed. Self-reported confidence has improved in relation to remote-working. Most respondents (56%) reported improved time-management and flexible working (30%) as the primary advantages of remote-working. Isolation from team members (44%) and barriers to communication (44%) were cited as the main disadvantages. 75% of respondents anticipate changing the way they work due to skills learnt during remote-working. Job satisfaction is now lower, however many recognised this was due to pandemic sequelae and other extraneous factors.

Conclusion
• Majority of staff have learnt additional skills and improved confidence in remote-working
• All staff now employ remote-working in Cardiff CRT and most plan to continue post-pandemic
• Further training needs have been identified in the virtual intermediate care setting
• Team communication and isolation remain an issue
• Job satisfaction has declined

1108: Communication, Connection and Care: Cardiff Community Resource Team (CRT) Remote-Working Experience during the Covid-19 Pandemic – Improving Staff Confidence in the Intermediate Care Setting.

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Introduction

The Covid19 pandemic represents an unprecedented challenge to global health and care services. As such, it has necessitated significant changes to working practices with a rapid shift towards more healthcare being provided remotely.1 A quality improvement project was conducted at Cardiff CRT to improve staff confidence in relation to remote working in order to optimise the care of older patients in the community during a period of significant restrictions to services.

Objectives

- To integrate the use of technology in local intermediate care services in Cardiff CRT
- To establish the advantages and disadvantages of remote working in Cardiff CRT
- To evaluate staff confidence in relation to technology and remote working
- To assess staff satisfaction in intermediate care services

Method

A survey was sent to Cardiff CRT staff in May 2020. The plan-do-study-act (PDSA) model was used to implement improvement interventions whilst allowing continuous service delivery. These included:

- Investment in hardware
- Updated software
- A daily team huddle
- Increased transparency throughout the multidisciplinary team (MDT) and
- Stricter referral criteria.

A follow-up survey was conducted in February 2022.

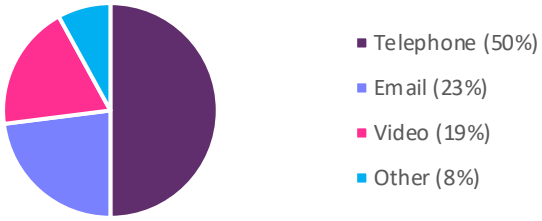
Results

Three key areas for improvement were identified:

i) Access to resources
ii) Team communication and
iii) Access to information.

The majority of respondents (62%) had no experience of remote working prior to the Covid19 pandemic. Now, a variety of virtual remote working technology is regularly employed:

Technology use in CRT (February 2022)



Self-reported confidence has improved in relation to remote working.

Most respondents (56%) reported improved time management and flexible working (30%) as the primary advantages of remote working. Isolation from team members (44%) and barriers to communication (44%) were cited as the main disadvantages. 75% of respondents anticipate changing the way they work due to skills learnt during remote working.

Job satisfaction is now lower, however many recognised that this was due to pandemic sequelae and other extraneous factors.

Conclusions

- Majority of staff have learnt additional skills and improved confidence in remote working
- All staff now employ remote working in Cardiff CRT and most plan to continue post-pandemic
- Further training needs have been identified in the virtual intermediate care setting
- Team communication and isolation remain an issue
- Job satisfaction has declined during the pandemic

Reference
[1] Nuffield Trust

Disclosure of Interest
None

Key Words
Covid19; Frailty; Older People; Community; Intermediate Care; Technology; Quality Improvement

SP - Scientific Presentation - SP - Cardio (Cardiovascular) [Poster]

1096. Multimorbidity, Frailty and Cardio Pulmonary Resuscitation Outcomes in the Covid era

ELIN HELEDD THOMAS; ALED RHYS LLOYD; JULIA SCAIFE; NICKY LEOPOLD

Swansea Bay University Healthboard

The SARS-COV2 heightened the need to identify frail people and those with multi-morbidity and establish early ceilings of treatment. Resuscitation guidelines changed as cardiopulmonary resuscitation (CPR) was classified an aerosol generating procedure (AGP). We assessed the impact of these changes in our tertiary centre with respect to CPR outcomes. We compared our data with a pre-pandemic study following the same methodology.

Methods A retrospective analysis of prospectively collected data from contemporaneous clinical notes and electronic records for all patients with a recorded cardiac arrest between June 2020 and June 2021. Data was collected on features of the cardiac arrest, clinical frailty scale (CFS), Charlson comorbidity index (CCI), survival at discharge, 30 days and 6 months. The comparator was our previously published cohort between April 2017 to March 2018.

Results Many fewer episodes of CPR since COVID with almost a 50% reduction in total events. ROSC observed in 66.67% with 35.7% of patients surviving to discharge in 2020-2021 compared to 62.0% ROSC and 25% survival to discharge in 2017-2018. 40.4% of arrests in 2020-2021 presented in a shockable rhythm compared to 24.8% in 2017-2018. Among the 2020-2021 cohort, 23.6% of patients had a CFS greater or equal to 5 compared to 43.8% in 2017-2018. In 2017-2018, 83.3% of patients had a CCI of greater or equal to 4, this was 64.2% for 2020-2021.

Discussion There was a dramatic reduction in cardiac arrest events on medical and surgical wards with little change in arrests within the cardiology department. The improvement in survival rate observed in this study is multifactorial but likely includes a less frail and comorbid population and a higher proportion of cardiac arrests in a shockable rhythm.

Conclusion CPR outcomes improved due to better patient selection. No evidence to show COVID ALS guidelines affect outcomes.

Multimorbidity, Frailty and Cardio Pulmonary Resuscitation Outcomes in the Covid era

Elin Thomas, Aled Lloyd, Julia Scaife, Nicky Leopold
Swansea Bay University Health Board

Introduction

- SARS-CoV-2 heightened the need to establish early ceilings of treatment
- Resuscitation guidelines changed as cardiopulmonary resuscitation (CPR) was classified an aerosol generating procedure (AGP)
- Data compared to pre-pandemic study results[1]

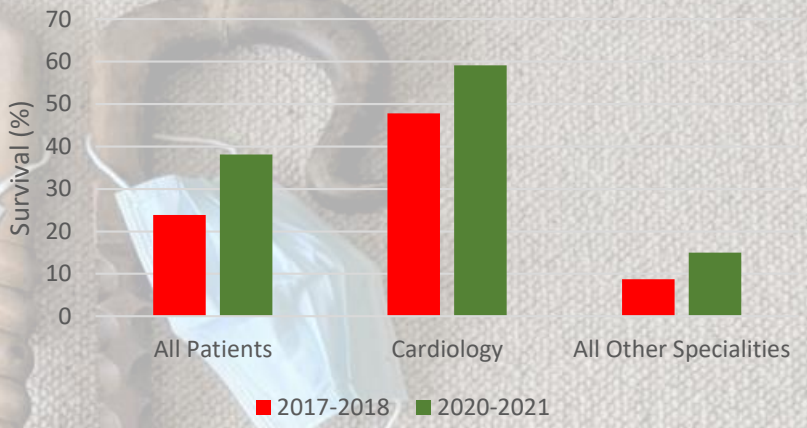
Methodology

- Retrospective analysis of prospectively collected data from contemporaneous clinical notes and electronic records for all patients with a recorded cardiac arrest between June 2020 and June 2021.
- The comparator was our previously published cohort between April 2017 to March 2018..

Results

- Almost 50% reduction in total numbers of CPR performed
- Improved rates of return of spontaneous circulation (ROSC) and discharge
- Fewer frail patients treated with CPR
- Improved survival rates during pandemic

Comparison of CPR Survival pre and during COVID

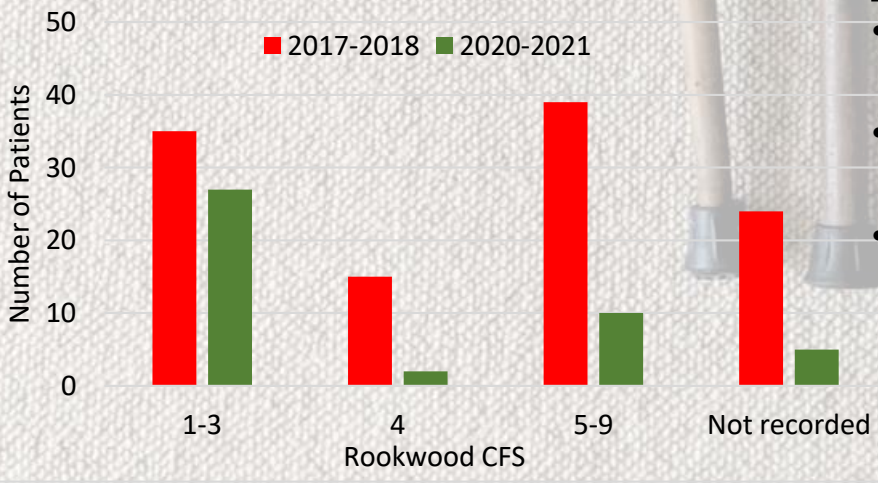


	Pre-COVID 2017-2018	COVID 2020-2021
ROSC	62%	66.67%
Survival to discharge	25%	35.70%
Shockable rhythm	24.80%	40.40%

Discussion

- Significant reduction in cardiac arrest events on medical and surgical wards with little change in arrests within the cardiology department
- Improved survival rate is multifactorial but likely includes a less frail and comorbid population and a higher proportion of cardiac arrests in a shockable rhythm

Number of patients receiving CPR by Frailty



Conclusion

- CPR outcomes improved due to improved patient selection
- No harm from additional emphasis on advanced care planning
- No evidence to show COVID ALS guidelines adversely affect outcomes

References
Frailty, multimorbidity and in-hospital cardiopulmonary resuscitation: predictable markers of outcome?; E Thomas, A Lloyd and N Leopold; Clin Med July 2021; vol. 21 no. 4

SP - Scientific Presentation - SP - BMR (Bone, Muscle, Rheumatology) [Poster]

1097. A QI project looking at the prescription of osteoporosis secondary prevention medications following a hip fracture

G Davies; S Gerrie

Care of the Elderly Department, Wrexham Maelor Hospital

A quality improvement project looking at the prescription of osteoporosis secondary prevention medications following a hip fracture G Davies; S Gerrie Care of the Elderly Department, Wrexham Maelor Hospital Introduction: There are well established guidelines for the management of older patients with clinically apparent osteoporotic fractures, both locally and nationally. This quality improvement project looks at our compliance with these guidelines amongst patients being admitted with a fractured neck of femur, and aims to improve our prescribing of osteoporosis secondary prevention medications.

Method; Round one evaluated patients admitted to Wrexham Maelor Hospital following a hip fracture between May and July 2021. Patients were identified via the National Hip Fracture Database (NHFD). Patient who were deceased were excluded. Electronic discharge notes were examined to ascertain the relevant information. Interventions included education, bone health assessment stickers and laminated information sheets on the orthopaedic ward. A re-audit was performed from November to January 2022.

Results; In round one, 19% of patients were discharged on bisphosphonates following a hip fracture. This improved to 46% following round 2, bringing us in line with national figures. On sub-group analysis particular improvements were seen in prescriptions of bisphosphonates for the groups that did not require a DEXA scan; females over the age of 75 (from 36% to 85%) and males over the age of 85 (from 20% to 50%).

Conclusions; The interventions have proven to be effective in improving the number of patients being discharged on osteoporosis secondary prevention medications. However, there are limitations in that this does not look at reasons why patients may not be given bisphosphonates. In addition, this study only looks at patients following a hip fracture. In future, such interventions should apply to all patients sustaining a clinically apparent osteoporotic fracture and should be co-ordinated through a local fracture liaison service.

THE PRESCRIPTION OF OSTEOPOROSIS SECONDARY PREVENTION MEDICATIONS FOLLOWING A HIP FRACTURE

Glesni Davies, Specialty Registrar, Sara Gerrie, Consultant Physician,

Department of Geriatric Medicine, Wrexham Maelor Hospital

Introduction

There are well established guidelines for the management of older patients with clinically apparent osteoporotic fractures, both locally and nationally. As per our health board's guidelines, following a fragility fracture females over the age of 75 and males over the 85 should be commenced on bisphosphonate therapy (unless contraindicated) without requiring any further imaging such as a DEXA scan.

This quality improvement project looks at our compliance with these guidelines amongst patients being admitted with a fractured neck of femur, and aims to improve our prescribing of osteoporosis secondary prevention medications.

Method

Round one evaluated patients admitted to Wrexham Maelor Hospital following a hip fracture between May and July 2021. Patients were identified via the National Hip Fracture Database (NHFD). Patients who were deceased were excluded. Electronic discharge notes were used in conjunction with data from the NHFD to ascertain the relevant information.

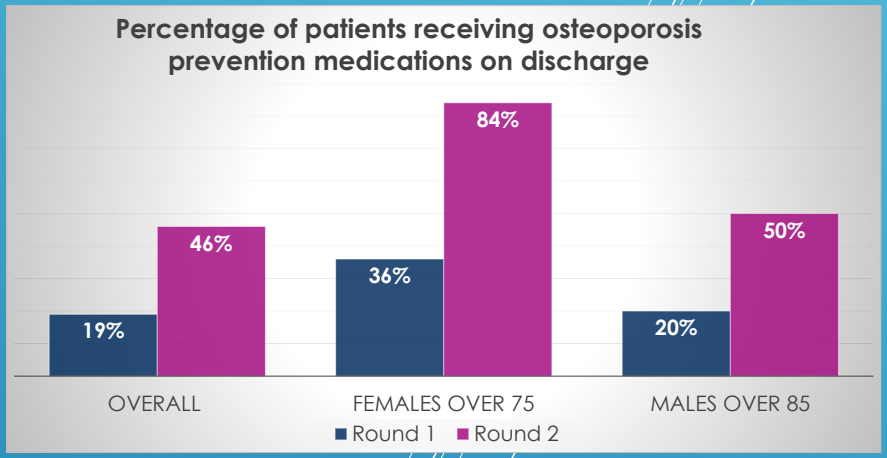
Following this, bone health assessment stickers were introduced and laminated information sheets were distributed on the orthopaedic ward. A re-audit was performed looking at patients from November to January 2022.

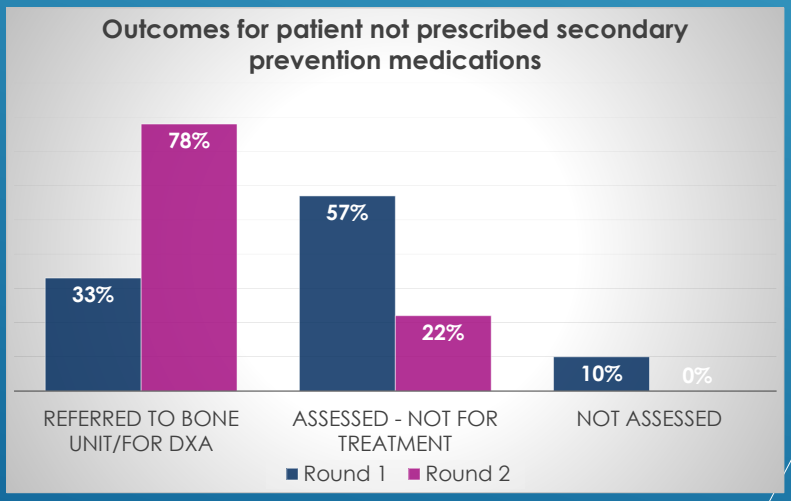
Results

In round one, 19% of all patients were discharged on bisphosphonates following a hip fracture. This improved to 46% following round 2, bringing us in line with national figures.

On sub-group analysis, particular improvements were seen in prescriptions of bisphosphonates for the two groups that do not require a confirmatory DEXA scan; for females over the age of 75 (from 36% to 85%) and males over the age of 85 (from 20% to 50%).

In addition, all patients in round 2 received a bone health assessment and there was a higher number being referred to the bone unit (from 33% to 78%).





Discussion

The interventions have proven to be effective in improving the number of patients receiving a bone health assessment, being prescribed osteoporosis secondary prevention medications and being referred to the bone unit. However, there are limitations in that this does not look specifically at reasons why patients may not be given bisphosphonates.

At our site the bone health assessments for patients following a hip fracture are primarily done by geriatricians. However, there is a large group of patients who sustain (non-hip) fractures where there is a potential opportunity to intervene and prevent hip fractures. No service currently exists locally to ensure such patients receive a bone health assessment.

Conclusions

The introduction of a bone health assessment sticker has been effective in improving the number of patients receiving a bone health assessment and being discharged on secondary prevention medications following a hip fracture.

In future all patients sustaining clinically apparent osteoporotic fracture should receive a bone health assessment, and this should be co-ordinated through a dedicated fracture liaison service.

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CQ - Clinical Quality - CQ - Patient Centredness [Poster]

1098. Improving the Recognition of Frailty at the Front Door

N Thompson1; E De Rosa1; J Boylan1; R Marsh1

1. Department of Geriatric Medicine, University Hospital Llandough, Penarth, Cardiff, UK

Introduction
Frailty is a state whereby there is increased vulnerability to adverse health outcomes following stressor events. NICE outlines the importance of identifying and grading frailty using the Clinical Frailty Scale (CFS). We conducted a Quality Improvement Project aiming to increase the number of CFS scores being completed in our Medical Emergency Assessment Unit(MEAU), to identify those who may benefit from a Frailty Team review and Comprehensive Geriatric Assessment.

Method
We calculated the number of patients that had CFS scores recorded on assessment in MEAU over two months, by using Business Intelligence System which logs scores uploaded to our workstation. Inclusion criteria was all over 65-year-olds admitted for at least one night. Exclusion criteria was those with a learning disability/stable long-term disability. Our first-round intervention was providing teaching to MEAU nursing staff on how to use CFS and record scores. Our second-round intervention was a Frailty Awareness Week. This consisted of ad-hoc teaching plus posters reminding staff of the importance of CFS scoring. The posters also included QR links to online CFS training resources. After each intervention we calculated the number of CFS scores recorded over a two-month period.

Results
Following first-round intervention, there was no improvement in the uptake of CFS scoring. Following second-round intervention, disappointingly, there was again no significant increase in the uptake of CFS scoring.

Conclusion
Our project demonstrates that initiating change within healthcare systems can sometimes be challenging. It can take time and perseverance. Our project highlights the benefit of QIP; changes are tested on a small scale and if an intervention has not worked, an alternative can be tested in the next PDSA cycle. Moving forward, we will survey nursing staff to feedback barriers they faced with CFS scoring, to identify issues that need addressing and to formulate a plan for our next intervention.

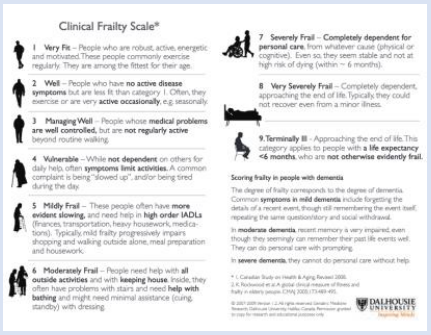
Improving Recognition of Frailty at the Front Door

N Thompson; E De Rosa; J Boylan; R Marsh
Department of Geriatric Medicine, University Hospital Llandough, Penarth, Cardiff, UK

Introduction

Frailty is a state whereby there is increased vulnerability to adverse health outcomes following stressor events. NICE outlines the importance of identifying and grading frailty using the Clinical Frailty Scale (CFS) (figure 1). We conducted a Quality Improvement Project aiming to increase the number of CFS scores being completed in our Medical Emergency Assessment Unit (MEAU), to identify those who may benefit from an Acute Frailty Team review and a Comprehensive Geriatric Assessment. Our initial aim was for 90% of eligible patients to have a CFS score recorded.

Figure 1:



Method (see figure 2)

We calculated the number of patients that had CFS scores recorded on assessment in MEAU over two months, by using a Business Intelligence System which logs scores uploaded to our workstation. Inclusion criteria was all over 65-year-olds admitted for at least one night. Exclusion criteria was those with a learning disability/stable long-term disability. Our first-round intervention was providing teaching to MEAU nursing staff on how to use CFS and how to record scores. Our second-round intervention was a Frailty Awareness Week, which consisted of ad-hoc teaching. As part of this we created posters (figure 3), which were displayed around the department, reminding staff of the importance of CFS scoring. The posters also included QR links to online CFS training resources. After each intervention we calculated the number of CFS scores recorded over a two-month period.

Figure 2:

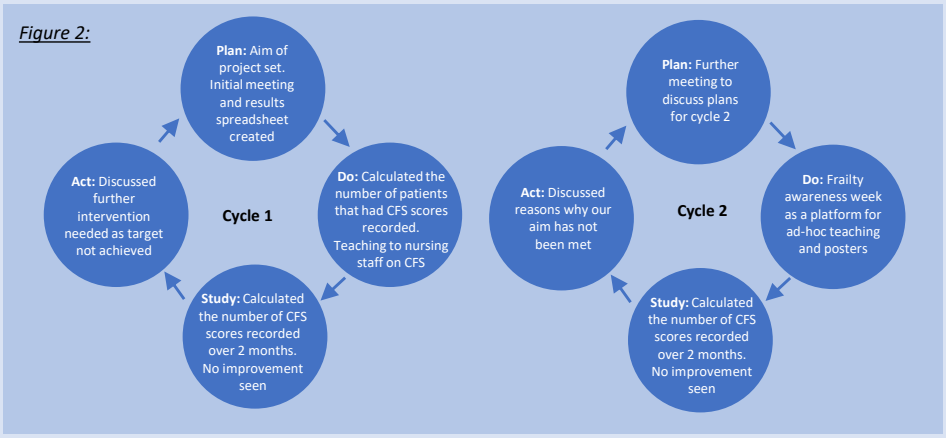
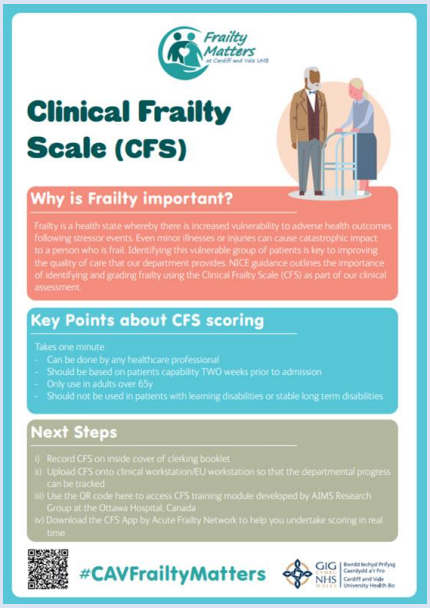


Figure 3:



Results

Following our first-round intervention, there was no improvement in the uptake of CFS scoring. Following our second-round intervention, disappointingly, there was again no significant increase in the uptake of CFS scoring. We remained far from reaching our target of achieving CFS scores for at least 90% of eligible patients.

Conclusion

Neither of our interventions, which both highlighted the importance of CFS scoring, were enough to increase the uptake of CFS scoring by nursing staff in our Medical Emergency Admissions Unit.

Further Thoughts

Our project demonstrates that initiating change within healthcare systems can sometimes be challenging. It can take time and perseverance. This study highlights the benefit of QIP; changes are tested on a small scale in a timely fashion and if an intervention has not had the desired impact, we can think about why this might be the case and an alternative can be tested in the next PDSA cycle.

Moving forward, we will firstly survey nursing staff to feedback barriers they faced with CFS scoring. This will help us to identify issues that need addressing and to formulate a plan for our next intervention.

CQ - Clinical Quality - CQ - Clinical Effectiveness [Poster]

1101. Evaluation of frailty documentation pre and during the COVID-19 pandemic in a large regional centre

A Venkatesh; DJ Burberry; EA Davies; A Ansar, S Aye, E Mwendwa

Morriston Hospital

Background
Identifying frailty can lead to improvements in patient outcomes through interventions such as CGA and prompt discussions around resuscitation and ACP.[Welsh;InternationalJournalofClinicalPractice;2014;290-293] Frailty is associated with a higher risk of postoperative mortality and morbidity, and mortality due to COVID-19.[Parmar;AnnalsofSurgery;2021;709-718, Dumitrascu;JournalofAmericanGeriatricsSociety;2021;2419-2429] Our audit considers whether the pandemic had any effect on documentation of frailty, and identifies interventions to improve this process.

Methods
We retrospectively reviewed notes to look for elements of social history which identify frailty including mobility, ADLs, and CFS. We conducted a series of spot audits in February 2020 (pre-pandemic), April 2021 (Wave 2), and November 2021 (Wave 3) across surgical and medical wards. Interventions and results February 2020 This cohort consisted of 62 patients and showed poor documentation across both medicine and surgery with an average of only 21% relevant social history recorded and 0% CFS scoring. Interventions that followed included an educational series by geriatricians and introduction of triaging tools based on CFS in response to the pandemic e.g. Swansea Hip interrogation Fracture Tool(SHiFT).[Cronin;BritishOrthopaedicAssociation;2020] April 2021 The relevant documentation improved to an average of 31% in this cohort of 37 patients. Interventions that followed included further educational sessions on frailty, a surgical liaison service, and the appointment of an orthogeriatrician. November 2021 This cohort consisted of 149 patients, average relevant social history continued to improve to 49%. Subgroup analysis showed 76% of orthopaedics patients had a CFS score, including 100% of NOF patients.

Conclusions
Frailty is important as it is linked to an increased risk of mortality and morbidity. In the pre-pandemic cohort, the results were poor. Improvements were seen after interventions such as educational sessions, pandemic triaging tools, and the surgical liaison service. However, there are still inconsistencies between teams. Future interventions include a CFS app, expansion of the surgical liaison service, and improved proformas.

Evaluation of frailty documentation pre and during the COVID-19 pandemic in a large regional centre

Ashwin Venkatesh; David Burberry; Elizabeth Davies; Aisha Ansar; Su Aye; Ennan Mwendwa

Introduction Identifying frailty can lead to improvements in patient outcomes through interventions such as Comprehensive Geriatric Assessment (CGA) and prompt discussions around resuscitation and advance care planning (ACP).[1] Frailty is associated with a higher risk of postoperative mortality and morbidity, and mortality due to COVID-19.[2][3] Our audit considers whether the pandemic had any effect on frailty documentation, and identifies interventions to improve this.

Method

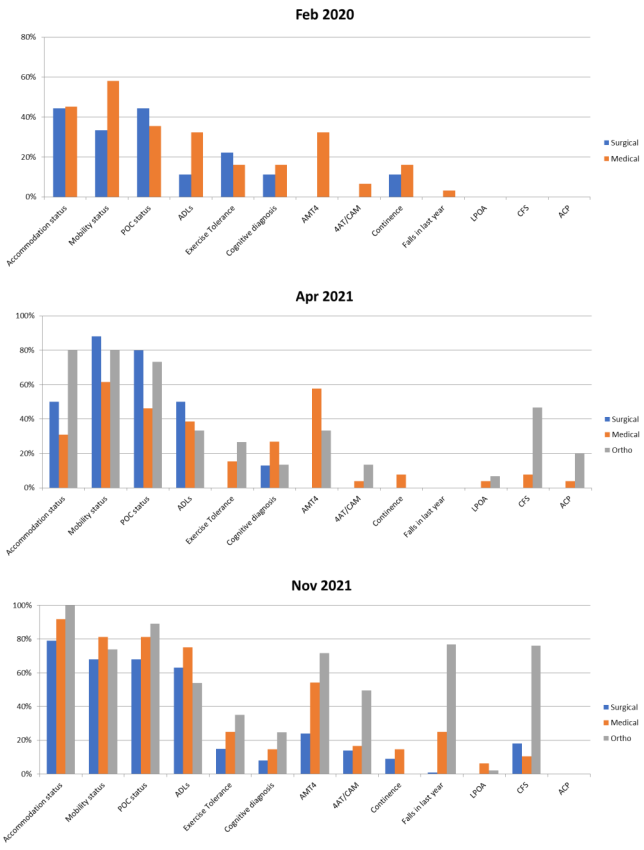
- Series of audits on frailty documentation across surgical and medical wards using review of notes
- February 2020 (pre-Covid-19), April 2021 (Wave 2), November 2021 (Wave 3)
- Accommodation, mobility, package of care, activities of daily living (ADLs), exercise tolerance, cognitive diagnosis, AMT4/4AT/CAM, continence, falls in last year, lasting power of attorney (LPOA), clinical frailty scale (CFS), ACP

Interventions and Results

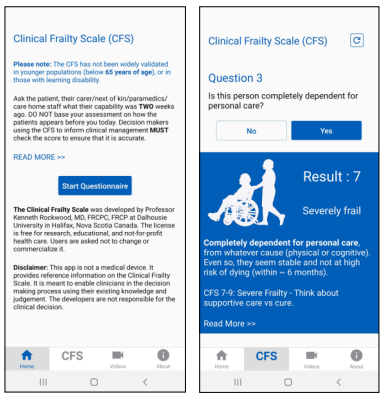
February 2020—This cohort consisted of 62 patients and showed poor documentation across both medicine and surgery (not including Orthopaedics) with an average of only 21% relevant social history recorded and 0% CFS scoring. Interventions that followed included an educational series by geriatricians and introduction of triaging tools based on CFS in response to the pandemic e.g. Swansea Hip interrogation Fracture Tool (SHiFT).[4]

April 2021—The relevant documentation improved to an average of 31% in this cohort of 37 patients. Interventions that followed included further educational sessions on frailty, a surgical liaison service, and the appointment of two orthogeriatricians.

November 2021—This cohort consisted of 149 patients, average relevant social history continued to improve to 49%. Subgroup analysis showed 76% of orthopaedics patients had a CFS score, including 100% of NOF patients.



Future Interventions: CFS App[5]



Conclusion

Documenting frailty is important as it is linked to an increased risk of mortality and morbidity. In the pre-pandemic cohort, the results were poor. Improvements were seen after interventions such as educational sessions, pandemic triaging tools, and the surgical liaison service. However, there are still inconsistencies between teams. Future interventions include a CFS app, expansion of the surgical liaison service, improved pro-formas, and integration of CFS into our electronic patient record.

References

1) Welsh et al, Comprehensive geriatric assessment – a guide for the non-specialist, International Journal of Clinical Practice, March 2014, 68(3):290-293
2) Parmar et al, Frailty in Older Patients Undergoing Emergency Laparotomy: Results From the UK Observational Emergency Laparotomy and Frailty (ELF) Study, Annals of Surgery, April 2021, 1;273(4):709-718
3) Dumitrascu et al, Association of frailty with outcomes in individuals with COVID-19: A living review and meta-analysis, Journal of the American Geriatrics Society, September 2021, 69(9):2419-2429
4) Cronin et al, COVID-19 causes a SHiFT in the sands for proximal femoral fracture management?, British Orthopaedic Association, April 2020
5) Acute Frailty Network, Clinical Frailty Scale App, https://www.acutefrailtynetwork.org.uk/Clinical-Frailty-Scale/Clinical-Frailty-Scale-App

CQ - Clinical Quality - CQ - Clinical Effectiveness [Platform Presentation]

1102 An Evaluation of a Geriatrician-Led Acute Medical Admission Unit at Morriston Hospital, Swansea

A Yusoff; E A Davies; D J Burberry; N Jones; C Walters; C Beynon Howells; D Davies; P Quinn

Department of Geriatric Medicine, Morriston Hospital, Swansea Bay University Health Board (SBUHB)

Introduction
The medical intake at Morriston Hospital is accepted on two units; Rapid Assessment Unit (RAU) and Acute Medical Assessment Unit. Both were acute physician-led until July 2021 (Phase 1). From July 2021, RAU became geriatrician-led (Phase 2). This evaluation concerns the performance of RAU.
Phase 1 (Acute Physician-Led Unit) Between 01/08/2020-30/06/2021, there were 3102 admissions with a median length of stay (LOS) of 2 days on RAU. 37.2% of patients were discharged directly from the unit. (SBUHB data). A detailed analysis of 496 patients consecutively assessed between November 2020–January 2021 showed a median LOS on RAU of 1, 28.8% were discharged directly from RAU. Overall health board (HB) median LOS for the cohort was 7. In over 70 years, median LOS on RAU was 1, overall HB LOS 9.

Phase 2 (Geriatrician-Led Unit) 1237 patients were assessed July-December 2021, with a median LOS of 2 days. 42.8% of patients were discharged from RAU. (SBUHB data). A detailed analysis of 566 patients consecutively assessed between September-November 2021 showed a median LOS on RAU of 2, 41.7% discharged directly from RAU. Overall HB median LOS for the entire cohort was 5. For the > 70 years, median LOS on RAU was 2, overall HB LOS was 7. Patient flow through assessment areas is dependent on the function of downstream medical wards. Mean LOS within medicine at Morriston increased 1.5 days between Phase 1 and Phase 2.

Results
Acute geriatricians have delivered the 72hr LOS standard that SBUHB has set for assessment areas. The unit has achieved a reduction in overall LOS for the cohort of patients evaluated ($p<.01$), especially for the > 70 years ($p=.007$). This data supported a change in practice; RAU has taken a frailty specific intake since January 2022.

An Evaluation of a Geriatrician-Led Acute Medical Admission Unit at Morriston Hospital, Swansea

Dr A Yusoff; Dr E A Davies; Dr D J Burberry; N Jones; C Walters; C Beynon-Howells; D Davies; P Quinn

Department of Geriatric Medicine; Morriston Hospital. Swansea Bay University Health Board (SBUHB)

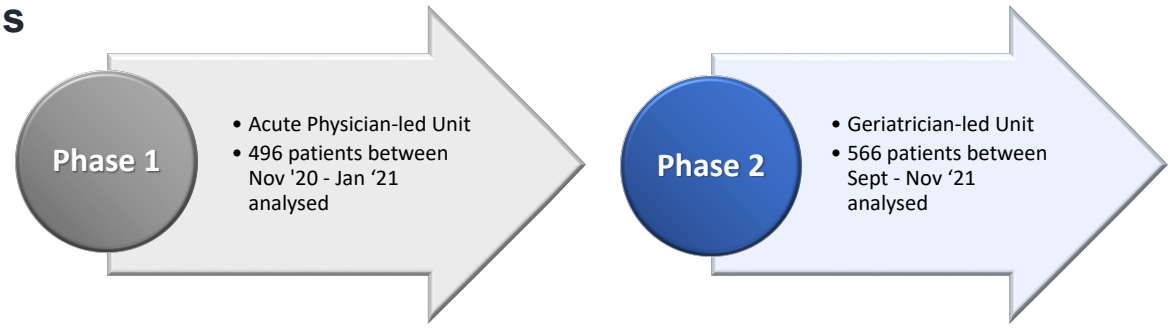
Introduction

- The medical intake at Morriston Hospital is accepted on two units; Rapid Assessment Unit (RAU) and Acute Medical Assessment Unit.
- Both were acute physician-led until July 2021.
- From July 2021, RAU became geriatrician-led.
- This evaluation concerns the performance of RAU.

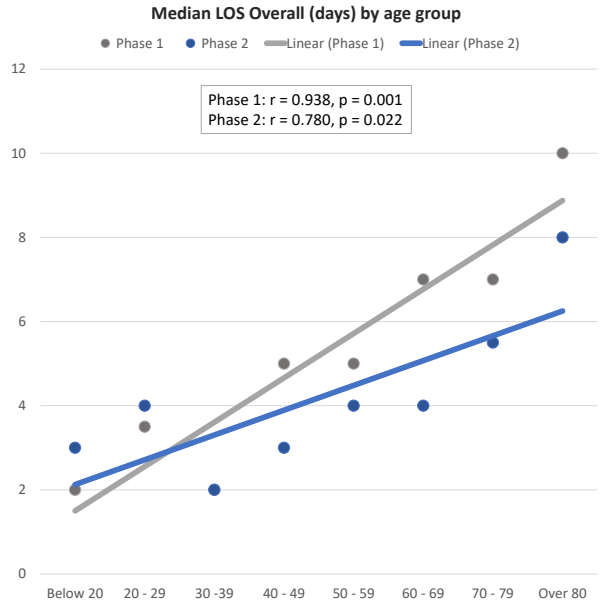
SBUHB Data

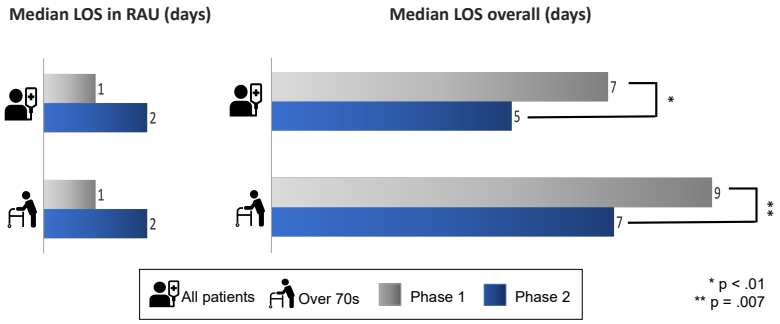
Period	Aug '20–June '21	July '21–Dec '21
No of admissions	3102	1237
Median LOS in RAU	2 days	2 days
Discharged directly from RAU	37.2%	42.8%

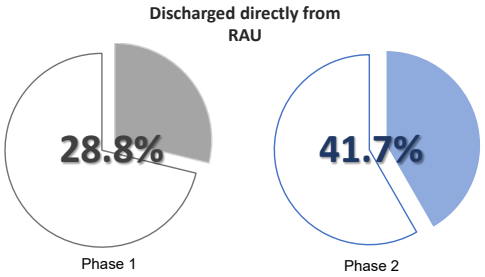
Methods



Results







Discussion

- Patient flow through assessment areas is dependent on the function of downstream medical wards.
- Mean LOS within medicine at Morriston Hospital increased 1.5 days between Phase 1 and Phase 2.

Conclusion

- The unit has achieved a reduction in overall LOS for the cohort of patients evaluated (p<.01), especially for the > 70 years (p=.007).
- Acute geriatricians have delivered the 72hr LOS standard that SBUHB has set for assessment areas.
- This data supported a change in practice; RAU has taken a frailty specific intake since January 2022.

CQ - Clinical Quality - CQ - Improved Access to Service [Poster]

1107. Admission avoidance in the frail population - use of an urgent clinic

D Allen1; A Probert1; D Gyimah2

1. Clinical Gerontology, Cardiff and Vale UHB; 2. Emergency Unit, University Hospital of Wales

Introduction: Cardiff and Vale UHB runs an Elderly Care Assessment Service (ECAS) which provides full Comprehensive Geriatric Assessment (CGA) for frail older people in a daily clinic. Historically, despite the large numbers of frail patients presenting to the Emergency Unit (EU), this service did not receive a significant number of referrals from the EU. A project was therefore designed to identify the reasons for the low referral numbers and introduce interventions to increase the number of referrals, therefore avoiding unnecessary admission of patients presenting with frailty syndromes.

Method:
The Geriatrics team engaged with the EU department to identify barriers to referral. Poor awareness of ECAS was improved by ensuring EU consultants understood referral criteria and could disseminate the information to junior staff. An email was sent to all EU staff to further raise awareness and to signpost to an eReferral system. A Geriatrics SpR was regularly present at EU handover to signpost appropriate patients. ECAS offered urgent appointment slots to EU to increase the confidence of the referring clinician that the patients would be seen promptly.

Results:
In the four months prior to intervention, the percentage of EU referrals as a total of all referrals to ECAS was between 0% and 3.5%. In Month 1 after the project had started, it was 8.2% and in Month 2 it was 16.4%. The project is ongoing with future interventions to include an EU staff survey to identify ongoing barriers to referral, followed by teaching sessions across EU to address issues raised and increase staff confidence in recognising frailty syndromes.

Conclusion:
Early results suggest that this multi-faceted intervention has had a significant impact on increasing referral numbers. Ongoing work aims to cement and encourage the use of outpatient services to reduce long EU stays and avoidable admissions.

Admission avoidance in the frail population – use of an urgent clinic

Debbie Allen; deborah.allen@wales.nhs.uk Abigail Probert: abigail.nelson@wales.nhs.uk

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Caerdydd a'r Fro | Cardiff and Vale University Health Board

BACKGROUND

Cardiff and Vale UHB runs an Elderly Care Assessment Service (ECAS) which provides full CGA for frail older people in a daily clinic. It was noticed by several Geriatricians that this service was not receiving a significant number of referrals from the Emergency Unit (EU), despite the large numbers of frail patients presenting to the EU and/or the medical take.

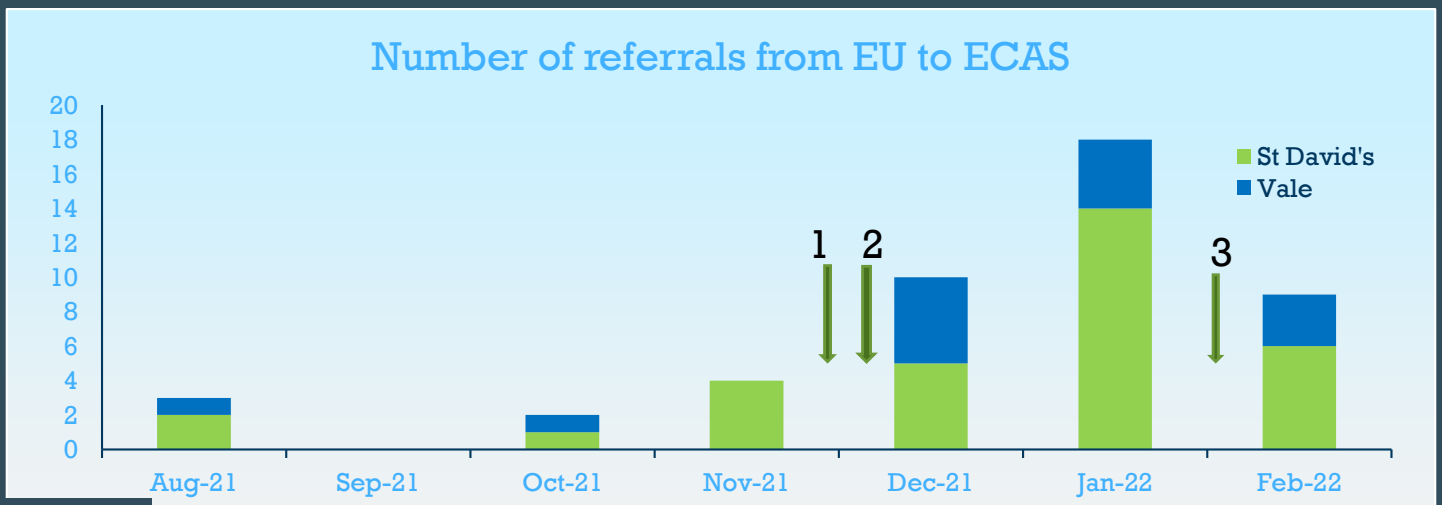
A project was therefore designed to investigate the reasons for the low referral numbers and introduce changes to increase the number of referrals, with a view to avoiding admissions if possible.

METHOD

Multifactorial interventions were implemented, including:

- Changing ECAS Triage processes so that EU patients are prioritized (1)
- Engagement with EU consultants and senior nurses (2)
- Meeting with EU Transformation team (2)
- Emailing all EU juniors to raise awareness of service (3)
- Attendance of Geriatrics SpR at EU Huddle (3)

RESULTS



	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
% of total ECAS referrals:	2.9%	0%	1.4%	3.5%	**8.2%**	**16.4%**	**7.4%**

CONCLUSION AND ONGOING WORK

Early results suggest that this project has had a significant impact on increasing referral numbers. Though the total number of referrals remains relatively small, the engagement of the EU department resulting in this change has been very encouraging. Planned future interventions include surveying staff to identify specific barriers to referral, and implementing teaching programs in light of these.

The authors are keen to ensure this project results in a sustained change in practice and would be keen to hear from anyone with experience of implementing a change in service usage.

1109. Chronic Kidney Disease ; Audit of NICE guideline compliance in medical inpatients in a DGH

K James ; A James ; C Roberts ; A Young

Care of the elderly department ; Princess of Wales Hospital, CwmTaf Trust, Wales

Introduction
Nice guidelines for Chronic Kidney Disease were updated in 2021 clarifying investigation and treatment of a falling eGFR. We felt that while we are very good in hospital at recognising when creatinine is chronically raised and doesn't need action we aren't always so good at recognising and managing CKD i.e. sending urine for ACR and commencing ACE inhibitors.

Method
We audited all medical inpatients from 26/1/22 to 31/1/22 using the clinical portal and medication chart reconciliation. We looked for all patients with an eGFR < 60 on two occasions 3 months apart. We went on to collect data including whether an ACR had been sent, by whom, diabetic status and medications. Results Of 207 medical inpatients 52 had CKD, the majority were not diabetic and all were over 60. More patients than expected had previously had a ACR test however these were in the main done by their GPs and rarely done in hospital. 12 of our patients met guidelines to be receiving either an ACEi or ARB at maximum dose. The majority were not taking either, with none of the patients that were prescribed one on the maximum dose. Only 9 of the 52 had been referred to nephrology.

Conclusion
We hypothesise the computer systems in general practice trigger more investigations to be done for CKD, we need to improve on investigating and maximising treatment for inpatients especially in light of patients current lengthy stays. We created a poster for our wards and provided education amongst the medical teams to try and improve this alongside better communication to primary care. We are also looking to improve our computer systems in line with general practice and using our pharmacy colleagues. As this is a rapidly developing area we intend to continue re-auditing this to try and improve compliance.

Chronic Kidney Disease ; Audit of NICE guideline compliance in a DGH

Dr K James, Dr A James, Dr C Roberts, A Young ANP
Princess of Wales Hospital, CwmTaf Healthboard

Introduction

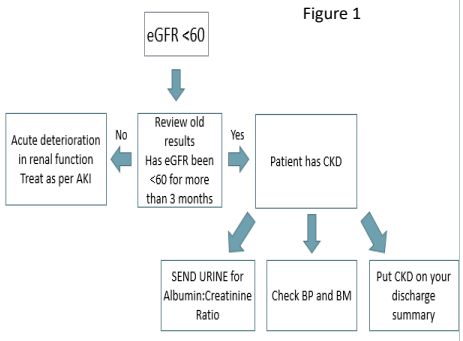
NICE Guidelines have been updated regarding investigation and management of Chronic Kidney Disease (CKD) (1). As a team we felt that whilst we are good at recognising an acute change in renal function; we are poorer at giving a formal diagnosis of CKD to our inpatients and further investigating and treating as per the guidelines. As some of our COTE patients are currently experiencing prolonged inpatient stays it is important to manage chronic disease as well as acute illness. Guidelines suggest that patients should be having urine samples sent for Albumin:Creatinine ratio (ACR) in order to risk stratify and guide intensity of monitoring.
Patients who have significant CKD and proteinuria should be prescribed either an ACE or ARB at maximum dose where tolerated.

Method

We performed an audit of all medical inpatients in POW hospital from 26 - 30/1/2022.
We identified medical inpatients with CKD using the definition of eGFR < 60 on two measurements 3 months apart and went on to use both the clinical portal and patient notes to look at various areas of the NICE guideline. This included:

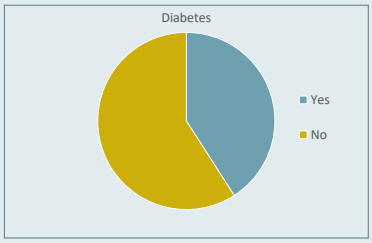
- Whether a urine albumin:creatinine ratio had been sent and by whom (hospital, general practice).
- If the patient has diabetes or hypertension.
- Whether a renal opinion has been sought.
- Whether the patient meets criteria for ACE/ARB, if it has been prescribed, and if so, whether they are receiving the maximum dose.

Figure 1

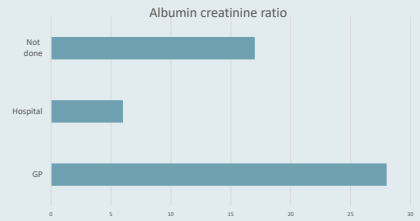


Results

Of 207 medical inpatients in 8 wards, 52 were identified as having CKD. Fifty-one of the patients were over 65 years old. Some of the results were as follows:

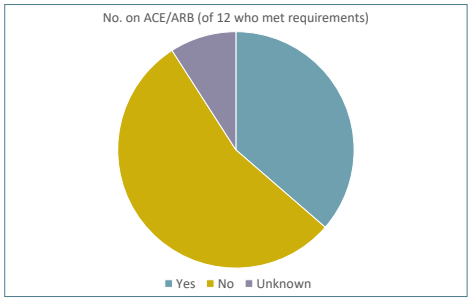


More patients than anticipated already had an ACR, however, the majority had been requested in general practice and spanned the last 10 years.



Current guidelines suggest an ACE/ARB if :
- DM and ACR > 3 or
- No DM with ACR > 30

Of Our Patients
- Twelve of our patients met these criteria
- Four were taking either ACE/ARB
  - ➢ However NONE were at the Maximum dose
- Nine patients were known to renal



Discussion

Whilst this is a large area to cover and try to improve, there were a number of key findings from this audit.

General Practice were significantly better at requesting Urine ACR, however, of these, many were not recent and the results were much lower than expected. Our hypothesis is that computer systems in GP are more advanced, in both preparing for follow up of results and planning future tests. In addition, hospital teams are likely less focused on chronic disease management when treating the acute illnesses of inpatients.

Although the numbers of patients became quite small when looking at those on drug therapy, none were on the suggested gold standard treatment. There were very few documented allergies or intolerances, as far as we could ascertain none of the final 12 experienced any.

On the whole, guideline compliance was relatively poor.

Conclusions

Our audit showed relatively poor compliance across the board. This likely represents the breadth of the area this guideline covers, and the number and diversity of practitioners involved in each patients' care.
We have focused on improving awareness in a number of ways:

- Producing a poster to improve awareness of the topic and placing it on the wards (Fig 1).
- We have several teaching sessions planned including with the pharmacy department.
- Improving coding on discharge summaries to inform GPs of diagnoses of CKD so patients are monitored in the community.

We aim to re audit this topic within the next few months.

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References

1) NICE Guidelines, NG 203 24th Novemeber 2021