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Book of Abstracts

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PLATFORM PRESENTATION: DEMENTIA SESSION: WEDS 12.15-12.30

Scientific Presentation - Parkinson's Disease

3758. CLINICAL AND COST-EFFECTIVENESS OF THE UCL LIVE WELL WITH PARKINSON'S SELF-MANAGEMENT TOOLKIT - AN RCT

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Introduction: Parkinson's disease (PD) affects 1/50 people over 65 years, with complex health and social care needs and difficulty accessing timely support. We co-designed and tested a self-management toolkit for people with PD and their carers (UCL Live Well with Parkinson's), to improve health outcomes and healthcare needs. The toolkit contains information about symptoms, treatment, optimising wellbeing, and practical advice. The sub-sections, personalised with the help of a supporter, cover information on health and support, allow symptom reviewing/tracking, and to work towards health priorities.

Method: The clinical and cost-effectiveness were tested in a single-blind RCT in England. We randomised community-dwelling participants with PD 1:1 to the intervention or treatment-as-usual. The primary outcome was health-related quality of life (PDQ-39) at 12-months. Outcomes were analysed using linear mixed models, controlling for baseline.

Results: We recruited 346 participants between January 2022–July 2023 (mean age 69 (SD 9) years,159 (46%) women, 321 (93%) white). Data collection was completed in August 2024 with 88% retention at 12-months. Small, but not statistically significant differences in PDQ-39 were seen for intervention participants (-1.03(-3.03 to 0.97); p=0.31). There were significant differences in favour of the intervention arm in symptom changes on the MDS-UPDRS part I and II at 6- and 12-months (-2.19(-3.95 to -0.43) and -2.61(-4.58 to -0.64)). We found significant differences in psychological distress (GHQ-12) (-0.87(-1.71 to -0.03)) and overall health status (EQ-5D-5L VAS) (3.87(0.32 to 7.41)) at 6-months. At 12-months, intervention group participants had significantly lower health and social care costs (mean incremental cost saving per participant -£1459(-£2903 to -£16)), inclusive of the average per-participant intervention costs of £284. There was no difference in 12-month QALYs (mean incremental QALYs 0.02(-0.01 to 0.04)) and hence dominates treatment-as-usual.

Conclusion: Our self-management tool has potential to improve PD symptoms and support cost-effective management of patients with PD.

PLATFORM PRESENTATION: DEMENTIA SESSION: WEDS 12.30-12.45

Scientific Presentation - Pharmacology

3767. RESULTS OF A RANDOMISED CONTROLLED STUDY TO REDUCE MEDICATION-RELATED HARM IN OLDER ADULTS AFTER HOSPITAL DISCHARGE

K Ali[1], E Mensah[1], J M Stevenson[2], S Nyangoma[3], V Hamer, N Parekh, C Rajkumar[1], J G Davies[4], M Touray[5], H Gage[5], S Fowler-Davis[6] on behalf of study collaborators

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Introduction: Medication-related harm (MRH) is a challenge for older adults in the period following hospital discharge. NHS Discharge Medicines Service (DMS), within the Community Pharmacy Contractual Framework, aims to reduce post-discharge MRH through improved communication between hospital, community pharmacists, and patients. The aim of the study was to investigate the effectiveness of an individualised medicine management plan (MMP) plus DMS in reducing medication-related harm compared to DMS only.

Method: Older adults ≥ 65 years were recruited from 8 hospitals in England and randomised to intervention (MMP of patient education about medicines and discussion around medication risk plus DMS) or control (DMS only). Baseline data included patients' clinical and social demographics and medication risk calculated using a risk-prediction tool at the point of discharge. At 8-weeks post-discharge, trained study pharmacists or doctors verified MRH via triangulation of outcome data obtained from telephone interview with study participants and / or carers, review of GP records and identifying cause of readmission if it occurred. A process evaluation assessed the acceptability of study methods by hospital pharmacists.

Results: A total of 274 patients were included (140 control, 134 intervention), mean age of 80.1 years (range 65–100), 151 (55.1%) females. In both study arms, MRH was strongly associated with hospital readmission (OR = 5.29, 95% CI: 1.57–17.77) and use of A&E services (OR = 4.21, 95% CI: 1.33–13.31). Although not statistically significant, there was a consistent trend toward reduced odds of adverse outcomes in the intervention group, OR= 0.52 (95% CI: 0.16–1.68). The process evaluation showed that the study strengths were a standardised medicine management plan, objectively assessing medications risk, and identifying opportunities for pharmacist-led interventions.

Conclusion: MRH after leaving hospital has a substantial impact on healthcare utilisation. The study intervention has the potential to deliver clinically important benefits through reducing MRH.

PLATFORM PRESENTATION: DEMENTIA SESSION: WEDS 12.45-13.00

Scientific Presentation - Health Service Research

3814. THE EFFECTS OF AN ONLINE PSYCHO-EDUCATION PROGRAMME ON PSYCHOLOGICAL OUTCOMES IN SPOUSAL CAREGIVERS OF OLDER ADULTS WITH FRAILTY

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Introduction: Spousal caregivers are fundamental to the support of older adults with frailty but often experience significant psychological challenges. This study aimed to evaluate the feasibility, acceptability, and preliminary effects of an online psychoeducation programme tailored for this group.

Methods: We conducted a single-blind, parallel-group randomised controlled trial. Spousal caregivers were randomly assigned to either the online psychoeducation intervention or an attention-control group. Feasibility was determined by eligibility, recruitment, attrition, and adherence rates. Acceptability was assessed via post-intervention satisfaction surveys and semi-structured interviews. Preliminary intervention effects were measured using primary outcome (psychological wellbeing) and secondary outcomes (positive aspects of caregiving, caregiving self-efficacy, coping and psychological distress).

Results: The trial proved highly feasible, with eligibility at 69.2%, recruitment at 66.7%, low attrition (13.3%), and high adherence (86.7%). Participant feedback from surveys and interviews confirmed the programme was both acceptable and valuable. Post-intervention, the group receiving psychoeducation demonstrated significantly greater improvements in both problem-focused (Hedges' g = 0.83) and emotion-focused (g = 0.75) coping compared to the control group. Although not statistically significant, positive trends were also observed for psychological wellbeing, positive aspects of caregiving and caregiving self-efficacy. However, the programme had a limited effect on reducing psychological distress.

Conclusions: This pilot trial demonstrates that an online psychoeducation programme is a feasible and acceptable intervention for spousal caregivers of older adults with frailty. It shows considerable promise in enhancing positive psychological outcomes in sustainable spousal caregiving. These encouraging findings strongly support the case for a larger-scale trial with extended follow-up to confirm the programme's effectiveness.

PLATFORM PRESENTATION: TISSUE VIABILITY: THURS 11.45-12.00

Scientific Presentation - Other medical condition

3700. THE GOAL TRIAL – COMPREHENSIVE GERIATRIC ASSESSMENT FOR FRAIL OLDER PEOPLE LIVING WITH CHRONIC KIDNEY DISEASE

B Logan[1]; A Viecelli[1]; D Johnson [1]; T Comans[1]; E Gordon[1]; L Gray[1]; C Hawley[1]; L Hickey[1]; M Janda[1]; A Jaure[2]; M Jose[3]; C Kiriwandeniya[1]; M Matsuyama[1]; G Mihala[1]; K Nguyen[1]; E Pascoe[1]; P Paul-Brent[1]; J Pole[1]; K Polkinghorne[4]; C Pond[3]; R Raj[3]; D Reidlinger[1]; N Scholes-Robertson[2]; A Valks[1]; G Wong[2]; R E Hubbard[1]

1. University of Queensland; 2. University of Sydney; 3. University of Tasmania; 4. Monash University

Background: Frail older people living with chronic kidney disease (CKD) have complex care needs and are at increased risk of adverse outcomes. Comprehensive geriatric assessment (CGA) benefits older people, but its effectiveness in allowing this population to attain their goals is unknown. GOAL investigates this.

Methods: This cluster randomised controlled trial recruited participants (Frailty Index [FI] >0.25; aged ≥65 years, or ≥55 years for First Nations people; CKD stage 3–5/5D [eGFR<59mL/min/1.73 m2]) from kidney outpatient clinics. Clinics were randomised 1:1 to CGA plus usual care (intervention) or usual care alone (control). The primary outcome was Goal Attainment Scaling (GAS) at 3 months. Secondary outcomes included GAS up to 12 months, quality of life (EQ-5D-5L), FI, mortality, hospitalisations and residential aged care admissions. Intention-to-treat analysis was conducted at the cluster- and participant-level. Exploratory analyses investigated effects of intercurrent events.

Results: 240 participants (mean age 76.9±6.6 years, median FI 0.39 [IQR 0.33-0.47]), 114 at 7 intervention clusters and 126 at 8 control clusters. Retention was challenging during COVID, with 22 (19%) not receiving their planned CGA. At 3-month follow-up, mean GAS scores were not significantly different between the intervention and control groups (45.2±11.7 vs 43.7±10.9, respectively, p=0.47). There were also no significant differences observed in the secondary outcomes. No serious adverse events were reported.

Conclusion: In frail older people living with CKD, CGA administered in outpatients did not improve their ability to attain their goals. Geriatricians should continue to manage this population's geriatric syndromes like falls, dementia and delirium.

PLATFORM PRESENTATION: CLINICAL QUALITY SESSION: THURS 14.45-15.00

Clinical Quality - Clinical Effectiveness

3843. TWO DAY CULTURE IN A TWO-HOUR WORLD: TRANSFORMING AN URGENT COMMUNITY RESPONSE (UCR) SERVICE THROUGH QUALITY IMPROVEMENT (QI)

J Adams; M Bull

Royal Surrey NHS Foundation Trust

Background: The Ageing Well Strategy within the NHS Long term plan established UCR services to meet the needs of older people in frailty crisis within 2 hours of referral. UCR services will be critical to meet the ambitions laid out in the NHS 10-year plan and will need to be more integrated with wider frailty pathways, both through Neighbourhood Health care and with acute hospital-based services. UCR 2-hour performance deteriorated over several months and variation in knowledge and skills were identified. A rapid improvement approach was used to transform the service using QI methodology.

Methods: A3 QI methodology was used to underpin rapid improvement over a 6-week period, including: An "understand" phase: Detailed process mapping Fishbone to categorise multifactorial problems. Baseline performance data: Benchmarking each staff member against the core capabilities for frailty and the core capabilities for UCR/Virtual Wards. Capturing staff experience through an emotional map using experience-based design. Creating a vision for a fully integrated UCR service with all staff having the knowledge, skills and competencies to deliver a safe effective service for older people with frailty. Rapid improvement over 6 weeks including: Daily PDCA and twice daily improvement huddles testing change daily. Use of standard work for handover, board rounds, staff allocation. Use of visual management. Creation of new roles including a clinician in charge and enhanced clinical practitioner. Co-location of clinician in charge and board rounds with single point of access and H@H Bespoke education and training and development plan for each staff member against the core capabilities.

Results: *UCR performance measures:* The 2 hour standard for UCR intervention fell to an average of 56.5% per month between January and April 2024 (range 46-68). Following the rapid improvement programme this improved to 81.3% in May 2024 and has been sustained over 12 months with an average of 83.77% per month (range 78.9-87.3%). The proportion of referrals allocated to 2 hour response improved from 35% to 65% and this was sustained over the 12 month period. *Quality Improvement skills:* 50% had QI basics training improved from 50% to 100%. 0% had QI practitioner training, with 3 staff members completing this in the following 6 months. *UCR core capabilities:* 50% met tier 2 standards, with development plans initiated. <20% had completed relevant level 7 modules, with training needs assessment completed in addition to creating an Enhanced Clinical Practitioner (ECP) role. >80% have now completed health assessment modules and 4 have transitioned to an ECP role. *Frailty core capabilities:* Tier 1 training improved from 71% to 100%. 14% were tier 2 trained, with development plans initiated. 0% were tier 3 trained, with workforce modelling initiated to move staff to an ECP role.

Conclusions: A rapid improvement approach using QI methodology can be used to transform complex multifactorial problems in a UCR service. Not only can this improve assessment within 2 hours of referral for older people in frailty crisis, it could lead to sustained performance through shifting the culture from a 2 day response to a 2 hour responsive service. When augmented by an education, training and workforce development plan, this can lead to lasting change and create a safe, effective, efficient UCR service.

PLATFORM PRESENTATION: CLINICAL QUALITY SESSION: THURS 15.00-15.15

Clinical Quality - Clinical Effectiveness

3753. THAT'S NOT MY DAD: IMPROVING DELIRIUM CARE AT LEEDS TEACHING HOSPITALS

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Leeds Teaching Hospitals NHS Trust

Introduction: Delirium affects 1 in 4 hospitalised older adults, doubling length of stay and increasing mortality sixfold. Yet, over half of cases go undetected. In 2019, delirium screening compliance at Leeds Teaching Hospitals NHS Trust was under 5%. No standardised care plan for delirium prevention or management existed. We aimed to embed a trust-wide, digital, person-centred strategy to detect and manage delirium in patients aged >65 across all departments.

Methods: Using the IHI model for improvement, we launched a strategy in March 2023: Spot it, Sort it, Stop it. A 4AT assessment was embedded into our electronic record (PPM+), with a score >0 triggering a mandatory nursing care plan based on the "PINCH ME" framework (Pain, Infection, Nutrition, Constipation, Hydration, Medications/Mobility, Environment). A live run chart tracked 4AT compliance and care plan use by department. Campaigns included ward-based education, short films, podcasts, posters, and governance engagement. A driver diagram describes our multiple targets for improvement and multiple PDSA cycles, Surveys evaluated staff confidence and knowledge.

Results: 4AT completion rose from 3.6% to 70.4%, with over 1,800 patients assessed monthly. Care plan compliance reached 60–90% across departments. Staff confidence in recognising delirium improved from 47% to 88%, and confidence in managing delirium rose from 43% to 86%. Falls reduced from 3.8 to 3.5 per 1,000 bed days, and length of stay decreased by 0.5 days. Staff increasingly recognised delirium as a medical emergency, using 4AT scores as a communication tool.

Conclusion: Our trust-wide strategy significantly improved delirium detection, staff confidence, and care quality for older adults. Sustained cultural and clinical change was supported by education, data visibility, and MDT engagement. Future plans include real-time ward dashboards, revised care plans, and continued rollout through our frailty education programme.

PLATFORM PRESENTATION: ADDRESSING ABUSE AGAINST THE OLDER ADULT: FRI 10.30-10.45

Scientific Presentation - Falls, Fracture and Trauma

3584. TOO FRAIL TO FAIL: FRAILTY AND THE LIMITS OF RESUSCITATION

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Background: Hundreds of cardiac arrest calls occur annually in hospitals, with a significant proportion involving patients aged 65 and above. Previous research has shown that survival to discharge in this population remains poor. Frailty is increasingly recognised as a predictor of adverse outcomes, but its relationship with CPR outcomes in older adults remains underexplored.

Objectives:
This audit aimed to:

- Identify which older inpatients are most likely to die following cardiac arrest.
- Explore the association between frailty and CPR outcomes.
- Provide guidance for DNACPR (Do Not Attempt CPR) conversations with patients and families.

Methods: We conducted a retrospective review of electronic health records for all inpatients aged ≥65 who received CPR between 1 January 2022 and 31 December 2024 at our institution. Clinical Frailty Scale (CFS) scores were extracted where available, and patient outcomes were analysed with respect to survival to discharge.

Results: A total of 71 patients over the age of 65 underwent CPR during the audit period. Of these, 62 (87%) died in hospital. Frailty was strongly associated with poorer outcomes. Among patients with a CFS score of ≥5 (mild frailty or worse), only one survived to discharge. This sole survivor had a witnessed arrest in the cardiac catheterisation lab during a percutaneous coronary intervention, with a downtime of less than 10 seconds.

Conclusions: Survival following inpatient cardiac arrest in older adults is rare, particularly among those living with frailty. Our findings support the use of the Clinical Frailty Scale as a valuable tool in guiding CPR discussions and decision-making. We recommend incorporating frailty assessment into routine care and resuscitation planning to facilitate more appropriate and patient-centred DNACPR decisions.

PLATFORM PRESENTATION: ADDRESSING ABUSE AGAINST THE OLDER ADULT: FRI 10.45-11.00

Scientific Presentation - Bone, Muscle, Rheumatology

3684. EFFECTS OF ACUTE HOSPITALISATION ON CHARACTERISTICS OF ACUTE SARCOPENIA IN OLDER ADULTS: A SYSTEMATIC REVIEW AND META-ANALYSIS

T Cartledge[1]; Q Tan[1, 2]; L Jones[1]; T Becque[3]; K Ibrahim[1, 4, 5]; S Lim[1, 5, 6]

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Introduction: Acute sarcopenia in hospitalised older adults is associated with poor outcomes, such as functional decline, increased risk of falls and prolonged hospital stays. Despite this, its development among older inpatients remains poorly understood. We aimed to quantify the effects of acute hospitalisation on sarcopenia outcomes in older adults.

Methods: Medline, Embase, CINAHL, and Web of Science were searched from inception until January 2025. Studies that included acutely admitted patients aged 65 years or older and reported changes in at least one measure of sarcopenia during hospitalisation were included. Barthel Index was also included. A random-effects meta-analysis was undertaken.

Results: Fifty-five eligible studies were included (n=14,919 participants, mean age=82.2 years). Grip strength significantly increased during hospitalisation (SMD=0.23, 95% CI: 0.13; 0.33). No physical performance measure showed a significant change, and muscle mass decreased when measured using MRI or DEXA. Barthel Index significantly decreased during hospitalisation when using a pre-admission score as baseline (SMD=-0.66, 95% CI: -0.92; -0.39). Both age and hospital length of stay had no effect on grip strength or Barthel Index.

Conclusions: This review has shown that grip strength improves during hospitalisation and decreases in muscle mass are observed when measured using MRI or DEXA. Muscle strength and physical performance on admission are less suitable baseline measures, as they are often adversely affected during acute illness and, therefore, not representative of true baseline capacity. The lack of improvement in physical performance outcomes is an important finding as it represents failure to return to pre-hospital baseline abilities.

PLATFORM PRESENTATION: Fri 11.30-11.45

Scientific Presentation - Cardiovascular

3690. EFFICACY AND SAFETY OF STATIN DISCONTINUATION IN OLDER PEOPLE LIVING WITH FRAILTY: A UK POPULATION-WIDE STUDY

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Introduction: In older patients, and in those living with frailty, the evidence for continued statin description is uncertain. Current guidelines advocate for an individualised approach, including consideration of deprescribing where the benefits are unclear.

Aim: Determine safety and efficacy of statin discontinuation in older people, stratified by frailty status.

Methods: This was a retrospective cohort study using data from Clinical practice research Datalink (CPRD) between 1998-2021. Inclusion criteria were age ≥65 years, with a 12-month statin medication possession ratio of ≥80%. Statin discontinuation was defined as no prescription for ≥180 days. Exposed participants were matched within practice 1:2 to those unexposed. The primary outcome measure was all-cause hospitalisation; secondary outcomes included major adverse cardiovascular events (MACE), muscle disorders, liver injury, new diabetes mellitus or cataracts. The effect of discontinuation was examined using Fine-Gray models accounting for competing risk of death, with inverse probability of treatment weighting to adjust for confounding. Results were stratified by electronic Frailty Index (eFI) category, dementia, care home residency, or housebound status in preceding year.

Results: The cohort included 65,727 participants who stopped a statin, and 131,453 who continued. The 1-year sub Hazard Ratios (sHR) for hospitalisation and MACE, with statin discontinuation, were 1.22 (95% CI 1.20-1.25) and 1.3 (95%CI 1.24-1.35) respectively. However, for those living with severe frailty (eFI ≥ 0.36), dementia, housebound or in a care home, risks of all-cause hospitalisation, stroke, myocardial infarction and heart failure, at 1 and 5 years, were either non-significant, or lower. Discontinuation was linked to lower risks of some statin-related adverse events (e.g. 5-Year sHR for new diabetes 0.79 [95%CI 0.74-0.84]).

Conclusions: Statin discontinuation is associated with an increased risk of hospitalisation and cardiovascular disease, but in those living with frailty, the relative risks of hospitalisation were lower. This may be important informing patient-centred decisions for this population.

PLATFORM PRESENTATION: Fri 11.45-12.00

Scientific Presentation - Falls, Fracture and Trauma

3708. IMPLEMENTING THE ACTION FALLS PROGRAMME INTO CARE HOMES IN ENGLAND (The FinCH Imp Study)

F Allen[1]; P Logan[1,2]; J Darby[1,3], K Robinson[1]; F Hallam-Bowles[1,3]; S Burgess[1]

1. University of Nottingham; 2. Stars Education and Research Alliance, University of Queensland; 3. Nottingham University Hospitals NHS Trust

Background: Falls are a leading cause of morbidity among older people living in care homes. The Action Falls programme consists of training and support for staff using a multicomponent falls risk assessment and guide to mitigating actions. The Action Falls programme has been shown to reduce falls in care homes by 43% in clinical trial. This study aimed to assess the feasibility and acceptability for wider implementation of Action Falls in care homes.

Methods: A mixed-methods implementation study was conducted across 57 care homes in four English regions. Care home staff were trained and supported to use the Action Falls programme for 12 months. Normalisation MeAsure Development questionnaire (NoMAD) surveys based on Normalisation Process Theory (NPT) were used to indicate how ready and engaged care homes were to use the new intervention. Qualitative data were also collected through observation fieldnotes and action plans resulting from quality improvement events held in each study region.

Results: 60% of care home staff received Action Falls training. Staff who attended training indicated stronger engagement and confidence in using the intervention. Key facilitators included strong leadership from care home managers and a perceived alignment with person-centred care. Barriers included staff shortages, competing priorities, and challenges integrating the Action Falls checklist into digital care systems. Observations highlighted the value of ongoing support from trained Falls Leads. The average cost of training delivery per home was £331.60 (excluding backfill costs).

Conclusions: The Action Falls programme is feasible, acceptable, and has potential for wider implementation across diverse care home settings. However, successful spread at scale is dependent on digital integration, and policy alignment. Future research should investigate potential new mechanisms for inhouse, care home training delivery and how to ensure sustainability through changing demands and focus.

PLATFORM PRESENTATION: Fri 12.00-12.15

Scientific Presentation - Parkinson's Disease

3845. THE FUTURE OF CLINICAL TRIALS? MONITORING MOBILITY AS AN OUTCOME MEASURE IN PARKINSON'S DISEASE: THE MOBILISE-D STUDY

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1. Newcastle University; 2. Medical School Hamburg; 3. Robert Bosch Hospital Stuttgart; 4. ISGlobal Barcelona; 5. University College Dublin; 6. Politecnico di Torino; 7. University Hospital Schleswig-Holstein and Kiel University; 8. Sheffield University; 9. KU Leuven; 10. University Hospital Erlangen; 11. Tel Aviv Sourasky Medical Center.

Introduction: A key challenge in clinical trials targeting disease modification in Parkinson's disease (PD) is the lack of sensitive, precise, and patient-relevant outcome measures. Digital mobility outcomes (DMOs), captured using body-worn devices, offer a novel, objective means to assess real-world gait and mobility—domains often impaired early in PD. The Mobilise-D consortium was established to develop and validate DMOs in PD and other chronic conditions. The objective of this work was to describe DMOs in a large, representative international cohort of individuals with PD and compare to controls and across disease stage; and to determine compliance and feasibility.

Methods: As part of the Mobilise-D Clinical Validation and Extension Studies, real world mobility of individuals with PD (n=601) and matched controls (n=232) was assessed using a single wearable device for seven days. Data were processed to yield 24 technically validated DMOs, representing different domains of real-world walking and mobility performance.

Results: DMO data were available for 531 PD and 223 controls. Significant differences between the groups were observed in 20 of 24 DMOs. Compared to controls, PD participants exhibited shorter daily walking duration and lower step counts, walking at a higher cadence and in fewer walking bouts per day. Findings also varied by disease severity, with differences observed particularly between controls vs. mild (Hoehn and Yahr stage I-II) and mild vs. moderate (Hoehn and Yahr stage III) disease. Compliance rates were high.

Conclusion: Distinct DMO patterns across PD severity and between PD and controls support their utility as sensitive, scalable outcome measures for future clinical trials and therapeutic development.

PLATFORM PRESENTATION: Fri 12.15-12.30

Scientific Presentation - Eyes, Ear, Teeth

3726. NAVIGATING PRIMARY CARE WITH HEARING LOSS: A MIXED METHODS STUDY OF LIVED AND PROFESSIONAL EXPERIENCES IN THE UK

E Heffernan[1,2,3]; K Ayling[4]; C Ewart[5]; S Smith[2,3]; S Calvert[2,3]; D Maru[6]; J Straus[5]; T Dening[7]; H Henshaw[2,3]

1. School of Sport, Exercise and Health Sciences, Loughborough University 2. NIHR Nottingham Biomedical Research Centre; 3. Hearing Sciences, School of Medicine, University of Nottingham; 4. Centre for Academic Primary Care, School of Medicine, University of Nottingham; 5. Expert by Experience; 6. General Practitioner with a specialist interest in ENT; 7. Mental Health and Clinical Neurosciences, School of Medicine, University of Nottingham

Introduction: Hearing loss is a long-term, progressive condition that affects approximately 18 million UK adults. It is especially prevalent amongst older adults. It can substantially impair quality-of-life and is associated with an increased risk of depression, loneliness, falls, and dementia. Evidence suggests that hearing loss is a substantial, yet frequently overlooked, barrier to accessing healthcare. This research aimed to examine the challenges experienced by adults living with hearing loss in UK primary care services and to develop recommendations for overcoming these challenges.

Method: The participants (N=413) included adults living with hearing loss and health professionals. They were recruited from an internal participant database, professional societies and networks, and charities. Their experiences were examined via a survey (n=400) and individual and group interviews (n=45). Recommendations for improving access to primary care were developed through a series of co-design workshops with an expert panel (n=18).

Results: Adults living with hearing loss can experience challenges (e.g., communication barriers, lack of awareness, facilities, or interpreters) at every stage of accessing and using primary care services (e.g., booking appointments, obtaining referrals and interventions, adhering to care plans). This can impact physical, mental, and social functioning, as well as privacy and safety. Recommendations for overcoming these challenges included staff training, hearing loss champions, standardised communication protocols, addressing the psychosocial impact of hearing loss (e.g., counselling, support groups), and utilising technology (e.g., speech-to-text applications). Perceived impediments to implementing these recommendations included time and financial constraints and prioritisation of other health conditions.

Conclusions: This study provides novel insights on the experiences of adults living with hearing loss in UK primary care services and has key implications for health professionals and policymakers. The findings suggest that, despite legal requirements (e.g., Accessible Information Standard) and efforts to raise awareness, many people living with hearing loss remain under-served in primary care.

PRESIDENTS ROUND

Scientific Presentation - Health Service Research

3345. EFFECTIVENESS OF HEALTH COACHING INTERVENTIONS ON PSYCHOSOCIAL OUTCOMES AMONG OLDER ADULTS: SYSTEMATIC REVIEW AND META-ANALYSIS

Y Yang; Z Wang

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Introduction: Health coaching has emerged as a potential intervention to improve health outcomes in older adults. However, the effectiveness on older adults have not been fully systematically synthesised. This review was to evaluate the effectiveness of health coaching interventions on anxiety, depression, quality of life, self-management behaviour, and self-efficacy among older adults.

Methods: A comprehensive and systematic search of PubMed, Scopus, CINAHL, Cochrane Library, APA PsycInfo, and ProQuest Dissertations & Theses Global was conducted from inception to October 20, 2024. The Cochrane risk-of-bias tool (RoB-2) was used to assess the methodological quality of included studies. Standardized mean difference (SMD) and 95% confidence interval (CI) were calculated using meta-analysis with random or fixed-effects. The certainty of evidence was assessed using the Grading of Recommendations, Assessment, Development, and Evaluations (GRADE) framework. Sensitivity analyses, subgroup analyses and publication bias tests were also performed.

Results: A total of 35 randomized controlled trials (RCTs) involving 20200 older adults were included in this review. Meta-analysis results indicated that health coaching interventions could statistically significantly improve anxiety (SMD: -0.09; 95% CI: -0.15, -0.04; I2: 0%), quality of life (SMD: 0.22; 95% CI: 0.05, 0.39; I2: 76%), self-management behaviours (SMD: 1.15; 95% CI: 0.45, 1.86; I2: 95%), and self-efficacy (SMD: 1.15; 95% CI. 0.45, 1.86; I2: 95%) among older adults but had no significant effects on depression (SMD: -0.26; 95% CI: -0.64, 0.12; I2: 98%).

Conclusions: Health coaching interventions may improve anxiety, quality of life, self-management behaviours, and self-efficacy among older adults. More high-quality RCTs with more information on follow-up outcomes, intervention effects for different demographic information, etc. are encouraged to explore the full effects of health coaching interventions, thus generating adequate evidence.

PRESIDENTS ROUND

Scientific Presentation - Parkinson's Disease

3403. ACCESSING HEALTHCARE FOR PARKINSON'S DISEASE IN KILIMANJARO REGION, TANZANIA: A CHALLENGE FOR HEALTH EQUITY

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Introduction: The global prevalence of Parkinson's disease, a common neurodegenerative disorder, is rising. Most people with Parkinson's live in low- and middle-income countries, where accessing healthcare is challenging. A growing body of literature has investigated the distribution and experience of Parkinson's disease in Tanzania, yet there remains a need to understand access to healthcare for the condition in this setting. This study aims to qualitatively explore the experience of accessing healthcare for Parkinson's disease in northern Tanzania's Kilimanjaro region.

Method: Twenty-seven semi-structured interviews were conducted with people with Parkinson's (n=12), caregivers (n=8), and healthcare professionals involved in care (n=7). People with Parkinson's and caregivers were recruited to achieve wide variation in demographic and health characteristics. Professionals varied by occupation and workplace. Direct observation of clinical settings and detailed field notes captured contextual information. Reflexive Thematic Analysis was used to analyse data inductively and identify patterns of meaning across the dataset.

Results: Three overarching themes were defined during analysis. The Price of Parkinson's considers the economic burden Parkinson's disease levies against individuals, and its implications for healthcare access. Making Sense of Parkinson's discusses how knowledge and perceptions of the condition influence healthcare access, whilst an Underprepared System describes how a healthcare system under-equipped to manage it poses barriers to accessing healthcare.

Conclusions: Accessing healthcare for Parkinson's disease in Kilimanjaro region is influenced by both healthcare system and patient factors and is often challenging for those affected by the condition and those involved in healthcare. This study highlights the need for the development of effective public health interventions for Parkinson's disease in this setting. A systems approach, focussing on care affordability, public awareness, specialist service capacity, management outside of the specialist setting, and research relating to novel diagnostics and therapeutics in Sub-Saharan Africa is recommended to improve healthcare access.

PRESIDENTS ROUND

Scientific Presentation - Psychiatry and Mental Health

3659. THE EFFECTS OF UNILATERAL UPPER LIMB MOTOR CONTROL TRAINING ON COGNITIVE FUNCTION IN OLDER ADULTS

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Introduction: Age-related cognitive decline, particularly in executive function and processing speed, is a major concern. Physical exercise is recognised as a strategy to support cognitive health (1), however not all older adults are physically able to perform the 'traditional' forms of exercise (i.e., resistance and endurance exercise), which have been shown to elicit this benefit. Motor control training (MCT) is emerging as a potential alternative exercise modality, however, to date the effect of unilateral, upper-limb MCT on the cognitive abilities of older adults has not been investigated.

Methods: Twenty disease-free older adults aged ≥65 years (10 male, 10 female; 73.0 ± 2.1 years) completed a 4-week unilateral MCT programme by the self-determined dominant upper limb. MCT was performed three times each week, with assessments of cognition (Trail Making Test (TMT), Montreal Cognitive Assessment (MoCA), and Stroop Colour-Word Test (SCWT)) before and after the MCT, and 4 weeks after cessation of the MCT. IL-2 and brain-derived neurotrophic factor (BDNF) were also evaluated at these timepoints as potential biomarkers of cognition. Data was analysed via one-way ANOVA with significance accepted as $p<0.05$.

Results: TMT (28.49 ± 6.54 vs. 24.37 ± 7.83 sec; $p = 0.01$), MoCA (25.8 ± 1.82 vs. 28.2 ± 1.24 point; $p < 0.0001$), and SCWT interference scores (raw, $p<0.0001$) significantly improved after MCT and remained improved at follow-up (TMT: 24.22±6.23 sec, p; MoCA: 28.6±1.31point, p=<0.0001; SCWT: 4.53 ± 7.43 vs.11.74 ± 9.90 point, $p<0.0001$). In contrast, IL-2 and BDNF were not altered by MCT ($p=0.21$ and $p=0.29$, respectively), nor did they change in the post-MCT period ($p=0.54$ and $p=0.65$, respectively).

Conclusion: Unilateral, upper-limb MCT may provide cognitive benefits in older adults, including in executive function and attention. As these improvements were attainable in just 4 weeks, it may be applicable to clinical situations such as surgical prehabilitation. The lack of biomarker changes suggests that longer interventions may be needed to produce measurable neurobiological effects.

Reference: 1. Erickson KI, Voss MW, Prakash RS, Basak C, Szabo A, Chaddock L, et al. Exercise training increases size of hippocampus and improves memory. Proceedings of the National Academy of Sciences. 2011 Feb 15;108(7):3017–22.

PRESIDENTS ROUND

Scientific Presentation - Eyes, Ears and Teeth

3674. SETTING THE RESEARCH AGENDA FOR CO-EXISTING DEMENTIA AND HEARING CONDITIONS: A JAMES LIND ALLIANCE PRIORITY SETTING PARTNERSHIP

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Introduction: Dementia and hearing conditions are both major public health concerns. Most people living with dementia also live with hearing conditions (e.g., hearing loss, vestibular disorders, hyperacusis). Furthermore, evidence suggests that hearing loss is a risk factor for the development of dementia. There is a critical need for research to explain the association between dementia and hearing conditions and to optimise assessments and interventions for this co-morbidity. This James Lind Alliance Priority Setting Partnership (JLA PSP) aimed to identify unanswered research questions about dementia and hearing conditions that are prioritised by people with lived experience and professionals from healthcare and social care.

Method: The participants were people living with hearing conditions and/or dementia, supporters (e.g. caregivers, relatives), clinicians, and social care professionals. A survey (N=404) gathered 422 research questions proposed by participants, which were collated to form 47 summary research questions. An evidence-checking process confirmed that these questions had not been answered by previous research. A second survey (N=560) produced a shortlist of 16 questions. At a final workshop (N=19), the top ten questions were identified. The process was overseen by a steering group of people with lived experience, supporters, and clinicians.

Results: The prioritised research questions spanned diverse topics, including training for clinicians about this co-morbidity, routine health checks that incorporate hearing and cognition, dementia risk reduction strategies for people living with hearing loss, the impact of auditory and cognitive training on cognition, and potential mechanisms underlying the link between hearing loss and dementia.

Conclusion: This novel JLA PSP was the first to identify research priorities for two different, yet co-morbid, health conditions. It can help ensure that future research about dementia and hearing conditions addresses the priorities of those most impacted: people with lived experience, supporters, and clinicians. It has important implications for researchers, funders, commissioners, and clinicians.

PRESIDENTS ROUND

Scientific Presentation - Falls, Fracture and Trauma

3675. THERAPISTS' PERSPECTIVES ON A NEW STRUCTURED TAILORED APPROACH TO REHABILITATION AFTER HIP FRAGILITY FRACTURE - THE STRATIFY FEASIBILITY RANDOMISED CONTROLLED TRIAL

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Background: The stratify feasibility randomised controlled trial explored a risk-stratified rehabilitation intervention, where patients with hip fracture were categorised as low, medium, or high risk of poor outcome and received tailored interventions accordingly. This qualitative study aimed to understand therapists' views on the acceptability of the approach, as well as barriers and facilitators to its implementation, to inform a future definitive trial.

Methods: Following delivery of the intervention, all therapists took part in semi-structured interviews. The topic guide and deductive thematic analysis were informed by the Theoretical Framework of Acceptability, the Theoretical Domains Framework, and fidelity domains (delivery, receipt, and enactment).

Results: Nine therapists (n = 5 physiotherapists, n = 4 occupational therapists) participated in interviews. All viewed the approach as acceptable and expressed positive attitudes towards the intervention. Key enablers included alignment with professional roles, permission to dedicate time to appropriate therapeutic activities of daily living, confidence in delivering the intervention, and optimism about its benefits. Reported barriers included limited time due to staffing and length of stay, challenges engaging participants in emotionally distressing circumstances, and the need for a consultee to support decision-making and goal setting, particularly in the high-risk subgroup.

Conclusion: The Stratify approach was acceptable to therapists. Key facilitators and barriers to implementation were identified to inform a future trial on the effectiveness of the approach.

PRESIDENTS ROUND

Scientific Presentation - Pharmacology

3682. OUTCOMES OF DEPRESCRIBING FOR OLDER PEOPLE WITH LIFE-LIMITING CONDITIONS: A SYSTEMATIC REVIEW

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Introduction: Polypharmacy and potentially inappropriate prescribing are common in older people with life-limiting conditions. While deprescribing - a structured approach to reducing or discontinuing medications - is one approach to address this, its impact in this population is not well understood. Therefore, this systematic review aimed to synthesise evidence on outcomes of deprescribing medication in this population.

Method: A systematic search of MEDLINE, Embase, Scopus, PyscINFO and CINAHL was conducted to identify original studies reporting clinical-, medication-, and system-related outcomes of deprescribing. Studies published in English between January 2000 and December 2024 were included and analysed. Results: A total of 17,457 studies were screened, of which 46 met the eligibility criteria. Most of them were pre-post interventional (n=14) and cohort studies (n=14), conducted in nursing homes/long-term care facilities (n=19) and hospitals (n =14). Studies were mostly conducted in the North America (n=20) and Europe (n=14).

Results: A broad range of outcomes were reported in the literature, predominantly on clinical-related outcomes. Particularly, medication reduction, and mortality and survival outcomes were the most common. All studies assessing the impact on the number of medications used reported either a reduction in overall medication burden or inappropriate medications (n=15), or no significant change (n=3). Mortality and survival outcomes were reported in 16 studies: 4 each showed improved survival and reduced survival, and the remainder found no significant change. For other outcomes, the studies showed that deprescribing did not generally worsen the outcomes in the majority cases.

Conclusion: This systematic review suggests that deprescribing has several beneficial outcomes, including reducing medication burden and healthcare cost. While there is no strong evidence for harm, a small proportion of patients may face risks, so a careful monitoring is essential. Further studies should explore how outcome vary by disease conditions and medication types.

PRESIDENTS ROUND

Scientific Presentation - Health Service Research

3736. EXPLORING FACILITATORS AND BARRIERS TO ENGAGEMENT WITH TECHNOLOGY AMONG OLDER ADULTS WITH AND WITHOUT FRAILTY

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Introduction: Literature reviews indicate older adults are less engaged in using digital technologies due to reasons such as fear of falling and perceived lack of time. However, there is limited literature on the facilitators and barriers to engagement in digitally enabled interventions, like remote exercise programmes with sensors, among older adults with frailty. This study aimed to explore the facilitators and barriers to engagement in digital interventions among community-dwelling older adults with and without frailty.

Method: Community-dwelling older adults at or above 65 years old across the United Kingdoms were invited to participate in this study. Qualitative data were collected using 1:1 semi-structured interviews to understand their experiences (SETREC 6875521). Frailty was measured using PRISMA-7 where a score of greater than two was considered Frail. Purposive sampling was conducted to ensure a representative cohort was included. Interviews were audio recorded, transcribed and analysed using Braun and Clarke thematic analysis.

Results: Overall, 26 participants were interviewed and 13(50%) were females. The mean age was 74.7(SD 7.67)years old, and mean duration of the interviews was 64(SD 21.2) minutes. Six (23%) were frail on PRISMA-7. Eight themes emerged: cost, usability and functions, personal motivation, influence of immediate network, external influences, device design, perceived health benefits, and concerns about privacy and data protection. Twenty-five subthemes which emerged were categorised into facilitators and barriers to engagement. Examples of subthemes are: clear provision of health benefits was a facilitator; concerns over privacy and data protection were barriers to engagement. Participants felt there was room to do more among stakeholders like government and technology companies.

Conclusions: The findings highlighted various facilitators and barriers which influenced engagement with digitally enabled interventions among community-dwelling older adults with and without frailty. Wider applications of digitally enabled interventions can be informed by recommendations to overcome barriers to engagement.

PRESIDENTS ROUND

Scientific Presentation - Other medical condition

3863. ASSOCIATIONS BETWEEN ACCELEROMETRY-MEASURED PHYSICAL ACTIVITY, SLEEP, AND MOBILITY IMPROVEMENT IN HOSPITALISED OLDER ADULTS

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Introduction: Mobility decline during hospitalisation is common among older adults and is associated with adverse outcomes including prolonged length of stay, institutionalisation, and mortality. While physical activity and sleep are key modifiable factors influencing recovery and mobility improvement, their relationships remain underexplored in acute geriatric settings.

Methods: We conducted a prospective observational pilot study involving 15 hospitalised older adults (mean age 84.9 years) admitted to an acute geriatric ward. Participants wore wrist- and thigh-worn ActiGraph wGT3X-BT accelerometers continuously during admission to measure sleep parameters and physical activity. Mobility was assessed at baseline and discharge using the de Morton Mobility Index (DEMMI). Accelerometry-derived metrics included daily time spent in light, moderate, and vigorous physical activity, moderate-to-vigorous physical activity (MVPA) as a percentage of waking hours, and sleep fragmentation indices (number of awakenings, sleep efficiency). Descriptive analyses and Mann-Whitney U tests were conducted to examine relationships between activity, sleep, and mobility changes.

Results: DEMMI scores improved significantly (mean change +6.8 points, 95% CI: –13.4 to –0.2, p=0.045). Participants spent a median of 63 minutes/day in light activity and 2.4 minutes/day in moderate activity. Median MVPA comprised 0.25% of waking hours. Sleep was fragmented (mean 18 awakenings/night; sleep efficiency 69%). Among participants with improved mobility (n=6), the mean number of nocturnal awakenings was 14.2 (SD=2.1) compared to 17.4 (SD=2.4) in those with stable or worsened mobility (n=5), though not statistically significant (p=0.114). Sleep efficiency was 76.4% (SD=19.9) in the improved group versus 80.1% (SD=3.7) in the stable/worsened group (p=0.680).

Conclusions: Despite low physical activity levels and fragmented sleep, mobility improved significantly during admission. Although participants with mobility improvement showed fewer nocturnal awakenings, differences were not statistically significant. Larger studies are needed to clarify these associations and to inform interventions targeting sleep and activity to optimise mobility outcomes in hospitalised older adults.

PRESIDENTS ROUND

Scientific Presentation - Other medical condition

3879. SHARING CARE HOME RESIDENTS' INDIVIDUAL-LEVEL DATA BETWEEN HEALTH AND SOCIAL CARE: THE DATA SHARING PARTNERSHIP PROJECT

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Introduction: Individuals' health data is routinely recorded in electronic health records in primary and secondary care. Care homes collect extensive data about residents, and many now use electronic care planning systems. Linked data could be useful in care homes, healthcare and administration, to highlight change in condition, or trends in needs. This project aimed to link individual-level data held in care homes with health data, and co-design dashboards to display this to care homes.

Methods: In the DataLoch Trusted Research Environment, in partnership with NHS Lothian, the University of Edinburgh and care home partners 1) LoCH DaLi (Lothian Care Home Data Linkage project): we identified the partner care homes using the Unique Property Reference Number and co-designed a dashboard of resident-level health information. 2) Data Sharing Partnership: We worked to ingest social care data and co-designed a dashboard to display linked health and social care data.

Results: We formed a successful partnership with three care providers (Braeburn Home, Leuchie House, Elder Homes) including four care homes. We established the ethical and governance processes required for data transfer and linkage and the related agreements. Metadata headers from care planning software were sent to DataLoch, and dummy data created. Dashboards were co-created with care home managers using dummy data. The managers provided positive feedback that the proposed report and dashboard would be useful, particularly with sequential reports. The ethical and governance aspects of sharing individual's data were discussed with University of Edinburgh and NHS Lothian, and after agreements were agreed and signed, secure data transfer was completed and reports with real data shared with care homes.

Conclusions: The ethical and governance framework at this interface between health and social care is complex. Data sharing has great potential but needs to be built on strong partnerships and trust between all parties.

POSTER

Scientific Presentation - Other medical condition

3878. SCOTTISH CARE HOMES' RESEARCH INVOLVEMENT AND PRIORITIES

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Introduction: Care home residents and staff have limited, though increasing, opportunities to participate in research. This project aimed to describe motivating and limiting factors for research participation and priorities in Scottish care homes.

Methods: In a cross-sectional study, a 21-item questionnaire was distributed to Scottish care homes for older people by ENRICH (Enabling Research in Care Homes) Scotland. It included questions on demographics and previous research involvement, with multiple choice and free-text response options. Mixed methods analysis was used including non-parametric descriptive statistics and thematic analysis. Ethical approval from University of Edinburgh SREG (ref: 2425 SREG 008).

Results: There were responses from 121 care homes, (28% "small" <30 beds, 42.9% "medium" 30-60 beds, 28.9% "large/very large" > 60 beds) with ~70% residents with dementia or other neuro-progressive conditions. 40.5% (of 131 responses, multiple responses allowed) had previously been involved in research (19.1% ageing-related, 19.1% dementia-related), 29.8% had chosen not to be involved, 16% reported not being offered opportunities to be involved. Key themes about research participation were that it allows staff/resident perspectives to be heard and can improve care practices. Respondents reported that research participation was decided by family (24.6%), resident (21.9%), manager (20.3%) or others. Important research motivators were altruism: benefits for residents (94 of 631 responses, 14.9%), to help others (13.8%), future generations (12.2%), to find a cure (11.1%) or new treatment (10.1%). Important barriers included workload pressures (82 of 243 responses, 33.7%), time constraints (32.1%), potential for harm (16%) or confidentiality concerns (10.7%). Future research priorities were dementia/neuro-progressive diseases (31 of 124 responses, 25%), staff-related issues (14.5%), activities/ quality of life improvements (10.5%), residents' mental well-being (8.1%) and medications/interventions (6.5%).

Conclusion: Many care home staff shows that many are keen to be involved in research, but require appropriate support, and the involvement and consideration of multiple stakeholders: staff, researchers, families, residents.

POSTER

Scientific Presentation - Other medical condition

3837. DIAGNOSTIC ABILITY OF SARC-F ACCORDING TO MUSCLE STRENGTH AND PHYSICAL PERFORMANCE TESTS

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Rationale: Sarcopenia, the progressive loss of muscle mass and strength, increases the risk of falls, disability, and mortality in older adults. The SARC-F questionnaire is commonly used to screen for probable sarcopenia, though the optimal cut-off remains debated. This study aimed to identify the most appropriate SARC-F threshold by examining its association with measures of muscle strength and physical performance.

Methods: Individuals aged ≥65 years who presented to a tertiary university hospital geriatric outpatient clinic between January 2022 and May 2024, were evaluated in this cross-sectional study. Patients with active inflammatory conditions, malignancy, or incomplete datasets were excluded. SARC-F scores were analysed against established performance tests: handgrip strength (HGS; <16 kg for females, <27 kg for males), sit-to-stand (STST >15 seconds), 4-meter gait speed(>5 seconds), and the Timed Up and Go (TUG >20 seconds). Receiver operating characteristic (ROC) analyses were performed to determine diagnostic accuracy.

Results: Among the 3,583 individuals screened, 1,355 met the inclusion criteria (mean age: 74.0±6.0 years; 64.9% female). A SARC-F score ≥4 was identified in 22.2% of participants. Using a cut-off of ≥2, sensitivity and specificity were 68.9% and 63.6% for HGS (AUC=0.705), and 68.6% and 68.3% for STST (AUC=0.735), respectively. A threshold of ≥3 was optimal for detecting slow gait speed (sensitivity 63.75%, specificity 83.4%, AUC=0.788), while a cut-off of ≥4 yielded the greatest diagnostic accuracy for TUG (sensitivity 85.2%, specificity:82.5%, AUC=0.881).

Conclusion: This study, involving one of the largest single-centre geriatric outpatient cohorts, supports a lower SARC-F threshold for improved early detection of sarcopenia. A novel perspective is introduced by proposing the SARC-F as a gradational marker of sarcopenia severity and functional decline, rather than a binary outcome.

POSTER

Scientific Presentation - Pharmacology

3508. EXPLORING OLDER PATIENTS' AND CARERS' PERCEPTIONS OF MEDICATION CHANGE COMMUNICATION DURING INPATIENT CARE

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Introduction: Effective communication about medication changes during hospitalisation is critical for patient understanding, satisfaction, and adherence. This service evaluation examined how older patients and their carers perceive healthcare professionals' communication around medication changes during inpatient care.

Methods: A qualitative study was conducted using semi-structured interviews with 10 participants (6 older inpatients, 4 carers) across four geriatric wards. Thematic analysis was applied. Sampling was guided by information power, with data saturation achieved after 10 interviews. Participants had a mean age of 77.5 years, eight patients were British, one Pakistani, and one Black African.

Results: Patients and carers described communication about medication changes as limited and inadequate, often leaving them feeling confused, anxious, and uncertain about decisions being made. There was a clear expectation for timely explanations delivered in straightforward language, with a strong emphasis on understanding the reasons behind each change. When communication was effective, it helped build trust, fostered a better medication understanding, and encouraged adherence. In contrast, poor communication undermined confidence and led to disengagement. Patients also expressed a strong wish to be involved in decisions, yet many felt marginalised or left out of important conversations. They placed high value on transparency and being offered treatment options. Carers emerged as key contributors to the process, often taking the initiative to seek clarification and advocate for the patient's needs. Their involvement was viewed as crucial to delivering safe, informed, and person-centred care.

Conclusion: Prioritising clear, timely communication, including explicit rationale for medication changes, along with shared decision-making and active carer involvement, can strengthen trust, support adherence, and improve continuity of care. These findings highlight the need to embed patient-centred communication into staff training and routine clinical practice. Ethics approval was not necessary for this study as it is a service evaluation. Local approval has been secured from the hospital Trust.

POSTER

Scientific Presentation - Psychiatry and Mental Health

3817. FEASIBILITY OF A CULTURALLY ADAPTED PICTURE DESCRIPTION TASK AS A MEASURE OF COGNITION WITHIN THE OLDER ADULT POPULATION OF HAI

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Introduction: Dementia is an increasing global health problem. Picture description tasks are a useful tool to assess semantic-based language deficits, which can occur during later stages of dementia. There is a paucity of research regarding culturally appropriate picture description tasks within sub-Saharan Africa.

Aim: Develop a culturally adapted picture description task and scoring method and evaluate its feasibility as a cognitive measure in two rural communities in the Hai district of Kilimanjaro, Tanzania.

Methods: An adaptation of a widely used picture description task was developed using community feedback. Five scoring methods were adapted from existing literature. One hundred and twenty-two participants aged ≥60 were sampled for assessment. Audio-recordings and handwritten records of participant responses were transcribed and translated for scoring and analysis.

Results: Eighty-five participants were excluded due to difficulties with task administration. Translated language samples from the remaining 37 participants were analysed. All scoring methods showed no statistically significant association with the IDEA (Identification and Intervention for Dementia in Elderly Africans) cognitive screen when controlling for age, sex and years of education. Education was significantly associated with four out of five scoring methods.

Conclusion: This is an informative first exploration of the cultural adaptation and co-production of a picture description task in sub-Saharan Africa. Most participants attempted the task, with initial analysis suggesting the task correlates with educational attainment more than cognition. Overall, the Banana Theft task shows potential, however, there are caveats to its use in a rural East African setting without additional training and support due to issues highlighted during this pilot study.

POSTER

Scientific Presentation - Incontinence

3657. SHORT-TERM CONTINENCE OUTCOMES IN MEN OVER 75 UNDERGOING ROBOTIC-ASSISTED RADICAL PROSTATECTOMY

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Introduction: As the incidence of prostate cancer rises with increasing life expectancy, more men over the age of 75 are candidates for curative treatment. Robotic-assisted radical prostatectomy (RARP) is commonly used in younger populations, but data on postoperative continence outcomes in older patients remain limited.

Objective: To evaluate short-term urinary continence outcomes in men aged ≥75 years undergoing RARP at a high-volume UK centre.

Methods: A retrospective analysis was performed on 36 men aged 75 or older who underwent RARP between June 2018 and June 2021. Continence was assessed using the ICIQ-SF questionnaire and pad usage at multiple postoperative time points up to 12 months. Continence was defined as the use of zero pads per day.

Results: At 12 months postoperatively, 63.9% of patients were fully continent (zero pads), and 19.4% used one safety pad daily, yielding an overall functional continence rate of 83.3%. Continence improved progressively over time, consistent with the gradual recovery process observed in this age group.

Conclusions: RARP appears to be a viable surgical option for carefully selected men over 75, offering favourable continence outcomes at one year postoperatively. Chronological age alone should not be a contraindication for RARP, and geriatric assessment tools may aid in patient selection. Larger, prospective studies are warranted to confirm these findings.

POSTER

Scientific Presentation - Health Service Research

3833. ASCERTAINMENT OF DELIRIUM IN OLDER ADULTS PRESENTING TO A PRIMARY CARE OUT OF HOURS (OOH) SERVICE: A RETROSPECTIVE COHORT STUDY

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Introduction: Out-of-hours (OOH) services provide emergency primary care outside normal GP hours, serving patients with higher health needs. Delirium affects 25% of hospitalised older adults, causes distress to patients and carers, and leads to poor outcomes. However, little is known about delirium presentations and prevalence in OOH services. We aimed to investigate delirium occurrence and management using case records from an OOH service in South-West England.

Methods: The OPEN database contains 33,345 consultations of patients ≥65 attending the OOH service between April 2019–March 2020. We screened consultations for delirium symptoms during April and July 2019, and January 2020. Records were reviewed by two GPs independently using DSM-V criteria to identify probable or possible delirium. We validated our search strategy by reviewing a random sample of 100 consultations initially classified as "search-negative" and assessed inter-rater reliability. Patient characteristics were compared using Chi-squared tests.

Results: Of 4,288 consultations with patients ≥65 in the study periods, 394 (9.2%) involved possible or probable delirium. A further 76 (1.8%) had end-of-life delirium and were excluded from further analysis. Patients with delirium were similar in age to those without, but more likely to live in residential care (29% vs. 14%, $p<0.001$) and have dementia (46% vs. 11%, $p<0.001$). 67% of delirious patients required home visits, compared to 22% without delirium ($p<0.001$). Delirium was not available as a coded diagnosis; only 6% of cases were coded as "Acute Confusion," whilst 20.9% were coded "Urinary Tract Infection". Patients with delirium were admitted to hospital twice as often as those without (21% vs 10%, $p<0.001$).

Conclusions: Delirium is a common OOH presentation, representing ~10% of consultations with patients ≥65. These patients often have cognitive impairment, require home visits, and are more likely to be hospitalised. Improved recognition and coding could support better management and service planning

POSTER

Scientific Presentation - Health Service Research

3748. MEASURING EXTENDED ACTIVITIES OF DAILY LIVING (eADLs) IN 2025: WHAT DO OLDER PEOPLE AND MULTIDISCIPLINARY PROFESSIONALS THINK?

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Introduction: Measuring extended Activities of Daily Living (eADLs) is an important part of functional assessment. Several eADL scales are currently used, resulting in heterogeneity and lack of standardisation. Existing scales are potentially outdated, containing activities which are no longer considered relevant by older people. We aimed to explore the perspectives of older adults and healthcare professionals on eADL assessment to inform new approaches to eADL measurement.

Method: Semi-structured qualitative interviews were undertaken with older adults and healthcare professionals. Perspectives were gathered on preferences around eADL assessment, scale administration and activities that could be included in a new scale. We also explored the contribution of education and digital literacy. Thematic analysis was used to develop themes from verbatim interview transcripts.

Results: A total of 41 interviews (online and in-person) were conducted with 21 older adults (>60yrs) and 20 professionals representing different members of the multidisciplinary team. Five themes were developed from interview data. Older adults identified that both physical and social activities should be included in eADL scales, and that technology has changed how eADLs are carried out. They also highlighted that views on the acceptability of receiving help must be considered to ensure accurate scoring. Professionals acknowledged that while eADL assessments could be conducted by a machine, face to face communication has key benefits. Inclusivity was consistently prioritised, with gender roles and financial factors identified as key influencing factors in eADL assessment.

Conclusions: Participants identified priorities for future approaches to eADL assessment that will offer a holistic assessment of eADLs and be inclusive to all, whilst reflecting the contemporary activities of life in the 21st century. This requires attention to sources of bias which can arise around inequities in education, access and finance. Further research is needed involving older people who are not digitally confident.

POSTER

Scientific Presentation - Falls, fracture and trauma

3869. FRAMEWORK-GUIDED DOMAIN MAPPING OF ADVERSE DRUG EVENTS IN OLDER ADULTS: A SCOPING REVIEW OF INTERSECTIONAL RISKS

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Introduction: Adverse drug events (ADEs) in older adults contribute to preventable harm, hospitalisation, and health inequalities. While age-related physiological changes affecting drug safety are recognised, less attention is paid to how sociodemographic and structural factors such as ethnicity and deprivation jointly shape vulnerability to ADEs. This limits the ability to design equitable medication safety strategies. This review examines how intersectional risks are currently conceptualised and analysed in ADE research, to inform more inclusive approaches to medication safety.

Method: We conducted a scoping review using JBI guidance and reported using PRISMA-ScR. Six databases were searched for peer-reviewed studies (2001–2024) on community-dwelling adults aged ≥65 years, examining ADEs and analysing at least two sociodemographic or health-related variables. A composite framework was developed using the National Institute on Aging Health Disparities Framework, National Institute on Minority Health and Health Disparities Framework, and Dahlgren & Whitehead model. This mapped five domains of influence: biological, behavioural, sociocultural, environmental, and healthcare system.

Results: From 7,900 studies, 47 met the inclusion criteria. All considered biological factors, but few examined behavioural (17.0%), sociocultural (19.1%), environmental (31.9%), or healthcare system (25.5%) domains. Only eleven tested interaction effects or conducted subgroup analyses. None employed advanced intersectionality-aligned approaches such as Multilevel Analysis of Individual Heterogeneity and Discriminatory Accuracy (MAIHDA) or latent class analysis. Sociodemographic factors were often simplified (e.g., binary ethnicity) and primarily treated as confounders rather than explanatory variables. Methodological quality was moderate to high, but reporting on equity-relevant variables was inconsistent.

Conclusions: Current ADE research inadequately captures the complexity of intersectional risks in older adults. By identifying this critical gap and offering a clear framework for equity-informed analyses, these findings can help promote a shift towards more personalised, inclusive, and system-aware medication safety. This could improve outcomes particularly for older adults experiencing multiple, intersecting disadvantages.

POSTER

Scientific Presentation - Falls, fracture and trauma

3841. CHARACTERISING GAIT SPEED AND FUNCTIONAL PHENOTYPES IN HEALTHY VERSUS NON-HEALTHY OLDER ADULTS USING AI-ENABLED ASSESSMENT

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Introduction: Gait speed is a validated biomarker of functional capacity, reflecting the integrated performance of multiple physiological systems. Traditional gait assessments are often challenging in clinical practice. This study evaluated the utility of GaitKeeper, an artificial-intelligence (AI)-enabled gait speed assessment tool, to characterise and compare functional and clinical phenotypes in healthy versus non-healthy older adults.

Method: A cross-sectional cohort study was conducted involving 25 healthy, community-dwelling older adults (mean age 78.3 years, 44% male). Their gait speeds and associated clinical phenotypes were compared to 84 'non-healthy' participants (mean age 79.4 years, 48% male) recruited from a Specialist Falls Clinic, a longitudinal exercise programme, and a mild cognitive impairment cohort.

Results: Healthy older adults demonstrated significantly faster gait speeds (mean 1.21 ± 0.30m/s) compared to non-healthy participants (0.94 ± 0.35m/s; p=0.001). Only 8% of healthy individuals had gait speeds below the clinical falls-risk threshold (≤0.8m/s), compared with 39.3% of non-healthy participants (p=0.007). Healthy older adults also exhibited significantly lower frailty (Clinical Frailty Scale scores 1–3: 76% vs. 31%; p<0.001), less mobility aid use (8% vs. 48.8%; p=0.0002), and less falls (28% vs. 56.6%; p=0.021) than non-healthy cohort. Even within the healthy cohort, gait speed differed significantly across frailty categories (median 1.34m/s non-frail, 1.13m/s pre-frail, and 1.10m/s frail; p=0.038), reinforcing its sensitivity as a marker of emerging decline. In this subgroup, slower gait speeds were significantly associated with higher frailty scores (ρ=–0.59; p=0.002) and limitations in self-reported usual activities (ρ=–0.43; p=0.032), although associations with comorbidity and fear of falling were not significant. These findings highlight the discriminative power of gait speed even among community-dwelling adults without overt impairment.

Conclusion: AI-enabled gait speed tools offer an efficient and objective method to detect early functional decline, particularly when used alongside broader clinical assessments. Its routine implementation may inform the timing of preventative interventions in ageing populations.

POSTER

Scientific Presentation - Other medical condition

3882. SHARING CARE HOME RESIDENTS' INDIVIDUAL-LEVEL DATA BETWEEN HEALTH AND SOCIAL CARE: A QUALITATIVE EVALUATION OF THE DATA SHARING

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Introduction: A large amount of data is collected on care home residents to support their daily care. The Data Sharing Partnership (DSP) project linked individual-level data held in care homes with health data, and co-designed dashboards to display back to care homes. This evaluation aimed to gather views and experiences of project participants to understand key processes and learnings to inform the development of an accessible and secure model for the use of individual-level care home data.

Methods: Qualitative methods were undertaken through in-depth semi-structured interviews with DSP project participants; researchers, care home managers, NHS quantitative data analysts, consultant geriatricians, and NHS innovation staff (n=14). Interviews were audio recorded and transcribed verbatim. Transcripts were coded using NVivo. Thematic analysis was undertaken to identify key themes. Ethical approval granted by Edinburgh Medical School Research Ethics Committee (ref 25-EMREC-003).

Results: Six main themes were developed: (i) Balancing innovation whilst navigating complex data governance; (ii) Timeliness of sharing care home data and its importance for residents' care and health/social care systems; (iii) Operational challenges in implementing shared care home data; (iv) Barriers/Facilitators to achieving the project's goals; (v) Key learning; (vi) Future work considerations. Interviewees emphasized the benefits of sharing care home data for resident care and broader health/social care system integration. Governance challenges over data controller responsibilities posed major obstacles, requiring lengthy discussions. Operational barriers included daily pressures in care homes and their fragmented data systems. Facilitators to study goals included partnership working and co-production involving care homes, data analysts, and residents/families. Barriers included slow governance processes delaying project timelines. Key learnings included the importance of partnership working, good communication and early governance engagement. Scalability requires resources and national co-ordination.

Conclusions: This proof-of-principle project identified a wide range of lessons that can inform future data sharing initiatives in the care home sector.

POSTER

Clinical Quality - Clinical Effectiveness

3292. A REVIEW OF A GENERAL PRACTICE'S PALLIATIVE CARE TO IMPROVE EARLY IDENTIFICATION AND EFFECTIVE COORDINATION OF THESE PATIENTS

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Introduction: This project was conducted as the practice had a proportionally low number of patients on the palliative care register (PCR) compared to the total patient population (0.15%). Roughly 1% of the population die every year and many deaths can be foreseen; as such practices should have around 1% of their total population on their PCR. Early identification of these individuals and inclusion on a PCR has been shown to lead to better quality coordinated care.

Method: A review of deceased patients at the practice was conducted noting their cause of death, if it was predictable, and their inclusion on the PCR. The practice's current PCR was also reviewed, taking into account if the individuals were coded correctly and if they had been offered a discussion regarding resuscitation or advanced care planning (ACP).

Results: The project showed less than half of the patients on the PCR were correctly coded and only two thirds had been offered or had a discussion regarding resuscitation or ACP. The review of deceased patients revealed less than a quarter of patients were included on the practice PCR and coded correctly. Those with frailty and dementia were the population most commonly left unidentified with over two thirds of deaths identifying the condition as a contributing cause.

Conclusion(s): The project's findings led to a review of the current PCR to ensure that all patients are appropriately coded and offered the opportunity to discuss resuscitation/ACP. Identifying the populations most commonly missed from the PCR has led to reviews of individuals from these groups for consideration of addition. Additionally, a guide for identifying patients who may benefit from palliative care has been created and distributed within practice. Finally, the practice has adopted the Daffodil Standards to encourage ongoing self-assessment and improvement in end of life care.

POSTER

Clinical Quality - Clinical Effectiveness

3355. USE OF PROCALCITONIN BLOOD TEST TO GUIDE ANTIBIOTIC USE IN THE POST-OPERATIVE ORTHOGERIATRIC SETTING

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Introduction: Procalcitonin is a biomarker produced in response to bacterial infections, particularly in sepsis. In the post operative setting it is difficult to determine if increases in traditional infective biomarkers (FBC and CRP) are driven by sepsis or are a consequence of surgery. The orthogeriatric team at Ysbyty Gwynedd created a guideline to use this blood test to help guide antibiotic use. An audit cycle was completed to assess the impact on antibiotic use and to ensure adherence to the guideline.

Method: The crux of the guideline is as follows: do not check procalcitonin within 24 hours of surgery, qualifying criteria for a test are fever or delirium or CRP >100, a positive test is indicated by procalcitonin >0.5, after a first procalcitonin returns positive the test must be repeated after 24 hours to assess response to antibiotic with a 50% fall in the value indicating adequate response. Data was collected about 51 patients post operatively over a six-month period. There were two cycles of data collection with a teaching session between cycles where problems with adherence to the guideline were discussed.

Results: Standard biomarkers of infection including CRP and neutrophil count were often unable to differentiate the consequences of surgery from bacterial sepsis. Only 25% of patients having a procalcitonin test were found to have a raised result indicating bacterial sepsis, despite nearly all these patients having a CRP over 100 and a neutrophil count > 7.5, x10^9/L. For 36 of the 51 patients, antibiotics were not started/stopped after reviewing the procalcitonin.

Conclusion: Elderly patients are more likely to suffer the negative consequences of unnecessary use of antibiotics due to polypharmacy, risk of C. Difficile and are more likely to develop resistant infections. Procalcitonin is a promising tool to guide antibiotic decisions in orthogeriatrics.

POSTER

Clinical Quality - Clinical Effectiveness

3412. ARE NHS RESIDENT DOCTORS REQUESTING CT SCANS APPROPRIATELY? A TWO-CYCLE AUDIT ASSESSING COMPLIANCE WITH ROYAL COLLEGE GUIDELINES

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Introduction: The appropriate use of CT scans is essential for patient safety and effective healthcare delivery. This audit aimed to evaluate whether resident doctors in the NHS are requesting CT scans in line with the Royal College of Radiologists (RCR) guidelines, and to assess the impact of educational interventions on improving compliance.

Method: A retrospective audit was conducted in two cycles. Cycle 1 involved reviewing CT scan requests made by resident doctors (up to ST2 level) for patients aged 80+ fin August,2024. The compliance with RCR guidelines was assessed on several criteria, including presenting complaint, clinical scenario, scan indication, prior tests, and background information. Following educational interventions such as posters and teaching sessions, Cycle 2 was conducted in October 2024, using the same criteria and assessment tools.

Results: Cycle 2 demonstrated significant improvement in the documentation of presenting complaints (69.35% to 90.77%), scan indications (69.35% to 83.08%), and previous tests (38.71% to 64.62%). Request and imaging details showed high compliance (100%) in both cycles. However, documentation of examination findings showed only a modest improvement (40.32% to 49.23%), indicating an area requiring further focus.

Conclusion(s): Educational interventions including posters in the wards led to substantial improvements in resident doctors' compliance with RCR guidelines, especially in documenting key clinical information. To sustain these improvements, integrating checklists into the CT request process and ongoing teaching are recommended.

POSTER

Clinical Quality - Clinical Effectiveness

3589. Embedding FRAX scoring into the Comprehensive Geriatric Assessment following an inpatient audit

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Introduction: Falls are a common presentation comprising 17% of all ED attendances in older people and can result in harm including fragility fractures (FFs). FFs lead to pain, functional decline, deconditioning, and high mortality. Validated tools such as FRAX can increase prescribing of antiresorptive medications (ARM), reducing harm. Comprehensive geriatric assessment (CGA) is the gold standard for assessing and managing geriatric syndromes including falls and can include fragility fracture risk assessment.

Method: An audit was conducted of all inpatients over one day on Colwell Ward at Isle of Wight NHS Trust. Patients were screened meeting NICE criteria for Bone Health Assessment (BHA). Notes were reviewed for evidence of FRAX scores or BHAs. Bloods were reviewed for vitamin D and calcium. Drug charts, medicine reconciliations, and GP records were screened to see if vitamin D, calcium, and anti-resorptive medications were prescribed previously. Following the audit FRAX scoring has been included in the CGA being piloted by the acute frailty team.

Results: Of 30 inpatients, 100% met NICE criteria for BHA. Mean and median age was 85 (72-96). 63.3% were female (19/30). 16.7% had a history of osteoporosis or osteopenia (5/30). 6.7% (2/30) had a note mentioning BHA in their medical notes, however zero patients had had a FRAX score calculated. 46.7% (14/30) had vitamin D checked and 93.3% (28/30) had had calcium checked. 6.7% (2/30) were already on ARM and the same percentage were started on ARM that admission. 56.7% (17/30) had vitamin D and calcium prescribed on their drug charts.

Conclusion: All patients met NICE criteria for BHA however few had FRAX scores completed. This may lead to avoidable fragility fractures. Reasons for few BHAs are likely multifactorial. Embedding FRAX within the CGA increases opportunities to identify at-risk patients. Re-audit is recommended after the CGA has been fully implemented locally.

POSTER

Clinical Quality - Clinical Effectiveness

3619. IMPROVING THE NUMBER OF INPATIENT FALLS BY INTRODUCING INPATIENT FALLS RISK ASSESSMENT BY DOCTORS IN GERIATRIC WARDS

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Introduction: Inpatient falls remain a major healthcare challenge, with an average rate of 6.6 per 1,000 occupied bed-days in NHS England and Wales hospitals. Prevention of falls during hospital stay based on identifying and managing the modifiable risks are challenging. Multifactorial falls risk assessment and prevention action plan (MFRA FPAP) is a proforma booklet adopted by ABUHB.

Method: The initial QIP (2022–2024) revealed incomplete and poor-quality MFRA. Falls champions were introduced for a period of time. It showed an improvement but was not sustained. Due to a rise in in-patient falls, the QIP was repeated. Eighty patients across three COTE wards were reviewed. Data collection included patient interviews, collateral histories, clinical notes, electronic systems (CWS), and GP records. Bone health was assessed using the FRAX UK score, and falls risk evaluated via MFRA, following NICE 2013 guidelines. We again identified ongoing gaps in MFRA and bone health. To address this, we introduced posters and teaching sessions to raise awareness of falls risk and implemented a one-page falls risk assessment proforma within the ward admission notes, to be completed by doctors along with an action plan.

Results: D4E ward had good compliance with the proforma. Notes of 48 patients (December–March) revealed over 90% completion in MFRA, cognitive, visual, auditory, mobility, footwear assessments, and ECG. Medication review was completed in 100% of cases. Lying/standing BP recordings improved significantly from 32% to 81%. However, bone health and sarcopenia assessments showed slight improvement. Nearly all reviewed elements had corresponding action plans. Falls data showed a reduction from 15 incidents in November to 7 in February.

Conclusion: The quality of falls risk assessment has significantly improved. We plan to extend the proforma to other wards, assign a physician associate to enhance compliance, and include it in our yearly induction programme to sustain improvement.

POSTER

Clinical Quality - Clinical Effectiveness

3436. A QUALITY IMPROVEMENT INITIATIVE ON THE 'DIAGNOSIS AND MANAGEMENT OF ACUTE HEART FAILURE IN OLDER ADULTS'

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Introduction: Recommendations from the revised European Society of Cardiology (ESC) guidelines (2023) have changed how we manage decompensated heart failure (HF) in acute hospitals. Adherence to ESC guidelines is associated with reduced mortality, readmissions and improved quality of life (www.escardio.org, 2023). This audit was conducted to compare our practice against the above ESC guidelines.

Method: Two PDSA cycles were completed between July 2024 and April 2025 in the Acute Frailty Unit and two Elderly Care wards. Patients presenting with decompensated HF above 65 years were included. Data were collected from electronic health records on diagnosis of HF and its phenotype, initiation of appropriate guideline-directed medical therapy, and diagnosis and management of anaemia. Interventions post 1st PDSA cycle include departmental teaching, discussing HF phenotype and the management at the board rounds, teaching during ward rounds, presentation at the governance meeting and displaying posters.

Results: The first PDSA cycle included 28 patients, and the second one included 42 patients. Five out of 28 patients (18%) had their phenotype mentioned in the initial clerking, and 11 (39%) in their discharge notes in the first cycle, compared to 23 out of 42 (54.7%) and 27 out of 42 (64.3%) in the second cycle. The patients investigated for iron deficiency improved from 43% to 69%, post intervention. Out of 12 patients with iron deficiency, only 5 received iron infusion in the 1st cycle, whereas 14 out of 15 received in the 2nd cycle (42% to 93%). 10 out of 22 (45%) eligible patients were started on SGLT2i in 1st cycle as opposed to 22 out of 28 (79%) in 2nd cycle. Out of 9 appropriate patients, only 3 were commenced on ACE/ARB/ARNI in the first cycle, which improved to 17 out of 18 post-intervention (33% to 94%). 3 out of 9 (33%) eligible patients were started on MRAs in the 1st cycle, which improved to 13 out of 13 (100%) in the 2nd cycle.

Conclusion: A significant improvement was demonstrated in the management of acute HF, during the second PDSA cycle. The interventions implemented were effective and transferable to similar settings in the UK.

POSTER

Clinical Quality - Clinical Effectiveness

3464. A Quality Improvement Project in Managing AKI in post operative femur fracture and other orthopaedic patients.

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Introduction: Acute Kidney Injury (AKI) is a serious and preventable complication in older adults following orthopaedic surgery. At Lincoln County Hospital, inconsistent AKI recognition and response led to a Quality Improvement Project (QIP) aiming to embed the trust's AKI bundle into routine postoperative care.

Method: A prospective, two-cycle audit was conducted on orthopaedic postoperative patients. Patient records and electronic data were reviewed for AKI recognition, management, and outcomes. Between cycles, interventions included targeted teaching sessions, visual reminders across wards, and the introduction of a structured AKI assessment proforma.

Results: Initial audit findings revealed only 20% adherence to the AKI care bundle. Following intervention, compliance rose to 100% in the second cycle. Clinician engagement with medication review and fluid assessments improved significantly, leading to earlier detection and fewer AKI cases. The project was presented at the hospital's Clinical Governance Meeting, where it was well received and subsequently integrated into the junior doctors' induction programme. It was also showcased at a regional quality improvement conference.

Conclusion: This QIP demonstrates that low-cost, high-impact interventions—driven by education, visibility, and practical tools—can dramatically improve AKI management in orthopaedic patients. By embedding these changes into routine practice and institutional teaching, we've established a sustainable, replicable model for improving postoperative outcomes in older adults.

POSTER

Clinical Quality - Clinical Effectiveness

3505. A QUALITY IMPROVEMENT PROJECT EXAMINING STANDARDS OF ADVANCE CARE PLANNING AND OUTCOMES OF FAST TRACK DISCHARGES

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Introduction: The British Geriatrics Society promotes Advanced Care Planning (ACP) for patients in their last year of life, reducing avoidable admissions; empowering them to make informed decisions; and helping them plan for their future care to align with personal values and goals. This Quality Improvement Project (QIP) aimed to investigate ACP documentation and the outcome of Fast-Track (FT) discharges in accordance with the EoL care strategy 2008.

Method: The first QIP cycle was completed by analysing the FT discharges between March 2023 and March 2024 from an Acute Frailty Unit. 51 patients were included. Data were collected from their electronic health records and were analysed using Microsoft Excel and Jamovi.

Results: The mean age of the patients was 84.96 years; the mean Clinical Frailty Score (CFS) was 6.1 with 72.5% of patients having a CFS greater than 5 (37/51). ACP was discussed and documented in 78.4% (40/51) of patients. 22% (11/51) did not have documented ACP. 54.9% (28/51) were FT to a Nursing Home, with 33.3% (17/51) FT to their own homes. 7.8% (4/51) of patients were readmitted within 30 days of discharge. 11.8% (6/51) of patients died in the hospital while awaiting FT discharge. 56.9% (29/51) died in the community, and 31.4% (16/51) remained alive at data collection. Of the 51 patients, 2% (1/51) were readmitted; 2% (1/51) had an Emergency Department (ED) attendance but were not admitted; 4% (2/51) attended an outpatient appointment, and 80% (41/51) did not return to the hospital. Based on the age profile, we would expect 9% to die, 15% to readmit, and 8% to return to the ED without admission within 30 days.

Conclusion: ACP discussions result in low readmission rates and ED visits demonstrating better patient outcomes, avoidance of unnecessary admissions, and reduced costs. The second cycle has been commenced.

POSTER

Clinical Quality - Clinical Effectiveness

3517. THINK DELIRIUM: A QUALITY IMPROVEMENT PROJECT (QIP)

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Introduction: Delirium affects up to 50% of older patients (aged over 65 years) in hospital and is associated with serious consequences including greater morbidity and mortality, longer hospital stays with consequent hospital acquired complications, and an increased likelihood of hospital readmission. Early recognition prompting effective management is critical in improving outcomes for patients with delirium.

Methods: This QIP was conducted amongst Foundation Year 1 doctors (FY1) working across all wards in a busy district general hospital to improve knowledge of delirium through educational interventions covering definitions, classification, assessment tools, management, predisposing factors, and prognosis. Baseline knowledge was assessed using a multiple-choice questionnaire with re-assessment following a face-to-face teaching presentation, and electronic poster. A follow-up survey assessing participant's perceptions toward delirium management was also conducted.

Results: Prior to intervention, an average of 25% of FY1 doctors selected the correct answer in assessment. This rose to 86% post-presentation and remained at 83% following circulation of the poster. Breakdown of results demonstrated a marked improvement of 59% of clinicians being able to define, and 95% able to classify delirium. An improvement of 51% was noted in the knowledge of assessment tools and a notable 94% in knowledge of pre-disposing factors. Baseline knowledge of prognosis was excellent at 89% and a 2% reduction was noted following interventions. 81% of clinicians felt their knowledge of delirium strongly improved following interventions and 60% strongly agreed to feeling more confident in managing delirium.

Conclusion: The implementation of two distinct educational interventions, through plan-do-study-act cycles, were successful in improving knowledge of delirium. Targeted teaching significantly improved knowledge and understanding, and a follow-up educational poster was a useful tool in promoting knowledge retention and reinforcement. These findings support the strategy of implementing focussed delirium education early in medical training as an avenue to improve patient care.

POSTER

Clinical Quality - Clinical Effectiveness

3555. MANAGEMENT OF URINARY TRACT INFECTIONS IN PATIENTS OVER 65S IN UHNM

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Introduction: Urinary tract infections (UTIs) are the second most common community-acquired infection and the leading cause of hospital infections in individuals over 65 years. UTI treatment is a major driver of antibiotic resistance (AMR), with E. coli being the primary pathogen causing this in the UK. Further, asymptomatic bacteremia is common in over 65s and does not lead to increased morbidity. However, unnecessary antibiotic exposure increases the risk of harm, including AMR and C.difficile infection, contributing to the rising AMR-related mortality.

Method: This study aimed to assess compliance with UTI management guidelines in the elderly care wards at Royal Stoke Hospital, comparing practice with University Hospitals of North Midlands (UHNM) guidelines. The UHNM guidelines for over 65s recommend starting antibiotics promptly for suspected urosepsis or pyelonephritis. But for suspected UTIs, antibiotics should only be started if multiple new symptoms are present, such as dysuria, urgency, incontinence, delirium, suprapubic pain, or hematuria. In cases with only one symptom, particularly delirium, antibiotics are not indicated, and alternative diagnoses should be considered.

Results: The audit consisted of 40 patients diagnosed with simple UTIs, and found that 38% were catheterised before diagnosis, and 18% had alternative diagnoses, such as hospital-acquired pneumonia. Urine cultures were performed in only 25% of cases before starting antibiotics. With the most prescribed antibiotic being Temocillin (40%). Notably, 62% of patients did not meet the UTI diagnostic criteria, primarily because antibiotics were started before urine culture results or when only one symptom, such as delirium, was present.

Conclusion: This study highlights the misdiagnosis and inappropriate treatment of UTIs in patients over 65s, which contributes to AMR and worsens patient outcomes. And proves adhering to guidelines is essential for improving care and reducing unnecessary antibiotic use, which we will further implement by increasing healthcare professionals' education on the topic.

POSTER

Clinical Quality - Clinical Effectiveness

3655. EMPOWERING FUTURE LEADERS IN GERIATRIC MEDICINE: A REGIONAL TEACHING DAY ON SERVICE DEVELOPMENT AND QUALITY IMPROVEMENT

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Introduction: The 2022 Geriatrics Medicine curriculum mandates that trainees demonstrate competence in leadership and management (1). The NHS Long Term Plan and Clinical Leadership Framework emphasise the need to develop clinical leaders capable of driving service improvement across the system (2, 3). However, structured leadership and Quality Improvement (QI) training within higher specialty training remains limited, as demonstrated by recent national evidence (4–5). This one-day teaching programme aimed to provide targeted training aligned with curriculum and NHS priorities.

Method: A one-day teaching programme was delivered to Higher Specialty Trainees in Geriatric Medicine. The lecture-based curriculum included sessions on the Clinical Directors' strategic vision, the role of QI within a hospital, case-based discussion on how to establish a new service and how to maintain and improve an existing service. Lectures were delivered by consultant geriatricians with management experience and introduced other leadership roles within the hospital system, including a QI Director, Consultant Therapists, and Clinical Programme Group (CPG) Transformation Programme Manager. Pre-course questionnaires assessed baseline understanding; post-course feedback evaluated perceived impact and confidence.

Results: Pre-course data indicated low confidence (demonstrated by self-rating confidence on a 5-point Likert scale) in key domains: understanding of clinical director role (12.5%), service development (12.5%), and departmental management structures (8.3%). Post-course responses demonstrated marked improvements in understanding: clinical director role (76.5%), service development (79.4%), and management structures (76.5%). All participants found the programme helpful and relevant (100%). Practical guidance for establishing a new service such as front-door frailty were particularly well-rated. Qualitative feedback highlighted the value of real-world examples and the insight provided by a range of hospital leaders.

Conclusion: This programme significantly improved trainees' confidence in leadership and service development, addressing known gaps in current postgraduate training provision. By aligning with curriculum standards and NHS leadership goals, it offers a replicable model for embedding leadership development in geriatric medicine training. There is scope for a programme such as this to be rolled out to higher specialty trainees in geriatric medicine nationwide.

References: Joint Royal Colleges of Physicians Training Board. Geriatric Medicine 2022 Curriculum. https://www.bgs.org.uk/sites/default/files/content/attachment/2022-02-28/ Geriatric%20 Medicine%202022%20curriculum%20FINAL_0.pdf; NHS England. NHS Long Term Plan. 2019. https://www.longtermplan.nhs.uk; NHS England. Clinical Leadership – A Framework for Action. 2021. https://www.england.nhs.uk/wp-content/uploads/2021/08/clinical-leadership-framework.pdf; Gale T, Grant L, Seal R. Clinical leadership: a framework for improving practice in surgery. NIHR Evidence; 2024. https://evidence.nihr.ac.uk/alert/how-to-improve-leadership-training-in-surgery; Lewis G, Saunders K, Chui W, et al. Understanding barriers to leadership development in district hospitals: a mixed-methods study. BMJ. 2024. https://pubmed.ncbi.nlm.nih.gov/38182412

POSTER

Clinical Quality - Clinical Effectiveness

3663. IMPROVING ANTIBIOTIC PRESCRIBING PRACTICES: A QUALITY IMPROVEMENT PROJECT

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Background: Antibiotic stewardship is critical to combating resistance. Our Quality Improvement Project (QIP) aimed to evaluate and enhance antibiotic prescribing practices across three DME wards by assessing guideline adherence, therapy duration, end date documentation, and concurrent proton pump inhibitor (PPI) use. Older adults are at higher risk of antibiotic associated complications, especially C. diff infection.

Methods: Baseline data were collected from the hospital's electronic prescribing system, evaluating prescriptions for indication appropriateness, duration compliance, documentation of therapy end dates, and PPI co-prescription. An educational intervention (intervention 1: poster highlighting prescriber responsibilities, intervention 2: educational talk on the topic) was implemented, followed by repeat audits to measure impact. Data were analysed quantitatively using percentage adherence to metrics and qualitatively via prescriber feedback.

Results: After the first intervention, adherence to prescribing guidelines improved by 3%(65% to 68%), therapy end-date documentation increased by 9%(75% to 84%), and unjustified PPI co-prescriptions decreased by 7%(50% to 43%). Following the second intervention, adherence improved by an additional 4% (68% to 72%), therapy end-date documentation increased by 1% (84% to 85%), and unjustified PPI co-prescriptions decreased by 10% (43% to 33%).

Conclusion: Targeted educational interventions effectively improved antibiotic prescribing practices. Further cycles will focus on sustaining and building upon these improvements to optimize antimicrobial stewardship.

Implications: This QIP demonstrates the impact of simple, structured interventions in promoting responsible antibiotic use and reducing risks of resistance.

POSTER

Clinical Quality - Clinical Effectiveness

3666. IMPROVING STRUCTURED MEDICATION REVIEWS TO ADDRESS POLYPHARMACY IN HOSPITALISED OLDER ADULTS: A TWO-CYCLE AUDIT

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Introduction: Polypharmacy - commonly defined as the use of five or more medications - is highly prevalent among older adults and is associated with increased risks of adverse drug events, falls, cognitive impairment, hospital admissions, and reduced quality of life. Inappropriate polypharmacy, where medications provide limited benefit or cause harm, represents a significant patient safety concern. Structured medication reviews (SMRs), supported by validated deprescribing tools such as STOPP/START and Beers Criteria, are essential for identifying and addressing potentially inappropriate prescribing. This quality improvement project (QIP) aimed to assess and improve SMR practices in hospitalised older adults with polypharmacy.

Method: A two-cycle prospective QIP was conducted on a Health Care of the Older Person (HCOP) ward at Lincoln County Hospital. Patients aged ≥65 years and prescribed ≥5 regular medications were included. Data was collected during two two-week periods from the same ward (Cycle 1: February 2025; Cycle 2: May–June 2025), with 20 patients reviewed in each cycle. Outcome measures included the prevalence of potentially inappropriate medications (PIMs), SMR completion, documentation in medical notes, and communication of medication changes to general practitioners via electronic discharge documents (EDDs). Interventions introduced between cycles included staff education sessions, e-mail reminders and visual reminders on the ward via posters.

Results: In Cycle 1, 40% of patients were prescribed PIMs. SMRs were conducted for 80%, with documentation also completed in 80%. In Cycle 2, 70% of patients were on PIMs; however, SMRs and documentation were both completed for 100%. Medication changes were communicated to GPs via EDDs for 100% of patients in both cycles. These results demonstrate improved consistency and quality in medication review processes.

Conclusion(s): Targeted, low-resource interventions significantly enhanced structured medication review practices. Embedding SMRs into routine inpatient care improves prescribing safety and optimises outcomes for older adults.

POSTER

Clinical Quality - Clinical Effectiveness

3667. A MULTI-CYCLE AUDIT AIMED AT IMPROVING PRESCRIBING FOR PATIENTS DYING WITH PARKINSON'S DISEASE: STILL ROOM FOR IMPROVEMENT

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Introduction: Caring for patients with Parkinson's disease (PD) approaching end of life (EoL) is challenging. A switch to transdermal rotigotine for dopamine therapy due to loss of an oral route can lead to delirium/agitation and several first-line symptom management medications used at EoL have anti-dopaminergic activity.

Aims: To analyse and improve prescribing for patients with PD at EoL in an acute hospital setting, focusing on: Dopamine replacement therapy Symptom management

Methods: Deaths where PD was entered on the medical certificate of cause of death (MCCD) were collated in 3 rounds of minimum 3 months duration spanning February 2021 to March 2024. After round 1 a new 'medicines information leaflet' relating to prescribing for patients dying with PD was introduced. After round 2 a new prescribing 'PowerPlan' for EoL symptom management in PD was added to the electronic prescribing system. Patient records were reviewed retrospectively and anonymised data stored on secure NHS drives. Ethics permission was not sought as this audit examined routine clinical practice.

Results: A total of 74 patients had PD on their MCCD over the 3 rounds of data collection. The vast majority (84%) had idiopathic PD. Patients were most frequently admitted taking oral co-beneldopa and/or co-careldopa. Across the 3 rounds, 41% of PD patients recognised to be dying were prescribed rotigotine patches. Comments on patient agitation were found in 38% of patients' records (52%, 33% and 42% respectively). Corresponding dose adjustments to rotigotine patches were made in just 3 cases. Anti-dopaminergic medications were prescribed for 47% of patients recognised as dying in round 1. This dropped to 7% of patients in round 2 but remained essentially unchanged from pre-intervention levels in round 3 at 50%.

Conclusion: Despite several targeted interventions, there remains scope for improvement in prescribing for patients with PD who are recognised to be dying.

POSTER

Clinical Quality - Clinical Effectiveness

3669. DOES CHOICE OF ANAESTHESIA PERIOPERATIVELY, AFFECT PATIENT OUTCOME POST- NECK OF FEMUR FRACTURE (NOF) SURGERY?

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Introduction: There is limited evidence regarding the optimal anaesthetic choice for neck of femur (NOF) surgery, particularly in comparing general anaesthesia (GA) versus regional anaesthesia (spinal). While some cohort studies suggest that regional anaesthesia may offer superior post-operative outcomes, including reduced delirium and shorter recovery times, the lack of clear guidelines leaves uncertainty about the best anaesthetic approach for improved patient outcomes.

Methods: This audit aimed to assess the impact of GA versus spinal anaesthesia on patient outcomes in NOF surgery. A cohort of 180 patients with a NOF, was drawn from 238 entries into the National Hip Fracture Database in 2024 at St George's Hospital, London. We compared outcomes between GA and spinal, focusing on post-operative delirium, length of stay (LOS), discharge destination and mortality.

Results: Of the 180 patients, 78.89% received GA and 21.11% received spinal. The results indicated that GA patients had a higher incidence of post-operative delirium (35.91% vs Spinal: 13.16%) and slightly longer LOS (18.92 days vs Spinal: 17.55 days). Discharge destinations were primarily home or bed-based rehabilitation, with GA patients being discharged home in 45.1% of cases and spinal patients 57.1%. Mortality rates were small (GA: 3.52% vs. Spinal: 5.26%); the difference observed between the groups was not statistical difference, possibly due to the few deaths recorded. Also, there was no statistical significance found between the anaesthetic choice compared to ASA grading (p-value=0.68) or pre-mobility status (p-value= 0.54).

Conclusion: The findings suggest that receiving spinal anaesthesia is associated with lower rates of delirium and shorter LOS, with a higher proportion of patients having been discharged home. Further investigation with a larger cohort is necessary to assess the impact of anaesthesia type on patient outcomes. We appreciate that patient factors can also influence anaesthesia choice, and individual patient considerations were not captured in this study.

POSTER

Clinical Quality - Clinical Effectiveness

3670. THE ROLE OF COMPREHENSIVE GERIATRIC ASSESSMENT AND SHARED DECISION MAKING IN GENERAL SURGICAL INPATIENTS

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1. East Kent Hospitals University NHS Foundation Trust; 2. Perioperative Care of Older People Undergoing Surgery (POPS) team

Introduction: Our perioperative service for older people undergoing surgery (POPS) commenced inpatient reviews in September 2024.

Method: Patients being considered for laparotomy aged 80 and over were prioritised as part of the national emergency laparotomy audit (NELA) recommendations. Other patients reviewed were multi-morbid and frail patients with other pathologies, aged between 65-80. All patients reviewed had a comprehensive geriatric assessment (CGA) and shared decision making (SDM) as required.

Results: In 3 months, 115 patients were seen. Median age 83, median clinical frailty score 4 (mild frailty: range 2-8). 22% had surgery, LOS range 2-96 days (2 longest were admitted pre-POPS), median LOS 7. 7% were readmitted within 30 days. 32% already had a DNA CPR/ReSPECT in place, POPS discussed treatment escalation with an additional 25% patients. End of life discussions and pathways instigated by POPS in 8 patients. SDM discussions regarding surgical treatment plans were undertaken in 11 patients. 18% did not need intervention, 55% chose not to have treatment and 27% chose to proceed with surgery after SDM. 53% of patients had medical complications, to which POPS gave input. For the laparotomy group aged 80 and over, 3 months pre and post POPS LOS analysis was undertaken. There was a reduction in LOS from 17 to 14.8 days. There were 4 patients readmitted within 30 days pre-POPS and none in the post-POPS group. Patient and colleague feedback were obtained. Patient feedback was adapted from experience-based design. Feedback on the POPS intervention was overwhelmingly positive.

Conclusion: The POPS intervention was well received by patients and colleagues. There was a trend in reduction in LOS (by 2.2 days) and readmission rates in the older laparotomy group. Quality of care was improved for all seen by virtue of medical input, SDM and escalation discussions.

POSTER

Clinical Quality - Clinical Effectiveness

3676. EVALUATION OF THE ROLE AND IMPACT OF WARD BASED OCCUPATIONAL THERAPISTS FOR OLDER PEOPLE WITH HIP FRACTURES

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Introduction: Occupational Therapists (OT) play a vital role in the rehabilitation of older people with hip fractures. However, a Sheffield Teaching Hospitals 2024 review showed that OT's were spending a significant amount of time completing discharge related admin, reducing face to face contact and opportunities for rehabilitation. Introduction of the care transfer hub (CTH) to a hip fracture ward in December 2024 was taken as an opportunity to reduce OT discharge administrative duties and re-establish the role of OT's in line with university training, core principles of the profession and job descriptions. The primary aims of this project were to focus on early goal orientated patient care, improve patients' functional outcomes, improve patient flow and reduce length of stay.

Methods: The project used an A3 service improvement methodology to establish new roles/responsibilities within the MDT following the implementation of CTH. The focus was on early intervention and functional rehabilitation. A modified Barthel was completed retrospectively for 30 patients prior to the implementation of CTH and 30 patients afterwards to measure the functional difference. Data was also collected regarding length of stay and discharge pathways. The workforce development team completed in depth shadowing of the OT's before and after to establish how the OT role had changed.

Results: Patient face to face contact time from Occupational Therapy doubled. After the change of practice, patients were discharged 16.1 points closer to their modified Barthel baseline. Length of stay decreased by 2.87 days. More patients were discharged on pathway 0 (40%) than prior to the change of practice (23%). Pathway 1 remained similar. Pathway 2 discharges decreased from 37% of discharges to 23% of discharges.

Conclusion: Earlier and more frequent Occupational Therapy intervention leads to better functional outcomes, reduced length of stay and reduction in community services requires for hip fracture patients.

POSTER

Clinical Quality - Clinical Effectiveness

3679. MEASURING THE IMPACT OF POLYPHARMACY REVIEWS WITHIN A 'HOSPITAL AT HOME' SERVICE

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Introduction: Inappropriate polypharmacy in complex, multimorbid, and frail older adults increases risks of adverse events, hospital admissions, and nonadherence. Polypharmacy review is an important part of Comprehensive Geriatric Assessment (CGA) with national guidance emphasising the goal being harm reduction rather than deprescribing. This audit evaluated the impact of polypharmacy review within the Dundee Enhanced Care at Home Team (DECAHT) geriatrician caseload.

Method: A retrospective audit of the 25 most recent patient discharges under DECAHT-geriatrician care (July–August 2024) was performed. Admission, inpatient, and discharge prescriptions were reviewed. Data included total medication count, any medication changes, anticholinergic burden (ACB) score, and high-risk medication use (anticoagulants, antihypertensives, diuretics, antidepressants, antipsychotics, opiates, benzodiazepines, insulin, and gabapentinoids). Data was collected and analysed using Microsoft Excel.

Results: Mean age was 79.6 years (female 78.8; male 81.1), and 64% were female. Mean medication number on admission was 9.64 (range 4–21) versus 9.44 at discharge. Mean ACB score decreased from 2.76 (range 0–11) on admission to 2.16 (range 0–8) at discharge. 9 patients (36%) had a high-risk ACB score of ≥3 on admission, following polypharmacy review 3(33%) dropped below to the high-risk threshold. 85 medication changes occurred across 22 patients (88%): 32 starts (commonly laxatives 28.1%, and analgesics 31.2%), 37 stops (antihypertensives 29.7%, analgesics 21.6%), and 16 dose/frequency adjustments. 17 patients (68%) had ≥1 medication stopped, with reductions seen in prescription of antihypertensives (–30%), antidepressants (–11%), opiates (–25%), and gabapentinoids (–50%).

Conclusion(s): Though 88% of patients had prescription changes made, and medications were stopped in 68%, there was minimal change in total medication count. Meaningful reductions were seen in anticholinergic burden and high-risk drug prescribing. These findings highlight the importance of targeted metrics - rather than medication number alone - to evaluate safe prescribing practices in frail, older populations.

POSTER

Clinical Quality - Clinical Effectiveness

3683. IMPROVING FRAILTY CODING THROUGH A SYSTEMS APPROACH IN PRIMARY CARE

H Kingston; R Podmore

Frome Medical Practice

Introduction: Frailty is a strong prognostic predictor. By incorporation routine frailty scoring as part of routine primary care this can help as guide to clinical teams.

Method: In 2021 we recognised that our we needed to improve identification of frailty. We undertook whole team training of nurse, GPs and Health Care Assistants, and incorporated scoring the Rockwood Clinical Scale as a routine part of regular chronic disease reviews and template for those over 80. An alert was added on the clinical system to highlight last Rockwood score or where this remained outstanding.

Results: In May 2020 we have proactively recorded frailty status as mild moderate or severe frailty or a Rockwood score in only 22% patients and 27% patients in May 2021 and 33% in May 2022. With implementation of a systematic approach the completeness of our data has improved from to 66% by May 2023 and has since steadily increased to 81% in May 2024 and 90% in May 2025. Comparison with neighbouring practices in Mendip where this change was not implemented shows a smaller incremental rise in completeness of recording from 33% in 2020 to 47% in May 2025.

Conclusion: Although in 2021 our proactive coding for frailty lagged behind the performance of other Mendip practices, we have been able to make improvements from coding 24.3% of those over 80 to now having coded 90.1% of this group through a systematic approach. Working as a whole practice team it has been possible to identify those living with frailty using Rockwood scoring. The coding of those at advanced age who are not frail can also help ensure this group continue to have full medical interventions and are not subject to age discrimination.

POSTER

Clinical Quality - Clinical Effectiveness

3685. IMPROVING ADVANCED CARE PLANNING THROUGH A SYSTEMS APPROACH IN PRIMARY CARE

H Kingston; R Podmore

Frome Medical Practice

Introduction: Frailty is a strong prognostic predictor. By systematic recording of frailty those with moderate or severe frailty can more clearly be identified and supported to have holistic discussions about priorities towards the end of life.

Method: In 2022 we recognised that our we needed to improve anticipatory care planning. We recognised the importance of having a systems approach to proactive discussions about care priorities with those identified as frail. We created a planning ahead leaflet to support these discussions https://health connectionsmendip.org/wp-content/uploads/dlm_uploads/2023/10/HC_A5_PlanningAhead_v4.pdf and proactively invited those with moderate or severe frailty to have discussions about their care priorities. This offer was coded on the medical records alongside consistent coding of their wishes using a standard template.

Results: We were recording anticipatory care wishes in 49% of those who were coded as moderately or severely frail in 2020 and 46% in 2021. This has steadily improved with this systematic approach from 51% in May 2022 to 65% by May 2023 and has been maintaining in subsequent years 66% in May 2024 and now 68% May 2025.

Conclusion: A systems approach has led to a sustained increase in the number of patients with moderate or severe frailty who have had advanced care priorities recorded on treatment escalation plans in primary care. By recording when offers of advanced care discussions are made, we are better able to identify the cohort of those who may not have received this proactive invitation. The opportunity to discuss care priorities with family and friends in a stable health setting can help ensure that clinical teams can provide personalised care and that patients and their relatives are supported to reflect and be fully involved in these decisions and to reduce harm of inappropriate admission or medical intervention.

POSTER

Clinical Quality - Clinical Effectiveness

3689. ENHANCING COORDINATION OF BONE PROTECTION PLANS IN ORTHO-GERIATRIC PATIENTS: A QUALITY IMPROVEMENT PROJECT

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Introduction: Bone health assessment forms a standard aspect of orthogeriatric care in line with NHFD* and NOGG**. Current recommendation is to administer first dose of bone protection medication during hospital stay due to high imminent fracture risk. We identified several cases where the first dose was delayed, including near misses and adverse events with potential for patient harm.

Methods: A process map of 20 patients was conducted to collect data on decision-making, documentation, and implementation of bone protection plans. A staff questionnaire identified key shortcomings and areas for improvement. A teaching session on the importance of bone protection was delivered to the ACM*** department. Trust guidelines were developed to support clinical decision making, and electronic system note redesigned for uniformity of documentation. This was included in the induction for incoming orthogeriatric team members. A re-audit was performed to assess whether patients received their first dose of bone protection prior to discharge.

Result: Of the sample initially collected 90% had a bone health plan made, however only 33% of these received their first dose before discharge. There were several barriers highlighted including lack of clarity/variation in documentation, inadequate replacement of vitamin D/Ca, not obtaining consent during the admission. This meant treatment was delayed in 56% and was not given in 10% of the cohort. Qualitative data collected from the questionnaire highlighted the causes in delays including requiring improvements in “clear communication and documentation”, prioritising “early consent”, and “clearer understanding of roles” of members of the team. Following implementation of the interventions, 100% of the sample had a bone health plan made, of these 81.25% were given their first dose of iv bisphosphonate prior to discharge, thus showing a 48.25% improvement.

Conclusion: The improvements achieved reduction in imminent fracture risk and decreased delays in first dose of bone protective medication being administered.

*National Hip Fracture Database

**National Osteoporosis Guideline Group

***Ageing and Complex Medicine

POSTER

Clinical Quality - Clinical Effectiveness

3692. ORTHOGERIATRICS: IMPROVING ASSESSMENTS AND THE USE OF BISPHOSPHONATES

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Introduction: At Doncaster Royal Infirmary we targeted an improvement in the care of patients admitted with a hip fracture. The first objective was to deliver more consistent Orthogeriatric Assessments. The second objective was to improve bone health assessments and the use of bisphosphonates for secondary prevention of fragility fractures.

Method: After a period of limited Orthogeriatric service, from January 2025, new medical support was provided in the form of 12 hours per week of Consultant time and support from a recently recruited Specialty Doctor. This supported the existing Specialist Nurse and Pharmacist. We introduced a bespoke electronic proforma for Orthogeriatric Assessments and aimed to see all new patients over age 60 yrs admitted with a fractured hip within 72 hours of admission. As part of this process we aimed to improve the use of bisphosphonates for secondary prevention of fragility fractures.

Results: Objective 1 - Orthogeriatric Assessment: The number of Orthogeriatric Assessments completed within 72 hours improved from 0% in December 2024 to 11.5% (January 2025), 18.9% (February), 41.4% (March), 77.6% (April) and 85.7% (May).

Objective 2 - Bisphosphonates The percentage number of patients started on bisphosphonate treatment increased from 13.1% (December 2024) to 16.9% (January 2025), 43.5% (February), 46.3% (March), 66.1% (April) and 59.5% (May).

Conclusion: More patients admitted to Doncaster Royal Infirmary with a hip fracture now receive an Orthogeriatric Assessment within 72 hours. This has resulted in a significant increase in the number of patients started on bisphosphonate treatment for secondary prevention. There are common clinical concerns that can limit the use of bisphosphonates. Some of these can be overcome with the latest evidence-based medicine and balancing risks and benefits.[1]

References: 1. Call to action: a five nations consensus on the use of intravenous zoledronate after hip fracture, A Johansen et al., Age and Ageing, 2023; 52:1-9

POSTER

Clinical Quality - Clinical Effectiveness

3711. IMPROVING EXERCISE TRAINING FOR SARCOPENIA OR FRAILTY: RESULTS FROM WAVE 2 OF THE BEPOP BENCHMARKING AND FEEDBACK INITIATIVE

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1. North Cumbria Integrated Care NHS Trust; 2. Newcastle upon Tyne Hospitals NHS Trust; 3. Clinical Trials Unit, University of Warwick; 4. West Yorkshire Integrated Care Board; 5. AGE Research Group, NIHR Newcastle Biomedical Research Centre; 6. AGILE, Chartered Society of Physiotherapy; 7. Research Centre for Health, Glasgow Caledonian University

Background: Resistance exercise is an effective, but often sub-optimally delivered therapy for sarcopenia and physical frailty in older people. The Benchmarking Exercise Programme for Older People (BEPOP) is a UK-wide quality improvement initiative that uses benchmarking and feedback to improve the quality of exercise delivery by physiotherapy services. We present results from wave 2 of BEPOP data collection.

Methods: NHS physiotherapy services across the UK submitted anonymised details for up to 20 consecutive patients referred for sarcopenia or frailty-related reasons. Data included sarcopenia diagnosis, baseline assessment and reassessment method, delivery of intervention (including type and progression of exercise) and signposting to follow-on exercise services. Descriptive data were analysed for five best practice recommendations and compared with results from wave 1 for sites taking part in both.

Results: Twenty-eight sites submitted data for 542 patients, mean age 82 (range 60-104) years, mean Clinical Frailty Score 5. Analysis across all sites showed that 279 (52%) participants had a strength-based assessment prior to programme start and sarcopenia diagnosis was undertaken in 316 (58%) participants by discharge from therapy. 496 (92%) undertook some form of resistance exercise but only 222 (41%) progressed intensity. Only 205 (38%) were reassessed at the end of programme using the same strength-based assessment as baseline and 238 (44%) were signposted or referred to follow-on exercise services. For sites taking part in both wave 1 and wave 2, performance for objective strength assessment improved in wave 2 (64% vs 52%), as did intensity progression (33% vs 11%) and onward referral (40% vs 31%).

Conclusions: We found improvements in several aspects of practice in wave 2 of BEPOP compared to wave 1. There remains considerable room for further improvement in delivery of resistance exercise for older people living with sarcopenia or frailty, which recommendations in the wave 2 report will address.

POSTER

Clinical Quality - Clinical Effectiveness

3714. IMPROVING COMPLIANCE WITH TREATMENT ESCALATION PLANNING IN MEDICINE OF THE ELDERLY (MOE) AND STROKE

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Introduction: Treatment Escalation Planning (TEP) is an essential part of delivering person-centred care and is a key component of Realistic Medicine. A TEP can help to avoid unnecessary interventions, demonstrates respect for patient's autonomy, and reduces uncertainty for both patients and staff who deliver their care. Our aim was to improve TEP compliance across MOE and Stroke in the Royal Infirmary of Edinburgh to >90% by June 2025.

Methods: Data was collected from electronic records (5 patients per ward, per week) for a total of eight months. Data collected included: a) presence of a TEP; b) documentation of: resuscitation status; c) goals of treatment; d) appropriate interventions; and e) communication with patient/family.

Results: Data was collected from 385 patients, from October 2024 to May 2025. During this period five PDSA cycles were completed: PDSA 1 - TEP Leaflet, PSDA 2 – TEP Poster, PDSA 3 – Weekly TEP Champion appointed, PDSA 4 – Departmental TEP teaching and PDSA 5 –TEP Poster edited based on feedback from doctors. TEP compliance remained stable with a median of 100% since January 2023. Documentation of resuscitation status was most reliably documented with a median of 70% since October 2022. There were improvements in documentation of communication (median 55% to 74%) and goals of treatment (median 58% to 80%). The median for documentation of specific interventions remained stable at 58%.

Conclusion: Completion of TEPs in MOE and Stroke remains high, and recent PDSA cycles have demonstrated improvements in communication and documentation of goals of treatment. These interventions have improved the quality of TEPs. We would postulate that this is a reflection of shared decision-making and a shift towards more person-centred care. Next steps will aim to embed TEP conversations in routine clinical practice for all patients who are frail, co-morbid and at risk of deterioration.

POSTER

Clinical Quality - Clinical Effectiveness

3722. ENHANCING JUNIOR DOCTORS' COMPETENCE IN ADVANCE CARE PLANNING: A FOCUSED TRAINING INITIATIVE

N Hashem

Leicester Royal Infirmary

Introduction: Advance care planning is a process that allows individuals to make decisions about their future healthcare, including end-of-life care, by discussing and documenting their preferences, values, and goals with healthcare providers and loved ones. These are especially critical for patients with serious, life-limiting conditions or for frail older adults who may face unexpected health crises. It is a commonly recognised barrier to care planning however that senior doctors often do not have the time to complete it for all patients who require them and that junior doctors lack confidence in having these discussions, this Quality Improvement Project aims at to increase the use of Advance care planning in the form of Emergency health care plan (EHCP) by empowering junior doctors to competently lead these discussions by introducing focussed teaching on the topic to regular teaching.

Method: Our objective was to organize teaching sessions for all junior doctors and LED doctors across University Hospitals of Leicester to educate them identifying suitable candidates and competently leading the discussion. So far, we have delivered these sessions during Geriatric departmental teaching, IMT teaching and trust grade teaching and have gathered feedback to assess the teaching. We have also been collecting information on the total number of EHCPs completed by the trust over various periods, following the introduction of focused Advance Care Planning training into regular junior doctor teaching.

Result: After completing the original round of teaching, we found an overall improvement in the confidence that individuals had in both holding conversations about EHCPs and documenting the forms. 63.2% of participants now felt confident in conducting conversations, with 78.9% feeling confident to complete the EHCP form itself in the electronic system. As of now, we have not demonstrated an improvement in the number of EHCPs completed, with an initial result of 39 over the three months before teaching, compared to 36 after teaching. The 3rd cycle showed 33 EHCPs done after extending teaching programme. It was also noted that almost all EHCPs were completed in the context of advanced frailty and were not utilised for younger patients with terminal conditions.

Conclusion: This initiative has been shown to increase junior doctors' confidence in leading ACP discussions, highlighting the need for such training to promote patient-centred care. Expanding this educational effort to include additional training for foundation-level doctors and GP trainees in 2nd cycle did not increase the number of EHCPs in total. However, it is interesting to note that despite the perceived increase in confidence, the total number of completed plans does not appear to have improved. This may be partly due to our not yet targeting all relevant groups; future rounds of the project should explore the ongoing barriers to completion.

POSTER

Clinical Quality - Clinical Effectiveness

3724. AN AUDIT OF INPATIENT FALLS - ARE WE ADEQUATELY ADDRESSING BONE HEALTH?

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Background: Falls in older adults frequently result in osteoporotic fractures, leading to longer stays, greater dependency, and long-term morbidity. Fragility fractures are estimated to cost the UK around £4.5 billion annually. Despite these serious implications, tools like FRAX, and routine assessments such as calcium and vitamin D levels, are still underused in the inpatient setting, especially following a fall. The National Osteoporosis Guideline Group (NOGG) recommends using the FRAX tool to estimate 10-year fracture risk and guide bone protection.

Objective: To evaluate: • Was a FRAX score calculated for patients who fell while in hospital? • Was bone protection initiated appropriately based on FRAX risk? • Was a vitamin D level checked within one year of the fall?

Method: A retrospective case review of 35 in-patients falls during April–May 2023 across the Trust was done. Patients identified via DATIX and then randomly selected. A custom-designed proforma was used to assess completion of post-fall assessment form, FRAX score, risk stratification and bone health management decisions.

Results: Most falls occurred in patients aged 70–90, consistent with NICE data indicating that 30% of people over 65 and 50% over 80 fall annually. Falls assessment sheet was completed in over 80% of cases. FRAX score was calculated in only 33.3% of cases. Among those, 60% of the patients were at intermediate risk, 20% at high risk and 10% at very high risk of future fractures. Among high-risk patients only 50% received oral bisphosphonates. Among patients without a FRAX assessment retrospective calculation showed 60% were very high risk and missed the opportunity for bone protection.

Key Findings: High compliance with Trust guidelines in completing post-fall assessments. Suboptimal FRAX score documentation, with more than half of fallers not being assessed for fracture risk. Retrospective FRAX scoring revealed many of these were at moderate or high risk and could have benefited from intervention. Calcium and vitamin D checks were performed more frequently than FRAX but still fell short of optimal levels. Concerns regarding bisphosphonate use in patients with renal impairment. Only 50% of intermediate-risk patients had safe creatinine clearance for bisphosphonates, and less than 10% of high-risk patients were eligible.

Recommendations: “Falls Alert Stickers” were introduced in high-risk areas. These include checkboxes for Calcium, Vitamin D, FRAX, and Creatinine Clearance, and a QR code linking to guidance for easy access. Clinician education on bone health management should be enhanced through Grand Rounds and departmental meetings, especially given the high proportion of elderly admissions. Post falls proforma was updated with a separate bone health assessment section and a QR code linked to guidelines. Conclusion: Falls remain a major issue in older inpatients, often resulting in serious fractures and long-term disability. Improving adherence to NICE and NOGG guidelines, particularly through routine FRAX use and attention to renal safety when prescribing bone protection, can improve outcomes. The implementation of Falls Alert Stickers, clinician engagement and revised post falls proforma are important steps toward improving practice.

References: Royal College of Physicians. National Audit of Inpatient Falls: Audit Report 2023 . London: RCP; 2023. [online] Available from: https://www.rcplondon.ac.uk/projects/national-audit-inpatient-falls Royal Osteoporosis Society. The Cost of Osteoporotic Fractures in the UK . Bath: ROS; 2022. [online] Available from: https://theros.org.uk National Osteoporosis Guideline Group (NOGG). Clinical Guideline for the Prevention and Treatment of Osteoporosis . Sheffield: NOGG; 2021.[online] Available from: https://www.nogg.org.uk National Institute for Health and Care Excellence (NICE). Falls in Older People: Assessing Risk and Prevention [CG161]. London: NICE; 2013 [updated 2022]. Available from: https://www.nice.org.uk/guidance/cg161

POSTER

Clinical Quality - Clinical Effectiveness

3479. RE-EVALUATION OF STROKE PATIENTS WITH NIHSS SCORE <5 AT SUNDERLAND ROYAL HOSPITAL

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Introduction: Controlling BP minimises the rate of ICH and reperfusion to promote adequate cerebral perfusion (2). Antiplatelets reduce the risk of recurrent stroke and other vascular events (3). Cholesterol reduction reduces the risk of stroke by reducing harming lipids (4). Diet and exercise are independent stroke reducers and positively impacts both weight and blood pressure (5). Smoking cessation can greatly reduce your risk of stroke (7) (8) (9). If carotid endarterectomy takes place sooner the absolute risk reduction (ARR) is increased and the outcome for the patient is much better (1).

Standards and Ethics: National Clinical Guideline for Stroke and it is under the section Acute Care Criteria for Carotid Doppler Ultrasound Scan (CDUS) include: Short lived symptoms (TIA), Minor non debilitating symptoms so that they can have further surgery (in this audit we have defined this as NIHSS score <5) and has to be anterior stroke. Ethic approval was not needed as it is focused on improving the quality of care within routine clinical practice and do not involve interventions or data collection beyond standard acre. The audit was registered with the audit department and the audit registration number is Ca11032.

Methods: A re-evaluation of 49 patients with an (National Institutes of Health Stroke Scale) NIHSS score admitted to E58 in Sunderland Royal Hospital between 21st June 2024- 67th August 2024 were analysed. Aims and Objectives

Aim: Complete cycle 2 of an audit investigating if ward E58 have improved their management of patients appropriate for CDUS

Objectives: Document how many patients had their carotid doppler ultrasound scans. Log how many were seen within 24 hours. Establish how many patients undergo vascular surgery. Calculate how long patients were seen between CDUS report and surgery. Demonstrate how many patients were treated correct with pharmacological therapy including: Correct statin treatment; Correct antiplatelet treatment. Demonstrate how many patients had non-pharmacological treatment explored. Diet, Lifestyle and Smoking cessation.

Results: 100% success rate in all strokes reviewed receiving the correct antiplatelet therapy. 25/30 (83.3%) patients were started on cholesterol lowering therapy. This is a three percent increase from last time. 4/30 patients (13.3%) were talked to about diet and exercise/lifestyle measures. This is a 2% increase from last time. The doctors did well in this study and were better at commenting on blood pressure. 18/30 (60%) of patients which is a great improvement as there were only 3% of cases commented on previously. Only one patient received vascular surgery and they did not have it within seven days. There were multiple factors leading to delay in surgery - they had their CDUS as an outpatient and there was a delay in the aorta CTa being ordered. Then the surgery was booked for 3 weeks after the aorta CTA was reported.

Conclusion: What we excel at: Prescribing antiplatelet medications and statins to stroke patients. Commenting on blood pressure and ensuring it is in range.

Improvements: Incorporate importance of ordering carotid dopplers within 24 hours of admission into ward induction so each doctor that rotates onto the ward knows to do this.
Take home message: There are some systemic issues that need to be addressed such as the ultrasound department only working Mon-Fri 9:00-17:00 so those admitted Friday afternoon. Early Sunday morning will never receive their US scan within 24 hours. Additionally, the stroke department does not have direct influence on vascular lists so emergencies take

References: 1. Brott TG. Carotid surgery to prevent stroke. Lancet Neurol. 2004 Aug;3(8):452-3. doi: 10.1016/S1474-4422(04)00818-X. PMID: 15261602. 2. Bowry R, Navalkele DD, Gonzales NR. Blood pressure management in stroke: Five new things. Neurol Clin Pract. 2014 Oct;4(5):419-426. doi: 10.1212/CPJ.0000000000000085. PMID: 25317377; PMCID: PMC4196458. 3. Kamarova M, Baig S, Patel H, Monks K, Wasay M, Ali A, Redgrave J, Majid A, Bell SM. Antiplatelet Use in Ischemic Stroke. Ann Pharmacother. 2022 Oct;56(10):1159-1173. doi: 10.1177/ 10600280211073009. Epub 2022 Jan 29. PMID: 35094598; PMCID: PMC9393649. 4. Wang W, Zhang B. Statins for the prevention of stroke: a meta-analysis of randomized controlled trials. PLoS One. 2014 Mar 18;9(3):e92388. doi: 10.1371/ journal.pone.0092388. PMID: 24643199; PMCID: PMC3958535. 5. Prior PL, Suskin N. Exercise for stroke prevention. Stroke Vasc Neurol. 2018 Jun 26;3(2):59-68. doi: 10.1136/svn-2018-000155. PMID: 30191075; PMCID: PMC6122300. 6. Spence JD. Diet for stroke prevention. Stroke Vasc Neurol. 2018 Jan 13;3(2):44-50. doi: 10.1136/svn-2017-000130. PMID: 30022800; PMCID: PMC6047334. 7. Papadakis, S. & McEwen, A. (2021) Very brief advice on smoking PLUS (VBA+). National Centre for Smoking Cessation and Training (NCSCT), Dorset, UK. September, 2021. https://www.ncsct.co.uk/publication_VBA+.php 8. Carr AB, Ebbert J. Interventions for tobacco cessation in the dental setting. Cochrane Database of Systematic Reviews. 2012 9. Holliday R, Hong B, McColl E, Livingstone-Banks J, Preshaw PM. Interventions for tobacco cessation delivered by dental professionals. Cochrane Database of Systematic Reviews. 2021

POSTER

Clinical Quality - Clinical Effectiveness

3728. THINK DELIRIUM, ACT FAST

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Introduction: Delirium is a common acute presentation among older adults, particularly following acute illness or surgery e.g. neck of femur fractures. Early recognition is crucial, as delirium is associated with increased morbidity, mortality, and prolonged hospital stays. NICE guidelines recommend the use of a validated tool, 4AT, for delirium screening in all patients aged ≥65 upon admission.

Aim and Objectives: Compliance with 4AT screening on admission. 4AT assessment on new onset of confusion Train nursing staff on 4AT screening for early identification of delirium.

Methods: Prospective data collection in two cycles: September–October 2024 (Cycle 1) and May–June 2025 (Cycle 2). Data were reviewed from electronic PICS notings. Parameters assessed included 4AT pre-admission and admission at Solihull Hospital (SH), new onset of confusion documentation and 4AT assessment. Our interventions included educational posters on wards and offices, teaching/training for nursing staff, part of MDT discussion and Departmental Teaching.

Results: Comparison of the Cycle 1 and 2: Compliance with 4AT screening on admission at SH improved from 66% to 95%. Pre-admission 4AT completion also increased, from 32% to 52%. In Cycle 2, 76% of 4AT assessments were performed by doctors and 19% by nurses, this marks a significant change from Cycle 1, where all 66% of assessments were conducted by doctors only. Comparison for new onset of confusion: Cycle 1, where 6 patients were charted as having new confusion, no 4AT screening. Cycle 2, 14 patients were identified but only 2 received a 4AT assessment.

Conclusion: Training the team is simple and cost-effective which has led to a significant improvement in compliance with 4AT delirium screening upon admission. However, continued education to consistent 4AT tool when patients are admitted or new confusion arises. Good documentation practices are still needed to maintain progress to further enhance early identification of delirium.

POSTER

Clinical Quality - Clinical Effectiveness

3745. DIGITAL CGA: INNOVATION, IMPLEMENTATION, AND AUDIT-DRIVEN EVALUATION

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Introduction: The Comprehensive Geriatric Assessment (CGA) is the gold standard for managing frailty in older adults, with strong support in the literature. However, gaps remain in the evaluation of electronic CGA's (eCGA's) and standardised implementation. The Frailty Intervention Team at Sandwell and West Birmingham delivers multidisciplinary care via CGA, but prior to intervention, assessments were often incomplete, with baseline compliance at just 23%. This was largely due to the absence of a user-friendly, embedded electronic solution.

Method: A root cause analysis identified key barriers to CGA completion. A three-month baseline audit established a 23% completion rate. In response, an electronic CGA (eCGA) was developed with key stakeholders, including the electronic patient record (EPR) provider. The eCGA launched on 1st March 2024 alongside structured team training. CGA 'champions' supported its adoption throughout the team. A target compliance level of 80% was set.

Results: Post-implementation (Phase 2) audit data show a 76%* completion rate, an increase of 53% from baseline. The number of CGAs reviewed in both baseline and follow-up audits remained consistent to ensure data reliability. Early findings indicate successful uptake and improved compliance with CGA delivery.

Conclusion: The introduction of a digital CGA significantly improved compliance and standardised practice within the frailty team. The eCGA is now embedded into routine care. Phase 3, a follow-up audit planned 12–18 months post-implementation, will assess sustainability. Additional benefits include improved usability, digital integration, and future potential for dashboard-based compliance tracking.

*Final audit figures to be confirmed prior to BGS Autumn Meeting.

POSTER

Clinical Quality - Clinical Effectiveness

3746. IMPROVING PRESCRIBING OF ANTICIPATORY MEDICATIONS FOR DETERIORATING PATIENTS IN AN ACUTE HOSPITAL SETTING

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Background: Anticipatory medications (AMs) support symptom management in patients nearing end of life. NICE guidance recommends early, individualised prescribing with shared decision-making. At WUTH, AMs are prescribed via a Cerner PowerPlan. A 2023 quality improvement project (QIP) identified delays in prescribing and inconsistent documentation. Interventions included junior doctor and pharmacist teaching, and feedback to the palliative team.

Methods: A retrospective review of adult inpatient deaths during October 2024 at Arrowe Park Hospital was undertaken. Exclusions included sudden and paediatric deaths. Extracted data from electronic records included AM timing, prescribing team and Care in the Last Days of Life (CILDOL) template usage. Results were compared to October 2023 data.

Results: 90 patients met inclusion criteria. AMs were prescribed in 98% of patients, up from 96% in 2023. Average time between prescribing and death improved from 6.9 hours to 4.8 days. 76% received AMs within one week of death. Prescription of all four recommended drug classes rose from 84% to 93%. Palliative care referrals occurred in 85% of cases. CILDOL use by the palliative team improved from 60% to 76%, but parent team use remained low (13%). Documentation of side effect discussions improved from 44% to 70%, though over half were brief.

Conclusions: Improvements were seen in timely and comprehensive AM prescribing following targeted education. However, underuse of the CILDOL template by non-specialist teams persists, highlighting the need for ongoing sustained education and system-level prompts. Regular re-audits are planned to embed best practice and support high-quality end-of-life care.

POSTER

Clinical Quality - Clinical Effectiveness

3752. THE NEUROSURGERY-GERIATRIC SERVICE: A MIXED-METHODS EVALUATION OF A NOVEL INTEGRATED CARE MODEL FOR OLDER NEUROSURGICAL PATIENTS

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Introduction: As neurosurgical procedures are increasingly performed on older patients, there is a growing need to incorporate geriatric care to optimise clinical outcomes. In response to this need, the neurosurgical and geriatric teams at our institution collaborated to establish a consultant-led neurosurgery-geriatric service for neurosurgical patients. This study aims to highlight our experience with this novel integrated model of care through staff feedback and a service review.

Method: This was a mixed-methods evaluation which involved two parts: a quantitative and a qualitative assessment. The quantitative phase involved a retrospective review of a prospectively collected patient database of neurosurgery-geriatric reviews. The qualitative phase involved interviewing 15 colleagues within the neurosurgery multidisciplinary team. The question posed was “what areas do you think the service should focus on to improve the care of elderly neurosurgery patients?”.

Results: 57 patient reviews were undertaken across 10 ward rounds. Additional medical input opportunities were identified in 55 out of 57 visits (96%). Further investigations were requested in 65% of visits (n = 37), while 67% (n = 38) received additional interventions. Notably, 53% (n=30) had medications optimised or altered. Four key themes were identified after a thematic analysis of the interviews, namely: the provision of holistic care; medication reviews and patient safety, interdisciplinary communication and staff education. Most staff interviewed reported that these areas are effectively addressed by the service.

Conclusions: The results of our study highlight the neurosurgery-geriatric service as a valuable innovation for enhancing patient care. It shows promise in optimising the management and outcomes of elderly neurosurgical patients by addressing the identified themes. Future longitudinal analysis will be undertaken to evaluate the service and assess secondary aims which are reduced length of stay on neurosurgery wards and increased discharges to patient homes or residential homes rather than secondary care for ongoing medical management.

POSTER

Clinical Quality - Clinical Effectiveness

3759. 'WHAT ARE WE GOING TO DO ABOUT THE CATHETER?' OUR TEAM'S WAY OF STARTING THE DISCUSSION

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Introduction: The cornerstone of catheter-associated urinary tract infection (CAUTI) prevention is avoiding unnecessary indwelling urinary catheter (IUC) insertion [1]. As part of a long-term project to reduce the number of catheters, the most common inserted device used across MOE wards in our hospital, we recently undertook a project to improve planning (does it need to stay, can we remove it?) and the reliability of information reconciliation around their use.

Methods: We designed a data collection tool, analysing key aspects of IUC care, measured our performance at least twice-yearly using data to educate and inform teams. After noting a drop off in documentation around planning, we designed an intervention for our electronic patient record: amending our multi-disciplinary team (MDT) prompt, encouraging teams each week to make a decision with regard to the necessity for ongoing catheterisation. A further two cycles of audit were performed following the intervention.

Results: Across the MOE footprint (up to 142 beds), the prevalence of IUC use averages around 25%. This has not changed significantly across the audit period. However, since the most recent intervention, there have been marked and sustained improvements in documentation and planning. Completion of risk assessment increased from 63 to 92%, notes of change date from 81 to 92%, MDT record of use of catheter from 56 to 83% and future plan from 6-58%.

Conclusion: We have increased the MDT awareness of our use of IUCs and by doing so seen sustained improvements in both planning and information reconciliation, thereby increasing safety. From this strengthened platform, we intend to link to ongoing work around CAUTI reduction. In a system where change of staff is a constant, creating a lasting message is difficult and it can leave improvers feeling like they are permanently on repeat. Encouraging measurement with local improvement ideas can lead to wins that lead to permanent change.

POSTER

Clinical Quality - Clinical Effectiveness

3761. PRE-EMPTIVE HOLDING OF ANTIHYPERTENSIVES AFTER NECK OF FEMUR FRACTURE SURGERY: A PDSA AUDIT IN AN ORTHOGERIATRIC WARD

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Introduction: Elderly patients undergoing surgery for neck of femur (NOF) fractures are at high risk of post-operative hypotension due to reduced physiological reserve. Hypotension in this context is associated with an increased risk of cardiovascular events and impaired recovery. Therefore, senior clinicians often pre-emptively hold angiotensin-converting enzyme inhibitors (ACE-Is) and calcium channel blockers (CCBs) for 48 hours post-operatively, but this practice is inconsistently followed by resident doctors. We audited the prevalence and impact of this practice and introduced an intervention to improve consistency.

Methods: A two-cycle audit was conducted on an orthogeriatric ward. Inclusion criteria were patients aged >65 requiring surgery for NOF fractures. Data collected included antihypertensive use on admission, whether antihypertensives were held post-operatively, systolic blood pressure on post-operative days (POD) 1–3, episodes of moderate (90–100 mmHg) and severe (<90 mmHg) systolic hypotension, and potential confounders (haemoglobin drop, fluid resuscitation, age). Ethical approval was waived. After the first cycle, an intervention was introduced: (1) an induction teaching session for resident doctors and (2) a revised post-op proforma prompting holding of ACE-Is and CCBs.

Results: Twenty-four patients were included pre-intervention, and 25 post-intervention. 75% of patients were taking at least one antihypertensive on admission. Already in the first cycle, patients in whom antihypertensives were held pre-emptively had significantly fewer days of severe hypotension in POD 1-3 (0.36 vs. 0.64 days, p =0.03). Prior to the intervention, antihypertensives were appropriately held in 40% of cases. Post-intervention, this rose to 88% (p=0.04). The average number of days with severe hypotension decreased from 0.62 to 0.28 (p=0.03), and hypotension incidence fell from 35% to 28% (p=0.01).

Conclusion: Pre-emptively withholding ACE-Is and CCBs post-operatively for 48 hours in elderly patients reduces the incidence and duration of hypotension. Teaching and documentation prompts can embed this practice into routine care and improve post-operative outcomes.

POSTER

Clinical Quality - Clinical Effectiveness

3771. IMPROVING CLINICAL FRAILTY SCORE DOCUMENTATION IN ONCOLOGY WARDS

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Introduction: The Clinical Frailty Score (CFS) allows appropriate frailty assessment to guide management plans for oncology patients. CFS documentation is not standard at our trust. We aimed to introduce CFS documentation in the Acute Oncology Service (AOS) clerking proforma and evaluate its use in patients aged >65 to help guide management.

Methods: Data was obtained from inpatients on the oncology wards via NerveCentre. Three PDSA cycles were completed:
Cycle 1 : An evaluation to identify how many patients had a documented CFS. Based on this, a poster was created, emailed to oncology staff, and displayed around the ward.
Cycle 2 : A teaching presentation was delivered to junior doctors on the oncology ward.
Cycle 3 : Nursing staff were informed and encouraged to discuss CFS during morning board rounds. Data was collected after each cycle.

Results: There was a total increase of 20% in documentation after all three interventions. The initial documentation rate was 4.4%. This rose to 6.6% after posters were introduced, increased to 15.5% following junior doctor teaching, and reached 24.4% after involving nursing staff in PDSA Cycle 3.

Conclusion: Educating junior doctors and involving nurses in discussions around CFS helped improve documentation. It has been noted that identifying the CFS on admission increases the likelihood of it being recorded. Since the improvement is still modest, we now plan to incorporate the CFS into the AOS clerking proforma to increase compliance and make documentation part of routine practice.

POSTER

Clinical Quality - Clinical Effectiveness

3776. SYNCOPE: THE INVALUABLE ROLE OF A MULTIDISCIPLINARY TEAM (MDT) IN MANAGING COMPLEXITY

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Introduction: Syncope is a common clinical problem[1] posing a diagnostic and therapeutic challenge, due to varied presentations and underlying pathologies[2]. Although an MDT approach is a recognised key component in patient care[3], there is no current guidance in the context of syncope.

The Syncope Service in QEUH Glasgow is run by Geriatricians with a specialist interest in Syncope. A formalised monthly MDT, introduced in November 2017, involves Geriatricians, Cardiologists, a Neurologist and Cardiac Physiologists.

Method: A retrospective case note analysis undertaken for patients reviewed at the Syncope MDT (November 2017-March 2023), assessed the impact on diagnosis, further investigation and treatment initiation.

Results: 149 patients, with an average age of 65, were discussed at the MDT. The reasons for referral were cardiology specialist advice (62.4%), neurology specialist advice (19.5%) and multi-specialty case review (16.8%).

Following discussion, cases of unexplained syncope decreased from 28.9% to 21%. The diagnosis of a cardiac rhythm abnormality increased from 11.4% to 19.5%, and a provisional diagnosis of a seizure disorder increased from 12.8% to a confirmed 14.8%, without the need for additional specialty clinic review.

The MDT facilitated prompt access to investigations such as ILR (9.4%) and commencement of appropriate treatment such as anti-epileptic medication (6.6%) or PPM insertion (8.6%).

Conclusion: By leveraging the collective expertise of diverse healthcare professionals, the syncope MDT enhances diagnostic precision, facilitates comprehensive investigations and streamlines the patient journey.

References:

[1]Chen,L.Y., Shen,W.K., Mahoney,D.W., Jacobsen,S.J., Rodeheffer,R.J.(2006). Prevalence of syncope in a population aged more than 45 years.Am J Medi,119(12),pp.1088-e1.

[2]McLintock,B., Reid,J., Capek,E., Anderton,L., Mitchell,L.(2019).Unscheduled care bed days can be reduced with a syncope pathway and rapid access syncope clinic.Br J Cardiol,26,pp.133-136.

[3]McAlister,F.A., Stewart,S., Ferrua,S., McMurray,J.J.(2004).Multidisciplinary strategies for the management of heart failure patients at high risk for admission:a systematic review of randomised trials.J Am Coll Cardiol.44(4):810-9.

POSTER

Clinical Quality - Clinical Effectiveness

3785. EIGHTEEN MONTHS OF OACOS: EVALUATING THE OACOS (OLDER ADULTS CANCER OPTIMISATION SERVICE) AT A DISTRICT GENERAL HOSPITAL IN SOMERSET

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Introduction: Increasing numbers of patients live with both frailty and cancer, highlights highlighting the need for onco-geriatric services. Comprehensive Geriatric Assessment (CGA) of older oncology patients increases QoL and treatment tolerance. Recent guidance from British Geriatrics Society stresses the importance of frailty assessment to identify and optimise frailty related issues, alongside collaborative decision-making with patients.

Methods: OACOS was created at a District General Hospital in Somerset to identify and medically optimise frail patients in whom the treating oncologist had concerns about their ability to tolerate radical cancer treatment. Patients were referred to the service for a therapy assessment and geriatrician-led CGA to further investigate and manage concerns relating to co-morbidity, social isolation, cognitive impairment and falls.

Results: Between September 2022 and March 2024, 68 patients were discussed in Oncogeriatrics MDT. 49 patients were seen in the accompanying Oncogeriatrics clinic. Reasons for not being reviewed included not meeting referral criteria, redirection to alternative specialist clinic, sole OT input required and patients declining. Patients seen in clinic had an average CFS of 4 and an average G8 score of 12.5. All patients seen in clinic saw a geriatrician consultant or registrar, with 84% of patients seeing a physiotherapist for a personalised assessment. 92% of patients had a treatment escalation plan completed. All patients had a medication review with 93% of those seen having at least one medication discontinued. Other key interventions included optimisation of blood pressure, cognition and anaemia.

Conclusions: Patient feedback has been positive, appreciating the opportunity to review their health, optimise medical issues and reduce medication burden. Oncologists have appreciated rapid access to holistic geriatrician review alongside therapy input to improve health outcomes. Further exploration into patient's reasons for declining review by OACOS may help identify barriers to access for some patients and the future clinic model.

POSTER

Clinical Quality - Clinical Effectiveness

3787. IMPACT OF CFS AND G8 SCORE ON PATIENTS ASSESSED BY THE OACOS (OLDER ADULTS CANCER OPTIMISATION SERVICE) AT A DGH IN SOMERSET

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Introduction: Comprehensive Geriatric Assessment (CGA) should be considered in all older patients with a cancer diagnosis. Initial frailty screening may highlight those who would benefit most from CGA to optimise their health through radical treatment. The G8 score assesses multiple domains and has been validated in oncology patients: lower scores indicate frailty. In contrast the CFS is not specifically targeted at cancer patients and is often unfamiliar to oncologists. OACOS does not currently utilise the G8 or CFS in its referral criteria; oncologists refer based on concerns for patients undertaking radical treatment.

Methods: Between September 2022 and March 2024, 68 patients were assessed by the OACOS and 49 patients seen in clinic. 100% of patients had a CFS calculated, 92% had a G8 recorded. 12 month follow up was completed on all patients to review outcomes, including complications of radical treatment, toxicities, changes to treatment, and changes to independent living status. Analysis was then sub-divided by G8 score and CFS.

Results: In patients with a CFS of 1-2, 50% experienced complications of oncology treatments compared to 71% of those with CFS 5-6. 83% with CFS 1-2 completed treatment, compared to 21% with CFS 5-6. 36% with CFS 5-6 had a change in independent living status. 50% with CFS 5-6 had treatment downgraded as a result of CGA outcome. 25% with a G8 of 12-14 had treatment downgraded, while 57% with G8 9-11 had treatment downgraded or stopped. Of those with G8 12-14, 75% completed treatment, whereas 29% of those with G8 of 9-11 completed treatment.

Conclusion(s): As expected, those with either a CFS or G8 score that indicated frailty had worse outcomes in this population. The use of CFS and G8 now needs to be considered as part of the referral criteria to ensure optimal utilisation of OACOS resources.

POSTER

Clinical Quality - Clinical Effectiveness

3809. QUALITY IMPROVEMENT PROJECT ON COLLATERAL HISTORY TAKING FOR GERIATRIC PATIENTS AT A DISTRICT GENERAL HOSPITAL IN SOUTH WALES

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Introduction: Knowledge of social history and functional baseline is of paramount importance in Geriatric Medicine. Often a lack of adequate history leads to poor treatment outcomes in patients with advanced frailty. At our hospital, we have tried to identify the possible areas of improvement in collateral history documentation and designed a short and objective pro forma that allows any doctor to take a detailed collateral history for geriatric patients.

Method: We retrospectively reviewed the notes of 30 inpatients in geriatric wards to assess documentation across various domains of collateral history. After identifying major gaps, we developed a concise collateral history pro forma. The first PDSA cycle involved implementing the proforma over 2 months, followed by a re-audit of 30 patients. A second PDSA cycle was completed after incorporating staff feedback and further refinement of the proforma.

Results: The initial audit revealed significant gaps in documentation - key areas such as baseline cognition, falls history, memory loss, and personality changes were recorded in fewer than 40% of patients. Following the introduction of the proforma, the first PDSA cycle showed marked improvements: falls and baseline cognition were documented in over 70% of cases, and coverage of mood, memory, and personality domains more than doubled. After further refinement based on feedback, the second PDSA cycle saw even greater gains - falls were documented in all patients, and memory loss, mood, and personality changes were each recorded in over 75% of cases. Broader social history areas such as food intake, employment, and ADLs also improved significantly. Notably, domains that were previously overlooked - like smoking, alcohol use, and finances - were now consistently captured.

Conclusion: Taking a detailed social history can be a difficult and time-consuming process for junior doctors, often leading to incomplete information. Our Collateral History Proforma aims to bridge that gap for any new doctor joining Geriatric Medicine. Its implementation is especially valuable in settings where paper-based records are still in use, ensuring that essential collateral history information is readily accessible and systematically documented.

POSTER

Clinical Quality - Clinical Effectiveness

3813. BUILDING BETTER BONES, A QUALITY IMPROVEMENT PROJECT TO ENHANCE BONE HEALTH IN THE OLDER PERSON'S UNIT

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Introduction: Fragility fractures can have a profound impact on older adults' quality of life. Optimising bone health by checking vitamin D level, FRAX score, and actioning outcomes provides a cost-effective strategy for reducing the incidence of these fractures. Our aim therefore is to promote awareness and undertaking of bone health assessments in the Older Persons Unit (OPU).

Methods: This was a pre-post cross-sectional study. Data was collected from 212 patient records over two separate days, one month apart. Patients admitted to the OPU at St Thomas' Hospital were included and data was obtained from patient records using EPIC. Three strategies were implemented to improve awareness, accessibility, and time efficiency: Posters with QR codes linking relevant resources and the FRAX tool were placed throughout the OPU. An email campaign targeted both junior and senior staff to raise awareness. A shared Epic 'SmartPhrase' which auto-populated relevant results and provided an easy-to-follow template for documenting FRAX scores and outcomes.

Results: In the first data collection, FRAX documentation was recorded for 13 out of 106 patients, compared to 22 out of 106 in the second cycle ($p = 0.096$). Notably, vitamin D assessment and management showed significant improvement: 80 patients had their vitamin D level checked in the second cycle compared to 63 in the first ($p = 0.013$). Treatment of vitamin D insufficiency (<25 nmol/L) also improved from 7 of 16 patients to 12 of 14 patients ($p = 0.017$).

Conclusion: There has been a positive shift in how bone health is addressed in older patients. Most notably, vitamin D testing and treatment significantly improved. While FRAX documentation showed modest gains, the increased focus on vitamin D reflects growing awareness of bone health. This is an encouraging trend, but further engagement is required to consolidate and sustain these improvements.

POSTER

Clinical Quality - Clinical Effectiveness

3827. IMPROVING DELIRIUM DETECTION IN OLDER INPATIENTS: A QUALITY IMPROVEMENT PROJECT ON 4AT TOOL UTILISATION

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Introduction: Delirium is an acute or subacute neuropsychiatric syndrome characterized by disturbed consciousness, attention, and cognition. It is common among hospitalized older adults and is often underdiagnosed, which can negatively affect patient outcomes. The 4AT tool is a rapid screening instrument for delirium, particularly suited for ward-based assessments. This Quality Improvement Project (QIP) aimed to evaluate the use of the 4AT score in diagnosing delirium in inpatients and to raise awareness among healthcare providers to improve its usage.

Method: A retrospective analysis was conducted over two cycles in three wards at Orpington Hospital. In the first cycle (14/04/2025–20/04/2025), notes from 60 inpatients were reviewed via the EPIC system to identify those diagnosed with delirium and whether a 4AT score was documented. Findings were presented at hospital educational meetings and geriatric journal clubs to educate staff. A second cycle was performed (23/06/2025–29/06/2025) using the same method on 56 patients to assess the impact of the intervention.

Results: In the first cycle, 28 of 60 patients (46.67%) were diagnosed with delirium, but only 8 (28.57%) had a 4AT score documented. In the second cycle, 25 of 56 patients (44.64%) had a diagnosis of delirium, with 11 (44%) having a 4AT score recorded. This demonstrates an improvement in the use of the 4AT tool following the educational interventions.

Conclusion: The QIP demonstrated that targeted education and awareness-raising among clinical staff led to improved use of the 4AT assessment tool for delirium. Continued efforts to integrate 4AT use into routine practice can enhance early recognition and management of delirium, ultimately improving patient outcomes.

POSTER

Clinical Quality - Clinical Effectiveness

3830. IMPROVING DOCUMENTATION OF COMPREHENSIVE GERIATRIC ASSESSMENT IN A NEW ELECTRONIC PATIENT RECORD SYSTEM ACROSS CARE SETTINGS

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1. King's College Hospital NHS Foundation Trust; 2. Maidstone and Tunbridge Wells NHS Trust; 3. Guy's and St Thomas' NHS Foundation Trust

Introduction: In October 2023, the electronic patient record system Epic® was introduced across two London NHS Foundation Trusts — King's College Hospital (KCH) and Guy's & St Thomas' (GSTT). This replaced legacy documentation processes, including the Comprehensive Geriatric Assessment (CGA). At KCH, a CGA template widely used by the multidisciplinary team was lost, leading to inconsistent CGA documentation, poor communication of outcomes at discharge, and reduced data usability. This quality improvement project aimed to standardise CGA documentation and communication across care settings.

Methods: A cross-site working group was formed including IT colleagues focused on Epic® optimisation. Key CGA domains and standard descriptors were agreed. New 'SmartPhrases' were created to present CGA findings clearly and these embedded into a redesigned discharge summary template. The Epic® CGA Navigator tab was rebuilt to support streamlined, structured data entry, enabling automatic population of discharge documents. Implementation was supported by departmental teaching and integration into ward rounds on a pilot ward at each Trust. Pre-intervention, a random sample of discharge summaries from geriatric wards was assessed for inclusion and clarity of CGA domains; post-intervention, discharge summaries from pilot wards were analysed.

Results: Pre-intervention, discharge summaries included an average of one CGA domain. Post-intervention, this increased to average five domains at KCH and four at GSTT. At least seven domains were included in 26% (10/38) and 16% (5/32) of discharge summaries at KCH and GSTT, respectively. Clarity improved from 11% (10/89) to 47% (18/38) at KCH, and 27% (41/153) to 56% (18/32) at GSTT.

Conclusion: This cross-site initiative improved CGA documentation and communication, enhancing clarity and consistency of discharge information. There has been an evolution in phraseology, particularly around the domains included within a CGA. Getting hospital-wide CGA will be an important enabler in frailty-attuned care across acute and community settings.

POSTER

Clinical Quality - Clinical Effectiveness

3832. REDUCING THE USE OF LORAZEPAM AND INCREASING ADHERENCE TO THE DELIRIUM GUIDELINE USING EPIC® DIGITAL SEARCH FUNCTIONS

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Introduction: Despite it's known deliriogenic properties, and contrary to trust guidelines, lorazepam is often used first line in the management of delirium at Manchester Royal Infirmary without a documented rationale. This project aims to improve adherence to trust delirium guidance - reducing the use of lorazepam in the pharmacological management of delirium and improving compliance with non-pharmacological elements.

Methods: Case identification was carried out using the hospital's Electronic Patient Record (EPR) system, Epic®. A report was created to display patients with a coded diagnosis of "Delirium", however, following assessment of the data quality it became clear that this report was failing to capture the expected patient population. A further report was created which displayed patients who had been prescribed medications used in delirium (Lorazepam, Haloperidol, Quetiapine, Olanzapine); data was collected over a 4-week period and patients who had been prescribed one of these medications for an alternative indication were excluded.

Once baseline data had been collected, a programme of education took place. This involved the distribution of posters which outlined key nursing steps, summarised the non-pharmacological and pharmacological management of delirium - highlighting haloperidol as first line and signposting to the full guideline. Data was then recollected using the same dashboard.

Results: There was a significant drop in the prescription of lorazepam by 70%. An average of 8.75 patients received pharmacological management for their delirium per week at baseline. This reduced to 2.6 patients per week following poster distribution. There was no corresponding increase in the use of haloperidol, with lorazepam remaining the first choice for the small number receiving pharmacological management. There was a significant increase in the use of non-pharmacological tools including behaviour charts.

Conclusion: Next steps include implementing a bespoke order set for prescribing in delirium with similar information to the distributed posters and linked to the delirium guidance.

POSTER

Clinical Quality - Clinical Effectiveness

3831. REDUCING DELAYS IN PRESCRIBING AND ADMINISTRATION OF PARKINSON'S DISEASE (PD) MEDICATION – THE IMPACT OF SYSTEM CHANGE

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Royal Albert Edward Infirmary. Wrightington, Wigan and Leigh NHS Foundation Trust

Introduction: Royal College of Emergency Medicine and NHS England define reduction of delays and omissions of critical medication as important strategic objectives. Data from Parkinson's UK indicate that only 37% of doses of PD medication are delivered on time during hospital stays. The aim of this QI project was to evaluate data from previous 2.5 years and evaluate effectiveness of our improvement work.

Method: Utilising hospital electronic reporting system, information was obtained on time from Emergency Department (ED) Triage document completion to time that PD medication was prescribed. Data on administration within 30mins was analysed for 3 months (July + Nov 2023 and June 2024). Questionnaires were sent to nurses, doctors and patients to obtain their perspectives. Electronic system was updated to include "is the patient on time critical medication (TCM)" question on ED Triage document and analysis of its effect was completed.

Results: For co-beneldopa, the average time from triage to first prescription decreased from 320mins in 2023, to 280mins in 2024 rising slightly to 301mins for the first 5 months of 2025. For co-careldopa those figures were 277mins/359mins/218mins for the 3 years. Delays to administering of medication were more prominent in November 23 (range 49-52% given within 30minutes of scheduled time) vs July 23 (range 60-69%) and June 24 (range 66-71%). Doctors reported low confidence in prescribing PD medication, while nurses outlined various barriers to timely administration. Two thirds of patients were satisfied with PD meds in hospital. Following introduction of TCM question in Triage document, time from ED triage to first prescription has gone down to 150mins for co-careldopa and 259mins for co-beneldopa.

Conclusion(s): Multiple interventions were introduced through the 2.5 years to improve performance. We need to continue this work to ensure that patients with PD get their medication on time.

POSTER

Clinical Quality - Clinical Effectiveness

3842. EMBEDDING AN IMPROVEMENT CULTURE ACROSS AN INTEGRATED FRAILTY PATHWAY THROUGH A MULTIDISCIPLINARY QUALITY IMPROVEMENT PROGRAMME

M Bull; J Adams; R Bird

Royal Surrey NHS Foundation Trust

Background: The NHS 10-year plan outlines the ambition to shift care from a hospital-centric model to integrated community-based systems, but little is known about how to implement this change. The integrated frailty crisis multidisciplinary team working across acute and community settings were motivated to improve services but lacked the confidence/knowledge to lead quality improvement (QI). A whole pathway QI practitioner development programme was established with projects aligned to the overarching system strategy to embed the change.

Methods: A structured training and coaching programme was introduced, aligned to the Trust's A3 QI methodology and underpinned by testing using Plan–Do–Study–Act (PDSA) cycles. The programme aimed to build sustainable improvement capability across Advanced Clinical Practitioners and Specialty Doctors. A fishbone analysis identified barriers to applying QI in daily practice. Staff received training in QI methods (including driver diagrams, measurement, and PDSA cycles) and were supported to deliver improvement projects. The programme was refined through multiple PDSA cycles and tests of change in coaching methods used. [JA1]

Results: Nine MDT members completed projects and achieved QI Practitioner certification. Confidence and knowledge in QI improved significantly (70% reporting limited/ no confidence/knowledge at baseline [JA2] vs 85% reporting some/good knowledge/confidence afterwards). Wider impact of the programme through QI initiatives included: Frailty identification in ED increased from 0% to 79%. Use of triage tools with CFS and NEWS2 rose from 0% to 100%. Standardised UCR board rounds improved collaboration and decision-making. A lunch club initiative enhanced patient activity, social connection, and staff morale.

Conclusions: It is possible to embed a culture of QI and align this to an overarching strategy to improve integrated frailty pathways across previously fragmented services. It is recommended to develop QI practitioner skills among frontline staff to maximise the benefits to transformation of pathways and services. Using QI methodology to design the QI programme and Testing and refining this through PDSA cycles ensured engagement, ownership, and measurable improvement. This model is scalable across any healthcare system.

POSTER

Clinical Quality - Clinical Effectiveness

3856. DELIRIUM – GETTING THE BASICS RIGHT ON A BUSY CARE OF THE ELDERLY WARD

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Introduction: Delirium is a disorder of attention and cognition that is commonly encountered on care of the Elderly wards. It is associated with a significantly increased risk of morbidity and mortality, both during and after hospital stays. Best practice guidance from NICE (National Institute for Health and Care Excellence) outlines standards for screening and preventing delirium. Where possible, appropriate preventative measures should be implemented to address underlying causes such as pain, hypoxia, constipation, and infection. However, when delirium occurs despite these measures, timely diagnosis and continued management of contributing factors are essential.

Methods: A single-cycle quality improvement project was conducted to assess the diagnosis and management of delirium in an inpatient geriatrics team. All patients aged 65 and over admitted during the assessment period (April 2025 – June 2025) were included. Audits were carried out fortnightly before (n=21) and after the intervention (n=20), focusing on the use of the 4AT screening tool and the prescription of analgesia (regular or as required), oxygen, laxatives (where indicated) and electrolyte replacement/ management plans. The intervention consisted of a ward-based education supported by a poster campaign.

Results: Following the intervention, there was a notable improvement in the prescription of laxatives (increasing from 57.1% to 84.6%), electrolyte replacement/management (from 81.0% to 100%), and oxygen prescription (from 36.3% to 61.5%). Prescription rates for analgesia remained consistently high (85.7 to 92.3%) both before and after the intervention. However, assessment for delirium using the 4AT tool declined post-intervention, with completion rates dropping from 38.1% to 15.4%.

Conclusions: Simple educational interventions can lead to improved implementation of preventative measures for delirium. However, screening for delirium remains suboptimal. In this population patients were normally admitted to our wards a few days after arrival into hospital - this was not routinely repeated. Further work is needed to integrate delirium screening more consistently into routine practice.

POSTER

Clinical Quality - Clinical Effectiveness

3857. BRIDGING THE TREATMENT GAP: ASSESSING OSTEOPOROSIS RISK IN PARKINSON'S DISEASE IN LINE WITH NOGG GUIDANCE

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Introduction: Parkinson's disease (PD) is recognised as both increasing the risk of falls and contributing to the development of osteoporosis. As a result, there is an elevated risk of fragility fractures, potentially leading to reduced quality of life and increased mortality. National Osteoporosis Guideline Group (NOGG), 2024, recommends that diagnosis of PD should prompt comprehensive assessment of fracture risk. Furthermore, updated guidance advises that clinicians modify FRAX scoring in patients with PD to ensure more accurate risk stratification. BONE-PARK 2 (BP2) algorithm was developed as a method of appropriately assessing risk in line with this guidance.

Methods: 50 patients reviewed in PD clinic in the past year were selected at random. Using clinical noting and GP encounters, FRAX and BP2 scores were calculated for each patient. A numerical score of 1-5 was allocated based on FRAX/BP2. Whether they are, or have previously been, prescribed bone protection was recorded. Scores were analysed by paired t-test to assess if the difference was statistically significant. The aim of this analysis was to determine if the increased fracture risk in the local PD population is sufficiently managed.

Results: T-test showed a statistically significant difference ($p<0.05$) between severity scores when FRAX & BP2 were used. A significant proportion of patients met treatment thresholds for FRAX (score 4-5) but were not prescribed bone protection. Many who were recommended lifestyle advice or measurement of BMD by FRAX, fall into treatment categories when BP2 is used.

Conclusions: These findings highlight a significant difference between FRAX and BP2 scoring, with BP2 identifying more individuals as requiring bone protection. Potential for improving care was also identified as many who met FRAX threshold for intervention, were not prescribed bone protection. This highlights the need for proactive risk assessment and implementation of prescribing guidance in this high-risk population.

POSTER

Clinical Quality - Clinical Effectiveness

3858. QUALITY IMPROVEMENT PROJECT TO IMPROVE REFERRALS FOR PATIENTS UNDERGOING EMERGENCY LAPAROTOMY TO AGEING AND COMPLEX MEDICINE

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Wrightington, Wigan and Leigh (WWL) NHS Teaching Trust

Introduction: Emergency laparotomy is associated with high risk of mortality and morbidity. NELA best practice tariff identifies Geriatrician input as a key performance indicator for all patients over 80 years of age and those who are over 65 and living with frailty. Evidence suggests geriatrician-led comprehensive geriatric assessment (CGA) may improve post-operative outcomes, but only 8% received one between 2019-2020 in our Trust (national average 27%). The aim of this project was to create a standardised referral system between general surgeons and ageing and complex medicine (ACM) team.

Method: This 3-cycle quality improvement project consisted of two key multi-faceted interventions, which were assessed using data from secretaries' emails and the Health Information System (HIS). The first intervention was a standardised referral proforma and pathway, aiming to reduce inappropriate and increase NELA referrals. The second intervention involved appointing a dedicated NELA nurse (summer 2024), who undertook a digital transformation project to improve the acute abdomen pathway, including building an electronic referral process to ACM team.

Results: The first intervention improved referrals for NELA patients from 0 (Sept 2023-Jan 2024) to 6 (March-June 2024). Since building the digital pathway and the referral order going live in March 2025, we have received and completed 18 NELA referrals (March-June 2025). Frailty scoring was made mandatory in the surgical assessment document and referral became active automatically. Geriatricians working on the frailty session absorbed the referrals and completed CGAs for all patients. In NELA audit figures, this has improved our performance from 40% of patients having had a geriatrician review in March 2024 to 100% for the period November 2024 to January 2025.

Conclusions: By working together across surgical and medical specialities, and particularly by creating the digital pathway for acute abdomen, we have significantly improved the percentage of general surgery patients receiving geriatrician review.

POSTER

Clinical Quality - Efficiency and Value for Money

3526. ANALYSIS OF CASES AND OUTCOMES FROM GPwSI WORKING CONCURRENTLY CROSS-SPECIALTY IN ACUTE FRAILTY AND SPECIALIST PALLIATIVE CARE

A Down

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Background: During the period September to December 2024 an individual GPwSI was working across specialist palliative care (0.2WTE) and acute frailty (0.6WTE) concurrently within the same Trust. To allow Specialist Palliative Care consultants to concentrate on ward/inpatient/complex cases, the GPwSI saw a variety of patients where the CNS felt a doctor was needed with unclear or undifferentiated problems.

Method: We analysed the case mix and outcomes of 38 cases seen, demonstrating that cross-speciality working has positive outcomes for doctors, patients and services and reduces acute admissions.

Results: Of the 38 cases analysed, 71% were home visits (patient's usual place of residence), 24% originated as cases identified as needed cross-specialty input whilst the GPwSI was working in ED/SDEC, and 5% were at the hospice/telephone. Over a third (34%) of patient contacts involved patients with non-cancer or frailty related symptoms. Outcomes of the visits varied widely - some were advice only, in two cases GPwSI and CNS administered anticipatory medications, most were referred on to other services e.g. Rapid Response, hospice inpatient unit, Frailty SDEC (Same Day Emergency Care). Patients were seen within 1-2 days on Frailty SDEC by the Frailty team (including GPwSI) for presentations that would otherwise likely have resulted in ED attendances or hospital admissions. At least 37% (up to 50%) of these contacts resulted in >1 ED attendances/admissions avoided through cross-specialty/sector working - some were seen multiple times in Frailty SDEC for follow up and prevention of crises. Presentations included deranged electrolytes, anaemia, infection, ascites. The 24% of cases seen in ED also involved more direct and rapid input from palliative care including inpatient hospice.

Conclusion: This cross specialty integrated method of working was highly successful in admission avoidance in those approaching the end of life, achievement of patient goals (PPC/PPD) and patient satisfaction. Staff also reported high impact of this way cross-sector working.

POSTER

Clinical Quality - Efficiency and Value for Money

3703. THE EFFECT OF A STROKE SDEC PATHWAY ON MRI WAIT TIMES AND ADMISSIONS IN PATIENTS PRESENTING WITH MILD STROKE SYMPTOMS

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Introduction: Rising stroke service demand in the UK is partly driven by patients with mild symptoms. The National Optimal Stroke Imaging pathway recommends an MRI within 1 hour in cases of mild symptoms and/or diagnostic uncertainty. Prompt imaging facilitates treatment and patient flow. The stroke same day emergency care (SDEC) aims to offer rapid investigations, treatment and discharge for patients presenting with mild symptoms and low probability of stroke. This study aims to investigate MRI wait times in patients presenting with mild stroke symptoms (NIHSS≤4) and assess whether an SDEC pathway reduces average wait time.

Method: A retrospective study was conducted in the stroke department at a single tertiary centre. Data were collected from the advanced care practitioner (ACP) stroke referral database during two 6-week periods: pre-SDEC (23/09/24–03/11/24) and during the SDEC pilot (04/11/24–16/12/24). Patients with NIHSS≤4 were included; patients with no adequate documentation or seen in TIA/outpatient clinics were excluded.

Results: During the pre-SDEC period, 172 patients from the ACP database were assessed by the stroke team. 73 patients had NIHSS≤4 and of these, 52 had MRIs with a mean wait time of 16h33m. Of the 73 patients with NIHSS≤4, 86% were admitted to a stroke ward. During the SDEC pilot, 202 patients from the ACP database were assessed by the stroke team. Of these, 104 had NIHSS≤4 and average MRI wait time was 11h34m. 66% of patients with NIHSS≤4 were admitted to the stroke unit. 40 patients with NIHSS≤4 were seen in SDEC; 29 had MRIs with an average wait time of 3h50m. Average MRI wait time and admission rate to the stroke unit were significantly lower in the SDEC period versus pre-SDEC ($p<0.05$).

Conclusion: The stroke SDEC pathway reduced MRI wait times and admissions to the stroke unit in patients presenting with mild stroke symptoms.

POSTER

Clinical Quality - Efficiency and Value for Money

3709. Improving the sharing of contact details and placement information between Geriatric registrars training in South Yorkshire

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Integrated Geriatric and Stroke Medicine, Sheffield Teaching Hospitals

Background: The 2022 revised Geriatric Medicine training curriculum requires trainees to spend more time with a range of healthcare professionals outside their ward placements, including in the community. Contacts and recommendations need to be shared to enable trainees to arrange these placements efficiently.

Introduction: Arranging placements was largely ad-hoc and time consuming with communication limited to emails and an informal WhatsApp group. This project aimed to establish a secure space for trainees to share information.

Methods: In January 2022, a SharePoint site was created through the trust's IT service. South Yorkshire geriatric trainees were given access and encouraged to upload useful contacts and recommendations. Trainees were surveyed in January 2023, followed by reminders to update information at the end of each placement and a second survey in March 2023. The number of contacts uploaded was tracked from March to July 2023, with reminders to use the site sent in April and July 2023. Oversight of the SharePoint was assigned to the Specialty Training Committee representatives. A final survey was carried out in January 2025.

Results: Initial use of the SharePoint was limited; only 50% of trainees used the site by January 2023 with minimal improvement by March 2023 despite reminders. Prompts in March and June 2023 led to increased contacts being uploaded, from 21 to 44. By January 2025 all trainees were using the SharePoint and the number of contacts uploaded reached 98. The final survey showed unanimously positive feedback. Trainees now encourage each other to use and maintain the site without prompting, and usage has expanded to include wider information and shared project documents.

Conclusions: Set up of the SharePoint was straightforward, however, initial engagement was limited. Over time a 'tipping point' was reached with sufficient data available on the site; trainees now consistently use it when arranging placements.

POSTER

Clinical Quality - Efficiency and Value for Money

3781. IMPROVING THE WEEKEND HANDOVER PROCESS ON OLDER ADULTS MEDICINE WARDS AT LEEDS TEACHING HOSPITALS

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Leeds Teaching Hospitals NHS Trust

Introduction: Clinicians covering six older people's medicine wards reported feeling burdened by requests for weekend review of patients without clear indications, reducing time for patient care. We aimed to standardise the process to streamline reviews, freeing up clinicians to deliver optimal care.

Methods: We developed a new electronic weekend handover process using existing capabilities within our electronic patient record. The COM-B behaviour change method was used with a focus group of clinicians including PAs, residents and consultants to identify targets to change behaviour. Fifteen potential tests of change were considered. Four were implemented over multiple PDSA cycles.

Key changes included: Mandatory documentation of review priority (1,2,3 or discharge). Clear documentation of review indication with recommended actions. Embedded mock examples of best practice to nudge behaviour. Engagement through meetings and informal senior/peer influence.

We collected weekly data for four months on: patients put out for review, number lacking a clear indication, and the number missing prerequisite actions. A survey of clinicians was performed.

Results: The number of reviews remained stable but the number of patients with no clear indication for review decreased from 11.5 to 2.5. Respondents rated the new system at 7.72/10 globally compared to 3.2 for the old system. 78% felt that the reason they were reviewing patients was clear. 72% found prioritisation easier. 87% of users of the old system reported quicker review times – none thought it was slower.

Conclusion: A structured electronic system using existing capabilities, informed by behaviour change and quality improvement methodology reduced the number of patients put out without clear review by 78%. Satisfaction with the new system was high and time was released for direct patient care. Further tests of change are planned to drive further improvements in safety and quality, but existing changes have been sustained and success shared with the organisation.

POSTER

Clinical Quality - Efficiency and Value for Money

3784. CLINICAL LEADERSHIP IN PATHWAYS USING CARE PROVIDERS: IMPROVING FLOW, EXPERIENCE, AND EFFICIENCY FOR FRAIL OLDER ADULTS

S Densem

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Introduction: Frail older adults are often discharged from hospital with complex needs into community care services. Without senior clinical oversight, many experience fragmented care, delayed reviews, inappropriate care planning, and avoidable readmissions. This project evaluated the impact of introducing clinical leadership into a care provider pathway designed to deliver short-term, post-discharge domiciliary care.

Methods: Over 11 weeks, 51 patients were supported, 43 of whom were on the care provider pathway. Using the Plan-Do-Study-Act (PDSA) framework, the project identified inefficiencies and tested solutions. Interventions included senior clinician-led home visits, MDT support, care plan reviews, and collaboration with community therapy and social care teams. Data was collected on care package changes, hospital length of stay, and therapy involvement.

Results: Key issues included: lack of formal policy for the pathway, no senior clinical oversight, unregistered care staff making key decisions, and poor end-of-life planning. Outcomes from clinical leadership interventions included: 12% of patients had reduced care packages prior to discharge; 24% had reduced care needs once home. Estimated 476 care hours released per week. Approximate cost saving of £7,000 per week. Senior clinician home visits proved the most impactful, enabling timely assessments, realistic care decisions, reduced dependence on social care, and improved patient experience. MDT engagement and end-of-life care planning also improved significantly.

Conclusions: Introducing senior clinical leadership to the care provider pathway significantly improved patient flow, care quality, and resource use. A 12-month Band 7/8 leadership role is recommended, jointly funded by acute, community, and social care partners, to oversee and define this pathway. This approach offers a sustainable model to manage complex discharges for frail patients while reducing system strain and supporting better outcomes.

POSTER

Clinical Quality - Efficiency and Value for Money

3850. UTILISING EPIC TO DEVELOP A DASHBOARD TO DRIVE IMPROVEMENT IN CARE OF THE OLDER PERSON UNDERGOING VASCULAR SURGERY IN MANCHESTER

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Manchester University NHS Foundation Trust

Introduction: Manchester Vascular Centre (MVC) is one of the largest Arterial Centres in the UK. It serves approximately 2 million people. Older people who are living with frailty are at increased risk of perioperative complications. Perioperative care for Older People undergoing Surgery (POPS) can reduce incidence of these complications by providing Comprehensive Geriatric Assessments (CGA) (Partridge et al 2017). In Manchester Royal Infirmary, the Older Person Assessment and Liaison (OPAL) team have been providing CGAs for older people living with frailty undergoing surgery. Manchester University NHS Foundation Trust uses EPIC electronic patient records". The team aimed to use EPIC to identify eligible patients and record outcomes.

Method: In 2024 the MRI began work with NHS Elect on a Quality Improvement Project aiming to improve reach of the service to improve outcomes. A report was created through EPIC which identified patients eligible for CGA. Using this report the team could identify the demand and reach for the service. Outcomes such as delirium assessment and length of stay (LOS) was measured.

Results: Data suggests an average of 30 patients aged 65+ are admitted weekly to MVC. Previously, 60% of these patients had a CGA. Data from the EPIC report enabled identification of the resources necessary to reach all eligible patients. A 6-week "Test of Change" was implemented with daily Geriatrician input leading MDT board rounds. As part of the test of change, educational sessions were provided to the nursing staff and medical team. Following the test of change, 100% of eligible patients had a CGA, closed LOS reduced by 6 days on average and delirium assessment compliance reached 100%.

Conclusion: Utilising EPIC, the team have identified the resources necessary to provide CGA for all older people living with frailty in MVC. Providing CGA has improved patient outcomes including delirium assessment and LOS.

POSTER

Clinical Quality - Improved Access to Service

3503. AN OVERVIEW OF THE DEMENTIA UK CONSULTANT ADMIRAL NURSE SERVICE SUPPORTING FAMILIES AFFECTED BY FRAILTY AND DEMENTIA

K Lyons; M Grundy

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 have developed a unique and innovative National frailty Consultant Admiral Nurse 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 24 months, with excellent quantitative and qualitative outcomes. To date, 1,196 people have received specialist frailty and dementia training. Clinical interventions equated to 4380 activities directly delivered to support families. Supporting Best Practice: 503 supporting best practice activities delivered. 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 the first two years of operational practice.

POSTER

Clinical Quality - Improved Access to Service

3638. INVESTIGATING IMPACTS OF URBAN AND COMMUNITY DESIGN ON PHYSICAL, MENTAL, AND SOCIAL WELLBEING AMONG ADULTS AGED 65 AND OLDER

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Aim: This study investigates the impact of urban and community design on physical, mental, and social well-being among adults aged 65 and older. The goal is to identify environmental factors that promote healthy aging and develop actionable strategies for creating aging-friendly environments that foster independence, mobility, and social engagement.

Method: A mixed-methods approach was employed, combining quantitative surveys with qualitative interviews across five urban and rural regions. A total of 1,000 older adults participated, with data collected on physical activity levels, mental health (using Geriatric Depression Scale), and social connectedness. Environmental assessments were conducted using Geographic Information System (GIS) mapping to evaluate walkability, access to green spaces, and proximity to essential services. Focus groups were conducted to understand community perceptions and preferences for aging-friendly environments. Statistical analyses were performed to identify key environmental predictors of well-being.

Result: Preliminary findings indicate that older adults residing in neighbourhoods with high walkability, accessible public transportation, and abundant green spaces report significantly higher levels of physical activity and lower rates of depression ($p < 0.05$). Social connectedness scores were 25% higher in communities with dedicated senior centres and intergenerational activity programs. Qualitative data highlighted a strong preference for age-inclusive public spaces, improved sidewalk infrastructure, and community safety measures as critical components of aging-friendly environments.

Conclusion: The results demonstrate that cultivating aging-friendly environments requires a holistic approach that integrates physical infrastructure with social and community support systems. Policies promoting urban planning designs that prioritize accessibility, green spaces, and intergenerational interaction can significantly enhance the well-being of older adults. These findings provide a foundation for actionable recommendations to policy makers urban planners, and community organizations aiming to foster inclusive, age-friendly environments.

POSTER

Clinical Quality - Improved Access to Service

3647. "ALL HANDS ON FSDEC": IMPLEMENTATION OF AN MDT DELIVERED SAME DAY EMERGENCY CARE UNIT FOR OLDER PATIENTS LIVING WITH FRAILTY

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Introduction: Older adults living with frailty are at high risk of harm in traditional emergency care settings whilst frailty prevalence is rising. The Frailty Same Day Emergency Care (FSDEC) service at University Hospitals of Leicester (UHL) was launched in January 2025 to provide rapid, specialist-led, multidisciplinary care outside the Emergency Department (ED) footprint.

The aim: to assess, treat, and discharge patients on the same day, avoiding unnecessary and unwanted admissions and aligning with the NHS Long Term Plan.

Method: FSDEC operated as a three-month pilot within the medical SDEC, open daily 0900–1700. Patients were referred from ED, GPs, ambulance services, and community teams. A multidisciplinary team (MDT) — including geriatricians, ACPs, nurses, therapists, pharmacists, and care coordinators — delivered integrated, person-centred care.

Results: Between January and March 2025, 471 patients were seen, with 75.5% discharged. Alongside the Frailty Emergency Squad (FES; frailty inreach team in ED), 835 discharges were achieved over 10 weeks, more than doubling previous rates. FSDEC improved ED flow and reduced inpatient bed days by approximately 573 per month. Staff reported improved satisfaction and decision-making. Despite challenges (e.g. space, IT, and social care delays), the service demonstrated feasibility and scalability using existing resources.

Conclusion(s): FSDEC offers a replicable model for urgent frailty care that is proactive, integrated, and person-centred. It delivers better outcomes, faster care, and aligns with national priorities. Now adopted as a substantive service, considerations are in place to extend hours, improve IT, and deepen community integration. FSDEC is poised to become a cornerstone of urgent care for older people across Leicester, Leicestershire and Rutland.

POSTER

Clinical Quality - Improved Access to Service

3717. PHARMACIST INTEGRATION IN OUTPATIENT CGA CLINICS: ENHANCING OUTCOMES FOR OLDER ADULTS

I Ali

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Introduction: The British Geriatrics Society (BGS) has described a Comprehensive Geriatric Assessment (CGA) as "a structured multidisciplinary approach offering gold standard care for older adults". A CGA is a multidisciplinary holistic assessment of an older person that addresses their health and wellbeing. The CGA outpatient clinic at MFT receives referrals for a range of complaints from falls reviews to vestibular issues, often with a referral delay of up to 12 months. The CGA clinic is managed by several healthcare professionals. Each clinician consultation requires a medicine reconciliation and a medication review to identify potential pharmaceutical issues. A gap analysis of the service identified no pharmacy representation at this clinic. A trial was conducted for a pharmacist to carry out medication reconciliations and reviews prior to the outpatient's appointment at the clinic.

Method: Pharmacist identified "new" cases attending the CGA clinic a week prior to the appointment. Pharmacist reviewed the referral entry, conducted a medicine reconciliation over the telephone, and documented the medication list with their intervention recommendations. At the appointment, the clinician reviewed the pharmacist entry, ran the consultation, and wrote a letter to their General Practitioner (GP) incorporating the pharmacist's recommendations, if appropriate.

Results: The trial was delivered over three days. The pharmacist reviewed 15 cases and reconciled 151 medicines. The average time to review a case was 35 minutes. There was a total of 68 pharmaceutical interventions made. A follow up process, using sample cases, highlighted that all pharmacists' interventions were actioned by their GP.

Conclusion(s): Integrating pharmacists into the outpatient CGA clinic improves clinical outcomes by making proactive pharmaceutical interventions streamlining clinician consultations, with the aim to reduce waiting times. Omission of pharmacists, who are the medicines experts, from a CGA review will not meet the BGS definition of "gold standard of care."

POSTER

Clinical Quality - Improved Access to Service

3727. ADDRESSING INEQUITIES IN DUAL-ENERGY X-RAY ABSORPTIOMETRY (DXA) ACCESS: A MULTI-DIMENSIONAL QUALITY IMPROVEMENT APPROACH

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Introduction: Dual-energy X-ray absorptiometry (DXA) is the gold standard for diagnosing osteoporosis and guiding osteoporosis treatment, particularly when used alongside fracture risk assessment tools such as FRAX. Limited access to DXA scans in some centres, highlighting the need to prioritise their use effectively. The project is aimed to improve DXA access and prompt reporting to meet Fracture Liaison Service Database (FLS-DB) national standards.

Methods: This multi-dimensional improvement project began in 2022 using the Model for Improvement. Process mapping identified inefficiencies, with ownership secured through Radiology Directorate and cross-divisional engagement involving Clinical Leads from Rheumatology and Care of the Elderly. A small multidisciplinary working group was formed to drive the change. Progress was monitored via FLS-DB Key Performance Indicator 5 (KPI 5): percentage of patients receiving a DXA within 90 days of fracture and DXA waiting list.

Results: Baseline results in 2021: 875 fragility fracture patients identified; 29.2% (255) scanned within 90 days, average DXA waiting list 1028/month. Initiatives between 2022 and 2024 included training of radiographer, expanding scanning from 3 to 5 days/week; dedicated DXA reporting training and non-reporting agreement for FLS patients. Impact of FLS expansion on DXA scan waiting: 2022: 1648 fracture patients identified; 16.8% (276) scanned; waiting list rose to 1541/month. 2023: 2179 fracture patients identified; 17.4% (379) scanned; waiting list increased to 1980/month. Impact of quality initiatives: 2024: 2621 patients identified; 25.7% (673) scanned (163% increase from 2021); DXA waiting list dropped to an average 849/month. 2025: DXA waiting list reduced further to average 786/month.

Conclusion: The quality improvement project initiated in 2022, took three years to streamline our referral pathways. Two radiology staff training and operating five-day DXA scanning helped reduce both the DXA scan waiting list and clinician reporting time. The current service has adopted good practices to improve DXA scanning provision to match the demand of increased fracture case identification. However, further improvement is needed.

POSTER

Clinical Quality - Improved Access to Service

3740. DEAF AWARENESS IN THE UK NHS: IDENTIFYING CHALLENGES AND OPPORTUNITIES FOR CHANGE

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Introduction: People with deafness or hearing loss (PDHL) face substantial communication barriers within the UK's National Health Service (NHS), leading to reduced access to care, lower engagement with services, and poorer health outcomes. Deafness can affect anyone but acquired hearing loss increases in prevalence and severity with age. A multidisciplinary working group comprising patients, clinicians, researchers, and charity representatives was formed to explore accessibility, communication practices, and deaf awareness across NHS services.

Method: A cross-sectional survey assessed the communication experiences of PDHL using NHS services, and the perceived impact on well-being. The survey incorporated rating scales and open-ended questions and was available in British Sign Language (BSL). Responses were analysed using descriptive statistics and thematic analysis.

Results: A total of 556 individuals completed the survey, including 50 family members or carers who had supported PDHL at NHS appointments. All participants had used NHS services in the past 24 months, with 10% identifying BSL as their preferred language. Thematic analysis of qualitative responses identified three main issues: (1) persistent accessibility challenges; (2) significant communication breakdowns across the patient journey; and (3) a lack of consistent, effective deaf-aware communication. Notably, 64.4% of PDHL respondents reported missing at least half of the important information shared during NHS appointments. Six key recommendations for change were established, including appropriate infrastructure to support accessible services, mandatory deaf awareness training for all healthcare professionals, and collaboration with PDHL.

Conclusion: This is the most extensive UK-based survey exploring deaf patients' experiences in the NHS to date, highlighting ongoing breaches of the Accessible Information Standards (AIS) and serious risks posed by poor communication. In response, the working group have developed British Society of Audiology Practice guidance on deaf awareness in healthcare settings. Future work will generate practical tools and resources to help achieve AIS compliance across NHS settings.

POSTER

Clinical Quality - Improved Access to Service

3742. A QIP to develop trust-wide guideline for Parkinson's patients while nil by mouth to improve confidence in clinicians.

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Introduction: Parkinson's disease is a progressive neurological degeneration of certain cells (called dopaminergic cells) within a specific part of the brain (substantia nigra). (1) Withholding PD medication or a prolonged delay in administering PD medication can lead to an increase in care needs and increases the risk of neuroleptic malignant type syndromes, which can be fatal. (2).

Method: Prospective data was collected amongst doctors of different grades working in the Trust using Google forms.

Results: Baseline data was collected in January 2025. 88.9% responders managed PD patients in their daily practice; majority of them were foundation year doctors (83.3%). 55.6% of the responders did not feel confident in managing patients with PD who were nil by mouth. 72.2% of the responders are not aware of the local pathways to request a specialist review and the OOH support available. A Trust-wide Parkinson's Guidelines was then developed in reference to Parkinson's patients who were nil by mouth or had swallowing difficulties; addressing all the concerned areas suggested in the baseline data collection. We then arranged two teaching sessions, first for the resident doctors in Geriatric Medicine department and a second session for Foundation doctors as they were identified as the target group of resident doctors during initial data collection. The second round of data collection was completed following these sessions. Following the sessions, we noted that the confidence level amongst responders significantly improved. We measured this on a rating scale of 1-5, with 83.3% responders reporting significant improvement in their levels of confidence managing PD patients who are NBM.

Conclusion: Symptomatic treatment, focused on replacing dopamine, is crucial in optimising patient outcomes and quality of life. (2) Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty. (3)

POSTER

Clinical Quality - Improved Access to Service

3750. A QUALITY IMPROVEMENT PROJECT TO IMPROVE THE REFERRALS TO THE OCCUPATIONAL THERAPY TEAM IN A DISTRICT GENERAL HOSPITAL

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Introduction: The Royal College of Occupational Therapists (OT) define OT as "supporting individuals to develop, recover, or maintain skills for daily life and personal fulfilment". At its core there is a focus on meaningful activities and occupation-based practice. However, workforce shortages and referral changes have altered OT roles, leading to a misunderstanding and under-recognition within the Multidisciplinary-Team (MDT). In our trust this led to the need for a referral form to trigger OT involvement in patient care to be introduced in 2024.

Method: An initial pilot questionnaire (n-30) of MDT members revealed a lack of understanding of the OT role. An anonymous quantitative cross-sectional survey gathered responses from a larger range of MDT professionals in acute hospital medical wards (n=100). 80% (n=80) of the MDT demonstrated incorrect awareness of the OT role with the majority thinking it was for discharge planning. A series of PDSA cycles were run to aim to improve the understanding of OT role. One month of referral data/trends were thematically analysed before and after interventions. Interventions included: OT referral guidance posters, access to a podcast episode on the OT role and a presentation delivered to teams.

Results: *Pre-intervention:* (February 2025) - 598 referrals. 139 (23%) referrals were declined -predominantly due to incomplete or inadequate rationale for OT involvement.
Post intervention: (June 2025) 483 referrals with 54 (11%) being rejected.

Conclusion: OT was primarily viewed as a discharge-planning role, reflecting limited understanding of its broader contribution in acute care. As a result, referrals were inappropriate - delaying patient care. Following educational interventions this improved month by month. This indicates there is a need for greater awareness and understanding of the role and skills of OTs across our trust. This can be supported by integrating broader perspectives on OT into both under/ postgraduate nursing and medical education.

POSTER

Clinical Quality - Improved Access to Service

3754. EAGLEcare: REDUCING HEALTHCARE UTILISATION FOR NURSING HOME RESIDENTS AT THE END OF LIFE

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Introduction: Older people living in Nursing Homes (NH) are often admitted to Acute Hospitals (AH) toward their end-of-life (EOL) due to the limited capacity to manage exacerbations and symptoms within NHs. The EAGLEcare (Enhancing Advance care planning, Geriatric and End-of-Life care in NHs in the East) Programme was set up to improve in-NH care and to reduce avoidable AH admissions and their unintended consequences.

Methods: A system of proactive case-finding for residents with specific and general indicators of advanced life-limiting illnesses was developed in collaboration with NH partners, to enable early symptom recognition and timely response(s), supported by NH General Practitioners (GPs) and an interdisciplinary team from the AH, with out of hours coverage by a collaborating home palliative care service. We retrospectively studied a cohort of residents who passed away between January 2019 and December 2023 from five NHs during their final 6 months of life. Parameters including hospital admissions, emergency department (ED) visits, length of stay (LOS), and specialist outpatient clinic (SOC) visits were compared between EAGLEcare-enrolled and non-enrolled residents. Propensity score matching (1:5 ratio) was used to balance baseline characteristics, and negative binomial regression was employed to assess programme impact.

Results: After matching, 369 enrolled and 393 non-enrolled residents were analysed. Residents enrolled in the EAGLEcare Programme had significantly lower rates of hospital admissions (aIRR = 0.86, 95% CI: 0.77-0.97, p=0.016), ED visits (aIRR = 0.82, 95% CI: 0.73-0.93, p=0.001), and shorter LOS (aIRR = 0.82, 95% CI: 0.69-0.97, p=0.024). However, SOC visit rates remained similar between groups.

Conclusion(s): The EAGLEcare Programme effectively reduced hospitalizations and ED visits among NH residents at the EOL, supporting the need for integrated care models. Expanding such initiatives could improve EOL care, reduce healthcare burden, and enhance patient outcomes.

POSTER

Clinical Quality - Improved Access to Service

3788. MULTI-STAKEHOLDER APPROACH: BUILDING ON EXISTING QUALITY INITIATIVES TO IMPROVE 52-WEEK FOLLOW-UP BASED ON FLS-DB GUIDANCE

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Introduction: Fracture liaison services (FLS) aim to prevent secondary fractures by promptly identifying patients above 50 years with fragility fractures. The standard recommendation by FLS Database (FLS-DB) is to identify 80% expected fragility fractures, commencing treatment for 50% and monitor 80% at 52 weeks.

Methods: A quality improvement methodology based on the model of improvement; Plan-Do-Study-Act (PDSA) cycles was introduced in 2022. The fragility fracture case identification increased from 22.7% (2021) to 41.1% (2022) and 58.4% in 2023, a 149% increase. Process mapping for the Aneurin Bevan FLS (AB-FLS) showed that follow-up clinics were only ad-hoc and not formalised. A separate clinic code for annual review of patients, led by Speciality Geriatric Trainee was tested in 2023. One-year follow-up clinic streamlined service and improved performance to 25.9% (360 cases) in 2023, just above the national benchmark (24.2%). Our objective is to introduce multi-stakeholder involvement to further improve and sustain 52-weeks follow-up improvement to meet the service demand and national target.

Results: Multiple PDSA cycles led to AB-FLS Quality Assurance group including clinicians, Pharmacist, Primary Care General Practitioner as Influencers and three Patient Representatives. Team met formally every 3 months to review interventions and introduce changes. Challenges were overcome by providing a dedicated 52-weeks follow-up clinic. In addition, engagement with Primary Care for longer-term osteoporosis care unless requiring specialist bone health reviews is ongoing. In 2024, AB-FLS identified 2620 cases (70%; National benchmark=39.9%) and commenced bone treatment for 1611 cases (61.5%; National Benchmark=56.4%). The 52-weeks follow-up improved from 25.9% (360 cases) in 2023 to 62.7% (1010 cases) in 2024, which is more than double the national benchmark (24.2%).

Conclusion: This work is aligned with Welsh Prudent Healthcare principles of evidence-based medicine, partnership working with patients and meeting the unmet needs of the most vulnerable. Collaborative efforts with diverse stakeholders including primary care and patient representative have improved 52-week follow-up in 62% fracture patients. The success of this multi-stakeholder quality initiatives offers compelling evidence that this model is scalable across Wales, providing a sustainable and impactful solution to managing osteoporosis and preventing secondary fractures.

POSTER

Clinical Quality - Improved Access to Service

3812. PREVALENCE OF FALLS CLINICS AND SERVICES LED BY GERIATRICIANS ACROSS EUROPE- A MULTINATIONAL SURVEY

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Introduction: Falls in older people are a major public health concern causing much morbidity, mortality and cost to health and social services. Frailty and co-morbidities are important risk factors for falls and a multidisciplinary approach and geriatric services are best suited to manage older fallers. Falls clinics led by geriatricians have been developed over the last three decades. However, as there is much variation in availability of geriatric services across Europe it is unclear to what extent Falls clinics/services exist across the continent. This study aimed to assess the prevalence of geriatrician-led Falls clinics/services across Europe.

Methods: A cross-sectional survey of the European Union of Medical Specialists-Geriatric Medicine Section was performed. Falls clinics/services were one of twenty-five types of geriatric services assessed. The questionnaire classified services into four levels: No-0(not available), Yes-1(Minority of institutions;<25%), Yes-2(Some;25%-75%) or Yes-3(Majority;>75%). A descriptive comparative analysis was performed. Results: Responses were obtained from 39 countries, which were categorized into four European geographic groups: Nordic(n=5), Central-West(n=9), Eastern(n=17) and Southern(n=8). Overall, 41.0%(6/39) of countries had some degree of falls services. All Nordic countries and most(88.9%;8/9) Central-West had at least some falls services, compared to only 37.5%(3/8) and none in Southern and Eastern countries respectively. Only four countries (Denmark, Ireland, Malta and United Kingdom) had Falls services in the majority of their institutions.

Conclusions: There is much variation across Europe in the presence of Falls clinics/services, which are commoner in Nordic/Central-West countries, less common in Southern countries and non-existent in Eastern countries. In part this is likely to be due to lack of recognition of geriatric medicine as a specialty in some countries. The World Falls Guidelines (Montero-Odasso et al,2022) advocate a multidisciplinary multifactorial approach to falls assessment and management in older people. These data should help policymakers to develop Falls service for older people across the continent.

POSTER

Clinical Quality - Improved Access to Service

3821. THE MIND-BODY CONNECTION: DEVELOPING INTEGRATED OLD AGE PSYCHIATRY AND CARE OF THE ELDERLY SERVICES FOR PEOPLE WITH PARKINSON'S

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Introduction: With approximately 17,300 new diagnoses per annum and the ageing population we are facing the ever-growing challenge of managing complexity in Parkinson's disease (1). It is recognised that the neuropsychiatric symptoms of Parkinson's disease are as common and at least as disabling as the motor symptoms (2). These symptoms remain under-recognised and under-treated and evidence suggests that they are frequently missed by non-psychiatric specialists (3). The complexities around the management of neuropsychiatric symptoms require specialist input and patients with Parkinson's Disease can face barriers to accessing psychiatric services (4).

Method: We established a working group which met regularly, including old age liaison psychiatrists and movement disorder specialists from the medicine for older people service. Appropriate patients were identified through triage of new outpatient referrals, from inpatient reviews and at fortnightly MDT meetings. Clinical outcomes were measured using the Clinical Global Impressions (CGI) scale measuring illness severity and improvement following clinic and MDT input.

Results: Between April 2024 and April 2025 MDT outcomes were recorded for 60 patients. This underestimates the true number discussed as records reviewed from this period were found to be incomplete. Between November 2023- February 2025, 12 integrated clinics and 34 patients were reviewed. The mean CGI-S score of patients seen in the clinic was 5.7 indicating that the majority of patients attending clinic were considered to be markedly ill. Following attendance at the clinic and associated interventions, the mean CGI-I score of patients was 2.5 demonstrating that most patients saw some benefit to attending the clinic. There was no evidence of harm from attending the integrated service.

Conclusion: An integrated service appears to provide benefit to patients living with Parkinson's disease and related movement disorders. The opportunity to discuss and jointly review Parkinson's patients with neuropsychiatric complications is valued by healthcare professionals.

References: NICE (2023). Parkinson's Disease: How Common Is it? [online] NICE. Available at: https://cks.nice.org.uk/topics/parkinsons-disease/background-information/prevalence/. Accessed 10/07/2025. Weintraub D, Aarsland D, Biundo R, Dobkin R, Goldman J, Lewis S. Management of psychiatric and cognitive complications in Parkinson's disease. BMJ. 2022 Oct 24;379:e068718. doi: 10.1136/bmj-2021-068718. PMID: 36280256. Shulman LM, Taback RL, Rabinstein AA, Weiner WJ. Non-recognition of depression and other non-motor symptoms in Parkinson's disease. Parkinsonism & Related Disorders. 2002 Jan;8(3):193-197. DOI: 10.1016/s1353-8020(01)00015-3. PMID: 12039431. Dobkin RD, Rubino JT, Friedman J, Allen LA, Gara MA, Menza M. Barriers to mental health care utilization in Parkinson's disease. J Geriatr Psychiatry Neurol. 2013 Jun;26(2):105-16. doi: 10.1177/0891988713481269. Epub 2013 Apr 15. PMID: 23589410; PMCID: PMC3644337.

POSTER

Clinical Quality - Improved Access to Service

3849. THE CASE FOR SPACE: DOES A DEDICATED FRAILTY SAME DAY EMERGENCY CARE (F-SDEC) UNIT IMPROVE THE IMPACT OF AN ACUTE FRAILTY TEAM?

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Background: National and local standards in acute frailty recommend a seven-day service, with front-door assessment and a dedicated frailty area. Many acute frailty teams struggle to maintain a dedicated space as they are vulnerable to becoming inpatient areas when bed pressures increase. The Acute Older Persons Unit (AOPU) at Guys and St Thomas has faced similar challenges and is based on the Acute Admissions Ward and the Emergency Department. This project assessed whether a dedicated Acute Frailty SDEC (F-SDEC) space increased the number of patients seen and the number of same-day discharges.

Methods: The AOPU was based in medical SDEC for a trial period of 16 weekends from 23nd February 2025 (F-SDEC). Th F-SDEC space has recliner chairs and consultation rooms but no beds or sluice meaning the referral criteria had to change excluding those who required two to transfer or needed a commode. Data was compared between the 3 weeks prior and for 5 weeks following the implementation of F-SDEC.

Results: The average number of new patients seen per weekend increased from 8 to 14 during F-SDEC. The number of same day discharges increased from 9/24 (37.5% of patients seen) to 33/62 (53.2% of patients seen). The mean clinical frailty score (CFS) decreased from 6.1 to 3.9. The most common presentation was falls (45.3%) pre-F-SDEC and falls (20.3%) and infection (20.3%) during F-SDEC.

Conclusions: F-SDEC increased the number of patients seen and the number of same-day discharges. The average CFS decreased due to the space not being suitable for the most frail patients. When advocating for space frailty services need to balance ambulatory requirements with the ability to serve the most frail patients. A dedicated F-SDEC area that accommodates the most frail patients has the potential to increase same day discharges and improve capacity across the system.

POSTER

Clinical Quality - Improved Access to Service

3870. THE NUMBER AND TYPE OF PHARMACIST INTERVENTIONS ON THE FRAILTY ASSESSMENT UNIT AT THE UNIVERSITY HOSPITAL OF NORTH DURHAM

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Introduction: The Frailty Assessment Unit (FAU) at the University Hospital of North Durham opened in April 2025. This is a hospital-based facility aiming to treat frail patients that can be discharged that day or transferred to a suitable place of care more rapidly than by standard hospital pathways. Patients mainly come from Accident and Emergency or are referred by GPs. FAU have received pharmacist input since June 2025. Data was collected over a two-week period to find the number and type of interventions made by the pharmacist.

Method: Data collection took place over a 2-week period in July, which equated to 9 working days. As patients were seen on FAU, the number of patients seen and type of interventions made by the pharmacist were recorded on a spreadsheet, then analysed.

Results: The number of patients seen by the pharmacist was 32, out of 47 patients admitted onto FAU on the same days. All 32 patients had a pharmacist medication reconciliation and review. The pharmacist prescribed medications for 6 patients. Out of the 32 patients, 26 had an intervention made by the pharmacist. The types of interventions included: changing incorrect doses, stopping medication which had been prescribed in error and amending timings of time-critical medications.

Conclusion(s): Overall, having pharmacist input on FAU reduced the number of medication errors. The number of patients seen by the pharmacist on FAU was limited by the pharmacist's time and quick turnaround time of patients. There is a pharmacy technician who has been recruited to assist on FAU, so the study should be repeated to analyse the impact of having two pharmacy professionals employed. There may be other interventions made by the pharmacist which were not captured in this data, for example ensuring safe storage of medication and quicker access to medications. Further studies could be carried out to capture this.

POSTER

Clinical Quality - Patient Centredness

2934. 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.

POSTER

Clinical Quality - Patient Centredness

3353. BETTER UPDATES, BETTER CARE: IMPROVING THE COMMUNICATION WITH RELATIVES IN OLDER 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

Clinical Quality - Patient Centredness

3458. ADVANCED CARE PLANS ON OLDER PERSON MEDICINE WARDS AT QUEEN ALEXANDRA HOSPITAL, PORTSMOUTH

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Background: Whilst working within the Older Person Medicine (OPM) department, we noted that there were many frail patients who were not having Advanced Care Plan (ACP) discussions. Our preliminary retrospective data collection showed that 39% of OPM inpatients died within a year of their admission. Patients with a Clinical Frailty Score (CFS) >7 or >2 admissions in the last year were at highest risk of this 1-year mortality.

Aim: Our quality improvement project aimed to highlight patients in which an ACP discussion may be appropriate and therefore improve the frequency of ACP discussions and their documentation, especially on the discharge summary for their General Practitioner (GP) and other Allied Health Professionals to access.

Methods: We developed a sticker which was placed in the medical notes of patients who met our inclusion criteria (CFS ≥ 7 and >2 admissions in last year) during a 2-week period in April/May 2024. This acted as a visual prompt to clinicians to consider ACPs and document if discussions had been initiated. It also prompted transcribing this information onto hospital discharge letters.

Results: Following our intervention, within 2 different clinical areas (OPM Same Day Emergency Care (SDEC) and an OPM inpatient ward), there was an 88% increase in the number of ACPs being completed for the appropriate patient cohort.

Conclusions: We expect that an increased number of appropriate ACPs being completed will result in reduced numbers of inappropriate hospital readmissions for patients who would be best managed in the community, including primary care. By more clinicians taking part in ACP discussions, we expect staff will feel more confident in having these conversations and subsequently ensure that the patient remains at the centre of all care, respecting their autonomy and involvement in shared decision making with regards to their health and advanced wishes.

POSTER

Clinical Quality - Patient Centredness

3463. AUDIT OF QUALITY OF ReSPECT FORMS IN SOUTHMEAD HOSPITAL

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Introduction: Since 2019, ReSPECT forms have been used to document patient wishes and appropriate escalation of treatment in our hospital. This audit examines the quality and completeness of ReSPECT forms in Southmead Hospital across medical and surgical wards, assessing adherence to national guidance as stipulated by the Resuscitation Council UK. The aim is to identify areas for improvement in documentation practices and issues for future QIPs.

Methods: This was a retrospective audit done for all inpatient wards in Southmead Hospital. The acute medical and surgical wards were excluded from the audit, namely 31A&B and 32A&B. The data was collected over 2 months from 20th March 2025 to 20th May 2025. A team of 11 resident doctors, most of them from their respective wards, collected the data on a single day of their choice by reviewing medical notes and assessing notes with ReSPECT forms. The data was collected and input on an Excel sheet that was sent to the doctors by the lead in a standard format using all 17 criteria as set by Resus UK, thereby making data analysis simpler. The Excel sheets were converted into raw numbers and percentages and fed into a table on MS Word. This was then used for the graphical representation of the data as well.

Results: The total number of ReSPECT forms assessed in this audit was 295 forms. Out of these, 205 were in medical wards and 90 were in surgical wards. The audit standard is 100% in all criteria Modified CPR signature criteria was excluded as out of the total number of patients, only 2 patients were children (stroke ward). The option D criteria was also excluded as out of all ReSPECT forms, only 3 of them had option D ticked. After all exclusions, the audit was done comparing 15 sections of the form. The best performing criteria were the presence of a signature in the CPR recommendation box and the presence of demographics or a hospital sticker. This was 99.3% (293) in both criteria in Southmead Hospital. The worst performing criteria was the presence of a mental capacity assessment in notes in case of a lack of mental capacity and reasoning behind the lack of mental capacity. These were 15.2% (11/72) and 48.6% (35/72), respectively, in Southmead Hospital. 2 ReSPECT forms with missing signatures on the CPR recommendation were in 8B and 28B, each (medical wards).

Conclusion: High compliance in areas such as demographics, signature of CPR recommendation and form placement in front of notes. No significant differences in high-performing categories across Southmead, Medical, and Surgical wards. While surgical wards fared worse in categories like date documented on percentage, the difference is not statistically significant ($p=0.12$), suggesting random variation due to a smaller sample size. However, the reasoning of lack of mental capacity CIs between groups did not overlap, and z-tests done show that medical wards performed significantly better than surgical wards at the 95% confidence interval ($p < 0.05$). Full MCA documentation in notes when a patient lacks capacity, compliance is universally low. All wards have very low compliance with legal proxy documentation. Only 22% compliance with values and fears documentation, suggesting a missed opportunity to reflect patients' wishes in advanced care planning. Despite some well-performing criteria, there is a lot of work to be done to reach the standard of 100% in all criteria. Educational interventions focusing on MCA documentation, legal proxy awareness and capturing patient values. To send raw data to all ward leads who can extract ward-specific data, which can feed into future QIPs. Schedule a re-audit within 6-12 months to evaluate the impact of interventions.

POSTER

Clinical Quality - Patient Centredness

3528. IMPROVING STAFF AWARENESS ON ELDERLY PATIENTS' SENSORY NEEDS ON GERIATRIC WARD

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Introduction: Lack of access to sensory aids like glasses or hearing aids, can lead elderly patients to experience disorientation, difficulties engaging with healthcare professionals, negatively impacting recovery and both patients and their next of kin's hospital experience. These challenges, combined with a lack of staff awareness of sensory needs of patients on a busy geriatrics ward highlight the need for focused interventions.

Methods: This quality improvement project utilised the Plan-Do-Study-Act (PDSA) methodology over a 12-week period. Documentation of sensory impairments and aids was assessed through bedside sheets, staff handover sheets, and interviews with staff daily. Each PDSA cycle had intervention followed by data collection and compared to baseline. PDSA cycle 1: Staff verbal reminders. PDSA cycle 2: Reminder posters displayed PDSA cycle 3: Symbols representing sensory impairments introduced on staff handover sheets. Pre- and post-intervention surveys assessed staff awareness and usefulness of intervention.

Results: The ward had an average occupancy of 22 patients a day. Approximately 53% of patients had sensory aids. Baseline data revealed significant gaps in documentation: no handover sheets noted sensory impairments or aids, and only 54% of bedside sheets were accurate. The three PDSA cycles yielded improvement in documentation and staff awareness with each subsequent cycle. By the end of third cycle, bedside sheet documentation rose by 30% compared to baseline and staff awareness improved by 17%. Post-intervention surveys 100% staff found the addition of symbols to handover sheets useful with improved quality of patient interaction.

Conclusion: After three PDSA cycles, the implementation of posters and symbols significantly improved documentation of sensory impairments, staff awareness and confidence in engaging with patients with sensory impairments. Future directions include exploring patient perspectives through anonymous surveys and evaluating the accessibility of aids. By prioritising sensory needs, hospitals can reduce deconditioning, enhance patient autonomy. and provide a more inclusive care experience.

POSTER

Clinical Quality - Patient Centredness

3628. THE USE OF ASSISTIVE TECHNOLOGY TO REDUCE HARM FROM FALLS - A SERVICE EVALUATION OF PATIENTS ADMITTED WITH A FALL

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Introduction: The risk of future falls in frail older adults who have fallen once remains high. Therefore, falls harm mitigation strategies are important for falls patients admitted to acute geriatric medicine care. How often Assistive Technology (AT) is offered in this regard is not known.

Method: A two-part Service Evaluation, Information Governance department approved.

1. Case note audit. Patients admitted to our department with a fall between 1st Sept - 30th Nov 2024.
2. 10 patient questionnaires about AT, completed during admission for a fall (May 2025).

Results: Audit - 112 returned cases, after exclusions, 81 included (4 - national data opt out, 16 – fall not primary complaint, 1 - not under geriatrician, 10 - not admitted). Female 47/81 (58%). Average age 87, average Clinical Frailty Score 5.7. Dementia diagnosis prior to admission - 24 (30%).

Previous fall related admission 26 (32%). Documented “has” falls AT already - 25 (30%) and “does not have” - 10 (17%). No documentation on presence/absence of AT in 46 (57%) of cases.

Onward referral for AT by Physiotherapist/Occupational Therapist in 35 (43%). Referral declined 2 (2%).

Questionnaire - Average age – 84. Female - 4 (40%). 6 had previous fall warranting admission. 7 had existing AT. 2 used pendant during this fall, 4 weren’t wearing it, 1 - family were present. Use of AT/family present associated with shorter waiting time for assistance (2.5 vs 4.1hrs).

7 said they would “definitely use” AT in the future. 7 said they would “feel safer” with AT at home.

Conclusion: Existing use of AT for falls is prevalent but not reliably documented at hospital admission. A high percentage of eligible patients are offered future AT. Patients who use AT have shorter waits for emergency assistance. Patients are generally receptive to the idea of using AT after a falls admission.

POSTER

Clinical Quality - Patient Centredness

3650. Optimising Bowel Management in Patients with Neck of Femur Fractures: A Quality Improvement Project Using Admission Pelvic XRays

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Introduction: Constipation affects up to one-third of adults over 65, with prevalence nearly doubling amongst hospitalised patients. Effective bowel management is crucial in older patients recovering from neck of femur (NOF) fractures, as postoperative constipation can delay mobilisation, increase complications, and prolong hospital stay. Despite debate on the reliability of pelvic X-rays (PXR) for assessing faecal loading, they offer an opportunity for early identification and proactive management.

Aim: To evaluate and improve constipation management in patients admitted with NOF fractures by implementing a protocol guided by PXR findings.

Methods: A retrospective review was conducted of patients aged ≥55 admitted with NOF fractures at Luton and Dunstable Hospital from September to October 2024. Exclusions included lack of admission PXR, no diagnosis of NOF, and postoperative complications. Constipation was graded (0 to 3+) based on faecal load on PXR. A bowel management guideline was then implemented, advocating early, targeted laxative use based on constipation grade. Post-implementation data from February to March 2025 was analysed using the same criteria.

Results: Pre-implementation (n=47), mean time to bowel opening was 5 days (0–10). Patients with higher constipation scores (2–3+) had delayed bowel opening (5.7 vs 4.4 days). Only 8% received triple laxative therapy on day 0. Post-implementation (n=49), adherence to the protocol resulted in a reduced mean time to bowel opening of 3.8 days. Patients with significant faecal loading (2–3+) opened bowels on average 2 days earlier when the protocol was followed. Greater adherence correlated with shorter time to bowel opening.

Conclusion: Introducing a standardised, proactive bowel management protocol based on PXR findings effectively reduced time to bowel opening in older patients with NOF fractures. Targeted laxative use from day 0, particularly in patients with significant faecal loading, may accelerate recovery and support earlier discharge. Continued education and adherence are key to sustaining improvement.

POSTER

Clinical Quality - Patient Centredness

3652. PILOT STUDY: PHYSIO LED COMMUNITY VOLUNTEERING SERVICE: PREVENTS FALLS, REDUCES DECONDITIONING AND IMPROVES SOCIAL CONNECTIVITY

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Introduction: Falls and fall-related injuries are a common and serious problem for older people. People aged 65 and older have the highest risk of falling. The human cost of falling includes distress, pain, injury, loss of confidence and independence, and mortality. Falls are estimated to cost the NHS more than £2.3 billion per year.

GIRFT has highlighted deconditioning as a major concern and study showed that 30% of older adults experience functional decline during hospitalisation, often unrelated to their admitting condition. In its reviews of geriatric and rehabilitation services GIRFT recommends hospitals and community services should work together to deliver integrated care pathways focused on maintaining independence.

According to Age UK, 1.4 million older people in the UK often feel lonely, and over 200,000 have not had a conversation with a friend or family member in over a month, increasing risk of depression, cognitive decline, and dementia, alongside more frequent GP visits and hospital admission.

This 8-week intervention, delivered by trained volunteer trained by a physio, aims to reduce deconditioning, incidences and fear of falling (FOF) and social isolation amongst older adults at high risk of falls and readmission to hospital.

Method: At risk patients were identified and referred by GPs & Care Home staff. Volunteers were trained to deliver a programme of rehabilitative, progressive exercises to patients in their homes or care home. Qualitative and quantitative outcome measures were taken at week 1 and week 8 of the intervention.

Results: 44 patients completed the 8-week programme in their homes; equating to over 370 one-to-one contacts. 1520 contacts were achieved through classes and one-to-one sessions in care homes.
After the programme, functional fitness measures indicated improvements in cohort of patient's mobility, balance, strength and endurance. On average:

- 30 seconds sit to stand increased by 28%
- Timed up and go scores decreased by 15%
- 180 degree turn (in steps) improved by 21%
- Hand grip strength improved by 15% (care home only)
- FOF score decreased by 13%
- Confidence to cope at home score increased by 24%
- 63% of people took on additional activities on completion of the programme

Conclusion: Targeted exercise, delivered by skilled volunteers trained by a physiotherapist can enhance functional fitness and improve health outcomes for elderly individuals at risk of falls, deconditioning and social isolation.

POSTER

Clinical Quality - Patient Centredness

3673. Quality Improvement Project in Patient Participation in Fluid Balance Monitoring

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Introduction: Patient participation in care is increasingly recognised as an alternative to medical paternalism, especially in fields like orthogeriatrics where accurate fluid balance monitoring is essential. Traditional systems often fail due to dynamic intake patterns and reliance on patient-reported data. This project aimed to enable and empower patients to participate in fluid intake recording, improving accuracy while reducing staff burden.

Method: A four-cycle quality improvement project was conducted on an orthogeriatric ward.
Cycle 1: Baseline measurement of fluid chart completion.
Cycle 2: A staff member recorded hourly patient-reported intake and measured remaining fluid volumes.
Cycle 3: Cognitively and physically able patients were supported to self-record intake.
Cycle 4: A pictorial fluid chart was introduced for patient use.

Results: Cycle 1: 54.5% had no chart; 45.5% were partially filled; 0% fully completed.
Cycle 2: 100% completion with staff support; average discrepancy 168.75 mL (range: 25–300 mL).
Cycle 3: Patient self-recording achieved 100% completion; average discrepancy 150 mL (range: 50–200 mL).
Cycle 4: Pictorial chart maintained 100% completion; discrepancy reduced to 133 mL (range: 50–200 mL).

Conclusion(s): Patient-led fluid balance monitoring is feasible and accurate when supported appropriately. A pictorial chart enabled broader participation, particularly for those with limited numeracy or literacy. This intervention empowered patients, aligned with holistic care values, and required minimal resources - freeing staff for other essential tasks. Future applications may include using pictorial tools to communicate fluid restrictions or targets.

POSTER

Clinical Quality - Patient Centredness

3678. INTERDISCIPLINARY CLINIC FOR DECISION-MAKING REGARDING DIALYSIS AND CONSERVATIVE CARE IN OLDER ADULTS WITH KIDNEY FAILURE

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Introduction: In 2023, we introduced a new interdisciplinary clinic to raise awareness of the choices available for older patients with advancing, near end-stage kidney disease. Patients and their close family were invited to attend the clinic for assessment and discussion of future options.

Rationale and Method: Many older patients with advanced kidney disease are relatively asymptomatic and have not considered what might happen and what would be their preferred option when they do become symptomatic. A proportion of such patients develop end-stage kidney failure in the context of an intercurrent illness and may not be able to express their preferences at this time. Families are then left uncertain whether their older relative would want dialysis (RRT) or not. Frail, cognitively impaired patients may then undergo inappropriate treatments with prolonged hospital stay and poor quality of life in their final weeks.

Results: During 2023 – early 2025, 81 patient-family groups attended the clinic. Patient medians: age 82 years. Clinical Frailty Scale 5. AMT 8. Barthel 87. eGFR 14mL/min. Median follow- up 14 months. 57% female. After full discussion 25 (31%) patients opted for RRT, of which 6 are currently receiving RRT. 1 additional patient died on RRT. 4 additional patients died and 3 changed their choice to Supportive Care (SC). Another 11 patients are still free of RRT. 54 opted for SC with 2 remained undecided. 21 have since died. Of the other survivors, none have changed their decision or received RRT. A patient-family questionnaire in a subset showed strong satisfaction with the clinic. A high proportion were referred for Advanced Care Planning.

Conclusions: An interdisciplinary, one-off clinic for elderly patients with near end-stage renal failure has shown success in raising awareness with good concordance between patients and family. So far, there have been no clinical deviations from patient's expressed wishes.

POSTER

Clinical Quality - Patient Centredness

3686. THINKING ABOUT THE FUTURE: A QI PROJECT TO EDUCATE AND IMPROVE THE UNDERSTANDING OF ADVANCE CARE PLANNING IN THE AMU

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Introduction: Advance care planning (ACP) allows patients with serious illness or deteriorating health to discuss future care preferences, supporting a more holistic, patient-centred approach. However, public awareness of ACP remains low and is cited as a key barrier to its uptake in clinical practice. A 2014 audit by the Royal College of Physicians revealed only 4% of 9000 hospital inpatients had any ACP documentation prior to admission. Lack of accessible information and insufficient training for health care professionals contributes to this gap, forming the focus of this quality improvement project (QIP).

Methods: Using the Supportive and Palliative Care Indicators tool (SPICT), we identified 10-25 patients per cycle who were suitable for ACP conversations. Reviewing clinical notes, we assessed whether ACP conversations occurred and whether patients were given any signposting information. All data was recorded in Excel to track progress across cycles.

Interventions: Our planned interventions included highlighting the project at daily AMU handover meetings, disseminating a high-quality leaflet with ACP information and signposting to locally and nationally endorsed resources, and use of ward posters to raise awareness of the project.

Results: From this review, we were able to evidence that of 10 patients initially audited, 0% had any ACP conversations during their AMU admission, 0% were given any information on ACP, and 0% had any form of ACP subsequently completed during their AMU stay. Following the planned interventions, 44% of 18 patients audited had ACP conversations during their AMU admission, 0% were given any information on ACP, and 39% had any form of ACP subsequently completed during their AMU stay.

Conclusions: Our interventions improved rates of ACP conversations and documentation but highlighted the continued lack of information provision. For the next QIP cycle, we plan to provide targeted teaching sessions for AMU resident doctors with the aim of improving ACP engagement. Our hope is that this QIP sets the precedent for and is the catalyst of change.

POSTER

Clinical Quality - Patient Centredness

3719. A QI PROJECT FOCUSSED ON IMPROVING CARE FOR PATIENTS LIVING WITH DEMENTIA BY ENGAGING WITH THE 'THIS IS ME' CLINICAL TOOL

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Introduction: Hospitalisation of people living with dementia often leads to an increase in behavioural and psychological symptoms, a risk of poor outcomes, a higher incidence of harm, and further cognitive decline. The "This is me" leaflet was designed by the Alzheimer's Society and, upon its completion, provides information about a person living with dementia. This helps to deliver personalised care and reduce distress and the issues associated with hospitalisation. Whilst working on the older people's wards at Ipswich hospital, we observed a low uptake of this clinical tool. We performed a baseline audit in May 2023 confirming only 1 in 10 inpatients living with dementia had a completed "This is me" leaflet.

Method: We adopted the Model for Improvement approach to our QI Project and were supported by the ESNEFT QI Team and dementia specialist nurse. Our first intervention in June 2023 involved speaking with 18 members of the multi-disciplinary team on the older people's wards to raise awareness of the "This is me" tool. Later we undertook a post-interventional audit on all four older people's wards. Our second intervention in June 2024 involved displaying an educational poster in the corridors leading to the older people's wards, about "This is me" and how it helps. A second post-interventional audit was completed during July 2024.

Results: The proportion of inpatients living with dementia who had a completed 'This is me' leaflet was 10% in our baseline audit, 43% following our first PDSA cycle, and 55% following our second PDSA cycle.

Conclusion: Focus and education on the use of "This is me" led to a 450% increase in the proportion of inpatients living with dementia, having a completed "This is me" on the older people's wards by the end of our second PDSA cycle. Further work is required to assess care improvement.

POSTER

Clinical Quality - Patient Centredness

3735. DEVELOPMENT OF AN ELECTRONIC COGNITIVE HISTORY TEMPLATE IN A DISTRICT GENERAL HOSPITAL IN NORTHERN IRELAND

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Introduction: Lagan Valley Hospital is 80 bedded district general hospital offering acute medical specialty admissions. Over 70% of admissions relate to older adults (> 65 years). Previous focused audits demonstrated high prevalence of delirium and undiagnosed dementia. Chart reviews highlighted variation in completeness and quality of cognitive history taking by all members of the multidisciplinary team. Development of a cognitive history template offers potential to improve patient care.

Method: Survey of doctors to assess baseline confidence in cognitive history taking, audit of in-patients (> 65 years) to assess cognitive history taken and by whom, development of electronic tool to screen for delirium and underlying cognitive impairment. Ward-based multidisciplinary education and subsequent dissemination of an electronic cognitive history template to all resident doctors.

Results: Our survey demonstrated that doctors were aware of many components required to take a cognitive history, but their confidence in completing the history was low. Audit of admissions showed that the majority of cognitive histories were obtained by specialist frailty nurses. Many older adults presenting with confusion did not have a cognitive history taken. Use of an electronic cognitive history template supported consistency across all ward areas and across the multidisciplinary team. Feedback on use of the template from members of the multidisciplinary team was positive.

Conclusions: Development of an electronic cognitive history template has ensured consistency of approach in collateral history taking, as well as better identification of patients with/at risk of delirium, particularly identifying those who may have underlying but undiagnosed cognitive impairment who may benefit from earlier referral to Memory services. As Encompass (EPIC) has now been adopted by all hospitals in Northern Ireland, it is possible for this to be more widely applied across healthcare trusts.

POSTER

Clinical Quality - Patient Centredness

3737. IMPROVING THE APPROPRIATENESS OF INPATIENT POLYPHARMACY REVIEWS: A THREE-STAGE RETROSPECTIVE QUALITY IMPROVEMENT PROJECT

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Introduction: Inappropriate polypharmacy is the use of medications with no evidence-based indication, unmet treatment goals, high risk of adverse drug reactions, or when the patient is unwilling / unable to take treatment as intended. This is particularly concerning in geriatric care, due to increased risk of hospital admissions, adverse drug reactions and significant healthcare costs. To address these risks, clinicians should conduct patient-focused medication reviews. This project aimed to assess and improve polypharmacy reviews at Royal Albert Edward Infirmary, with a focus on reducing inappropriate polypharmacy and its associated risks.

Method: Data was collected retrospectively from September 2024, December 2024, and June 2025 (n=60), using 'Hospital Information System'. Demographics included age, sex, clinical frailty score and primary diagnosis. Admission and discharge medications were reviewed, alongside anticholinergic effect on cognition (AEC) scores, documentation of medication changes, patient involvement and formal medication reviews. Interventions included weekly combined doctor-pharmacist ward rounds, electronic deprescribing alerts, and education sessions for doctors.

Results: Documented deprescribing discussions increased from 0% (baseline Sept 24) to 45% (Dec 24) and then 60% (Jun 24). The proportion of regular medications discontinued rose from 5.4% to 19.3% to 28.6% over the three cycles. Despite these efforts, on average, patients were discharged with a higher number of medications before intervention - initially 9.1 vs 10.3, then 11.2 vs 10.9 post intervention and higher again - 9.6 vs 11.0 in cycle three. As a result, discharge AEC scores across cycles one, two and three reflected this, with a 15% increase, 5% decrease and 4% increase, respectively. Commonly deprescribed medications included anti-hypertensives and statins; commonly initiated medications included laxatives and vitamin supplements. Analgesia was often adjusted.

Conclusions: System interventions in frailty to promote polypharmacy reviews can reduce the number of inappropriate medications. Ultimately, patient centred medication reviews will optimise polypharmacy management, reduce harm and improve patient outcomes.

POSTER

Clinical Quality - Patient Centredness

3743. SCREENING FOR LONELINESS IN GERIATRIC INPATIENTS USING THE UCLA (UNIVERSITY OF CALIFORNIA, LOS ANGELES) LONELINESS SCALE (VERSION 3)

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Background: Loneliness is common among older adults and linked to poor health outcomes. In the UK, around 1.4 million older people experience frequent loneliness, a number expected to rise. Despite its impact, loneliness is often unrecognized in acute hospitals. The UCLA Loneliness Scale Version 3 (UCLA-3) is a brief, validated 3-item tool with 77% sensitivity and 61% specificity, suitable for routine geriatric screening.

Objectives: · Assess feasibility of UCLA-3 for rapid loneliness screening
· Determine loneliness prevalence in older inpatients
· Explore integration of UCLA-3 into geriatric care pathways

Methods: A cross-sectional study of 50 randomly selected patients, aged 65 and over on geriatric wards at MMH, between,1st to 31st of May 2025 was conducted. The data which included UCLA-3 scores, completion time, demographics, and Clinical Frailty Scale (CFS) status was collected by the resident doctors.

Results: Of the 50 participants, 41/50 (82%) completed the UCLA-3 in under 5 minutes,7/50 (14%) between 5-15 minutes and 1/50(2%) took more than 15 minutes. 1/50(2%) patient's questionnaire completion time was not recorded.
· Moderate to severe frailty (CFS scores 6–9) was observed in 24 /50 (48%) of the screened patients.
· Loneliness (UCLA score 6–9) was identified in 16/50 (32%), while 34/40 (68%) were classified as not lonely (UCLA score 3–5).
· Among those identified as lonely,8/16 (50%) were moderate to severely frail

Conclusion: The UCLA-3 is a quick, practical and reliable bedside screening tool for early detection of loneliness, which among frail older adults may be a modifiable risk factor.

Recommendations:
· Screen all elderly patients for loneliness due to high prevalence
· Incorporate UCLA-3 scoring routinely into Comprehensive Geriatric Assessments and discuss high UCLA-3 (score 6-9) during MDT meetings
· Refer all lonely individuals to NHS loneliness support and involve local charities for additional help

POSTER

Clinical Quality - Patient Centredness

3756. QUALITY IMPROVEMENT PROJECT TO REDUCE ANTICHOLINERGIC BURDEN IN OLDER PATIENTS: IMPACT ON READMISSION, DELIRIUM, LENGTH OF STAY

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Introduction: Anticholinergic medications are widely prescribed to manage pain, urinary incontinence, allergies. Patients with high frailty scores are more susceptible to anticholinergic adverse effects such as falls, cognitive impairment, urinary retention. The Anticholinergic Burden Score (ACB) is a tool used to quantify the cumulative anticholinergic effect of patients' medications. A score of 3 or more is associated with an increased risk of mortality and worse cognitive function. This quality improvement project aims to quantify and reduce ACB scores of patients admitted to the Acute Integrated Frailty Unit (AIFU) with a view to reduce hospital readmissions and overall mortality.

Methods: The medical team used the ACB score database to create an automated Excel calculator, which identifies each drug in a patient's medicine reconciliation list, assigns its database score, and calculates a cumulative ACB score. For cycle 1, we analysed ACB scores and patient data for 100 retrospective patients admitted to AIFU. Following cycle 1, we enlisted the help of frailty specialist nurses, who admitted 100+ patients to AIFU during in-reach ward rounds, used the calculator to obtain pre-admission ACB scores, and recorded them in patients' electronic notes. Following cycle 2, we created a poster for AIFU and presented the project at our local audit meeting as to provide structured education in ACB score calculation, medication alternatives for score reduction, and deprescribing strategies. Following the poster and presentation, for cycle 3, the medical and nursing team will collect data for another 100 patients admitted to AIFU and calculate three-month re-admission rates for our cycle 2 cohort. Our aim is the reduction of discharge ACB scores and of the overall 3-month readmission rate.

Results: In the retrospective data collection, 28% (28/100) of AIFU patients had an ACB score of 3 or more. At discharge, 27% (27/100) of these still had ACB scores of 3 or more. 33% of these patients had been re-admitted at 3 months after discharge. In cycle 2, 33.7% (27/80) of admitted AIFU patients had ACB scores of 3 or more. With the involvement of specialist frailty nurses and recording the ACB scores in patients' notes, only 30% (24/80) of these still had ACB scores of 3 or more at discharge.

Conclusion: The involvement of specialist frailty nurses and recording ACB scores in patients' notes saw a small improvement in ACB score reduction for AIFU inpatients at discharge. Going forward, we aim to quantify the effect of the educational presentation and poster on ACB scores, calculate 3-month re-admission rates for these patients, and identify the barriers to prescribing alternative low ACB score medications or deprescribing altogether. We aim to implement this practice on other geriatric medicine wards in the hospital and trust with a view to reduce readmissions in the clinically frail patient population.

POSTER

Clinical Quality - Patient Centredness

3757. NOURISH MOVE CONNECT THRIVE: PROMOTING ACTIVITY FOR OLDER ADULTS WITH DEMENTIA IN CARE HOMES

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Care Home Therapy In Reach - St George's University Hospitals NHS Foundation Trust

Purpose: Extreme pressures on the health and social care systems, alongside poor health and well-being outcomes for older people living with dementia (PLWD) in care homes, led to develop a QI programme of therapy-led training and intervention, in care homes demonstrating the benefits of proactive, preventative approaches using a Plan-Do-Study-Act cycle.

Methods: The Care Home Therapy In Reach Service comprises a specialist multidisciplinary team (dietetics, occupational therapy, speech and language therapy and physiotherapy), providing support in Wandsworth Care Homes. We worked with care home staff and residents, providing a tailored programme of training promoting an enabling approach.

Training topics included: Meaningful Activity, Physical Activity, Nutrition, Communication, and Dementia-Inclusive Environment using both theory and practical training approaches. A variety of outcome measures including grip strength, confidence scales, nutritional intake and activity audits were taken.

Results: The programme was completed in 6 care homes with promising outcomes: improved confidence of staff, increased grip strength of residents and improved opportunity for activity. Staff felt empowered to provide a more enabling approach, however it was identified that further support was needed to sustain implementation of improvements.

Conclusion(s): The work demonstrated that training led by therapy teams can enable staff in care homes to support PLWD living more active lives and prevent consequences of sedentary lifestyle including contractures, pressure sores and hospital admissions. The needs of bedbound residents were also considered and further work is needed to provide more in depth and practical training for staff, for example in postural management of people with advanced dementia.

Impact: Enabling approaches can reduce carer dependence and promote aging well. Benefits include improved health and well-being for PLWD, cost-saving for the health and social care and improved staff retention. Therapy teams are best suited to lead in this area and promote holistic management and a proactive approach.

POSTER

Clinical Quality - Patient Centredness

3779. CONTINUOUS SUBCUTANEOUS INFUSION OF FUROSEMIDE FOR TREATMENT OF DECOMPENSATED HEART FAILURE IN FRAIL OLDER PEOPLE IN A HOSPITAL

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Introduction: Decompensated heart failure is a common acute presentation to hospital amongst the frail older population where treatment often involves intravenous furosemide. Whilst this is effective in inducing a diuresis, it can be associated with negative effects of hospital stay such as hospital-associated infections and deconditioning. Continuous subcutaneous infusion (CSCI) of furosemide is well-established as a palliative treatment for end-stage heart failure and there is growing evidence that CSCI Furosemide is as safe and effective as intravenous in the management of acute episodes of decompensation, whilst preventing hospital admission. This study retrospectively assesses the use and effectiveness of CSCI Furosemide for patients under York Virtual Frailty Ward.

Methods: 10 episodes of care using CSCI of furosemide were identified between November 2023 and May 2025. Included care episodes were those where patients received CSCI Furosemide, had a diagnosis of end stage heart failure and were housebound (CFS ≥6). All individuals received either 160mg or 230mg of CSCI Furosemide over a minimum treatment course of 48 hours. Patient records were reviewed to assess weight change and symptom burden pre- and post-CSCI Furosemide. Bed days saved by preventing hospital admission were calculated.

Results: The average weight loss through treatment was 0.83kg/24 hours. All patients reported an improvement in symptom burden (oedema/mobility/breathing/fatigue). Two patients experienced a mild localised skin reaction, but treatment was able to continue safely with modifications. 40 bed days were found to have prevented through this community treatment.

Conclusion: This study demonstrates that CSCI is an effective treatment for management of decompensated heart failure of frail older individuals in the community. Although mild adverse effects may occur, they were short lived and did not prevent the treatment continuing. CSCI Furosemide offers benefits beyond its intended use including reducing risk of hospital-acquired harm and prevention of hospital bed days in an already strained system.

POSTER

Clinical Quality - Patient Centredness

3783. Conversation not Consultation - A Patient-Centred Approach to Discharge Planning for Older Adults

S Densem

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Introduction: Older adults admitted to hospital often have complex discharge needs related to medical, functional, and social vulnerabilities. At Poole General Hospital (PGH), delays were frequently observed not due to clinical reasons, but due to insufficient, impersonal communication between staff and patients.

Methods: Over a 15-week period, 179 patients received intervention from a physiotherapist working within the PGH Discharge Team to promote timely and safe discharges. A descriptive approach was used to log and analyse interventions across the Emergency Department (ED), Same Day Emergency Care (SDEC), Acute Medical Unit (AMU), and inpatient wards. Emphasis was placed on early, person-centred conversations exploring social context, expectations, and discharge planning.

Results: Conversational interventions contributed to admission avoidance in 35% of front-of-house cases, particularly within AMU. Additionally, 20% of patients had a reduced length of stay (<5 days). The most common delays were linked to staff not initiating discharge discussions early, and patients being unaware of discharge options. Staff often cited time pressure or uncertainty over responsibility as barriers to engaging meaningfully. Where authentic conversations occurred, patients and families reported greater clarity, reassurance, and readiness to return home.

Conclusions: Embedding conversational, strengths-based dialogue early in the hospital journey significantly improves discharge outcomes for older adults and can reduce hospital length of stay. A shift from consultation to conversation should be prioritised through education, cultural change, and operational support across geriatric services.

POSTER

Clinical Quality - Patient Centredness

3792. IMPROVING DISCUSSIONS ABOUT RESUSCITATION WITH FRAIL OLDER ADULTS: CLINICIANS' PERSPECTIVES

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Background: Frailty is a poor prognostic indicator following cardiopulmonary resuscitation (CPR). Discussions about Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions are often contentious. While existing research focuses on patients' and relatives' perspectives, there is a lack of in-depth studies exploring clinicians' experiences of DNACPR discussions. This study aims to explore how clinicians' personal and professional beliefs and experiences influence their approach to DNACPR conversations with frail, older adults.

Methods: Ninety clinicians from primary and secondary care across the UK, all experienced in resuscitation discussions with frail older patients, participated in either semi-structured interviews (n=45) or focus groups (n=5). Participants included doctors of various grades, nurses, and advanced practitioners. Data were analysed using thematic analysis.

Results: Four key clinician-related themes emerged: professional experience, specialty culture, emotional response, and personal values. Some junior clinicians reported a lack of confidence in leading DNACPR discussions. Participants described how specialty culture shaped approaches, with geriatricians and palliative care teams most likely to initiate discussions. Some clinicians reported agreeing to CPR decisions that contradicted their medical judgment to avoid conflict with patients or families. Many expressed a personal preference for non-resuscitation in similar circumstances, influenced by professional exposure. A lack of formal training and a reliance on an informal "apprenticeship model" were also commonly reported.

Conclusion: Clinician-specific factors appear to be important in DNACPR conversations with frail older adults. Addressing the personal and emotional aspects of these discussions is essential to improving clinician confidence and the overall quality of resuscitation decision-making.

POSTER

Clinical Quality - Patient Centredness

3805. FRAILTY SAME DAY EMERGENCY CARE: ONWARD DESTINATION AND EFFECTIVE UTILISATION OF VIRTUAL WARDS

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Introduction: This study of patients attending East Surrey Hospital's (ESH) Frailty Same Day Emergency Care (FSDEC) unit was designed to assess the interrelationship between onward destination from FSDEC, including existing location-based virtual wards (VW) offering ongoing care and remote monitoring at home, outpatient clinics and comorbidity. In ESH in October 2024, a 6-space FSDEC was created. Patients are pulled from the ED in the morning, with a small number being referred from GPs and community Urgent and Emergency Care teams.

Method: Data were reviewed from February 2025 to April 2025, in this time, for all 285 patients attending ESH FSDEC, patient records were reviewed to determine onward destination from FSDEC and to calculate Charlson Comorbidity Index (CCI). Outcomes included discharge to usual residence, discharge home under the care of a VW, or admission to further acute care. Additionally, any planned follow-up at point of discharge from FSDEC was recorded.

Results: Of the 285 patient encounters, 212/285 (74%) were discharged on the same day, 149/285 (52%) were discharged home, 63/285 (22%) were discharged under the care of a VW and 73/285 (26%) were admitted as inpatients. 80/285 patients (30%) attending FSDEC were discharged with planned follow-up outpatient appointments with a geriatrician or another specialty. CCI scores ranged from 3-11, with a mean score of 6.

Conclusion: This study provides evidence to support the East Surrey Hospital FSDEC model of care, with 74% of patients attending being discharged home the same day. The study shows a large proportion of patients, 22%, receive care & monitoring at home under a VW following discharge, a vital method of admission avoidance; suggesting these two services are important to be commissioned together. Analysis of Charlson Comorbidity Index scores also demonstrates the complex health background of those attending FSDEC and their need for specialist care.

POSTER

Clinical Quality - Patient Centredness

3806. IMPROVING GP SATISFACTION WITH INFORMATION PROVIDED ON PALLIATIVE DISCHARGE LETTERS FOLLOWING HOSPITAL ADMISSION

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Background: This project was undertaken on a medical ward involving both the medical and palliative care teams. It was in response to a survey completed in which only 53% of Belfast Trust General Practitioners (GP) reported satisfaction with the information provided in hospital discharge letters regarding palliative patients. This can have a significant impact on patient care in areas such as symptom management, ceilings of treatment and preferred place of death and is very relevant for the older population and their families as many of these patients would prefer to avoid a further hospital admission. Our aim was to improve GP satisfaction with the information provided in hospital discharge letters for palliative patients by 10%.

Methods: Following the baseline survey results, a hospital palliative discharge template was developed. This involved patients with complex palliative needs and/or for end-of-life care. Additionally, the patient's GP was given a verbal handover prior to discharge in order to avoid delays in information. Following the first round of discharges the ward team provided feedback on the current template, including ease of use and suggestions for necessary amendments needed and the template was amended based on these results.

Results: The third cycle of this project is still in progress. This involves surveying the GP's who received the new template to find out if the information provided was satisfactory for them to provide good, patient centred care. Results will be compared to the baseline survey and results reviewed.

Conclusions: This project has highlighted the importance of patient centred palliative care, ensuring that the patient's care needs and wishes are known. If the results from the third cycle show an improvement in GP satisfaction, our team will provide education to the wider hospital team and aim to implement the use of this template as standard practice.

POSTER

Clinical Quality - Patient Centredness

3810. A QIP PRESENTATION: REDUCING DECONDITIONING: SIT UP, GET DRESSED, KEEP MOVING

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Introduction: Deconditioning remains a significant challenge for hospital inpatients, particularly the older patients. National campaigns such as “End PJ Paralysis” and “Sit Up, Get Dressed, Keep Moving” endorsed by the British Geriatrics Society, highlight the importance of maintaining mobility during hospital stays. We designed a QIP to raise awareness of deconditioning among nursing staff and resident doctors and to identify barriers preventing mobilisation.

Method: We conducted a QIP on a geriatric ward at Lincoln County Hospital, collecting quantitative data on the frequency of patients sitting out of bed, sitting up for meals, wearing appropriate footwear, and wearing their own clothes. Qualitative feedback was obtained through short interviews with nurses and healthcare assistants (HCAs) to explore reasons patients remained in bed. Patients receiving end-of-life care, those medically unwell (NEWS>5), or those with baseline immobility (i.e bed bound) were excluded. Following an initial cycle, teaching sessions were delivered to staff and resident doctors over two weeks before repeating data collection.

Results: In the first cycle, 69% of patients sat out of bed daily, 50% sat up for meals, 42% wore appropriate footwear, and 26% wore their own clothes. After staff education, the second cycle showed no significant improvement: 64% sat out of bed, 48% sat up for meals, 40% wore appropriate footwear, and 36%wore their own clothes. Barriers identified included patient factors (fatigue, lack of motivation and awareness), equipment shortages (e.g. recliner chairs), staffing pressures, and difficulty accessing personal clothing. Notably, some patients who could mobilize independently remained in bed. This showed that the risk of prolonged bedrest is even greater for those needs support.

Conclusion: Despite increased staff awareness, this QIP showed a neutral impact on outcomes, highlighting that education alone is insufficient. Multifactorial barriers, including patient factors, limited equipment, and staffing constraints, been identified and have to be addressed collectively to improve outcome.

POSTER

Clinical Quality - Patient Centredness

3811. IMPROVING PATIENT DIGNITY AND MOBILITY THROUGH APPROPRIATE URINARY CATHETER BAG SELECTION: A MULTI-SITE QIP

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Introduction: Indwelling urinary catheters are commonly used in hospitalised adults. Measuring bags, while necessary for fluid monitoring in specific cases, are often used by default without clear indication. This can restrict mobility, affect dignity, and contribute to functional decline in patients with preserved mobility. This project aimed to evaluate the usage of urine collection systems and their impact on patient well-being and improve the usage of less restrictive leg bags where appropriate.

Methods: QIP was conducted on medical wards at two hospital sites. Cycle 1 (Jan–Feb 2024) included a prospective audit of n=116 with short-term indwelling catheters. Patients requiring long-term catheters or strict fluid balance monitoring were excluded. Data were collected from clinical records and interviews with staff and patients, assessing catheter bag type, clinical justification, and its impact on dignity and mobility. Baseline mobility was assessed using the Bedside Mobility Assessment Tool (BMAT). A flowchart was then introduced to support appropriate bag selection based on clinical need, mobility, and patient preference. Cycle 2 (n=120) was completed in July 2025.

Results: In Cycle 1, 84% of patients had measuring bags, but 59% were deemed to be suitable for leg bags. BMAT scores indicated 49% of patients were non-ambulatory. Of the mobile patients, 19% reported dignity concerns, and 13% felt mobility was affected. After the intervention, measuring bag use decreased to 58%, and leg bag use rose to 42%. Patient-reported dignity concerns reduced from 19% to 7%, and mobility restriction from 13% to 12%.

Conclusions: This project identified a care gap where default use of measuring bags often overlooked clinical need, dignity and mobility. Implementation of a flowchart and education delivered to nursing and medical staff improved awareness and encouraged patient-centred urine collection bag selection. Embedding this in local training and inductions could support wider adoption across similar settings.

POSTER

Clinical Quality - Patient Centredness

3822. HEARING AID SUPPORT FOR OLDER ADULT PATIENTS

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Introduction: Hearing aids often appear broken and whether due to the battery or earwax simple fixes can allow patients to hear. This project aimed to improve hearing impaired patients' experience and healthcare by providing support for hearing aids across Elderly Medicine wards in a large teaching hospital in Leeds.

Method: A survey evaluated the proportion of patients with non-functional hearing aids, with qualitative questions to evaluate the impact. The first intervention was a toolkit showing how to check if a hearing aid worked, how to fix common issues, to go alongside spare batteries with a QR code link for further information. As a second intervention, teaching sessions were arranged for ward staff to improve knowledge and encourage staff to fix issues.

Results: 101, 100 and 102 inpatients were surveyed for the baseline data collection, 1st re-audit and 2nd reaudit respectively. 1 in 4 patients had hearing aids with them and the primary outcome measure of 'Are both hearing aids working' improved from 56% to 70% to 87% after each intervention. The most common issue found was a flat battery and the prevalence reduced from 5 to 2 to 1. When asked what difference a working hearing aid makes: "It makes all the difference, I wouldn't manage, I don't want to miss anything", with one relative stating "I think it's hugely important, people may just think she's confused if she can't hear what you're saying, when she's as sharp as a tack in there."

Conclusion: There was a clear improvement in the proportion of working hearing aids after each intervention and feedback from patients reinforced how impactful having a working hearing aid is. This has shown that providing hearing aid support is a practical and meaningful way of improving patient care that can be easily implemented elsewhere.

POSTER

Clinical Quality - Patient Centredness

3829. EVALUATING AND IMPROVING POST-OPERATIVE PAIN MANAGEMENT IN HIP FRACTURE PATIENTS: A MULTIDISCIPLINARY QUALITY IMPROVEMENT PROJECT

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Introduction: Early mobilisation following hip fracture surgery is a key determinant of better health outcomes and reduced mortality. However, high levels of postoperative pain and inconsistent analgesia administration were noted as barriers to mobilisation on our dedicated femoral fracture unit. This quality improvement project aimed to understand pain and analgesia on the unit, and in doing so, target better pain relief to improve outcomes through optimised engagement with therapy.

Methods: Baseline data were collected on 26 post-operative patients to assess subjective pain scores (or Abbey Pain Scale where appropriate), pre-operative prescribing bundle adherence, and administration of PRN analgesia. Semi-structured interviews with ward nurses and therapy staff explored barriers to effective pain management and access to PRN analgesia. Using Model for Improvement methodology multiple Plan-Do-Study-Act (PDSA) cycles were undertaken, including a test of change to trial use of a buprenorphine patch, staff education to target prescribing behaviours and nursing workflow optimisation.

Results: Initial data showed 30% of patients reported pain ≥8/10 on day one, with poor correlation between pain scores and PRN analgesia administered. Qualitative data revealed key barriers included staff workload, controlled drug (CD) access delays, poor interprofessional communication, and hesitancy around use of stronger opioids.

Introduction of a one-off buprenorphine patch resulted in a 20% reduction in day one pain and a 23% reduction on day two. The highest reported pain was 7/10 (vs 10/10 pre-intervention). No significant increase in postoperative delirium was noted. However, PRN administration remained inconsistent despite improvements in pre-op analgesia bundle prescribing and communication strategies.

Conclusion: This multifaceted, multidisciplinary quality improvement project has provided valuable insight into understanding pain and analgesia on the hip fracture unit. The project has highlighted focus areas for strategies to reduce postoperative pain. However further work is required to address persistent barriers to PRN analgesia administration and promote sustained prescribing behaviours.

POSTER

Clinical Quality - Patient Centredness

3836. IMPROVING THE USE OF PAINAD ON GERIATRIC WARDS – AN AGONISING CHALLENGE

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Introduction: Pain is a major concern in cognitively impaired patients. Communication challenges contribute to poor recognition and undertreatment, negatively impacting prognosis and quality of life. The National Dementia Audit highlighted that structured pain assessment for people with dementia admitted to hospitals remains a significant area for improvement. The PAINAD (Pain Assessment in Advanced Dementia) scale aids in structured pain recognition through objective assessment. We implemented a quality improvement project aiming to improve PAINAD utilisation in inpatient geriatric wards.

Methods: Using the 'Plan-Do-Study-Act' (PDSA) approach, baseline data was collected from inpatient wards at two large teaching hospitals: Queen's Medical Centre (QMC), Nottingham and Royal Derby Hospital (RDH), where PAINAD is recommended by local trust guidelines. Frequency of PAINAD use in patients with dementia and/or delirium was observed. Based on gaps identified, the first cycle intervention was board-round discussions to improve awareness around pain recognition and identify high-risk patients and opportunities for PAINAD utilisation. In the second cycle, bite-sized teaching for ward staff was conducted across both sites, and posters highlighting use of PAINAD displayed on the wards.

Results: Baseline data of 60 patients showed inconsistent pain assessment documentation; neither site used PAINAD routinely, prompting the first cycle of action. 42 opportunities for PAINAD utilisation were identified in board-round meetings over 5 days. PAINAD was completed in 14% of these opportunities. In some instances, the score was actioned with appropriate analgesia. Use of PAINAD remained inconsistent across both sites, prompting the second PDSA cycle, for which data collection is ongoing.

Conclusion: PAINAD utilisation remained suboptimal despite efforts to highlight the importance of recognising pain in inpatients with dementia. With consistent use, PAINAD could enable robust assessment and pain management in these patients. Future interventions to be considered include prompts on electronic prescription systems to encourage pain assessment in targeted patient groups.

POSTER

Clinical Quality - Patient Centredness

3846. IMMINENT FRACTURE RATES WHILST ON ANABOLIC TREATMENT FOR OSTEOPOROSIS

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Introduction: Osteoporosis affects approximately 3.5 million individuals in the UK, resulting in over 500,000 fragility fractures annually. An initial fracture significantly increases the risk of subsequent fractures, particularly in very high-risk patients. Current clinical guidelines advocate a "treat-to-target" strategy, recommending anabolic treatment for individuals at very high risk of fracture. The objective of this study was to evaluate biochemical safety, service delivery efficiency, and imminent fracture risk among osteoporosis patients receiving anabolic agents.

Methods: We conducted a retrospective review of Aneurin Bevan Fracture Liaison Service (AB-FLS) between August 2023 and June 2025. Of the initial 71 patients identified, 62 patients who received Romosozumab were included in the final analysis. Three Romosozumab patients were excluded due to disengagement from follow-up or declining treatment. Patients treated with Teriparatide (n=5) and Abaloparatide (n=1) were excluded due to small sample sizes. Data collected included patient demographics, fracture types, T-scores at the spine and femoral neck, biochemical markers (serum calcium, alkaline phosphatase (ALP), 25-hydroxyvitamin D [Vit D]), service metrics (waiting times from initial consultation to treatment initiation), incidence of hypocalcaemia (calcium <2.20 mmol/L), ALP elevation (>25% from baseline), vitamin D deficiency (<50 nmol/L), re-fracture incidence, and mortality.

Results: Mean age for all women (n=62) was 72 years (range 40–83), 58% were vertebral, 24% were wrist/arm. Mean T-score at spine and femoral neck were −3.20 (range −5.39 to −0.70) and −2.65 (range −4.40 to −0.90) respectively. Median treatment initiation time post-initial consultation was 42 days (interquartile range 35–78 days). Biochemically, hypocalcaemia occurred in only 1 patient (1.6%) at the 4-month follow-up. Significant ALP elevations (>25%) were most common at 2 months (45%, 28/62) and gradually declined over subsequent follow-ups. Pre-treatment vitamin D deficiency was present in nine patients, all of whom received supplementation. Four patients (6.5%) experienced re-fracture between 84 to 275 days (mean 167 days). No mortality was recorded post initiation of anabolic.

Conclusion: Romosozumab treatment demonstrated good biochemical safety profiles and a low incidence of hypocalcaemia. We observed delays of nearly 6 weeks in treatment initiation for very high-risk patients. Given the observed imminent fracture risk of 6.5% whilst on treatment, efforts to reduce treatment delays by introducing stronger partnerships working with a dedicated FLS Pharmacists could be tested.

POSTER

Clinical Quality - Patient Centredness

3854. UNDERSTANDING PATIENT EXPERIENCE ON THE OLDER PERSON'S ACUTE MEDICAL UNIT (OPAMU) AND THE ACUTE FRAILTY PATHWAY AT UHW

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Introduction: The older population are more likely to suffer from chronic diseases, requiring more frequent hospital admissions, therefore, in University Hospital of Wales there is a dedicated Older Persons Acute Medical Unit (OPAMU). The OPAMU, opened in 2023, admits frail patients directly from the Emergency (ED) and Acute Medicine (AM) Departments for comprehensive geriatric assessment before discharge or onward hospital stay. Main objective: To understand how our patients felt throughout different steps of their journey to the OPAMU.

Secondary objective: To assess how the patient experience has changed since the last time feedback was collected in 2022.

Methods: We designed a questionnaire tailored to reveal patient experience across a variety of aspects of their journey on the OPAMU. This included broad questions about their assessment in ED/AM, comfort, and treatment, and detailed questions about their pain needs, discharge planning and communication on the ward.

Results: We received 18 responses and participants answered very positively. 100% felt comfortable on the ward, 94% felt listened to and informed on their treatment plan; 89% felt their pain needs were met, found staff respectful, and felt appropriately prepared for discharge, by answering “agree” or “strongly agree”. There was a statistically significant increase in positive responses to participant comfort (78% vs 53%), patient admission (44% vs 16%), and being prepared for discharge (89% vs 39%), compared to the study in 2022 (all $p<0.05$). Additionally, there was an increased positive response to participant experience of treatment (72% vs 68%) and communication with staff (72% vs 53%).

Conclusions: Our study revealed that the OPAMU is an overwhelmingly positive experience for older persons requiring specialist geriatric care. Whilst understanding the limitations of this study, the best steps moving forward would be to identify aspects of care needing improvement, then incorporate changes, and repeat the study in 6 months.

POSTER

Clinical Quality - Patient Centredness

3866. INNOVATIVE INTERNATIONAL APPROACHES TO DEMENTIA CARE: A CHURCHILL FELLOWSHIP PROJECT

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St George's University Hospitals NHS Foundation Trust - Care Home Therapy in Reach Service

Introduction: Dementia affects nearly one million people in the UK. Many older adults in care settings experience sedentary lifestyles, contributing to poor health outcomes. This Churchill Fellowship explored innovative dementia care models in Europe and Japan, focusing on the role of enabling and activity-based approaches. The aim was to identify effective, transferable strategies that promote well-being and function for people living with dementia (PLWD).

Method: Over two weeks, 14 care and community settings were visited across Belgium, the Netherlands and Japan. These included care homes, specialist housing and community-based organisations. Observations focused on how activity was embedded in daily life, staffing models, environment design and sustainability of care delivery.

Results: Three key themes emerged across all settings: leadership and care ethos; access to nature and community connection; and integration of activity into daily life. In the Netherlands, 'care farms' embedded movement into purposeful routines through dementia-friendly design. Belgium sites demonstrated structured therapy and co-created volunteer support. Japan highlighted intergenerational, community-based models encouraging purpose and independence. Activity was not an add-on but central to care, supporting identity, reducing distress, improving mobility and enhancing social inclusion. Staff reported increased job satisfaction and acted as enablers, supporting families and volunteers. Reported outcomes included improved mood, reduced behavioural symptoms and better quality of life.

Conclusion: International models show how embedding meaningful activity into dementia care enhances well-being, preserves function, and supports dignity. These approaches represent a shift from reactive care to proactive, life-affirming support. UK practice can benefit by adopting key elements: enabling environments, empowered staff and role of green spaces in dementia-inclusive care. This work supports the growing call for all clinicians to have increased awareness regarding prevention, care and public health strategies for PLWD from diagnosis to end of life.

POSTER

Clinical Quality - Patient Safety

3329. DOLS RENEWAL TRACKING AUDIT: IMPROVING COMPLIANCE WITH THE MENTAL CAPACITY ACT 2005

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Introduction: The Deprivation of Liberty Safeguards (DOLS) ensure that individuals who lack capacity are not unlawfully deprived of their liberty. The Mental Capacity Act 2005 and the DOLS Code of Practice mandate the timely renewal of urgent DOLS authorisations. However, lapses in renewal can lead to legal and ethical concerns. This audit evaluates the effectiveness of a systematic tracking system for DOLS renewal to improve compliance with legal standards and enhance patient care.

Method: A retrospective audit was conducted over two cycles. The first cycle involved a three-month pre-intervention review of renewal submissions, while the second cycle assessed compliance over two months after implementing a tracking system using a whiteboard to monitor renewal deadlines. Data sources included patient records, DOLS documentation, and staff input. The compliance standard was set at 100% timely submission of renewal requests as per the Mental Capacity Act 2005 and the DOLS Code of Practice. Ethical considerations were addressed by anonymizing patient data to maintain confidentiality.

Results: The pre-intervention compliance rate was 79%, with 34 out of 43 patients having timely renewals. After the intervention, compliance improved to 84.7%, with 39 out of 46 patients having timely renewals, showing a 5.5% increase in compliance. Despite these improvements, some delays persisted, attributed to manual tracking limitations and workload pressures.

Conclusion(s): The implementation of a simple tracking system improved compliance with DOLS renewal processes. However, challenges such as manual errors and staff workload require further interventions. Future recommendations include introducing an electronic tracking system with automated alerts, providing regular staff training, and conducting audits every six months to ensure sustained compliance and continued improvement in adherence to legal requirements.

POSTER

Clinical Quality - Patient Safety

3424. ASSESSING IV CANNULA USE: AN AUDIT ON REDUCING UNNECESSARY PROLONGATION AND ASSOCIATED RISKS

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1. New Cross Hospital; 2. New Cross Hospital

Introduction: The use of intravenous (IV) cannulas is a common clinical practice; however, their prolonged or unnecessary use can increase the risk of complications such as thrombophlebitis, infection, and patient discomfort. This quality improvement project was undertaken to evaluate current practices within the clinical setting and to identify areas for improvement.

Methods: Data was collected over the period of 2 weeks in March 2025 and it was collected every Monday, Wednesday and Friday. The inclusion criterion was patients admitted to the Stroke Unit at New Cross Hospital and the exclusion criterion was patients who did not have a cannula inserted or a non-occupying bed. An intervention was put in place via an oral presentation at the departmental meeting.

Results: Cannula insertion rates were 29.06% and 49.57%. Documentation rates decreased in the first week to 58.82% but recovered to 74.14% in the second week. Reasons for insertion drastically decreased to 38.24% and 18.97%. There was a significant increase in cannula prolongation to 88.24% and 98.28%.

Conclusion: Cannula insertion rates were similar across both cycles, with a slight decrease in Cycle 2. Documentation rates dipped in week 1 of Cycle 2 but recovered in week 2 and largely remained consistent. A notable decline was observed in the documentation of reasons for cannula insertion, especially in Cycle 2. The proportion of cannulas inserted for longer than 72 hours dramatically increased in Cycle 2, indicating a significant shift in practice. In Cycle 1, the average prolongation rate was 30.82%, while in Cycle 2, it surged to 93.26%, representing an approximate threefold increase. In Cycle 1, a notable proportion of prolonged cannulas had documented reasons, while in Cycle 2, a large number of prolonged cannulas lacked documented reasons. This concerning trend highlights a potential gap in understanding or adherence to best practice guidelines, suggesting a need for targeted training and reinforcement of protocols.

POSTER

Clinical Quality - Patient Safety

3484. OPTIMISING NECK OF FEMUR FRACTURES SURGICAL TIMING FOR IMPROVED PATIENT OUTCOMES: AN EXCELLENCE OF SERVICE CLINICAL AUDIT

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Background: Hip fractures represent a significant global health burden, leading to substantial morbidity, mortality, and healthcare costs. Delays in surgical intervention are consistently linked to poorer patient outcomes. This audit aimed to evaluate and enhance hip fracture management at Southampton General Hospital (SGH) through targeted quality improvement initiatives.

Methods: An interventional clinical audit was conducted at SGH, a Major Trauma Centre, comparing a pre-intervention period (December 2023 – March 2024; n=272 patients) with a post-intervention period (September 2024 – December 2024; n=291 patients). The methodology adhered to NICE guidelines. Data were collected via consecutive sampling from the National Hip Fracture Database (NHFD), Pathpoint eTrauma, and CHARTS/EDMS. Interventions focused on increasing surgical capacity (e.g., additional theatre allocation, dedicated hip fracture team), implementing comprehensive multidisciplinary medical evaluation, optimising imaging, addressing pre-existing conditions, standardising anticoagulation reversal, and improving overall patient care. Mean operating times, 30-day mortality rates, and length of hospital stay (LOS) were assessed and compared between cycles.

Results: The overall average patient age was 84 years. In the pre-intervention cycle, the mean operating time was 80 hours, with a 30-day mortality rate of 4.7%. Surgical delays affected 57.4% of patients. Post-intervention, the mean operating time significantly decreased to 55 hours, and the 30-day mortality rate reduced to 3.0%, notably lower than the national average of 5.9% for the same period. Despite these improvements, the proportion of delayed surgeries increased slightly to 63.9%. A key finding was that in the post-intervention cycle, an equal number of patients (n=6) died in both the non-delayed (5.7%) and delayed (3.2%) groups, suggesting that enhanced medical optimisation during delays contributed to improved outcomes. Delays consistently correlated with prolonged LOS in both cycles.

Conclusion: Targeted quality improvement initiatives at SGH significantly reduced the average time to hip fracture surgery and improved overall mortality rates. The crucial role of comprehensive medical stabilisation in mitigating mortality risks, even when leading to surgical delays, was evident. Despite systemic challenges inherent to a major trauma centre, these interventions demonstrate a positive impact on patient outcomes. Ongoing efforts should focus on sustainable theatre capacity, streamlined diagnostic pathways, and continuous auditing to optimise patient care.

POSTER

Clinical Quality - Patient Safety

3591. A CLOSED-LOOP AUDIT ON CATHETER CARE AND DOCUMENTATION PRACTICES IN ELDERLY CARE WARDS IN A TERTIARY CENTRE

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Introduction: Indwelling urinary catheters are widely used on acute geriatric wards but are a well-recognised source of morbidity, contributing to catheter-associated urinary-tract infections (CAUTIs), delirium and functional decline. National guidelines (NICE, BAUS) emphasise best practice in documentation, securement, drainage, and timely trial without catheter (TWOC). Sub-optimal practice noted after cessation of a national catheter-care audit prompted a two-cycle, closed-loop audit to assess current standards and evaluate targeted interventions.

Methods: A spot audit in April 2025 surveyed all Health and Ageing Unit (HAU) wards at a tertiary centre in South London, including in-patients aged ≥65 years with indwelling catheters (n = 24). Data were extracted from clinical records and bedside inspection using standardised pro-forma. An improvement bundle was then introduced—targeted MDT education sessions plus escalation of findings to key stakeholders. A second spot audit in June 2025 on the same wards (n = 16) evaluated post-intervention outcomes.

Results: Complete documentation of catheter insertion improved from 50% to 100%. Catheter indication documentation rose from 50% to 100%, with 82% indication for catheters being appropriate. The proportion of catheters appropriately secured with a G-strap rose to 93%. Use of 2L drainage bags increased from 58% to 88 and inappropriate urometer use was eliminated. Maintenance indicators showed clear improvement: bag/valve dated (87%), drainage bag above floor level (87%), and malfunctioning systems reduced to 13%. TWOC documentation improved significantly following our intervention. CAUTI prevalence also halved from 29% to 13% among current admissions.

Conclusion: This low-cost, multi-modal intervention improved documentation, securement, and maintenance standards for catheter care in older patients. Sustained focus on proactive TWOC planning will be key in future cycles. This model demonstrates the value of iterative audit and MDT-level engagement to reduce catheter-related harm in geriatric settings.

POSTER

Clinical Quality - Patient Safety

3672. ENHANCING ELECTROLYTE MANAGEMENT IN HOSPITALISED OLDER ADULTS THROUGH THE INTEGRATION OF A TRUST-SPECIFIC ELECTRONIC PRESCRIBING

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Introduction: Electrolyte disturbances are common among older inpatients and are associated with increased risks of delirium, falls, cardiac arrhythmias, and prolonged hospital stays. Despite their prevalence and impact, local guidance for managing these imbalances is often lacking or inconsistently applied. At Rotherham NHS Foundation Trust, no standardised guideline existed for adult electrolyte correction, which disproportionately affected the older inpatient population. To improve the timely and accurate management of electrolyte derangements - particularly in older adults - by implementing a trust-specific, evidence-based guideline embedded into the electronic prescribing system (MediTech), aiming to: reduce the average number of days electrolytes remain deranged and to improve adherence to appropriate correction protocols Promote safer, standardised care for older patients.

Methods: The guideline, developed collaboratively with the pharmacy, clinical governance, and EPR coding teams, was integrated into MediTech, allowing keyword-based access at the point of prescribing. Data was collected across two six-week cycles. Outcome measures included the average number of days electrolytes remained deranged, the percentage of patients with deranged electrolytes, and adherence to guideline-based prescribing.

Results: Cycle 1: (Mar–Apr 2024): Median days of electrolyte derangement reduced from 6.25 (pre-guideline) to 4.31 days (31% reduction). Correct prescribing increased from baseline to 60.1%.
Cycle 2: (Nov 2024–Jan 2025): Median days further reduced to 3.04 (29.5% reduction from Cycle 1), and correct prescribing rose to 81.8%. The proportion of patients presenting with deranged electrolytes remained stable (~33–36%), likely reflecting acute admissions.

Conclusion: Embedding a trust-specific electrolyte guideline within the electronic prescribing system significantly improved electrolyte correction in hospitalised patients, with particular benefit to older adults who are at increased risk from delayed or inappropriate treatment. Sustained improvements in prescribing accuracy and treatment timelines highlight the importance of system-level interventions in enhancing geriatric inpatient care. Future steps include continued prescriber education, user feedback, and annual audits to maintain progress.

POSTER

Clinical Quality - Patient Safety

3677. IMPLEMENTATION AND DEVELOPMENT OF A CHEST WALL TRAUMA PATHWAY TO IMPROVE PATIENT SAFETY

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Background: A Quality Improvement Project (QIP) at University Hospitals Dorset involving multiple specialties (Older People's Services, General Surgery, Pain Team, Anaesthetics, Emergency Department, Radiology, Pharmacy) focused on improving care for adult patients with Chest Wall Trauma. Incidence and severity increase significantly with age (recent audits found a 12% mortality), with complications that can be life-threatening. Key to good management is early injury recognition, effective pain control, frailty assessment, and timely escalation planning.

Introduction: A series of deaths following falls in older patients revealed delayed or missed diagnoses of traumatic haemothorax. In 56% of cases, significant chest trauma went unrecognised. A Chest Wall Trauma (CWT) pathway was introduced. A notable issue was reluctance among resident doctors to prescribe NSAIDs in older patients, with only 24.5% receiving appropriate NSAID therapy.

Our aims: Earlier recognition, frailty identification, optimal analgesia, and reduced morbidity/mortality.

Methods: The CWT pathway was developed through 3 PDSA cycles, using QI methodology. Retrospective data was collected via coded and bulk admission data. Initial cycles revealed under-recognition of injury, suboptimal analgesia, weak shared care between surgery and OPS, and limited escalation planning. These insights informed pathway iterations, now in its 4th version.

Results: Prompt injury recognition improved, with 94–96% of patients receiving early trauma CT scans. Paracetamol and opiates were prescribed in 100% of cases. NSAIDs remained underutilised in older adults (24.5% prescribed). Collaborative care improved markedly, with >94% of patients admitted under the most appropriate specialty (up from 58%). Escalation planning has been found to be reactive, with only 45% of patients having a documented escalation status during admission.

Conclusions: Timely injury recognition and appropriate ward admission have improved significantly. The 4th pathway iteration includes clearer NSAID guidance for older patients, structured escalation prompts, and digital integration within the Electronic Patient Record (EPR) improving availability of the pathway. Research Ethics approval not obtained as Clinical Audit Facilitator did not feel it was necessary.

POSTER

Clinical Quality - Patient Safety

3681. READMISSIONS AFTER FRAILTY EMERGENCY SQUAD DISCHARGE IN THE EMERGENCY DEPARTMENT

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Introduction: The increasing prevalence of frailty in the ageing UK population poses significant challenges for healthcare systems, particularly in emergency departments (EDs). Frailty is a leading factor in hospital readmissions among individuals over 65 years old. This project aims to analyse readmissions of frail patients within 7 and 30 days of ED discharge following comprehensive geriatric assessments (CGAs).

Method: This retrospective audit aimed to identify 7-day and 30-day readmissions of patients discharged by the Frailty Emergency Service (FES) at Leicester Royal Infirmary over a six-month period (April - September 2021) and potential readmissions related to the first presentation. Data were collected using Electronic Health Records and anonymised by the ED audit team, with variables including age, gender, ethnicity, readmission status within 7 and 30 days, and reasons for readmission. Preventability of readmissions was assessed by comparing diagnosis from the first visit and the following admission to the hospital, considering positive if at least one diagnosis was repeated, a descriptive statistical analysis was performed. The scope of practice involves only patients older than 65 that have a CFS of 6 or above for any reason, or a CFS of 4 and above but have presented to ED with a geriatric syndrome.

Results: During the six-month period beginning April 1, 2021, the FES team in ED performed 749 discharges, including 705 primary visits and 34 revisits (4,6%). Of the 749 discharges, 110 patients required hospital readmission within 30 days, resulting in an overall readmission rate of 14,68%, increasing to 15,68% when adjusted for primary visits on the first 30 days and 52 on the first 7 days which represents 6,94% readmission rate in total. The potential preventable visits for the first 7 days after discharge was 40 (76,92%) and 68 (61,81%) in the first 30 days. The primary reasons for readmissions included falls, infections, delirium, and social problems. For patients with multiple visits, only data from the initial visit was included in the analysis.

Conclusion(s): The overall results reveal FES readmission rates align with global CGA studies but highlight potential for improvement. Falls and infections were identified as primary causes of readmissions, with insufficient MDT involvement linked to higher rates. A multifactorial intervention, emphasising MDT collaboration, team expansion, and improved follow-up care, is proposed to reduce readmissions.

POSTER

Clinical Quality - Patient Safety

3702. Hypomagnesaemia and Acute Cognitive Decline in Older Adults: An Evaluation of Clinical Practice and Cognitive Outcomes at an NHS

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Introduction: Magnesium is essential for regulating cardiovascular, neuromuscular and respiratory functions. Hypomagnesemia in older adults is often overlooked and insufficiently managed. Inadequate monitoring and correction of hypomagnesemia may leave old and frail patients more vulnerable to acute cognitive decline which in some cases can be preventable. This study assessed the current management of hypomagnesaemia in older adults admitted to the geriatric wards of an NHS Trust and its association with acute cognitive decline.

Methods: A retrospective review of old and frail patients admitted to geriatric wards across two hospital sites over a month was conducted. Patients aged 65 years or above and those aged between 55 to 64 with clinical frailty were included. Electronic records were used to compare acute cognitive outcomes in patients with hypomagnesaemia and those with normal magnesium levels. Multivariate analysis was performed to assess predictors of acute cognitive impairment.

Results: Of the 667 hospitalised older adult patients included in our study, 149 (22.3%) had hypomagnesaemia, while 518 (77.7%) had normal levels. Among the 149 patients with low magnesium, 18 (12.2%) had moderate to severe deficiency (</= 0.5 mmol/L); of these, 27.8% received intravenous supplementation, 38.9% received oral supplementation and 33.3% received no treatment. The remaining 131 patients had mild hypomagnesaemia (<0.7 mmol/L), 45 (34.4%) received some form of supplementation, while 86 (65.5%) had none. Only 60 (40.3%) of all hypomagnesaemic patients had follow up magnesium levels checked. In the multivariable logistic regression model, adjusting for age, sex and potential clinical confounders, patients with hypomagnesaemia had 2.35 times greater odds of developing acute cognitive deterioration (OR (Odds ratio) = 2.354; 95% CI (Confidence interval) : 1.543–3.604; $p < 0.001$). These findings suggest an independent association between hypomagnesaemia and cognitive decline, underscoring the need for improved recognition and management in clinical practice.

Conclusion: Hypomagnesaemia may be a significant contributor to acute cognitive impairment in old and frail patients.

POSTER

Clinical Quality - Patient Safety

3712. IMPROVING THE SAFETY AND CONTINUITY OF CARE FOR PATIENTS ON APOMORPHINE: A THREE-CYCLE QUALITY IMPROVEMENT PROJECT

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Introduction: Apomorphine is an adjunct therapy used in Parkinson's disease, requiring careful coordination at discharge. A local review identified inconsistency in discharge documentation, supply of equipment, and communication with the movement disorder team. This quality improvement project aimed to improve discharge safety and communication through implementation of a structured checklist.

Method: Cycle 1 involved the introduction of an apomorphine discharge checklist on Ward L5, with compliance monitored and feedback provided. In Cycle 2, further improvements included medical staff education and ensuring full stock of apomorphine equipment on the ward. In Cycle 3, the Parkinson's Disease Nurse Specialist (PDNS) led monitoring of discharges and delivered ongoing staff training. Data were collected retrospectively across three cycles:
Cycle 1 : March to December 2020
Cycle 2: May–July 2021
Cycle 3: November 2022–May 2024

Results: Following Cycle 1, compliance improved across all three measures (0% to 100%). In Cycle 2, a single identified case showed full compliance. In Cycle 3, of six patients: 100% of patients were discharged either with an appropriate supply of apomorphine and equipment, or the pharmacist documented that the family already had a sufficient supply of all necessary medications and equipment. 33% had movement disorder team contact details documented. 83% had an identified and satisfied receiving team. Performance dipped in Cycle 3, attributed to weekend/on-call discharges, staff turnover, and one discharge from surgical ward.

Conclusion: This quality improvement project showed that initial implementation of the checklist led to significant improvements in discharge safety for patients on apomorphine. However, sustainability proved challenging due to staffing changes and variability in ward practices. This work highlights the need for ongoing education ensure safety in complex medication discharges.

POSTER

Clinical Quality - Patient Safety

3718. ENHANCING BONE PROTECTION FOR OLDER ADULTS POST-HIP FRACTURE: STREAMLINED BISPHOSPHONATE THERAPY AND REFERRAL COMMUNICATION

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Introduction: Hip fractures in older adults represent a significant clinical challenge, with high morbidity and mortality rates. Bisphosphonate therapy is the primary treatment for preventing secondary fractures. At Meadowlands Ward, a rehabilitation unit at Musgrave Park Hospital, inconsistent discharge planning resulted in missed opportunities for continued bone protection and essential follow-up care.

Methods: A quality improvement project was carried out for patients aged 65 and older with fragility hip fractures who received IV Zoledronic acid (IV Zol). A standardised 'traffic light' discharge pathway was developed to streamline ongoing bisphosphonate therapy: Green indicated eligibility for repeat IV Zol due to contraindications for oral bisphosphonates; Amber signified suitability for oral bisphosphonates after one year; Red identified patients unsuitable for further bisphosphonate therapy because of frailty. SmartPhrase templates were incorporated into the electronic health record to produce standardised letters for patients on the Amber pathway. These letters informed General Practitioners (GPs) and patients about IV Zol administration and recommended reviewing oral bisphosphonate therapy after one year. Three audit cycles were planned. After Cycle 1, an educational poster explaining the pathway criteria was introduced. Following Cycle 2, staff education sessions were held to reinforce the 'traffic light' system and the use of SmartPhrases.

Results: In Cycle 1, 60% (12/20) of patients were correctly assigned to a pathway and this increased to 70% (14/20) in Cycle 2. Cycle 3 showed further improvement, with 95% (19/20) of patients correctly assigned. Among Amber pathway patients, SmartPhrase use in GP communication rose from 12.5% (1/8) in Cycle 1 to 83% (10/12) in Cycle 2. This fell to 69% (9/13) in Cycle 3, highlighting the need for ongoing education to maintain consistent documentation.

Conclusion: A standardised, criteria-based discharge protocol improved allocation to bone protection pathways and enhanced GP communication. Integration into electronic systems and targeted staff education were key to the intervention's success.

POSTER

Clinical Quality - Patient Safety

3730. ENHANCING DELIRIUM DOCUMENTATION AT THE HOSPITAL-COMMUNITY INTERFACE

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Introduction: Delirium is common in older inpatients and associated with cognitive decline, underlying dementia, and mortality. NICE recommends that current or resolved delirium diagnosis is communicated to general practitioners (GPs) upon discharge. However, a 2021–22 study at Lister Hospital found that only 25% of delirium cases were documented in discharge letters. This gap poses significant risks to patient safety, as unresolved delirium may be overlooked, and underlying dementia missed. This project aimed to improve documentation of delirium diagnoses, resolution status, and follow-up advice in discharge letters.

Method: Electronic patient records were retrospectively analysed for patients aged ≥65 years with a recorded 4AT score ≥4 under Unplanned Care at Lister Hospital.

Cycle 1 targeted resident doctors with formal teaching and ward-based education on delirium assessment and documentation practices. Wards with high delirium rates were prioritised.

Cycle 2 expanded to the multidisciplinary team (MDT), with teaching delivered at a Trust Clinical Governance meeting, Nursing Manager Huddle, and alongside Dementia Champions during Dementia Awareness Week. Posters and patient information leaflets were distributed.

Results: Following Cycle 1, 4AT reassessment on discharge rose from 5% to 13%. Delirium documentation in discharge letters improved significantly from 54% to 76%. Discharge advice to GPs recommending referral to memory clinics more than quadrupled from 5% to 22%. After Cycle 2, 4AT reassessment reached 16% and follow-up advice 25%. Delirium documentation dipped to 61% but remained above baseline.

Conclusion: Sustained improvement is achievable through targeted educational interventions reinforced across the MDT. Resident-focused teaching yields rapid improvements – and it will continue moving forward – but sustainable change requires wider MDT engagement. Long-term progress may necessitate systemic changes, such as integrating delirium prompts into electronic discharge templates. Future work could assess downstream outcomes, including GP follow-up, community referrals, dementia diagnostic yield, and re-admissions.

POSTER

Clinical Quality - Patient Safety

3744. COMPLIANCE WITH THE NORTHERN ENGLAND EVALUATION AND LIPID INTENSIFICATION GUIDELINES ON PRESCRIBING STATINS AFTER STROKE OR TIA

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Introduction: The Northern England Evaluation and Lipid Intensification (NEELI) guidelines recommend that for secondary prevention after stroke and transient ischemic attack (TIA), the lipid profile should be checked within 24 hours of admission and atorvastatin 80 mg should be started once daily. If the starting dose was lower than 80 mg, plans should be made for statin uptitration in three months. The aim is to evaluate adherence to NEELI guidelines on checking lipid profile and prescribing statin therapy for optimal secondary prevention after stroke or TIA.

Method: This is a retrospective study. A random sample of 51 and 48 patients was selected for the first and second cycles, respectively, taking into consideration the inclusion criteria. Statins prescriptions during admission were reviewed and plans for uptitration in the community. The audit has examined the lipid profile checks and whether they were performed within 24 hours of admission. The audit was conducted in two cycles: before and after the implementation of the intervention. The intervention involved conducting ward teaching on optimal lipid management and NEELI guidelines after the first cycle to raise awareness among doctors.

Results: During the first cycle, a 74% gap was identified in prescribing the correct dose of statins. Seventy-three percent of patients had their lipid profile checked during admission, with 95% of these tests completed within the first 24 hours. Only 8% had plans for statin uptitration in the community. On the second cycle, the gap in prescribing statins decreased to 73%. Lipid profile checks increased to 79%, with 81% completed within the first 24 hours. Documentation of plans for statin uptitration increased to 26%.

Conclusion: Improvement in guideline compliance was noted, accompanied by a slight decrease in lipid checks within 24 hours. Plans are to continue regular ward teaching and provide posters.

POSTER

Clinical Quality - Patient Safety

3765. REDUCING ANTICHOLINERGIC BURDEN (ACB) WITHIN THE ELDERLY CARE WARDS THROUGH IMPLEMENTATION OF AUTOMATED ALERTS

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Introduction: Polypharmacy is a major risk for older patients aged 65 and above. Commonly prescribed medications may have anticholinergic properties causing dry mouth, constipation, and urinary retention which can exacerbate delirium in older adults[1]. ACB scores help quantify the cumulative effect of these medications. ACB scores of three or more are associated with confusion, falls and death[2].

Aim: To evaluate whether automated alerts of ACB scores help reduce scores and encourage medication reviews in older patients.

Method: Over two weeks, automated alerts were set up within the hospital's online noting system, which is simulated to flag high ACB scores based on inpatient drug charts. The alert identified the total ACB score and highlighted offending medications. Data was collected from 40 patients across four elderly care wards over two weeks, on alternate days. ACB scores were calculated using an online ACB calculator. ACB scores collected before and after two simulated alerts were analysed and compared.

Results: Out of 40 patients, 12 had an ACB score of 3 or more before the simulated alerts. Following two automated alerts, this reduced to 9 patients, which equates to a 25% reduction. However, in 31 patients, the ACB score remained unchanged. The ACB scores increased in 8 of the 40 patients. Furthermore, lansoprazole was the most common offending drug, followed by tricyclic antidepressants.

Conclusion: Our study demonstrated that automated reminders could facilitate regular medical reviews and reduce anticholinergic burden in elderly patients. However, this would work better in combination with regular teaching sessions to increase awareness. Importantly, proton pump inhibitors (PPIs) were prescribed to over a quarter of patients. This raises questions about the necessity of these medications in this age group and a potential QIP looking at deprescribing PPIs as per the deprescribing algorithm.

POSTER

Clinical Quality - Patient Safety

3823. USING SIMULATION AS A LEARNING TOOL IN GERIATRIC MEDICINE IN MERSEY DEANERY

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Introduction: Simulation is widely considered as a valuable tool in medical education. It offers a controlled 'practice' environment for all medical professionals to develop their skills clinically and in communication. Geriatric medicine is a complex speciality in which simulation can be particularly beneficial, allowing trainees to manage age-related conditions and multimorbidity in a safe setting, where errors can be corrected and through reflection, practice can be improved. By using simulation, Mersey trainees have enhanced their confidence in managing the unique challenges of caring for older adults.

Methods: The Mersey deanery trainee representatives for geriatrics worked alongside medical education faculty at two simulation centres (Aintree and Whiston) to develop tailored scenarios from real-world experience covering deteriorating patients with frailty and multimorbidity. Simulation technology was used and each session included specific communication scenarios mirroring difficulties faced by the medical registrar looking after older adults, which is different from the deanery-provided GIM simulation training. Four sessions have been delivered to date, with further sessions planned twice a year going forwards. Scenario feedback focuses on non-technical skills and human factors.

Results: Feedback for the training sessions has been excellent. All participants at the most recent session in May 2025 reported the training was 'excellent' or 'good' and all agreed that their confidence was improved in managing clinically unwell patients. Feedback from each previous session has been used to inform the development of subsequent sessions.

Conclusion: The use of simulation is a well validated tool in improving confidence in clinical scenarios while maintaining safety in a controlled environment. The specific tailoring of scenarios to specialty trainees improved confidence in managing the complexities associated with the deteriorating frail patient. Feedback is strongly positive and support from local simulation centres ensures we can continue to offer this specialised simulation training to our registrars in the future.

POSTER

Clinical Quality - Patient Safety

3852. FROM BROAD-SPECTRUM TO BROAD THINKING: FRAILTY-BASED ANTIBIOTIC STEWARDSHIP IN ACTION

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Introduction: Since COVID-19, Clostridioides difficile infection (CDI) rates have increased nationally, including at South Warwickshire Hospital Foundation Trust (SWFT) during 2022–2023. A Quality Improvement Project (QIP), in collaboration with the Antimicrobial Stewardship (AMS) team, identified older adults with frailty as high-risk for receiving broad-spectrum antibiotics, which were linked to higher CDI rates and poorer outcomes. To address this, a frailty-specific antimicrobial guideline was introduced to reduce inappropriate broad-spectrum antibiotic use, particularly co-amoxiclav, and improve clinical outcomes. The QIP aimed to evaluate prescribing practices, ensure adherence to trust guidelines, and encourage multidisciplinary collaboration.

Method: In 2022, 40 patients (20 in-patients, 20 virtual frailty ward patients) were audited. Data from the first cycle showed that 75% of in-patients received antibiotics outside of guidelines, with 50% of these prescribed co-amoxiclav. It was found that acute frailty presentations (e.g., delirium, falls, "off legs") were often misdiagnosed, leading to unnecessary broad-spectrum antibiotic use. In response, the new guideline introduced an "Acute Frailty Syndrome" category, promoting 2 to 3 narrow spectrum alternatives when the infection source was unclear. The guideline was implemented across inpatient and community settings, with targeted education delivered to high-impact areas such as Emergency Medicine and the Frailty Assessment Area.

Results: A second audit cycle in 2025 showed significant improvements: only 20% of in-patients were prescribed antibiotics outside guidelines, and inappropriate co-amoxiclav use dropped by 45%. Re-admission rates within 30 days also fell from 15% to 5%.

Conclusion: In conclusion, introducing a frailty-specific antibiotic guideline and strengthening multidisciplinary practices led to safer prescribing, reduced CDI risk, and better outcomes for older adults living with frailty at SWFT.

POSTER

Scientific Presentation - Big Data

3661. USING DATA LINKAGE TO IDENTIFY PREDICTORS OF CARE HOME ENTRY AFTER PSYCHIATRIC HOSPITAL DISCHARGE: A RETROSPECTIVE COHORT STUDY

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Background: Pathways into care homes represent a critical yet under-researched aspect of decision-making for individuals, families, and professionals. Prior research links recent psychiatric hospital discharge to higher risk of care home entry from hospital. This retrospective cohort study used linked health and care home data to identify predictors of care home admission following psychiatric hospital discharge within the previous six months.

Methods: We included adults moving-in to care homes between 1/4/13 and 31/3/16, recorded in the Scottish Care Home Census. Data were linked to inpatient stays, community prescribing, and mortality records to identify diagnoses, comorbidities, polypharmacy, frailty, healthcare use, and deaths. Regression models identified predictors of care home entry following recent (within six months) psychiatric hospital discharge compared to those without.

Results: Following adjustment, individuals entering a care home after a recent psychiatric hospital discharge were more likely to be male (OR 1.60, 95%CI 1.43-1.78), and of a younger age. A hospital diagnosis of any fracture within the past three years (OR 1.90, 95%CI 1.48-2.44), or dementia within the past six months (OR 1.31, 95%CI 1.11-1.55) were significant predictors of moving-in after psychiatric hospital discharge. Furthermore, combined psychiatry and hospital diagnoses three years before moving-in of delirium (OR 1.75, 95%CI 1.38-2.21), dementia (OR 9.05, 95%CI 7.51-10.91), depression (OR 3.97, 95%CI 3.29-4.79), or mental and behavioural disorders due to alcohol (OR 2.10, 95%CI 1.71-2.58) were significant predictors of moving-in to a care home after a psychiatric hospital discharge.

Conclusions: This study identifies important differences in the individuals entering care homes after a psychiatric hospital discharge compared to those with non-psychiatric backgrounds. These provide useful insights to a complex clinical population which can guide more supportive practices. Further exploration involving staff, carers, and patients could help shape more informed pathways from psychiatric settings into care homes.

POSTER

Scientific Presentation - Big Data

3749. Clinical Determinants of 180-day Hospital Readmission and Mortality in Older Adults with Dementia: A UK-Based Cohort Study

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Introduction: Older adults with dementia occupy approximately one quarter of acute hospital beds in England. The risk of hospital readmission within six months of discharge increases with multiple long-term conditions, reduced mobility, and limited interdisciplinary collaboration between primary and secondary care. Subsequently, hospital readmission can increase the risk of mortality in this population. This study aimed to quantify the clinical determinants of readmission and subsequent mortality in older adults with dementia in England.

Method: A retrospective cohort study was conducted using anonymised data from adults in England aged 65 and over with a recorded diagnosis of dementia. Cases were identified through primary care electronic health records in the Clinical Practice Research Datalink (CPRD) GOLD, between April 1997 and November 2018. Readmissions within 180 days were identified using linked Hospital Episode Statistics. Adjusted logistic regression assessed factors associated with readmission, and Cox proportional hazards regression identified predictors of one-year mortality following readmission.

Results: The cohort included 24,956 patients from 253 general practices (mean age 81.93 years; 61.6% female). Chronic obstructive pulmonary disease (odds ratio [OR]=1.26, 95% confidence interval [CI]: 1.15-1.39), diabetes mellitus (OR=1.21, CI: 1.13-1.30), and chronic kidney disease (OR=1.14, CI: 1.07-1.22) were strongly associated with readmission. Medication review in primary care within one year prior to admission (OR=1.08, CI: 1.02-1.14), and primary care consultation within two weeks of discharge (OR=1.21, CI: 1.15-1.28) were also associated with readmission. One-year mortality following readmission was associated with age (hazard ratio [HR]=3.20, CI: 2.49-4.11 for ages 90+ versus 65-69), multiple long-term conditions (HR=1.21, CI: 1.05-1.41 for 4-5 conditions versus none), prescriptions for antipsychotic medication (HR=1.37, CI: 1.22-1.53), and care home residence (HR=1.33, CI: 1.10-1.62).

Conclusion: Knowledge of clinical factors associated with readmission and mortality can inform advanced care planning between health and social care professionals, older adults with dementia and their families.

POSTER

Scientific Presentation - BMR (Bone, Muscle, Rheumatology)

3694. UPHOLDING EQUITABLE ACCESS TO SECONDARY FRACTURE PREVENTION FOR ADULTS 80 YEARS AND OLDER

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Introduction: Fragility fractures increase re-fracture and mortality risk, especially within two years. Fracture Liaison Services (FLS) aim to prevent secondary fractures by ensuring quality care for patients over 50. This study assesses equity of care in an existing FLS for patients above and below 80 years and evaluates re-fracture and mortality outcomes.

Methods: We retrospectively reviewed 2,190 patients seen by Aneurin Bevan Fracture Liaison Service (AB-FLS) from January-December 2023 using national FLS Database (FLS-DB) data. After excluding 14 patients with missing data, 2,176 were categorized as: below 80 and above 80 years. Data on previous fractures, re-fractures, and fracture type (hip/femur, spine, wrist, humerus, pelvis, others) were collected. Patients were followed until March 31, 2025, for re-fractures and mortality.

Results: The cohort's mean age was 78.6 years (range: 50–103), with a significant female predominance (76.9%, p<0.0001). Prior fractures were recorded in 50.7% (n=1104), with a mean interval of 6 years (range: 0–36). Most (93.3%) lived in the community, 6.7% were in care homes. AB-FLS reviewed 1103 (50.7%) patients aged 50–80 and 1073 (49.3%) aged over 80, with no significant group differences. Female distribution was similar (78.8% vs.75%). Bone treatment was initiated in 1207 (55.2%) patients. Over 27 months follow-up, 1801 (82.8%) had no re-fracture. Overall, 17.2% (n=374) re-fractured (mean time: 253 days, range: 2–767 days). A significantly higher patients re-fractured in over 80 years (n= 209, 55.9%, mean 235 days) as compared to under 80 years (n=165, 44.1%, mean 276 days, p=0.023). At 12 months, 264 (12.1%) re-fractured: 154 (58.3%) over 80 (mean 137 days) and 110 (41.7%) under 80 (mean 151 days, p=0.008). By 27 months, 503 patients had died. One-year mortality was 18.6% (n=387), significantly higher in those over 80s (75.7%, n=293) than under 80 (24.3%, n=94, p<0.0001).

Conclusion: The AB-FLS has demonstrated equitable care over the consecutive twelve-month period; however, further assessment over a longer timeframe is needed for confirmation. Given the significantly higher risk of re-fracture and mortality in older patients, secondary fracture services should be tailored to better address the needs of this population, ensuring true equity in healthcare.

POSTER

Scientific Presentation - BMR (Bone, Muscle, Rheumatology)

3733. IMPLEMENTING THE BOOST (BETTER OUTCOMES FOR OLDER PEOPLE WITH SPINAL TROUBLE) PROGRAMME FOR OLDER PEOPLE WITH SPINAL STENOSIS

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Introduction: Lumbar spinal stenosis is a disabling condition affecting older people and there is a need to provide effective rehabilitation. The BOOST programme is a group physical and psychological intervention for people with spinal stenosis that we evaluated in the BOOST randomised controlled trial (RCT). The BOOST programme significantly improved walking at 6 and 12 months, reduced falling risk and was cost-effective compared to best practice advice. Disability improved at 6 months.

Method: A two-stage implementation study.
Stage 1: We worked with stakeholders to optimise the programme for implementation and evaluated delivery of the optimised programme at 4 sites. Participants completed the Oswestry Disability Index (ODI) and 6-minute walk test at baseline and 6 months.
Stage 2: Integrating stage 1 feedback, we developed and evaluated a Massive Online Open Course (MOOC) to train physiotherapists.

We evaluated outcomes when delivering the BOOST programme by a subset of MOOC learners at 9 sites. We used a synthetic control method to test the optimised programme and compare with the BOOST RCT.

Results: MOOC evaluation: 31 learners enrolled in the MOOC. 24/31 (77%) provided feedback and were satisfied with the training and confident to deliver the programme. 21/24 (87.5%) intended to implement it. At 6 months, 18/31 (58%) responded. 12/18 (66%) reported delivering the programme and 4/18 (22%) reported using programme elements.

Clinical outcomes: In total, 105 participants attended the optimised BOOST programme. 83 participants completed follow up (79%). Implementation study participants had larger reductions in ODI compared to the BOOST trial control arm [-4.65 points (95% CI -1.53, -7.78)] and walked further [64.85m (95% CI 42.21, 87.49)]. Increases in walking were twice that seen in the RCT.

Conclusions: We demonstrated successful implementation of the BOOST programme using a MOOC to train physiotherapists. Improvements in outcomes suggest optimisation was worthwhile.

POSTER

Scientific Presentation - BMR (Bone, Muscle, Rheumatology)

3772. MOBILITY AND STRENGTH TRAINING WITH AND WITHOUT PROTEIN SUPPLEMENTS FOR PRE-FRAIL/FRAIL OLDER PEOPLE WITH LOW PROTEIN INTAKE

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Introduction: Regular exercise to improve muscle strength and balance is recommended for older people. Providing extra protein to older people may enhance the benefits of exercise especially in people who have insufficient dietary protein. Our study evaluated the feasibility of conducting a definitive trial to evaluate the effectiveness of mobility and strength training +/- protein supplements for pre-frail/frail older people with low protein intake.

Method: A multi-centre feasibility randomised controlled trial in 4 NHS community trusts.

Recruitment: via physiotherapy caseloads, an existing cohort study and community advertising. Participants: ≥60 years, pre-frail/frail, reported walking difficulties and low protein intake (<1g protein/kilogram body weight(kgBW)/day). The recruitment target was 50.

Interventions: everyone undertook exercise 2x/week supported by a physiotherapist for 24 weeks. Half were randomised (1:1) to receive 24 weeks of daily protein supplements increasing protein intake up to 1.6g/kgBW/day.

Feasibility outcomes: recruitment, intervention fidelity, adherence, tolerance and study retention.

Clinical outcomes: Short Physical Performance Battery, 6-Minute Walk Test and participant reported outcomes (baseline and 5–8-month follow-up).

Results: Initially recruitment focused on existing caseloads, but patients were more unwell and disabled than anticipated and ineligible. No participants were recruited from the cohort. A community recruitment strategy was implemented, and we randomised 20 participants, but we ran out of time to fully implement this strategy. We achieved good intervention fidelity. The median number of exercise sessions completed was 10.5/16 (IQR 7, 13). Six participants received supplements which they tolerated well and took regularly. Fourteen participants (70%) completed follow-up with no difference in retention between arms. All clinical outcomes showed a trend towards larger improvements in the exercise+protein arm but were not statistically significant.

Conclusion: A definitive trial would not be feasible as originally proposed. Recruitment was the biggest challenge with community advertising proving most successful and the recommended method for a future trial.

POSTER

Scientific Presentation - BMR (Bone, Muscle, Rheumatology)

3778. EFFECTS OF METFORMIN ON BIOMARKERS IN OLDER PEOPLE WITH SARCOPENIA: ANALYSIS FROM THE MET-PREVENT RANDOMISED CONTROLLED TRIAL

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Background: Chronic inflammation and metabolic dysfunction are posited to contribute to sarcopenia and physical frailty; both are targets for metformin therapy. We investigated correlations between physical performance measures and inflammatory and metabolic biomarkers in a group of older people with sarcopenia and frailty/prefrailty and investigated the effect of metformin treatment on this biomarker panel.

Methods: We analysed samples collected at baseline and follow-up (4 months) from the randomised controlled MET-PREVENT trial. MET-PREVENT recruited participants aged 65 and over with probable sarcopenia (EWGSOP2 guidelines) and 4m walk speed <0.8m/s. Participants received 500mg metformin 3x/day or matching placebo for 4 months. Blood sampling and physical performance measures (handgrip strength, 4m walk speed, six-minute walk distance, 5x sit to stand) were conducted at baseline and 4 months. Biomarkers were measured using ELISA and Luminex platforms for insulin, CRP, adiponectin, leptin, MCP-1, IL-1b, IL-6, IL-8, and TNF-a. Baseline correlations and correlations of changes between baseline and follow-up, were analysed using Spearman's test; median change between baseline and follow-up in the metformin and placebo groups was compared using Mann-Whitney tests.

Results: Seventy-two participants were studied, mean age 80 years. Higher baseline IL-6 concentrations correlated with lower six-minute walk distance, (r=-0.40, p=0.008); other correlations were non-significant. Increased IL-1B and decreased adiponectin between baseline and 4 months were correlated with worsening grip strength (r=-0.25, p=0.04; r=0.29, p=0.016); increased TNF-a and decreased MCP-1 were correlated with worsening 5x sit-to-stand time (r=0.38, p=0.02; r=-0.32, p=0.04). Metformin treatment reduced circulating insulin concentrations more than placebo (median change between baseline and 4 months: -178pg/ml [IQR -462, 180] vs 147pg/ml [IQR -89, 353]; between-group p=0.04) but did not significantly change other biomarkers compared with placebo.

Conclusions: In this trial population, only weak and inconsistent correlations were seen between physical performance and inflammatory/metabolic biomarkers, and metformin did not beneficially affect most biomarkers measured.

POSTER

Scientific Presentation - BMR (Bone, Muscle, Rheumatology)

3791. RISING BURDEN OF PELVIC FRACTURE: A NEED FOR PROMPT IDENTIFICATION TO MINIMISE HARM

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Introduction: Pelvic fractures are a common fragility fracture, associated with adverse clinical outcome but often under recognised. There is a wide range of incidence 6.9-78.6/100,000/year being reported in the UK. There is a paucity of studies describing incidence and adverse outcomes including mortality and re-fracture risk. The objective of this study is to measure incidence of fragility fracture for the population of Gwent (592,000), compare baseline characteristics with all fragility fractures and measure clinical outcomes of pelvic fractures.

Methods: All fragility fracture patients seen by Aneurin Bevan Fracture Liaison Service (AB-FLS) between January 2022 and June 2024 were reviewed retrospectively. The clinical outcomes for pelvic fracture including re-fracture and mortality were analysed at 12 months.

Results: A total of 5310 fragility fracture patients were observed for 2.5 years and 5% (n=263) had pelvic fracture. The incidence of pelvic fracture over 2.5 years was 17.7/100,000/year. However, due to improved fragility fracture case identification, incidence for the year 2024 was 36.6/100,000/year. 52.1% (n=137) patients with pelvis fracture had previous fragility fracture. Mean age of all pelvic fracture patients (n=263) was 83.7±8.4, whereas mean age for all the fragility fracture patients seen by AB-FLS (n=5310) was 79.7±8.7, the difference being statistically significant ($p<0.001$). Females were 81.7% (n=215) which was higher as compared to all females seen by AB-FLS were 77.8% (n=4136), but this was not significant on difference between proportions test, p=0.18. Only 5.3% patients were admitted from care home (n=14) which was comparable to all the patients seen by AB-FLS (5.5%, n=294) and not significant on difference between proportions test, p=0.97. Moreover, 60.1% (n=158) pelvic fracture patients were hospitalised which was higher than all fragility fracture admitted to hospital (48.4%, n=2570) and was a significant difference between proportions test, p=0.004 61.2% (n=161) were started on osteoporosis treatment. 23.6% (n=62) pelvic fracture patients died at 12 months. Although 85.2% (n=224) had no fracture, 14.8% (n=39) had re-fracture at 12 months. 11.4% (n=30) re-fractured at 12-months involving hip, wrist, spine, humerus or pelvis. 2.7% (n=7) of the total pelvic fracture had hip fracture within 12 months.

Conclusion: Over 60% patients with pelvis fracture required inpatient care which was significantly higher in comparison to all fragility fracture admissions (48%). Pelvic fractures were associated with high one-year mortality (23.6%). More research is needed to close this gap, so we can better understand the impact of pelvic fractures on health services.

POSTER

Scientific Presentation - Diabetes

3818. COMPARING AGE, COMORBIDITY AND EVENT RATES BETWEEN SGLT2 INHIBITOR TRIAL PARTICIPANTS AND PEOPLE TREATED IN ROUTINE CARE

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Introduction: Randomised controlled trials are often criticised for excluding older people with multiple long-term conditions. This study used individual participant data (IPD) for 25 trials of sodium glucose co-transporter-2 inhibitors (SGLT2i) to compare baseline characteristics, comorbidities, and event rates between trial participants and community SGLT2i-treated people.

Methods: Trials were identified through a systematic review with subsequent application for IPD. Community SGLT2i-treated people in routine care were identified from SAIL databank. For each trial, we applied the eligibility criteria to the community SGLT2i-treated populations. We then assessed the proportion eligible/ineligible for each trial; compared age, sex and comorbidities between trial participants and those eligible/ineligible in routine care; compared rates of serious adverse events in the trials to the expected rate in community SGLT2i-treated participants; and compared the rate of major adverse cardiovascular events (MACE) and mortality between trial and community participants.

Results: Mean age was similar between trial participants and eligible community-treated participants. The number of comorbidities was consistently lower in trial populations compared people treated in the community. However, compared with other trial populations, participants in the large cardiovascular outcome trials (CANVAS, CANVAS-R, CREDENCE and EMPA-REG) had higher levels of comorbidity and rates of serious adverse event, MACE and mortality that were broadly similar to the expected rate in the community. For the remaining trials, the serious adverse event rate was lower in the trials than the expected rate based on community SGLT2i-treated participants.

Conclusion: While people with comorbidity are under-represented compared to routine care populations in most trials, the large cardiovascular outcome trials were more representative of SGLT2i-treated patients with similar rates of serious adverse events. While our findings support calls for caution regarding trial representativeness, the criticism that trials are not representative does not apply equally to all trials, some of which closely reflect current drug use.

POSTER

Scientific Presentation - Diabetes

3819. POLYPHARMACY AND POTENTIALLY INAPPROPRIATE PRESCRIBING IN TYPE 2 DIABETES: A NATIONALLY COMPREHENSIVE ANALYSIS OF SCOTTISH DATA

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Introduction: This study assessed national trends in polypharmacy and potentially inappropriate prescribing among people with type 2 diabetes in Scotland, 2012 to 2022.

Methods: We analysed nationwide data from the Scottish Care Information–Diabetes database. Individuals aged ≥40 years with type 2 diabetes between 2012 and 2022 were included. Medication counts were based on unique medications dispensed per year excluding those for short-term indications (e.g. antibiotics). Potentially inappropriate medications were based on 2023 Beers criteria applied to people over 65 years. A Poisson mixed-effects model with individual-level random intercepts assessed the relationship between polypharmacy and gender, age group, and socioeconomic status, Elixhauser comorbidity index and the hospital frailty risk score.

Results: 387,338 people with type 2 diabetes were included. Median number of medications dispensed was 9 (IQR 5-13). People over 65 were dispensed a median of 2 (IQR 1-3) potentially inappropriate medications. Adjusted medication counts were modestly higher in older people (rate ratio [RR] 1.06, 95% confidence interval [CI] 1.06-1.06 at age 80+ compared to 40-59), females (1.14, 1.13-1.14), in more deprived areas (1.24, 1.23-1.24 in most deprived vs most affluent quintile) and with higher comorbidity (1.12, 1.12-1.13 in 4+ vs 0 comorbidities) but not with high frailty risk (1.00, 1.00-1.00). Potentially inappropriate medication showed a similar pattern except a stronger association with comorbidity (1.24, 1.23-1.25) and a positive association with high frailty risk (1.24, 1.23-1.25). Rates of polypharmacy and potentially inappropriate prescribing showed minimal changes across calendar time.

Conclusions: Polypharmacy is the norm among people with type 2 diabetes, and most people aged over 65 are prescribed two or more potentially risky medications each year. Understanding how this impacts diabetes management, risk of adverse outcomes, and quality of life is a priority in order to optimise care for people with type 2 diabetes.

POSTER

Scientific Presentation - Education / Training

2506. 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

Scientific Presentation - Education / Training

3323. "I'M WORRIED I WON'T TRULY UNDERSTAND HOW TO HELP THEM": MEDICAL STUDENTS' PERCEPTIONS OF COMMUNICATING WITH CONFUSED PATIENTS

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Introduction: Hospital inpatients can present as confused for a multitude of reasons, thus learning how to effectively communicate with confused patients is a key skill for medical students. Fourth year is the first clinical year at our medical school. A verbal feedback session with fourth year medical student year representatives identified confidence in communicating with confused patients as a key concern of the cohort.

Methods: 40 fourth year medical students were surveyed using an online form. The students rated their confidence in communicating with confused patients on a Likert scale and were asked to explain this answer in under 100 words. These responses were collated into a Microsoft Excel Spreadsheet, and then thematic analysis using NVivo 12 software was applied to identify key themes.

Results: 20% (8/40) of students rated themselves as 'very unconfident', 33% (13/40) as 'somewhat unconfident', 38% (15/40) as 'neither confident or unconfident', 7% (3/40) as 'somewhat confident', and 2% (1/40) as 'very confident'. Key challenges identified by students included: unclear patient understanding or capacity (16 references), student communication style (15 references), patient distress or agitation (9 references), obtaining accurate information (7 references), and misunderstanding the patient (7 references). An e-learning resource including videoed simulated scenarios was created to attempt to address these challenges. 24 students who undertook the e-learning were surveyed at the end of the module. 4% (1/24) rated themselves as 'neither confident or unconfident', 88% (21/24) as 'somewhat confident', and 8% (2/24) as 'very confident', with no students rating themselves as 'very unconfident' or 'somewhat unconfident'.

Conclusion: Medical students at the beginning of their clinical years lack confidence and identify several key challenges in communicating with confused patients. An understanding of these challenges is important for those working in Geriatric Medicine, particularly those involved in medical education. E-learning and utilising technology can be a helpful tool in developing students' learning and confidence in this area.

POSTER

Scientific Presentation - Education / Training

3342. FRAILTY NEXUS: COMMUNITY OF PRACTICE FOR FRAILTY RESEARCHERS AND HEALTHCARE PROFESSIONALS

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Background: There has been success in implementing frailty education for healthcare professionals, but there remains a need to improve the knowledge and skills of researchers and healthcare professionals to develop, implement and evaluate frailty-focused research. This paper describes how the Australian Frailty Network developed and evaluated a virtual community of practice (VCOP), a proven model for fostering knowledge mobilisation, to support researchers and healthcare professionals in advancing frailty research and practice in Australia.

Methods: A survey of prospective members sought to define the VCOP's purpose, membership and structure. An evaluation was undertaken 18 months post-commencement, guided by the RE-AIM framework to assess reach, effectiveness, adoption, implementation and maintenance.

Results: Fifty-five prospective members completed the initial survey. There was wide agreement from respondents to be inclusive in defining membership. The preferred purposes of the group included networking, opportunities to gain feedback, review frailty research, and knowledge and skill acquisition. In response, Frailty Nexus was launched, with three core components ('Learning Link-Up', online learning events; 'Nexus News', newsletter sharing learning and research opportunities; 'Nexus Nook', a library of shared resources). Membership totalled 618 from 81 organisations. Ninety-six percent of surveyed members expressed satisfaction with Frailty Nexus.

Conclusions: Frailty Nexus is contributing to capacity building in multidisciplinary and translational frailty research. This VCOP could serve as a model that can be adapted by others to improve research outcomes and policy implementation.

POSTER

Scientific Presentation - Education / Training

3495. ENHANCING PARKINSON'S DISEASE CARE IN CARE HOMES: A SCOPING REVIEW OF STAFF EDUCATION AND TRAINING INTERVENTIONS

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Introduction: Parkinson's disease (PD) is the second most common and fastest-growing neurodegenerative condition globally. Many older adults with PD reside in care homes, where staff may lack the necessary training to manage the condition effectively. This scoping review aimed to examine the evidence on education and training interventions for care home staff in relation to PD care.

Method: A scoping review was conducted in accordance with the PRISMA-ScR framework. Six databases were searched for empirical studies focused on PD-related training or education for care home staff. Inclusion criteria were applied, and data were extracted and thematically analysed. Study quality was appraised using JBI checklists.

Results: Seven studies met the inclusion criteria. Four key themes emerged: (1) improved staff knowledge and confidence following training; (2) enhanced care practices, including better communication and medication management; (3) lack of specialist PD education across the sector; and (4) the importance of communication-focused training. Most studies were of moderate quality, and a significant gap in published research was noted.

Conclusion(s): While available evidence suggests PD-specific education for care home staff may improve knowledge and care quality, this area remains significantly under-researched. Development, implementation, and evaluation of comprehensive and accessible training programmes are urgently needed to support staff in delivering high-quality care for people living with PD in care homes.

POSTER

Scientific Presentation - Education / Training

3671. "SHAPING AGEING EDUCATION TOGETHER": COMMUNITY AND STAKEHOLDER ENGAGEMENT TO IMPROVE GERIATRIC MEDICINE EDUCATION

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Introduction: Improving ageing education for health professionals requires meaningful involvement of those with lived experience. Giving older adults a voice in curriculum design and delivery helps shape education to be inclusive, authentic, and relevant, preparing students for person-centred care.

Methods: We hosted a community engagement outreach workshop, bringing together multidisciplinary health professions students (n=7: medicine; pharmacy) and educators (n=26), with older members of the public (n=8) and other key stakeholders in older peoples' care (n=12: care home staff; charity representatives; researchers). The workshop began using a creative focus to stimulate reflection, followed by mixed small group discussions exploring participants' lived experiences of ageing, caring for older people, and/or ageing education. Groups identified opportunities for innovation where there was mismatch between current teaching and lived experience of ageing, with particular focus on opportunities that would involve older people, multiple professions, and community settings. Discussion points were noted and have been grouped into broad themes.

Results: Participants emphasised the value of early and repeated engagement with community-dwelling older people to build empathy and skills beyond clinical settings. The arts were identified as a powerful means to deepen understanding and challenge ageism. Involving older adults as co-educators emerged as essential for humanising ageing education. Additionally, interprofessional education was recognized as crucial to preparing students to work effectively within multidisciplinary teams.

Conclusions: Our workshop identified practical strategies to transform undergraduate ageing education by connecting multidisciplinary students with older people in the community and those involved in the care of older people, giving them a meaningful voice in curriculum design and delivery. Incorporating these diverse insights will help us to innovate geriatric medicine teaching in a manner that meaningfully prepares students to care for our ageing population.

POSTER

Scientific Presentation - Education / Training

3847. CONTINENCE AND TRAINING OPPORTUNITIES AND BARRIERS IN SPECIALITY GERIATRIC MEDICINE TRAINING

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Introduction: We know continence is important to older people but can often be overlooked in clinical practice. Continence can now be selected as a theme for service in the new geriatric medicine curriculum but there is concern that the uptake of this is poor. Our aim was to understand and quantify continence training opportunities and understand current and potential uptake of Continence as a Theme for Service.

Method: A short online survey was created and resident doctors training in geriatric medicine were invited to complete it from December 2024-April 2025. The survey was included in the BGS trainees bulletin in January 2025 and sent to trainee representatives to distribute.

Results: 56 responses were received. Responses were from doctors from 12 regions and doctors from both early (48%) and late (52%) stages of training. Most responses reported including continence in a comprehensive geriatric assessment always, or almost always (55%), however most felt unconfident or very unconfident (52%) that they could meet the core continence curriculum outcomes. Only a small proportion of doctors from this sample were very likely, or likely, to pursue continence as a theme for service (9%). The most selected reason for not pursuing a theme for service in continence, following being more interested in another theme, was lack of access to specialist continence clinics (25%) and a lack of consultants with a specialist interest (8.9%).

Conclusion: Resident doctors training in geriatric medicine recognise continence as an important aspect of a comprehensive geriatric medicine. However, interest in continence as a theme for service is limited and lack of access to specialist clinics and training is a major factor in this. Ensuring resident doctors are aware of specialist clinics, and can access them, as well as consultants who have an interest, is key to improving interest in the sub-speciality.

POSTER

Scientific Presentation - Education / Training

3867. IMPROVING FRAILTY EDUCATION FOR UNDERGRADUATE MEDICAL STUDENTS AT A UK TEACHING HOSPITAL

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Introduction: 'Instant Ageing' technologies and simulated ward rounds are established parts of geriatric medicine teaching in many centres. However, these once innovative methods received negative feedback when delivered during our undergraduate BMBS programme. We set out to explore whether adding gamification to established teaching methods could enhance student knowledge, attitudes towards frailty and perceptions of their attachment.

Method: We designed a 'Frailty Escape Room' where students rotated around stations completing tasks related to falls, polypharmacy, delirium, frailty assessment, pressure sores, activities of daily living and Comprehensive Geriatric Assessment. Students undertook tasks under time conditions whilst wearing different 'instant aging' simulation equipment. Successful task completion generated a code that, when combined, enabled 'escape' from the room. Students were assessed using pre-post session questionnaires. Four Likert-scale (score 1-4) questions evaluated empathy/understanding of life with frailty, confidence in assessing, managing and communicating with older people living with frailty. Sixteen single best answer multiple choice questions assessed core knowledge. Summary statistics were calculated and test item performance before and after teaching were compared using pairwise student t-tests and chi-square for parametric scale and categorical variables respectively. Anonymous free-text feedback was collected at the end of the session to assess student satisfaction.

Results: 121 students completed the Escape Room and pre/post-testing. Mean (SD) Likert scores increased from 2.2(0.7)-3.3(0.6), 2.5(0.5)-3.2(0.5), 2.1(0.5)-2.9(0.5) and 2.8(0.6)-3.4(0.5) for empathy/understanding, confidence investigating, managing and communicating with older people with frailty respectively ($p<0.05$ for all). Mean (SD) total knowledge score increased from 8.5(2.1)-11.8(1.9) ($p<0.05$), with significant improvements across all except three questions. Free-text feedback indicated high student satisfaction, and attendance has improved markedly following the teaching intervention.

Conclusions: Introduction of gamification to existing simulated ward round and instant ageing teaching improved student attendance and satisfaction. The teaching improved knowledge of, and attitudes towards, care of older people.

POSTER

Scientific Presentation - Education / Training

3873. DEVELOPING A CARE HOME PLACEMENT FOR UK MEDICAL STUDENTS

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Introduction: The British Geriatrics Society recommends medical students experience older people's care in multiple settings, but most never visit care homes and have little opportunity to experience what's special about care in these settings. We describe co-development by medical students and a care home provider of an undergraduate BMBS care home placement.

Method: A BMBS undergraduate Special Study Module (SSM): mapped undergraduate learning outcomes to published care home medicine competencies; interviewed care home staff; and conducted a medical student focus group exploring how to structure a placement. This was developed into a rotational programme via a second SSM through modest reduction in self-directed learning time. Three further SSM students undertook placements to explore feasibility, taking before and after placement tests of: knowledge about learning outcomes; attitudes towards care home residents (Australian Ageing Semantics Differential); and their healthcare (Medical Conditions Regard Scale). Students and the care home managers submitted written reflections.

Results: Placement competencies covered assessment of: mental capacity, cognition, delirium, clinical frailty score, and medical history including collateral from family and staff. Care home staff wanted students to learn about the full lives care home residents lead and the range of competencies staff deploy to support this. The resulting placement comprised three one day visits involving specific tasks and resident case studies. Students piloting placements improved mean scores for knowledge (8.5[SD0.7]-9.3[SD0.6]; higher=better), attitudes to residents (114.0[SD9.8]-140.5[SD11.9]; higher=better), and their medical care (40.3[SD2.5]-36[SD0]; lower=better). Students described improved understanding of asset-based and person-centred care, and less therapeutic nihilism. The care home manager highlighted opportunities to learn about effective discharge correspondence from hospitals.

Conclusion: A BMBS undergraduate care home placement was successfully co-designed by medical students and a care home provider. Staff and students were positive about the experience and student knowledge and attitudes about care homes and their residents improved through completion.

POSTER

Scientific Presentation - EET (Eyes, Ear, Teeth)

3333. Phacoemulsification in Older Adults: A Systematic Review

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Introduction: Phacoemulsification is a widely used cataract surgery technique, particularly in older adults, offering significant improvements in vision and quality of life. As the global population ages, understanding the outcomes and risks of this procedure in elderly individuals becomes increasingly important. This review aims to assess the safety, efficacy, and potential complications of phacoemulsification in older adults.

Method: A search was conducted across three databases - PubMed, Scopus, and Cochrane - for studies published between 2020 and 2025. Inclusion criteria were studies focusing on phacoemulsification in older adults, reporting on clinical outcomes, safety, and efficacy. Only peer-reviewed, full-text, and English-language articles were considered. From an initial pool of 376 papers, 41 were selected for review based on relevance and quality of evidence.

Results: The findings demonstrated a significant enhancement in best-corrected visual acuity (BCVA) following surgery, with a majority of patients achieving 20/40 or better within weeks of the procedure. Functional vision improvements were observed across various daily activities, including reading, mobility, and overall quality of life. Complication rates remained relatively low, with posterior capsular opacification (PCO) being the most common long-term issue, requiring subsequent Nd:YAG laser capsulotomy. Other complications, such as transient intraocular pressure elevation and corneal edema, were typically mild and self-limiting. Patients with pre-existing conditions such as diabetes, glaucoma, and age-related macular degeneration exhibited slightly higher complication rates but still benefited significantly from the procedure. Although recovery times were generally similar to those in younger populations, some studies indicated delayed neuroadaptation in older adults, particularly in those receiving multifocal IOLs. Despite this, patient satisfaction remained high, with most individuals reporting increased independence and an improved quality of life.

Conclusion: Phacoemulsification in older adults shows promising results, with minimal complications and high satisfaction. The procedure enhances independence, with advancements in techniques further improving outcomes and reducing risks.

POSTER

Scientific Presentation - EET (Eyes, Ear, Teeth)

3596. THE ASSOCIATIONS BETWEEN HEARING LOSS AND DEMENTIA AND THE THERAPEUTIC POTENTIAL OF HEARING AIDS: AN EXTENDED LITERATURE REVIEW

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Introduction: Research has suggested that age-related hearing loss (ARHL) may increase the risk of dementia, an incurable and prevalent condition. Unlike dementia, ARHL is prevalent but undertreated and modifiable. In the absence of a cure and under the pressure of an ageing population, preventative strategies targeting dementia are crucial. This review therefore explores the association between ARHL and dementia in more depth and considers the evidence that hearing interventions such as hearing aids (HAs) may reduce the subsequent risk of dementia.

Method: A comprehensive search strategy was used in four online databases (PUBMED, EMBASE, Medline and PsycINFO) in addition to cross-referencing. Selection criteria were then applied to search results, followed by the screening of titles and abstracts, quality assessment and content analysis using NVivo.

Results: Six broad hypotheses, with varying degrees of support, explain the ARHL-dementia association as either causal, common or reverse causal. Causal mechanisms linking ARHL to dementia involve information degradation, sensory deprivation or an increased cognitive load on perception, whereas common pathways suggest a third variable underlies both conditions. Preclinical dementia pathology may also cause hearing loss on a reverse causal pathway, or it may be that ARHL impedes cognitive test performance, leading to dementia overdiagnosis. In terms of prevention, evidence is mixed, inconsistent and largely based on observational data, with a lack of corroboration from randomised controlled trials (RCTs). Whilst some studies show a protective effect against dementia through HA use, others have shown no significant neurocognitive benefit.

Conclusion: Although plausible, individual hypotheses are insufficient in explaining the ARHL-dementia link; pathways likely interact and cascade together. Without a definitive mechanistic pathway, the therapeutic potential of this association remains unknown. To fully appreciate the power of HAs in preventing dementia, larger RCTs with extended follow-up periods and comprehensive cognitive test batteries are needed.

POSTER

Scientific Presentation - Epidemiology

3242. CHARACTERISING PATIENTS UNDERGOING SURGERY FOR LUMBAR SPINAL STENOSIS IN THE UK: WHAT DOES THE BRITISH SPINAL REGISTRY TELL US?

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Introduction: Lumbar spinal stenosis (LSS) is the most common reason for people over 65 to undergo surgery, affecting ~10% of the community-dwelling population. Surgery for lumbar spinal stenosis has a variable outcome. We estimated the association between pre-operative patient demographics, surgical variables and patient-reported outcome measures (PROMs) with a clinically important change (30% change from baseline) in physical function at 6-months in a large, national registry database.

Methods: We used data from the British Spinal Registry (2013-2023). Anonymised data included demographics, PROMs (Oswestry Disability Index (ODI); back and leg pain on the visual analogue scale (VAS)) at 6-weeks and 6-months, surgical approach, surgery duration and intra-operative blood loss. We used descriptive and multivariate analyses.

Results: 2667 patients provided 6-month follow-up data on the ODI. They were on average 68.8 years of age (SD 11.5 years), male (n=1364/2667, 51%), and from higher socioeconomic areas (mean Index of Multiple Deprivation rank 83.7, SD 40.2). Prior to surgery, most patients had severe disability (mean ODI 46.9, SD 17.3), moderate leg (VAS mean 6.8, SD 2.5) and back pain (VAS mean 6.1, SD 2.5). Only 25% of the included sample (539/2119) achieved a clinically important improvement in ODI. Baseline back pain severity (OR 0.9; 95% CI 0.9, 1.0) reduced the odds; while more severe leg pain (OR 1.1; 95% CI 1.1, 1.2), baseline severe ODI (OR 4.3; 95% CI 3.3, 5.7) and male gender (OR 1.3; 95% CI 1.0, 1.6) increased the odds of achieving clinical change.

Conclusions: Patients undergoing surgery in the UK are severely disabled by symptoms prior to surgery. The available data suggests a substantial proportion of patients do not achieve a clinically important change by 6 months.

POSTER

Scientific Presentation - Epidemiology

3725. DEVELOPING A MODEL TO PREDICT MOBILITY DECLINE IN COMMUNITY DWELLING OLDER PEOPLE

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Introduction: Being able to walk is a priority for older people and is key to maintaining independence. Declining mobility is an early predictor of loss of independence, reduced quality of life, increased health care use and death. The aim of this study was to develop and validate a prediction model to identify when an older person was at risk of self-reported mobility decline over a 2-year period.

Method: We used self-reported data from a prospective cohort study of 5,409 people aged 65 years and over in England (The Oxford Pain, Activity and Lifestyle (OPAL) Cohort Study). Mobility status was assessed using the EQ-5D-5L mobility question. The outcome was any mobility decline at two years. Thirty-one candite variables were entered into the model including demographic factors, pain, walking, falls, comorbidities, general health and physical activity. LASSO logistic regression was used to select predictors. Models were internally validated using bootstrapping. Scores were assigned to identified predictors to calculate an individual's risk of mobility decline.

Results: Over 18% of participants who could walk at baseline reported mobility decline at year two. The following variables were identified as predictors: Age Adequacy of income; Body Mass Index; Usual walking pace; Difficulties maintaining balance; Confidence to walk; Use of walking aid; Change in walking ability over 12 months; Lower limb pain; Current pain/discomfort severity; Number of health conditions; Physical tiredness; Self-reported general health; Current mobility level.

Conclusions: A prediction model for mobility decline were developed and internally validated. These questions could be used as an assessment tool within primary care or by older people themselves. External validation is required. We are working with stakeholders to understand how this model could be used to help older people maintain mobility.

POSTER

Scientific Presentation - Epidemiology

3815. DISPARITIES IN FALL MORTALITY AMONG HYPERTENSIVE OLDER ADULTS: AN EPIDEMIOLOGICAL ANALYSIS OF GEOGRAPHIC AND GENDER DIFFERENCES

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Introduction: Falls are a leading cause of death in older adults, with hypertension (HTN) potentially increasing this risk. However, trends in fall-related mortality with co-existing HTN remain understudied. We hypothesise an increasing trend in fall-related mortality among older adults with HTN, with disparities by sex, region, and place of death.

Methods: A retrospective analysis of adults ≥65 years was conducted using CDC WONDER (1999–2023). Age-adjusted mortality rates (AAMRs) per 100,000 were stratified by sex, region, and place of death. Trends were assessed using annual and average percentage change (APC & AAPC).

Results: From 1999 to 2023, 215,214 fall-related deaths with co-existing hypertension were recorded, showing a significant increasing mortality trend ($p < 0.000001$). Males had higher mortality than females (20.39 vs. 17.13 per 100,000), with significant AAPCs of 11.24% and 10.57%, respectively. In males, AAMRs rose from 2.93 in 1999 to 42.59 in 2023, with sharp increases from 1999–2001 (APC: 45.19%) and 2018–2021 (APC: 13.56%). Females showed a similar trend, rising from 2.87 to 35.57, with notable spikes in the same periods (APC: 42.44% and 13.43%). Most deaths occurred in medical facilities (52.84%), followed by nursing homes (19.09%), hospices (12.99%), and homes (10.86%). Regionally, the Midwest had the highest AAMR (22.88), followed by the West (18.58), South (18.15), and Northeast (14.11), with corresponding AAPCs of 10.81%, 8.68%, 11.45%, and 10.86%.

Conclusion: Mortality rates among older adults has risen significantly over the past two decades, with consistently higher rates in males and marked regional disparities. The predominance of deaths in medical and long-term care facilities underscores the need for enhanced fall-prevention strategies in these settings. Targeted interventions, particularly in high-burden regions like the Midwest and sex-specific approaches are essential to mitigate this growing public health concern.

POSTER

Scientific Presentation - Epidemiology

3820. DOES THE FRAILTY INDEX APPLIED TO RANDOMISED CONTROLLED TRIALS REALLY MEASURE FRAILTY?

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Background: Cumulative deficit frailty indices (FI) from randomised controlled trials (RCT) are increasingly used to assess whether trial findings are applicable to people living with frailty. However, some applications of the frailty index have been criticised for including to narrow a range of deficits. The aim of this analysis is to examine the range and type of deficits included in these frailty indices and compared these to those from observational studies.

Methods: We identified 19 RCTs assessing treatment effect modification using the FI, as well as 18 observational studies assessing mortality risk associated with frailty, from recent systematic reviews. We extracted the FI deficits included from each study. We compared the number of deficits, data sources (e.g. medical history, physical measurements, questionnaires) and physiological domain (e.g. cardiometabolic, neuro-cognitive, physical function) of the deficits from each source.

Results: The number of deficits was similar between RCT frailty indices (median 41 deficits, interquartile range [IQR] 35-50) and observational studies (median 35, interquartile range 31-45). Broadly similar data sources were used to identify deficits. However, in RCTs of cardiovascular conditions, cardiometabolic deficits made up a greater proportion of deficits (median 47% of included deficits, IQR 38%-51%, compared to 19%, 14%-24%, in observational studies). Cardiovascular RCTs included fewer physical function measures (median 4% [3%-9%], compared to 16% in other RCTs of other conditions [13%-17%], 17% in observational [13%-23%]).

Conclusion: In many cardiovascular RCTs, FIs focus on cardiometabolic deficits rather than measures of function. It cannot be assumed that these FIs adequately capture the broad physiological vulnerability that characterises frailty in clinical practice. We need to establish if such indices adequately capture risk of outcomes of importance to people living with frailty if such studies are to inform care. Until then, caution is required when assessing applicability of trials to people living with frailty.

POSTER

Scientific Presentation - Epidemiology

3885. FACTORS SHARED BY MONOZYGOTIC TWINS EXPLAIN UNEXPECTED ASSOCIATIONS BETWEEN FRAILTY AND MENOPAUSAL HORMONE REPLACEMENT THERAPY

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Introduction: Menopausal hormone replacement therapy (HRT) is first-line treatment for distressing vasomotor symptoms, and increasingly popular. However, data on the association of HRT with ageing-related conditions including frailty is lacking.

Method: We analysed women in the Danish population registry (n=471206), Danish Twin Registry and TwinsUK cohort (n=1547). In Denmark, we assessed frailty age 65, 70 and 75, using a modified Hospital Frailty Risk Score. This linked to national prescribing data, to ascertain HRT use by age 55, adjusting for birth year, education and income. In TwinsUK, we assessed frailty after age 65 using a frailty index (TwinFI). HRT use, and covariates (BMI, smoking, alcohol use, education and deprivation) were ascertained from retrospective questionnaires. Analysis used conditional/fixed-effects generalised estimating equations, examining within twin-pair frailty associations.

Results: HRT associated with higher frailty scores amongst both Danish women (beta=0.21, P<0.001) and TwinsUK (beta=0.035, p=0.01) equivalent to ageing 5 years. However, in TwinsUK, HRT only associated with higher frailty for the within-pair analyses in dizygotic twins (Dizygotic: beta=0.061, p=0.01, Monozygotic: beta=0.013, p=0.36). This was robust to multiple sensitivity analyses, including HRT subtypes, duration and imputation.

Conclusions: We found an unexpected relationship between HRT use and higher frailty across both Denmark and the UK. However, twin analysis suggests this relationship is not causal, but confounded by factors shared within monozygotic twins, including genetics. Further investigation is needed to determine whether individuals prescribed HRT are already on the path to frailty, and whether this would be an apt opportunity to intervene.

POSTER

Scientific Presentation - Falls, fracture and trauma

3411. A QUALITATIVE RAPID REVIEW OF FACTORS THAT AFFECT THE IMPLEMENTATION OF PHYSICAL ACTIVITY PROGRAMMES FOR OLDER ADULTS

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Background: Physical inactivity in community-dwelling older adults is modifiable, and physical interventions are effective in reducing age-related decline and disease. Despite this, engagement and retention of older adults in community physical activity (PA) programmes are limited. This review explores factors affecting implementation of effective PA programmes for older people in the community.

Methods: Review of qualitative literature identified from MEDLINE, Social Policy and Practice, PsycINFO, CINAHL, Cochrane Library and Frontiers in Rehabilitation Science from 1999-2024. Data were extracted inductively by two independent reviewers and synthesised thematically using the Capability, Opportunity and Motivations (COM-B) and Theoretical Domains Frameworks (TDF).

Results: 8647 articles were identified from searches and 57 (42 qualitative, 15 mixed-methods) studies included in the review. The review found complex interacting factors that affected the delivery of PA interventions (skillset of the instructors, regular training and habit formation) alongside factors that influenced older adult's motivations to first engage in PA interventions and to maintain physically active over time (social influence of others, family members influence, resources and environmental conditions). A key finding was the identification of facilitators that are required to create both a cohesive, social environment for the intervention to take place, alongside the need for tailored interventions that meet the needs of participants.

Conclusions: This review has extended previous works by including factors that are influential to PA from the perspectives of intervention deliverers and highlighted the importance of assessing the needs of those who deliver the intervention. These factors should be taken into consideration when implementing programmes to support older adults to engage long-term with PA interventions.

POSTER

Scientific Presentation - Falls, fracture and trauma

3551. REHABILITATION AFTER PELVIC FRAGILITY FRACTURE IN OLDER ADULTS: A SCOPING REVIEW

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Introduction: To synthesise the evidence available on components of reported rehabilitation interventions following pelvic fragility fracture in older adults and describe outcomes measured.

Methods: A scoping review reported according to the Preferred Reporting Items for Systematic Review and Meta-Analysis Scoping Review extension. A systematic search of Cochrane CENTRAL, Embase, MEDLINE and PEDro for studies of rehabilitation among patients 60 years and older with non-pathological pelvic fragility fracture, published up to May 2024. Single case studies were excluded. Screening and study selection were completed in duplicate by four independent reviewers. One reviewer completed extraction with accuracy checked by a second reviewer. A narrative synthesis approach was employed with text and tables.

Results: 17 studies reporting on rehabilitation after pelvic fragility fracture were identified. For 13 studies, descriptors were limited to mobilisation strategies with 9 citing unrestricted mobilisation as the first prescription. Three studies reporting multicomponent, multidisciplinary (physiotherapy-led), rehabilitation interventions across inpatient and community settings, incorporating exercise, psychological components, and education/advice were identified. 31 outcome domains were identified with key domains including pain, mobility, activities of daily living, quality of life, and mortality. There was an absence of consensus on which patient reported outcome instruments to use to measure relevant domains.

Conclusions: There is overall limited evidence to guide rehabilitation for older adults following fragility fracture of the pelvis. A standardised approach to rehabilitation should be designed which improves outcomes which matter most to those people affected.

POSTER

Scientific Presentation - Falls, fracture and trauma

3598. RESILIENCE MEDIATES THE RELATIONSHIP BETWEEN BASELINE HEALTH AND FUNCTIONAL RECOVERY IN OLDER PATIENTS FOLLOWING HIP FRACTURE

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Introduction: Hip fractures in older adults often lead to prolonged disability and reduced quality of life. While baseline physical health is a known predictor of recovery following hip fracture, the underlying causal mechanisms remain poorly understood. There is growing interest in the influence psychosocial factors – for example, psychological resilience – have on recovery. This study examines the relationship between baseline psychological resilience and 12-month recovery of functional outcomes following hip fracture surgery in older patients.

Methods: A 12-month, multi-centre pilot cohort study was conducted with 125 adults aged ≥50 years, hospitalised for hip fracture. A final analytical sample of 86 participants (mean age 72.5 years) was analysed for longitudinal outcomes. Baseline psychological resilience (measured by CD-RISC10) and physical health (handgrip strength) were assessed during acute hospitalisation. The primary outcome was functional outcomes at 12-months, measured using the Modified Barthel Index, Parker Mobility Score and SF-36 Questionnaire (Physical Function). Mixed-effects regression models evaluated the association between baseline resilience and functional recovery over time. Causal mediation analysis was performed to assess whether resilience mediated the effect of baseline physical function on recovery.

Results: Resilience was directly associated with improved physical function in the 12 months following hip fracture surgery. Resilience partially mediated the relationship between baseline physical health and recovery of mobility, and recovery of self-rated physical health. Respectively, resilience mediated 22.5% of the total effect between baseline physical health and mobility after 12-months, and 23.6% of the total effect between baseline physical health and self-rated physical health after 12-months. Resilience was a complete mediator of the relationship between baseline physical health and recovery of independence when performing activities of daily living, mediating 24.0% of the total effect.

Conclusions: These findings suggest that enhancing psychological resilience may be an effective strategy for improving recovery outcomes among older post-operative hip fracture patients, alongside traditional physical rehabilitation.

POSTER

Scientific Presentation - Falls, fracture and trauma

3705. VISION SCREENING IN OLDER ADULTS WHO ATTEND HOSPITAL FOLLOWING A FALL: A SCOPING REVIEW

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Introduction: The assessment of impaired vision is included in falls prevention guidance for older adults but implementation is variable. We conducted a scoping review to better understand current practice and inform future implementation research around vision assessments for older adults attending acute hospitals following a fall.

Methods: JBI methodology was followed. MEDLINE, AMED, EMBASE, PsychInfo, CINAHL and WebofScience were systematically searched for literature on the assessment of vision in older adults attending acute hospitals following a fall. Sources eligible for inclusion had a mean/median population age of 65 years old or over, included patients presenting to an acute hospital setting following a fall and described vision assessments in these patients. Grey literature, conference abstracts and sources where a full text was not possible to retrieve were excluded. Title, abstract and full-text screening were completed by two independent reviewers. Data extraction and charting of the data were performed by the primary author, using a data extraction tool. Data analysis comprised descriptive statistics of study characteristics and content analysis of vision assessment methods used.

Results: We included 27 studies from 13 countries, spanning 1978-2023. Studies reported various vision assessment methods. Questions frequently asked in vision assessments included: presence of visual symptoms (n=9), date of last eye test (n=9) and previous ocular history (n=5). The most common visual function assessed was distance visual acuity, which was assessed in 12 studies. Six studies used standardised screening tools. The most common post-screening interventions were advising an eye test with an optometrist (n=8), advising an ophthalmology referral (n=7) and patient education (n=6).

Conclusions: The literature on vision screening in this population was sparse and there was heterogeneity in current practices, highlighting the need for standardised screening protocols. More research is needed to evaluate vision screening services in this population and to explore barriers to implementation.

POSTER

Scientific Presentation - Falls, fracture and trauma

3707. THE IMPACT OF DIGITAL CARE RECORDS ON THE SPREAD OF THE ACTION FALLS PROGRAMME IN CARE HOMES

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Background: Falls are a leading cause of morbidity among older people living in care homes. The Action Falls programme includes a multicomponent falls risk assessment checklist and guidance on mitigating actions. It demonstrated a 43% reduction in falls in a clinical trial. Initially developed as a paper-based tool embedded within care plans, Action Falls faced limited adoption when adapted as a standalone digital version. Care homes indicated they could not implement digital checklists that operated outside their electronic care planning systems. Since the COVID-19 pandemic, the Digitising Social Care Programme (initiated in 2021) has rapidly expanded the use of digital care records. Adoption increased from 40% of providers in December 2021 to 72% by mid-2024. This study reports on implementation efforts within the FinCH Imp National Study to embed the Action Falls checklist into digital care record systems.

Methods: We engaged with care software providers, care homes, commissioners, and industry bodies to enable direct integration of the Action Falls checklist into digital care systems. A free, collaborative licensing model was offered to encourage adoption by software manufacturers.

Results: Over a three-year period, we approached four individual care software manufacturers and their national industry body representing over 52 companies. Two providers agreed in principle to adopt the checklist, though concerns about development costs and limited demand were noted as key barriers. Facilitators identified included potential mandates from professional bodies or Minimum Operational Data Standards, and market incentives such as competitive advantage.

Discussion: The digitisation of care records has introduced care software providers as new stakeholders in the implementation of evidence-based interventions into care homes. Navigating this landscape is complex due to the intersection of healthcare, social care, and private provision. Building sustained, collaborative partnerships is essential to embedding clinical evidence into digital systems and ensuring impact at scale in care homes.

POSTER

Scientific Presentation - Falls, fracture and trauma

3715. A QUALITATIVE EVALUATION EXPLORING CO-PRODUCTION IN CARE HOMES

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Introduction: Co-production approaches are increasingly used in research. However, they are not often evaluated in care home settings. The study aimed to explore how co-production occurred in a series of workshops around falls management in care homes.

Methods: Sixteen stakeholders (care home residents and relatives, care home staff, health and social care professionals) participating in co-production workshops in a systematic action research study were invited to take part in a qualitative evaluation. The workshops were developing a model for delivering falls training in care homes across Nottinghamshire. Non-participant observations of workshops explored stakeholder interactions. Nine stakeholders participated in reflection meetings to share their experiences of the process. Framework analysis mapped key themes to the National Institute for Health and Care Research's (NIHR) co-production principles.

Results: Nine themes were identified. Sharing power was influenced by opportunities to challenge dominant voices, resulting from the influence of the research team and separate stakeholder groups, and wider integration challenges across the health and social care system. Inclusion of all perspectives was affected by variable involvement of key stakeholders in the workshops and supported by a flexible approach. Respecting and valuing knowledge was influenced by self-confidence and supported by appreciating diverse stakeholder expertise and experiences. All stakeholders reported benefits of participating in co-production workshops, for example helping others and learning about falls management. However, reputational concerns and fatigue were potential harms of participation. Team dynamics changed as relationships developed.

Conclusions: Co-production was largely a positive experience for stakeholders and the NIHR's key principles were partially achieved based on our qualitative findings. Co-production in care home settings is a complex process affected by multiple factors, including the individuals involved, stakeholder relationships, organisational priorities, and integration across the system. Future research should consider organisational power dynamics at all stages and create safe spaces for inclusive participation.

POSTER

Scientific Presentation - Falls, fracture and trauma

3786. IS THERE ANY ASSOCIATION OF FEAR OF FALLING WITH SINGLE OR RECURRENT FALLS?

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Introduction: Fear of falling is a common psychological consequence following falls and fragility fractures, contributing to functional decline, reduced quality of life, and increased risk of further falls and fractures. The Fracture Liaison Service (FLS) routinely assesses fall risk to prevent secondary fractures. This study evaluates the quality of falls assessment with respect to psychological impact like fear of falling. In addition, we assessed an association of fear of falling with single or recurrent falls among patients seen by Aneurin Bevan Fracture Liaison Service (AB-FLS).

Methods: A retrospective cohort analysis was conducted on 2,176 patients reviewed by AB-FLS between January and December 2023. Falls risk assessment was documented in 81.3% (n=1768 patients). Complete data on both falls frequency and fear of falling was only available in 50.2% (n=1093 patients), which is a limitation of this study. Data were stratified into recurrent falls (≥2 falls) and single fall groups.

Results: The mean age was 79.4±9.6 years (range = 50-100). Women were 76.9% (n=1675) and men were 23.1% (n=501). Only 5.5% (n=60) patients were admitted from care homes. Single and recurrent falls occurred in 59.7% and 40.3% of patients respectively. The mean age (SD, range) for patents with single falls and recurrent falls were 79.1±9.5 (50-100) and 79.8±9.7 (53-100) respectively. Fear of falling was reported by 40.2% (n=365). Majority of patients (89.6%, n=327) who reported fear of falling have recurrent falls and in comparison, only 10.4% (n=38) patients with a single fall reported fear of falling, the difference being statistically significant ($p<0.001$).

Conclusion: This study demonstrates fear of falling was not assessed in nearly half of the patients with fragility fractures. This study has also shown a strong association between recurrent falls and fear of falling. Patients experiencing recurrent falls were 8.6 times more likely to report fear of falling compared to single only fallers. Tailored interventions addressing both physical and psychological factors need to be incorporated in the falls assessment for patients seen through FLS.

POSTER

Scientific Presentation - Falls, fracture and trauma

3790. ACCEPTABILITY OF A TECHNOLOGY-BASED DUAL-TASK PROGRAMME FOR FALLS PREVENTION - A MIXED-METHODS STUDY

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Introduction: Falls are a major health concern for older adults. Dual-task (DT) training, which integrates cognitive and physical exercises, has shown greater benefits for balance and mobility than physical training alone. This study evaluated the acceptability of a blended DT training programme, combining supervised and self-directed components, and delivered via a mobile application for older adults with a history of falls.

Methods: Community-dwelling older adults aged 65+ with ≥2 falls in the past year were recruited. Participants completed the DT programme using the Peak Brain Training app: 12 weeks of blended supervised and self-directed training (Phase 1) and 12 weeks of self-directed training (Phase 2). Adherence was self-reported, and post-programme focus groups were conducted. Quantitative data were analysed using descriptive statistics, and qualitative data using Framework Analysis.

Results: Forty-three participants were recruited (39 via community events; 27 females, mean age: 79 years) and 4 via NHS falls prevention services referrals (3 females, mean age: 75 years). Adherence was 80.6% in Phase 1, dropping to 50% in Phase 2. Retention was 79.9%. Focus group feedback (n = 28; 20 females) indicated a preference for in-person recruitment over text/letter invitations, an explanation for low NHS referral uptake. Key facilitators of adherence included social interaction, structured routines, a sense of achievement, enjoyment of the app, and the blended delivery format. Barriers included competing priorities, low motivation, unsuitable home environments, and lack of personalised exercises.

Conclusions: The DT programme was acceptable to older adults, particularly the supervised components. Social and structured routines supported adherence. Reduced adherence in phase 2 highlights the need for additional strategies to sustain motivation. This study demonstrates the feasibility of using technology to deliver cognitively engaging interventions. When paired with structured support, technology can be effectively integrated into fall prevention exercise programmes for older adults with a history of falls.

POSTER

Scientific Presentation - Falls, fracture and trauma

3801. IMPACT OF HISTORY OF RECURRENT FALLS ON RISK OF RE-FRACTURE AND MORTALITY: A 27-MONTH FOLLOW-UP STUDY

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Introduction: Fragility fractures are a major cause of morbidity in older adults and are often preceded by falls. Identifying patients at greatest risk of refracture is vital for optimising secondary prevention strategies within Fracture Liaison Service (FLS). This study measures impact of history of single or recurrent (2 or more) falls on the incidence of re-fracture and mortality among patients seen by Aneurin Bevan Fracture Liaison Service (AB-FLS).

Methods: This study included fragility fracture patients (n= 2,176) reviewed by AB-FLS between January and December 2023. Complete data on both frequency of falls was only available in 1093 patients (50.2%), which is a limitation of this study. Clinical outcomes included re-fracture rates and mortality over a 27-months follow-up until 31st March 2025 was completed retrospectively.

Results: The mean age was 79.4±9.6 years (range = 50-100). Women were 77.7% (n=849). Only 5.5% (n=60) patients were admitted from care homes. Previous history of single and recurrent falls was reported in 58.2% (n=636) and 41.8% (n=457) of patients respectively. The mean age (SD, range) for patents with single falls and recurrent falls were 79.1±9.5 (50-100) and 79.8±9.7 (53-100) respectively. The one-year mortality rate in patients with history of single falls and recurrent falls was 12.6% (n=80) and 15.1% (n=69) respectively, and this was not statistically significant (p=0.24). The re-fracture rate in patients with history of single falls and recurrent falls was 11.3% (n=72) and 15.1% (n=69) respectively, and this was not statistically significant (p=0.64). However, over 27 months, the overall re-fracture rate in patients with previous recurrent falls was 22.1% (n=101) and in comparison, patients with previous single falls were 15.1% (n=96), which was statistically different (p=0.003).

Conclusion: This study demonstrates a strong association between history of recurrent falls and risk of re-fracture after 2 years. Enhanced fall prevention and tailored follow up for fragility fracture patients, particularly those with history of recurrent falls needs to be explored further to minimise re-fracture risks and improve long-term outcomes.

POSTER

Scientific Presentation - Gastroenterology

3642. EVALUATING THE CLINICAL BENEFIT OF A TRAIL OF NASOGASTRIC FEEDING IN PATIENTS WITH ACUTE DYSPHAGIA SECONDARY TO DELIRIUM

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Introduction: The risk of acute oropharyngeal dysphagia is increased in delirium, and is associated with longer hospital admissions, malnutrition, dehydration and sarcopenia. To promote swallow rehabilitation and facilitate recovery from delirium, nasogastric tubes may be trialled for feeding and medication.

Methods: This retrospective observational study of senior health wards in a London hospital identified 24 patients with delirium who had a nasogastric tube inserted for acute dysphagia. Data was collected on the swallow rehabilitation (based on recommended IDDSI levels following assessment by speech and language therapists) and associated complications of nasogastric feeding, including ionising radiation, treatment of aspiration pneumonias and mortality.

Results: Primary outcomes showed that whilst 29% (n=7) patients sustained clinical benefit from the nasogastric feeding trial (i.e. were rehabilitated to a safe swallow), 58% (n=14) did not and were classified as Eating and Drinking with Acknowledged Risk post-trial. The clinical benefit was more prevalent in patients with Parkinson's Disease (50%, n=2) and in those who did not have pre-existing dysphagia (46%, n=6). Patients who regained a safe swallow after nasogastric feeding had a longer length of stay, but lower 30-day mortality and fewer treatments for aspiration pneumonias.

Conclusion: Although small, this study suggests that trials of nasogastric feeding do not always facilitate complete recovery of swallow function in patients with acute dysphagia in the context of delirium, but that in successful cases there is reduced 30-day mortality and no increased risk of associated complications. The authors highlight the complexity of predicting outcomes for patients with delirium and acute dysphagia and the need for further research to help clinicians make informed decisions.

WITHDRAWN

POSTER

Scientific Presentation - Health Service Research

3695. DEPRESCRIBING MEDICATIONS WITH ANTICHOLINERGIC BURDEN IN OLDER HOSPITALISED ADULTS: A SYSTEMATIC REVIEW

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Background: Use of anticholinergic medication is increasing, especially among the older population due to polypharmacy and co-morbidities. High anticholinergic burden is associated with adverse effects such as reduced mobility and future dementia risk. Acute hospital stay may be an appropriate time to target this commonly overlooked problem.

Aims: To explore the effects of deprescribing medications with anticholinergic burden on health outcomes of hospitalised older people.

Method: Medline, Web of Science, Cochrane Library and Embase were searched for relevant papers from database inception to September 2024. Studies that involved a deprescribing or medication review intervention to reduce anticholinergic burden within a hospital setting in older people (≥65 years old) were included. Synthesis Without Meta-analysis guidelines were used for narrative synthesis and Joanna Briggs Institute Checklists were used for quality assessment.

Results: 2042 papers were identified, and eight papers were included in this review. There was heterogeneity of design and outcomes across the studies with generally short follow-up. Study designs included: cohort (n=4), pre-post quasi-experimental (n=3) and audit (n=1). Outcomes reported included: medication-related outcomes (n=8), acceptability (n=4) and clinical outcomes (n=1). No studies reported on safety or costs. Six studies reported a reduction in anticholinergic burden score following the intervention, two studies demonstrated a significant reduction in the proportion of patients taking anticholinergic medication following intervention. The quality of the studies varied and ranged from poor to moderate.

Conclusion: This review found that deprescribing interventions within a hospital setting may be acceptable and successful in reducing anticholinergic burden in older adults. However, effectiveness of intervention on important clinical outcomes could not be determined due to short follow-ups and limited data on clinical outcomes, costs, and safety. In future, there is a need for randomised controlled trials to focus on clinical outcomes and involve longer durations of follow-up.

POSTER

Scientific Presentation - Health Service Research

3698. INTRODUCING EHSAS- A TOOL FOR RAPID COMMUNITY-BASED SCREENING IN LOW RESOURCE RURAL SETTINGS TO ASSESS ELIGIBILITY FOR CGA

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Background: Comprehensive Geriatric Assessment (CGA) is a cornerstone of geriatric care but is challenging to implement in low- and middle-income countries (LMICs) due to scale, workforce limitations and the absence of culturally appropriate tools. Community Health Workers (CHWs) play a critical role in rural India, yet they lack a suitable screening instrument to identify older adults who require further and detailed CGA.

Objectives: To develop and validate the Elderly Health Status Assessment and Screening (EHSAS) tool - a concise, culturally adapted, and multidimensional screening tool for early identification of common geriatric syndromes among rural community-dwelling older adults in India.

Methods: We employed a three-phase mixed-methods approach: tool development (literature review, expert consensus, face and content validation, field testing with older adults and CHWs), scale development (exploratory factor analysis, convergent and discriminant validity testing), and scale evaluation (cut-off score determination, diagnostic accuracy testing, and reliability assessment). The tool's performance was benchmarked against standard geriatric assessment instruments, with frailty status as the criterion variable.

Results: The final EHSAS tool comprises 11 items spanning the key geriatric domains, excluding the frailty item. A cut-off of ≥3 "Yes" responses was selected based on ROC curve analysis and Youden's Index to maximise sensitivity and specificity. It demonstrated good psychometric properties, including high internal consistency (Cronbach's alpha > 0.7), substantial test-retest reliability (Cohen's kappa > 0.79), and balanced diagnostic accuracy (sensitivity 76.3%, specificity 76.5%, negative predictive value 93.2%). Field testing confirmed that EHSAS was usable by and acceptable to CHWs and older adults.

Conclusion: The EHSAS tool fills a critical gap in geriatric care in LMIC settings by offering a validated, brief, and culturally appropriate screening instrument for CHWs. Its adoption can strengthen early detection of geriatric syndromes and support timely referrals for CGA, ultimately improving health outcomes for older adults in resource-constrained rural areas.

POSTER

Scientific Presentation - Health Service Research

3825. DETERMINANTS OF WILLINGNESS TO USE HOME-CARE ROBOTS AMONG OLDER ADULTS IN MAINLAND CHINA

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Introduction: Amidst the growing demand for eldercare and a shortage of qualified caregivers, the Chinese government is actively promoting the development and deployment of robot-assisted care services for community-dwelling older adults (OAs). Understanding the factors that drive this population to embrace home-care robots is crucial for the successful implementation of such technologies. This study specifically aimed to delineate the determinants influencing the willingness of Chinese OAs aged 60 and above, who have not previously used home-care robots, to adopt this emerging technology as potential users.

Method: A total of 589 community-dwelling OAs (mean age 68.6 ± 7.5 years) were recruited through convenience sampling in Shanghai, China. The OAs completed a structured questionnaire designed by the research team, administered via a cross-sectional survey methodology.

Results: Among the OAs, 57.3% (n = 337) expressed willingness to use home-care robots. Statistical analysis indicated that OAs with higher education levels ($p < 0.01$), greater monthly income ($p< 0.01$), and elevated expectations regarding filial care ($p< 0.05$, $F=2.83$) were more inclined to adopt the technology. Additionally, those living alone ($p< 0.05$), currently receiving long-term care ($p< 0.05$), and possessing greater experience with technology ($p< 0.01$, $F=4.97$) demonstrated a higher likelihood of willingness to use home-care robots.

Conclusion: The findings highlight the importance of socio-demographic and experiential factors in determining OAs' willingness to use home-care robots in China. To enhance their willingness, targeted strategies should focus on improving digital literacy, especially for OAs with lower educational attainment. Furthermore, addressing the specific needs of those living alone or receiving long-term care might also increase their willingness.

POSTER

Scientific Presentation - Health Service Research

3855. HOW DO CARE HOME STAFF USE DATA TO IMPROVE CARE IN CARE HOMES FOR OLDER PEOPLE?

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Introduction: Standardising data collection and collation in care homes is a policy priority. The DACHA study piloted and tested a care home Minimum Dataset This follow-up study aimed to understand how care homes deploy data to improve care.

Methods: Interviews with care home staff, residents, relatives and other stakeholders (n= 22) from three care homes, explored data usage. Interview data were synthesised and thematically analysed with findings used to inform worked examples of how data informs care. These exemplars were presented at workshop with commissioners, healthcare providers and Electronic Care Record (ECR) vendors to test their relevance and resonance for services working in and with care homes.

Results: Exemplars developed from the findings focused on systematically using data for predicting unwellness/agitation, the importance of valuing soft data to support individualised care and supporting relatives' involvement in and understanding of the care being provided. Discussing the data they needed for care and developing exemplars led staff to refine and change ECR data fields and include quality of life outcome measures. The process also supported an exploration of day-to-day decisions staff made about what is important to document, how systematic this was, and if what mattered to the residents was always captured. The findings highlighted the importance of peer support and training to build staff confidence in using data and ensure data collected were meaningful and the basis for decision making.

Conclusion: Staff and relatives already use data in multiple ways to understand and support care delivery. Discussion about how data collection could inform care decisions led staff to develop skills in data literacy to appraise care delivered and value the process of data capture as an aid to practice.

POSTER

Scientific Presentation - Health Service Research

3877. FACTORS IMPACTING RETENTION IN REHAB RCTS WITH COMMUNITY DWELLING OLDER PEOPLE WITH FRAILTY: SYSTEMATIC REVIEW AND META ANALYSIS

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Introduction: The UK and global life expectancy is increasing, but life years lived in ill health is also increasing. Disease burden, and health and social care service use is highest in older age. Prevention, treatment and management of conditions of older age (e.g. frailty and multi-morbidity) is a research priority. Efficient trials need to better recruit and retain older participants to produce robust and generalisable evidence for our aging population. Synthesised qualitative and quantitative evidence regarding trial retention does not generally include the oldest and frail in society, and recommendations likely do not resonate with this population who have different needs and barriers to research participation. Here we present a systematic review and meta-analysis of participant and trial characteristic impacting retention rates in physical rehabilitation trials in community dwelling, frail, older people.

Method: Medline, Embase, CENRTAL, CINAHL and PEDro were searched from 2010-2025. RCTs of physical rehabilitation intervention in a frail community dwelling population were included. Two reviewers independently screened studies before extracting aggregated study data.

Results: Following automated deduplication,18942123 titles/abstracts were screened, 255340 with full text screen, 4036 studies were included. Pooled retention rates were 84%82%, with no between trial arm impact. Meta-regression analysis indicates significant retention effect of trial duration, mode of data collection, and geographical region. Average trial participant age and frailty severity, type of primary outcome, and number of trial sites, trial size (sample size) were not significantly associated with retention rates. Other retention strategies were very sparsely reported.

Conclusion: Retention rates observed are very similar to those reported in another frailty trials review, and lower than retention in trials generally (89%). Simple trial design change may significantly improve retention for this population. The aggregate nature of age and frailty severity data likely impacted analysis. Individual participant data analysis is required to further explore these associations.

POSTER

Scientific Presentation - Health Service Research

3880. A REVIEW OF THE FIRST YEAR OF IMPLEMENTATION OF A NOVEL FRAILTY TRIGGER AT TRIAGE

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Introduction: Emergency Department (ED) Triage identifies patients with urgent needs. Frailty is not routinely identified and older patients presenting atypically may inappropriately be triaged as low priority. The introduction of a frailty modifier at triage is recommended in international guidelines but is not yet widely-adopted. Our research team created a bespoke Frailty Trigger for use at triage and introduced it as a mandatory step in the local hospital IT patient management system.

Method: A Frailty Trigger (FT) was developed following a systematic review and two-round eDelphi, this process has been published previously. This FT was introduced into the local hospital IT patient management system in August 2024 and became a mandatory step at triage for all adults ≥65 years presenting to ED. Variables recorded were demographic, Manchester Triage Score (MTS), Triage start time, Frailty Trigger score and time stamp, Patient Experience Time (PET) in ED, Inpatient Length of stay (LOS), 30 and 90 day readmission rate and 12-month mortality

Results: 3,337 adults over 65 years were screened for frailty at triage between August 2024-January 2025. Those screening positive for frailty on the FT were statistically significantly older than those who screened negative. They were more likely to have MTS scores reflecting greater urgency at triage (i.e. low scores). These patients had statistically significantly longer PET times and LOS, if admitted. Scoring positive on the FT at ED triage was associated with a statistically significant 3.16 times increased odds of death at follow-up (95% CI: 2.31-4.32, $p<0.001$), after adjusting for age, biological sex and MTS score. Reflecting this, survival time was reduced even after adjusting for these variables, with those screening positive for frailty being 3 times more likely to be dead during the follow-up period than those not flagged as frail (hazard ratio 2.99, 95% CI: 2.21-4.05, $p<0.001$).

Conclusion: FT positive older adults in ED were older, with more urgent triage presentations and poorer hospital outcomes, including longer PET times, hospital length of stay and higher mortality. Multicentre use of the FT is required to examine the feasibility and acceptability of the Frailty Trigger in larger emergency departments.

POSTER

Scientific Presentation - Other medical condition

3341. GOALS OF FRAIL OLDER PEOPLE LIVING WITH CHRONIC KIDNEY DISEASE: A MIXED METHODS STUDY

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Background: Frail older adults with chronic kidney disease (CKD) have complex care needs, and their priorities may differ from those assumed by healthcare providers. Understanding their goals is crucial to delivering person-centred care. This study aimed to identify and categorise the goals of this population, and determine any association with participant's frailty status, quality of life, and CKD stage.

Methods: We report the goals of frail older people living with moderate to severe CKD enrolled as participants in the GOAL trial, a cluster-randomised controlled trial assessing the effectiveness of comprehensive geriatric assessment. This study employs a mixed-methods approach, utilising triangulation design and a data transformation model. Participants set goals by Goal Attainment Scaling. Deductive content analysis was undertaken, aided by a pre-specified matrix (physical health; psychological health; function; planning; social engagement). Descriptive statistics assessed relationships between goals and participant characteristics.

Results: The 224 participants (mean age 77 [±6.7]; 56% male; 84% white/European; median FI 0.39 [IQR: 0.33-0.47]) set 408 goals in the categories of function; physical health; social engagement and leisure; psychological health; and future readiness. Most participants set one or two goals (n=183, 82%). They were most frequently set in the function (n=172, 42%), physical health (n=86, 21%), and social engagement and leisure (n=79, 19%) domains. The number and nature of set goals were similar across participant frailty status, quality of life (EQ-5D-5L) scores or CKD stage.

Conclusion: Frail older adults with CKD most frequently focus their goals on function, physical health, and social engagement and leisure. These goals did not vary by participants' frailty status or CKD stage. This study's findings can guide healthcare professionals in ensuring management plans consider these identified priorities. Geriatricians may have a role in managing this population given the commonality of these goals with those of older people more generally.

POSTER

Scientific Presentation - Other medical condition

3513. SATISFACTION WITH SHARED DECISION MAKING, AND DECISION REGRET IN OLDER ADULTS UNDERGOING ELECTIVE COLORECTAL CANCER SURGERY

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Introduction: Involvement of Geriatricians in peri-operative assessment acknowledges the altered physiology of frail patients and helps to evaluate realistic outcomes as part of patient-centred shared decision making. This is with the aim of addressing modifiable risk factors, preventing complications, preparing for a realistic recovery and ensuring that treatment options are aligned to what is important to the patient. There is data suggesting improved survival following geriatric peri-operative assessment but little analysis from the patient's perspective; their thoughts about the shared decision-making process, regrets about having surgery and the impact it has had on their quality of life. This study aims to identify success of our peri-operative clinic based on patient-centred parameters.

Methods: We identified 69 patients seen in our joint Anaesthestic and Geriatrician peri-operative assessment clinic before elective colorectal surgery. These patients were over the age of 65, had multiple co-morbidities and had their surgery between 2022-2024. Participants answered a standardised 'Shared Decision-Making Questionnaire' (SDM-Q-9) and 'Decision Regret Scale' over the phone.

Results: 45 patients were able to answer our questionnaires. 9 patients had died, 14 did not answer or declined and 1 was incorrectly identified. Ages ranged from 69 to 91, with the majority undergoing laparoscopic hemicolectomies. 100% of respondents felt the team helped them understand information regarding the operation, and 93% felt they made the decision jointly with the doctor. Though 6% felt that the operation did them harm, 100% agreed that it was the right decision and would go for the same choice if they chose again.

Conclusion: Our study suggests that patients are very satisfied after having undergone surgery and had realistic expectations and goals from combined pre-operative assessment. The shared decision-making analysis is positive and demonstrates the importance of stressing 'not having surgery' as an option to patients. The subjective and retrospective nature of the study may limit results.

POSTER

Scientific Presentation - Other medical condition

3569. EXPLORATION OF MEANINGFUL ACTIVITIES FOR OLDER ADULTS IN ACUTE HOSPITAL SETTINGS: A SCOPING REVIEW

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Background: The global population of people aged 65 years and over is expected to rise from 761 million in 2021 to 1.6 billion by 2050. Many of these older adults have multiple comorbidities and functional impairments that make them particularly vulnerable during acute hospitalisation. Engagement in meaningful activities can be vital to older people's care, particularly in acute hospitals. Evidence suggests that such engagement can have a positive impact on the patients' hospital journeys. To ensure individualised support, it is important to understand the purpose of meaningful activities for older adults in acute hospital settings, including their definitions, implementation methods, and impact on patients.

Objectives: The aims and objectives of this scoping review were to:

- provide evidence of the impact of engagement in meaningful activities on older adults;
- identify barriers to the delivery of these activities; and to
- source evidence regarding older adults' experiences and perspectives on meaningful activities in hospitals.

Methods: The review stages identified in the Arksey and O'Malley framework were used. The electronic databases MEDLINE, CINAHL and PsycINFO were searched to discover relevant articles on meaningful activities/ older adults in acute hospital care. The results are reported according to the preferred reporting items for systematic reviews and meta-analyses (PRISMA) extension for scoping reviews. A total of 3,466 titles were identified in an initial search that used the term "meaningful activity". Screening these articles using the keywords "older adults" and "acute care setting" cut this figure to 34. Some of these were duplicates or the studies had not been carried out in the UK; after excluding these, 24 articles related to the research interests remained. These 24 articles were screened and six were found to apply to adults 65 years and older. These six were analysed in the review.

Findings and Conclusion: The findings regarding the meaningful activity experiences of older adults in acute hospitals indicate that comprehensive models of care that embrace physical, psychological, social and spiritual frameworks are required. Summarisation of the data led to the identification of three themes: "physical, social and art activities", "the benefits of meaningful activities", and "the desire for meaningful activity". Regarding the latter, patients in the studies highlighted the importance of taking part in meaningful activities during their acute hospital journeys. Regarding the first two themes, the reported observations and reviews of the evidence indicate that interventions that include physical exercise, music and art therapy improve mental health and well-being and alleviate anxiety and depression in older adults. Loneliness and isolation among some older patients may be eradicated through social interaction. However, implementation of such models in acute hospital settings poses a challenge, given the shortage of staff, particularly those trained in meaningful activity.

POSTER

Scientific Presentation - Other medical condition

3578. T-CELL CO-SIGNALING IN NORMAL HUMAN AGEING – A SILVER BULLET FOR AGEING?

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Introduction: Even in "healthy" ageing, the immune system undergoes significant changes, with these immune system aberrations being collectively known as immunosenescence. These changes are complex, occurring both in the innate and the adaptive immune system, though recent focus has been on changes in the adaptive immune system due to increasing availability of highly targeted immunomodulatory drugs coming into clinical use. Managing immunosenescence is important for older adults as these immune changes contribute to their increased susceptibility to infections, poor response to vaccines, weakened cancer immunosurveillance and increased risk of autoimmune disease. This narrative review considers the underlying mechanisms of T-cell co-signalling changes, as a potential modifiable target in immunosenescence.

Method: Structured searches of Medline OVID, SCOPUS, Web of Science and PubMed were performed with MeSH terms relating to ageing, T-cell co-signalling and therapeutic interventions. Duplicates were removed, abstracts screened, and papers organised thematically.

Results: The literature highlights a general decrease in excitatory signalling, with a concurrent increase inhibitory signalling, in T-cells in healthy ageing. This leads to lower proliferative capacity of T-cells in response to a novel antigen and thus a less competent immune response. Potential interventions to overcome these changes exist, spanning from lifestyle interventions such as horticultural therapy, to use of monoclonal antibody therapies to directly modulate immune responses.

Conclusions: T-cells have worsening function with age, in part due to weakened excitatory cos-signalling and strengthened co-inhibitory signalling. There is potential for these changes to be modified with novel medical therapies to overcome age-relate immune changes.

POSTER

Scientific Presentation - Other medical condition

3734. THE IMPACT OF DIGITAL INTERVENTIONS TO REVERSE FRAILTY - SYSTEMATIC REVIEW AND META-ANALYSIS

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Introduction: Frailty is defined as a clinically recognised state of increased vulnerability, reflecting a decline in an individual's psychological and physical reserves. Digital interventions, such as smartwatches, are increasingly utilised to monitor and support the health of older adults. Evidence on the effectiveness of digital interventions in reducing or reversing frailty is limited. This systematic review aimed to investigate the types of digital interventions tested and the resulting outcomes.

Method: The following databases: Medline, CINAHL, Scopus, PsychInfo and Embase were searched from time of origin until July 2024. A search strategy was designed to identify randomised controlled trials assessing the impact of digital interventions on older adults. Outcome measures explored include frailty, wellbeing and quality of life. Narrative synthesis was performed for all studies and meta-analysis was performed for outcomes reported in four or more studies. Risk of bias was conducted using Cochrane Risk of Bias-2 tool.

Results: From 4476 titles and abstracts screened, 17 studies were included following full text review. Overall, 12 studies included exercises as a component or the sole form of intervention. The mean duration of intervention was 4.04 (SD 2.56) months. Mean adherence to the intervention was 59%. The most reported frailty-specific outcome was walking speed (n=8), while the least reported outcome was self-reported exhaustion level (n=2). Meta-analysis showed non-exercise-based interventions showed significant improvements in SPPB. There was no statistically significant change in TUG and handgrip strength. Narrative synthesis indicates there was insufficient evidence to evaluate the impact of digital interventions on frailty, cognition, wellbeing, activities of daily living and health-related quality of life.

Conclusions: The findings suggest low technological readiness and adherence among digital interventions for older adults. Narrative synthesis of overall frailty and outcome measures showed mixed results and insufficient evidence on the impact of digital interventions on frailty and outcomes reviewed.

POSTER

Scientific Presentation - Other medical condition

3793. OLDER PEOPLE'S PERCEPTIONS OF FRAILTY AND ADVANCED CARE PLANNING

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Introduction: Advanced care planning (ACP) is particularly relevant for those living with frailty, who are at heightened risk of sudden health changes and loss of cognitive ability. The concepts of frailty and ACP are understood differently by older adults and health care professionals (HCPs). This abstract represents the qualitative component of a mixed methods study aiming to evaluate older people's perspectives of frailty, including how and why they build self-perceptions of frailty, and their perceptions of ACP.

Method: Ten community dwelling, older adults, (aged seventy years plus), registered with a single GP practice, were interviewed, alongside a 'close person' if they wished. Participants were purposively sampled from a pool of survey respondents. Semi structured interviews were analysed using reflexive thematic analysis.

Results: Four themes were identified: 'Focus on the familiar first', 'Dependency: the good, the bad and the ugly', "If you don't use it, you will lose it"; don't give in to frailty – keep going, 'Attitudes towards frailty matter; you need to have mental grit'. ACP is not familiar to most older people and family is often consulted before HCPs. What people want to plan for may not be health related. Being independent and able to keep going were key to many older people's frailty identity. Some older adults feel there is a choice in how one responds to frailty, placing great importance on having a positive mental attitude.

Conclusions: Understanding older people's priorities for future planning can help HCPs to engage in ACP conversations with an open mind. Knowing that families have often already been involved in future planning discussions may allow a 'way in'. Insights into how older people construct their frailty identity, and the importance placed on positive attitudes, keeping going and independence, may allow for conversations to be more aligned with their values.

POSTER

Scientific Presentation - Other medical condition

3795. HOSPITAL-ACQUIRED INFECTIONS IN OLDER VASCULAR INPATIENTS (≥60 YEARS): A SINGLE CENTRE COHORT STUDY AND OUTCOMES ANALYSIS

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Background: Older adults undergoing vascular surgery are particularly vulnerable to hospital-acquired infections (HAIs) due to frailty, multi-morbidity, and the high prevalence of emergency interventions. HAIs in this population significantly affect recovery, length of stay, and survival.

Methods: We conducted a single-canter retrospective analysis of vascular inpatients aged ≥60 years that developed new HAIs during admission between 1st June 2020 and 31st July 2021. Patients with diabetic foot infections, pre-existing surgical site infections (SSIs), or Clostridium difficile were excluded.

Results: 943 Patients were admitted to our vascular centre from over 14 months. Out of 157 new HAIs, 134 (85%) occurred in patients aged ≥60, with male predominance (54.5%). 111/ 134 (83%) followed emergency admissions while 23/134 (17%) cases were associated with elective admissions. 24/134 (18%) patients did not undergo active vascular intervention. 589 vascular procedures were performed across all admissions. 171 of them were carried out in the 134 admissions and were complicated by new (HAI). Group A (UTI/chest infections, 104/134 (78%); chest infections (55/104 = 53%) or UTI (35/104 = 34%) or both (14/104 = 13%). Their mean LOS was 29 days, and 30-day mortality was 30%. Mean hospital stay in Chest infections or UTI was not significantly different at 30 days and 31 days sequentially. Combined chest infection and UTI cases had significantly longer length of stay (42 days) compared to either chest infections or UTI ($p < 0.001$) with higher female LOS compared to males (49 vs. 32 days; $p=0.02$) Group B (non-UTI/chest HAIs, 30/134 (22%); they had bacteremia and Surgical Site Infections. The Mean LOS was 28 days; 30-day mortality was 16.7%

Conclusion: HAIs represent a major source of morbidity and mortality among older vascular inpatients, especially after emergency admissions. While UTIs and chest infections are the most frequent, SSIs and bacteremia carry the greatest morbidity and mortality

POSTER

Scientific Presentation - Other medical condition

3803. A CROSS-SECTIONAL COMPARISON OF OLDER PEOPLE'S SELF-PERCEIVED FRAILTY AND THEIR ELECTRONIC FRAILTY INDEX SCORE

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Introduction: Small, qualitative studies suggest discrepancies between older adults' measured and self-perceived frailty. Any mismatch will have implications for frailty interventions and advanced care planning. We therefore, aimed to report the relationship between older adults' self-perceived frailty and the Electronic Frailty Index (eFI), an objective screening tool measure of frailty, in a large, unselected cohort of older people.

Method: One thousand people aged ≥ 70 years, randomly selected from a single GP practice, were sent a survey, asking them to rate their own frailty using self-report measures (an ordinal scale, a binary scale, Self-rated health (SRH) and PRISMA-7. We analysed a) agreement between self-perceived frailty (ordinal scale) and eFI categorised frailty (weighted Kappa and Gwet's second order agreement co-efficient [AC2]), b) discrimination of each self-report measure for eFI defined frailty (threshold ≥ 0.12) and c) logistic regressions exploring predictors of self-perceived frailty (binary scale).

Results: 375 people were included in the analysis (median age 76, 51% female). Agreement was 'fair' between self-perceived frailty and eFI using linear weighted kappa (k = 0.25) and quadratic weighted kappa (k = 0.37). Agreement was higher with linear and quadratic weighted AC2 (k = 0.65 and 0.81 respectively). As eFI severity increased, agreement with self-perceived frailty decreased. Self-perceived frailty was poor at discriminating frailty as categorised by eFI. PRISMA-7 outperformed the other measures. SRH performed least well. The optimal eFI cut point for discriminating self-perceived frailty was 0.17. Multivariate regression showed that increasing age (OR 1.10, 95% confidence intervals [CI] 1.02-1.18) and depression (OR 1.51, 95% CI 1.31-1.74) were the only significant predictors of self-perceived frailty. Sex, anxiety, eFI category and deprivation were not significant.

Conclusions: The mismatch between self-perceived and e FI-categorised frailty, especially in those categorised as severely frail, may have implications for frailty management and advanced care planning.

POSTER

Scientific Presentation - Other medical condition

3838. POLYPHARMACY, SEVERE MENTAL ILLNESS AND IMPAIRED MOBILITY IN MULTIPLE LONG-TERM HEALTH CONDITIONS: A SCOPING REVIEW

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Introduction: Multiple long-term health conditions and multimorbidity (MLTC-M) disproportionally impact older people. Literature highlights associations between polypharmacy, mobility issues, and severe mental illness and MLTC-M. Co-existence of polypharmacy, mobility issues, and severe mental illness with MLTC-M may impact on older people's health outcomes, however the extent to which these have been explored is unclear. Aim This scoping review aimed to describe the evidence regarding interventions and outcomes associated with the intersection of polypharmacy, mobility issues, and severe mental illness with MLTC-M.

Methods: Medline, Embase, Scopus, Psychinfo and CINAHL were searched for evidence sources that discuss at least two of polypharmacy, mobility issues, and severe mental illness with MLTC-M. Two reviewers independently screened titles and abstracts and full texts against the inclusion and exclusion criteria. Data pertaining to people's interventions and outcomes were extracted and synthesised narratively.

Results: 6540 studies were included in the title and abstract screening and 1237 proceeded to full text screening. Research exploring the interaction between polypharmacy, severe mental illness and mobility collectively accounts for 5% of evidence sources progressing to full text screening. Roughly a third of included papers are concerned with polypharmacy and mobility, such as higher drug burden increasing the risk of falls. Papers reporting on polypharmacy and severe mental illness also make up roughly a third, such as tardive dyskinesia and kinesia. Just under a third of papers discuss the relationship between severe mental illness and mobility, such as high prevalence of metabolic syndrome in schizophrenia causing mobility limitations.

Conclusions: The results of the review suggest that there could be a bidirectional relationship between severe mental illness and impaired mobility, mediated by polypharmacy. Drug-drug interactions could increase the risk of mobility problems in older people with severe mental illness and increase psychiatric problems in older people with impaired mobility.

POSTER

Scientific Presentation - Other medical condition

3839. A SCOPING REVIEW OF RANDOMISED CONTROLLED TRIALS OF VACCINES THAT RECRUITED CARE HOME RESIDENTS: LESSONS FOR FUTURE TRIALS

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Introduction: Older care home (CH) residents are particularly vulnerable to infections and often experience adverse outcomes. Despite this group being prioritised for vaccination, no COVID-19 vaccine trials recruited CH residents. Given that the social and biological characteristics of CH residents may influence vaccine effectiveness, it is crucial to test vaccines in this population.

Methods: The Widening Access to Trials in Care Homes (WATCH) project was established to develop best practice guidance on designing and conducting vaccine trials in the CH population. As part of this project, a scoping review was conducted using the Joanna Briggs Institute methodology to identify vaccine trials that recruited CH residents and reported recruitment challenges and strategies. A comprehensive search was carried out in five databases: EMBASE, MEDLINE, PsycINFO, CINAHL, and Cochrane Library, from 1990 to 2025. Three authors independently screened articles and extracted data. Results are reported as descriptive summaries.

Results: We retrieved 701 articles and included 20 studies from 11 countries. 7479 participants from 238 CHs were recruited to influenza (N=17) or pneumococcal (N=3) vaccine trials. Median sample size was 270 and the weighted mean age was 82.3 years. Screen failure and dropout rate averaged 70% (seven studies) and 8% (five studies), respectively. The two most common reasons for screen failure were residents' declining participation (46%) and not meeting eligibility criteria (27%). Death (21%) was the most common reason for dropout. Barriers identified include eligibility criteria and recruitment, consent and assent issues, ethical and regulatory concerns, CH-related factors, and study time frame and logistical factors. Facilitators identified include recruitment and data collection methods, consent and assent factors, and collaboration with CHs.

Conclusion: Our review is the first to report quantitative and qualitative evidence on barriers and facilitators to recruiting CH residents in vaccine trials. The findings will assist researchers in planning future vaccine trials in this population.

POSTER

Scientific Presentation - Other medical condition

3859. QUANTIFICATION OF MACRO- AND MICRONUTRIENT INTAKE IN OLDER ACUTE HOSPITAL INPATIENTS

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Background: 3.7 million UK older adults are estimated to be malnourished and the malnutrition rate in European hospitalised older adults is 53%. In preparation for a clinical trial of dietary supplementation, we set out to evaluate sufficiency of macro- and micro-nutrient intake in older people presenting to acute hospital before and during inpatient stays.

Methods: We reviewed dietary intake for consecutive admissions to the Older People's Assessment Unit of Whipps Cross Hospital, London, during April 2025. Patients completed a dietary recall questionnaire for the 24 hours immediately pre-hospitalization via interview. For inpatient intake, meals were photographed before and after the patient had eaten. Nutrient content of foods was calculated using Dietbox software. Adequacy of nutrient intake was assessed using UK Government Dietary Recommendations.

Results: 21 patients were able to participate in dietary recall, and 50 had inpatient dietary intake evaluated. Pre- and post-admission median (IQR) calorie intake was 1263.0 (1061.0-1656.0) and 1817.5 (1111.3-2140.4) kcal respectively. 24% and 86% of participants were protein [67.1(53.4-78.9) g/day] and carbohydrate [160.7(107.9-230.7) g/day] malnourished pre-admission, and 24% and 98% of inpatients had inadequate protein [77.9(51.3-103.1) g/day] and carbohydrate [178.7 (103.9-196.6) g/day] intake respectively. Intake of calcium, copper, fibre, magnesium, sodium, pyridoxine, potassium, riboflavin, selenium and vitamins A, C, D and E were suboptimal in over half of participants pre-admission, and only sodium (due to higher salt intake) and vitamin C improved substantially after admission. Creatine intake was below the 1g/day target in 71% and 68% of participants pre- and during admission respectively.

Discussion: Macronutrient intake was suboptimal in the majority pre-admission and, whilst calorie intake improved, neither protein nor carbohydrate intake were better on admission. Micronutrient deficiency was common and did not improve substantively on admission. Participants were unlikely to be able to meet the increased metabolic demands associated with admission.

POSTER

Scientific Presentation - Other medical condition

3862. INTERLEUKIN-6 IS BETTER ASSOCIATED WITH FRAILTY THAN C-REACTIVE PROTEIN - FINDINGS FROM THE FRAXI STUDY

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Background: Frailty is known to be associated with vascular ageing. The causative factors for frailty are not well understood. Inflammation and oxidative stress are suggested to contribute to frailty, with some studies in humans investigating this. In this study, the correlation between biomarkers of inflammation and frailty were explored.

Methods: Fifty community dwelling adults ≥70years (mean age ± standard deviation: 79 ± 5years, 46% male) with clinical frailty score (CFS ≤ 6) were followed up for six months. Vascular parameters such as pulse wave velocity and cardio-ankle vascular index were measured at baseline. All other study measurements such as timed up and go test, sarcopenia, mini-mental state exam, and biomarkers such as interleukin-6 (IL-6) and C-reactive protein (CRP) were measured at both time intervals.

Results: Thirty-six participants had biomarkers analysed, and at baseline, mean CFS was 3.5 (±SD 1.4) and at follow up, mean CFS was 4.0 (± SD 1.5). At baseline, positive correlations were observed between chronological age ($r=0.4$; $p<0.05$) and CFS ($r=0.3$; $p<0.05$) with IL-6, with no correlations between IL-6 and vascular parameters of ageing. At follow up, IL-6 remained positively correlated with CFS ($r=0.3$; $p=0.08$) and chronological age ($r=0.4$; $p<0.05$); with no significant correlations observed between CRP and chronological age, CFS or vascular parameters.

Conclusion: IL-6 correlates more closely with chronological age and frailty compared to CRP, suggesting that IL-6 is a better biomarker measure of frailty in the study cohort.

POSTER

Scientific Presentation - Other medical condition

3865. COGNITIVE FRAILTY AND ARTERIAL STIFFNESS - FINDINGS FROM THE FRAXI STUDY

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Background: Cognitive frailty, defined as the presence of physical frailty and cognitive impairment in the absence of dementia, is a common finding among older adults. The causative factors for cognitive frailty are not well understood. It is known that vascular factors such as arterial stiffness are associated with ageing and frailty. In the Frailty and arterial stiffness-role of oxidative stress and inflammation (FRAXI) study, the correlation between cognitive frailty (assessed by the mini-mental state examination (MMSE)), clinical frailty score (CFS) and arterial stiffness was explored.

Methods: The longitudinal FRAXI study included fifty community dwelling adults ≥70years (mean age ± standard deviation: 79 ± 5years, 46% male), with CFS ≤ 6 and no active malignancy, who were followed up for six months. Measures of arterial stiffness included pulse wave velocity (PWV, Complior®) and cardio-ankle vascular index, measured at baseline. Other study measurements: MMSE, timed up and go test), sarcopenia, geriatric depression scale, interleukin-6 and high sensitivity C-reactive protein biomarkers were measured at baseline and 6 months.

Results: All fifty participants were assessed for cognition using MMSE, with mean CFS at baseline of 3.5 (±SD 1.4) and at follow up, 4.0 (± SD 1.5). At baseline, MMSE strongly correlated with both functional and phenotypic frailty as assessed by Charlson's Comorbidity Index ($r=-0.3$; $p<0.05$) and CFS ($r=-0.5$; $p<0.001$). Similarly, MMSE strongly correlated with measures of arterial stiffness; PWV-carotid femoral ($r=-0.4$; $p=0.01$) and PWV-carotid radial ($r=-0.4$; $p<0.005$). At follow up, MMSE remained strongly correlated with CFS ($r=-0.3$; $p<0.01$).

Conclusion: Cognitive frailty correlates strongly with measures of vascular ageing. Arterial stiffness can be used as a vascular measure to identify older adults at risk of cognitive impairment.

POSTER

Scientific Presentation - Other medical condition

3884. IDENTIFYING BIOMARKERS OF ACCELERATED AGEING IN CANCER PATIENTS FROM ROUTINE CLINICAL DATA

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Introduction: Cancer and ageing have a bidirectional relationship: age is the strongest risk factor for cancer, and cancer and treatments can accelerate ageing. Consequently, biological age of patients with cancer is likely to deviate from chronological age. Validated biomarkers of biological age are needed to quantify this and stratify interventions to minimise accelerated ageing.

Methods: Using the BioAge R Package, PhenoAge was calculated from eight blood test results of patients attending the Geriatric Oncology Liaison Development (GOLD) clinic at Guy's Hospital between 2022 and 2025. PhenoAgeAccel, a biomarker of accelerated ageing, was the residual from a linear regression of PhenoAge by age.

Results: Data were available for 173 patients (62% male). Mean PhenoAge was higher than mean age (84.3 (12.6) vs 76.2 (7.24), $p<0.001$), though the two were correlated ($r=0.579$, $p<0.001$). Unlike age, PhenoAge and PhenoAgeAccel were associated with one-year mortality (PhenoAge OR = 1.083, 95% CI: 1.038-1.136; PhenoAgeAccel OR = 1.096, 95% CI: 1.047-1.155, $p<0.001$). In all patients, PhenoAge correlated with Clinical Frailty Scale and Timed Up and Go (CFS: $Rs=0.31$, $p<0.001$; TUG: $Rs=0.25$, $p<0.005$), whereas there were no correlations with age (CFS: $Rs=0.1$, $p=0.21$; TUG: $Rs=0.16$, $p=0.07$). PhenoAgeAccel correlated with the number of CGA interventions made per patient ($Rs=0.17$, $p<0.05$), but age and PhenoAge did not. Patients with diabetes had a higher PhenoAgeAccel (3.40 (9.78) vs -1.71 (10.53), $p=0.002$). In patients receiving systemic anti-cancer treatment (SACT), PhenoAgeAccel pre-SACT was lower than when measured post-SACT (2.18 (10.64) vs. -2.87 (7.98); $p=0.048$) overall and in matched samples ($n = 21$, 7.76 ± 11.98 vs -2.87 ± 7.98, $p<0.001$).

Conclusions: PhenoAgeAccel is a promising biomarker to identify older people with cancer who may benefit from holistic geriatric assessment, dose reductions, or future geroprotective measures. This process could be automated through integration of PhenoAge within electronic healthcare record systems and clinician alerts.

POSTER

Scientific Presentation - Parkinson's Disease

3352. THE MOTOR PROFILE OF PATIENTS WITH IDIOPATHIC PARKINSON'S DISEASE IN THE HAI DISTRICT OF NORTHERN TANZANIA

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Introduction: Parkinson's disease (PD) is the second most common neurodegenerative condition globally. Its cardinal motor signs are bradykinesia, rest tremor, rigidity, and postural instability. The motor symptoms of PD often lead to dependence on others to perform daily activities. Globally, the incidence of PD is rising. However, for countries in sub-Saharan-Africa such as Tanzania, research on the motor aspects of PD and the associated disability is sparse. The primary aim of this study was to determine the motor symptoms, and burden of motor symptoms, in newly diagnosed people with idiopathic PD (IPD) in the Hai district of Tanzania. The secondary aim was to ascertain the level of disability amongst this group.

Method: A questionnaire was completed by households in Hai to screen individuals for the cardinal symptoms of PD. Positive responders were assessed for symptoms of PD in their community and, as necessary, were diagnosed by a neurologist. The Movement Disorder Society-Unified Parkinson's Disease Rating Scale was used to measure the frequency and severity of each motor symptom. Additionally, the total score was used to represent the burden of motor symptoms. PD was staged using the Hoehn and Yahr scale and the Barthel Index was used to measure disability. To classify the scores, validated cut-off values were used.

Results: Thirty-one individuals with IPD were identified. Of these, twenty-one participants were newly diagnosed and not taking PD medication during data collection. The burden of motor symptoms amongst participants was classified as severe, and the most common motor subtype was tremor-dominant PD. Seventeen participants demonstrated a moderate or severe level of disability.

Conclusions: Motor burden and disability were prevalent amongst newly diagnosed people with IPD in Hai. Despite trends, definitive conclusions on the total burden of motor signs and level of disability were limited by incomplete data and recruitment issues.

POSTER

Scientific Presentation - Parkinson's Disease

3706. PERCUTANEOUS ENDOSCOPIC GASTROSTOMY IN ATYPICAL PARKINSONIAN SYNDROMES: SURVIVAL AND ASPIRATION RISK IN AN INTERNATIONAL COHORT

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Introduction: Dysphagia frequently occurs in movement disorders, leading to malnutrition and aspiration. Percutaneous endoscopic gastrostomy (PEG) provides nutrition directly into the stomach, bypassing the dysfunctional swallow. However, PEG insertion is a complex decision, both clinically and ethically. Although PEG outcomes have been reported in other neurological disorders, there is limited research in atypical Parkinsonian syndromes such as Multiple Systems Atrophy (MSA), Progressive Supranuclear Palsy (PSP), and Corticobasal Degeneration (CBD). Insertion rates for these disorders remain variable, reflecting the paucity of research and lack of consistent guidelines. Basic mortality and morbidity data would help inform practice. To our knowledge, this is the first international study to assess whether PEG insertion improves survival and reduces aspiration pneumonia in atypical Parkinsonism.

Method: International retrospective study of 72 patients with MSA, PSP or CBD. Survival was recorded from reported onset of dysphagia to death. Secondary outcomes included hospital admission rate for aspiration pneumonia.

Results: Mean survival for the PEG group (n=12) was 45.5 months (95% CI 34.6 – 56.4), compared to 20.8 months (95% CI 16.8 – 25.1) in the non-PEG group (n=60). From the onset of dysphagia, the mean hospital admission rate for aspiration pneumonia was almost identical (PEG: 0.064/month, non-PEG: 0.062/month). However, within the PEG group, admissions for aspiration pneumonia increased following PEG insertion (0.054 to 0.145/month).

Conclusion: PEG insertion may improve survival in atypical Parkinsonism, though we found no evidence of reduced aspiration risk. Given the rarity of these conditions, international registries may help to determine the safety and efficacy of PEG use.

POSTER

Scientific Presentation - Parkinson's Disease

3844. TOWARDS DIGITAL MOBILITY OUTCOME MEASURES IN PARKINSON'S DISEASE: MOBILISE-D TO EJS ACT-PD

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Background: A key challenge for disease-modifying trials in Parkinson's disease (PD) is the lack of sensitive, patient-relevant outcome measures. Digital mobility outcomes (DMOs), captured using body-worn devices, offer a novel, objective means to assess real-world gait and mobility. The Mobilise-D study validated DMOs in PD, demonstrating that the analytics software could accurately and reliably monitor mobility in the real world. However, to progress towards regulatory qualification, demonstration of responsiveness to therapy is required. The Edmond J Safra Accelerating Clinical Trials in Parkinson's Disease (EJS ACT-PD) multi-arm multi-stage (MAMS) trial provides a unique opportunity to advance this work.

Methods: The EJS ACT-PD trial will commence in autumn 2025; overall the trial will recruit 1600 participants across 43 sites and will embed DMOs as an exploratory endpoint. Participants will apply a body-worn sensor every six months, and DMOs such as gait speed, stride length, and number of walking bouts will be extracted using the validated Mobilise-D pipeline. The largely remote setup, including sensor application, is designed to enhance accessibility.

Results: To evaluate the potential of DMOs as digital trial endpoints, analyses will include DMO correlation with and predictive of the main trial outcomes, in addition to longitudinal change of DMOs. The study will also assess adherence, data completeness, and acceptability, informing the feasibility of remotely deploying DMOs in large MAMS trials. Demographic comparisons between those who consent to the digital measures study and the main trial cohort will identify any participation biases.

Conclusion: Embedding DMOs within the EJS ACT-PD trial allows comprehensive evaluation in a large PD population. The findings will support the development and validation of DMOs as digital biomarkers, helping accelerate early Go/No-Go decisions and paving the way for regulatory qualification. This has the potential to speed up the evaluation of therapies and ultimately improve outcomes for people with PD.

POSTER

Scientific Presentation - Parkinson's Disease

3861. DOPAMINERGIC AGENTS IN DEMENTIA WITH LEWY BODIES: A NARRATIVE REVIEW

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Introduction: Dementia with Lewy Bodies (DLB) is the second most prevalent cause of degenerative dementia, with many DLB patients eventually developing parkinsonism. Dopaminergic agents, although somewhat efficacious in relieving motor symptoms, risk exacerbating non-motor, and especially neuropsychiatric, features. There is also limited practical guidance on managing parkinsonism in acutely admitted DLB patients with impaired swallowing.

Objectives: This summary narrative assumes a critical synoptic perspective of the literature concerning the use of dopaminergic agents in DLB. Here, we aim to collate evidence-based and patient-responsive findings to assist clinicians in adopting best-practice for managing parkinsonism in this population.

Methods: A literature search was conducted via PubMed, Embase, SCOPUS, and Web of Science centred on original research, in the form of randomised control trials and observational studies. We primarily evaluated: agents used, dosage, tolerability, and improvement in motor symptoms. As a secondary objective, we explored non-oral routes for patients who become nil-by-mouth.

Results: Contemporary research is centred around levodopa, and more recently, adjunctive therapy with zonisamide and mevidalen. Levodopa proves effective, albeit with dose-dependent deterioration in non-motor symptoms. Zonisamide, a non-canonical dopaminergic, shows non-inferiority compared to levodopa escalation, with increased tolerability and noteworthy improvements in non-motor symptoms. High-dose mevidalen yields clinically significant improvements in parkinsonism, particularly bradykinesia and rigidity. No studies examined non-oral routes in DLB. Nevertheless, data from Parkinson’s disease and atypical parkinsonism populations offer initial suggestions into viable, non-oral administration routes.

Conclusions: Despite the disease burden of parkinsonism in DLB, there is a paucity of data related to its management with dopaminergic agents. Emerging evidence suggests adjunctive therapies may be favourable to levodopa dose escalation. There is a lack of evidence to inform non-oral treatment approaches in the context of impaired swallowing. Further DLB-centred research is essential to optimise patient-centred management of DLB parkinsonism via oral and non-oral routes.

POSTER

Scientific Presentation - Pharmacology

3390. ESTABLISHING THE PREVALENCE OF PRESCRIPTIONS FOR PHARMACOGENETIC TESTABLE MEDICATIONS IN A GERIATRIC MEDICINE INPATIENT COHORT

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Introduction: Genetic testing in medical practice is becoming increasingly commonplace. Particularly relevant to geriatric medicine and polypharmacy is the science of pharmacogenetics; the testing of an individual patient to check for drug-gene interactions, which can determine if a new or existing prescription is a good fit for them. We wanted to establish the prevalence of prescriptions for medicines that have a known pharmacogenetic target in a population of people admitted to a geriatric medicine department at a UK teaching hospital.

Methods: We conducted a retrospective cohort analysis, using a year's worth of electronic prescribing records (1/6/23 -31/05/24), for patients admitted under the care of any named geriatrician at a single site teaching hospital in the UK. We cross referenced those prescriptions against a reference list of pharmacogenetic medications (PGxMed) with a known applicable pharmacogenetic test.

Results: The department recorded 9115 admissions over this time period. Most patients received at least one PGxMed prescription, with nearly two thirds (61%, or 5528 out of 9115) of admissions in one year being associated with at least one PGx medication. 6 was the highest number of PGxMed prescriptions recorded against a single patient (3 instances). "Cholesterol lowering", "Analgesic" and "Anticoagulant" were the top three classes of medication by frequency respectively.

Conclusions: Prescriptions for PGxMeds are highly prevalent in geriatric medicine in-patients, and more research is required to determine what the most cost-effective PGx testing approach is. There could be a role for PGx to help identify ineffective or harmful medication in this patient group. Given that geriatricians possess an acknowledged expertise in medication review, whilst PGx is still a nascent field of testing from a UK perspective, it is one for them to be aware of since it is likely to become of more relevance in clinical practice over the next few years.

POSTER

Scientific Presentation - Pharmacology

3794. EFFICACY AND SAFETY OF REGULAR ANALGESIA FOR PAIN AND QUALITY OF LIFE IN LONG-TERM CARE RESIDENTS WITH DEMENTIA: A SYSTEMATIC REVIEW

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Background: Dementia is a growing global health concern. People with advanced dementia frequently experience chronic pain that is poorly recognised and inadequately treated, causing substantial distress for individuals and caregivers (1). Although analgesic prescriptions are increasing worldwide (2), no evidence-based consensus on pain management exists in this population.

Aims: To evaluate the efficacy and safety of regularly administered pharmacological analgesia for treating pain and improving quality of life (QoL) in long-term care residents with dementia.

Methods: MEDLINE, CENTRAL, and Embase were systematically searched in February 2025. Two reviewers independently screened studies, extracted data, and assessed risk of bias. A narrative synthesis was undertaken, supplemented by meta-analyses of selected outcomes.

Results: Five moderate-to-high risk of bias randomised controlled trials (RCTs) and one low-risk of bias non-RCT comprising 720 participants were included. Despite prevalent baseline pain, regular analgesia did not significantly reduce short-term pain on two dementia-specific pain scales: MOBID-2 (standardised mean difference (SMD) 0.08, p =0.42) and DS-DAT (SMD 0.59, p =0.24). Paracetamol (SMDs −1.30 and −1.11, p ≤0.04) and pregabalin (SMD 3.53, p <0.01) reduced medium-term pain and were well tolerated. However, buprenorphine was ineffective, associated with neuropsychiatric, gastrointestinal, and musculoskeletal adverse effects, and a ~4.7-fold higher discontinuation rate. Sleep was the only QoL domain to show improvement with regular analgesia (SMD 0.29, p <0.01), though sedative effects cannot be excluded. Effects on agitation, activities of daily living, cognition, and depression were inconsistent or negligible.

Conclusions: Regular analgesia does not consistently reduce pain or improve QoL in institutionalised persons with dementia. Buprenorphine was notably ineffective and exhibited a questionable safety profile. Pregabalin may represent an under-utilised option for treating neuropathic pain. Further high-quality, methodologically homogenous trials are needed to clarify the analgesic effect of paracetamol, pregabalin and opioids. Until then, pharmacological analgesia should remain one component of holistic pain and behaviour management in this population.

POSTER

Scientific Presentation - Psychiatry and Mental Health

3816. VERBAL FLUENCY TASKS AS A COGNITIVE MEASURE FOR THE OLDER ADULT POPULATION IN THE HAI DISTRICT OF NORTHERN TANZANIA

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Introduction: Cognitive decline is rising globally among ageing populations, disproportionately affecting low- and middle-income countries. Standard cognitive assessments face challenges in culturally diverse settings. Verbal fluency (VF) tasks, which require generating words based on specific criteria within a set time, have been adapted across cultures, valued for their brevity and ability to detect early cognitive impairment.

Aim: To assess the feasibility and validity of VF tasks in Hai district, northern Tanzania, by evaluating refusal rates, construct validity, and criterion validity. We hypothesise that higher VF scores are associated with lower age, female sex, higher educational attainment, and higher Identification and Intervention for Dementia in Elderly Africans (IDEA) screen scores.

Method: This study, conducted from February to May 2024, recruited 126 participants aged 60 or over using convenience sampling from two villages. VF tasks were adapted to local context using community feedback. Feasibility was assessed through refusal rates, construct validity through correlations with demographic and clinical variables, and criterion validity by comparing VF scores with the IDEA screen cut-off for probable dementia.

Results: Phonological fluency tasks had the highest refusal rates (9.52% to 13.49%). VF scores significantly correlated with age, years of education, grip strength, Clinical Frailty Scale scores, and IDEA screen scores. The area under the receiver operating characteristics curve ranged from 0.713 (market-item) to 0.897 (words beginning with C).

Conclusion: VF tasks demonstrated acceptable feasibility, promising construct validity and fair accuracy in detecting probable dementia. The high specificity of words beginning with C, animal, and verb naming tasks suggests their potential as clinical tools for ruling out cognitive impairment.

POSTER

Scientific Presentation - Psychiatry and Mental Health

3701. *HOLDING ON TO ME* IN THE CONTEXT OF DEMENTIA: A CLASSIC GROUNDED THEORY

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Background: Within the literature, there is much debate regarding the loss or persistence of self in the context of dementia, particularly advanced dementia. Yet there is a lack of consensus as to what constitutes self. Additionally, sense of self for people with dementia can be vulnerable to the attitudes of others, impacting how others see them and how they see themselves. This has implications for person-centred care and support, wellbeing and autonomy.

The aim of this study was to generate a theory, explaining how people with dementia process or resolve issues relating to sense of self, understood primarily in terms of their main concern of losing me .

Method: Classic Grounded Theory methodology was used to achieve the study aim. Concurrent data collection and analysis consisted of 26 semi-structured interviews and six autobiographies written by people living with dementia. Person and Public Involvement (PPI) was used to enhance relevancy, robustness and meaningful engagement with people with dementia.

The theory of *Holding on to Me* was generated and consists of three main properties: *Holding Tighter*, where individuals hold tighter to the core elements of themselves, who and what has meaning for them. *Letting Go*, where individuals let go of certain aspects of their lives they can no longer manage or control in order to hold on to their overall sense of self. Finally, individuals engage in *Relational Grappling*, sustaining and forging connections that assist in achieving their goals, whilst balancing these relationships with maintaining sense of self and independence.

Conclusion: This research provides a multivariate theory of how people living with dementia hold on to their sense of self. It offers valuable insights for families, caregivers, healthcare providers, and policymakers, in terms how the self can be recognised and supported in dementia. This in turn enhances wellbeing, promotes independence and autonomy and reduces excess disability. This is essential to ensuring care and support is person centred and people with dementia have active involvement in their lives.

POSTER

Scientific Presentation - Respiratory

3350. FIRST DECAF SCALE STUDY PREDICTING MORTALITY IN ACUTE COPD EXACERBATIONS IN LATIN AMERICAN GERIATRIC PATIENTS

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Introduction: Acute exacerbations of chronic obstructive pulmonary disease (AECOPD) represent a significant cause of hospitalization and mortality, particularly among geriatric populations. The DECAF score (Dyspnea, Eosinopenia, Consolidation, Acidemia, and Atrial Fibrillation) has emerged as a simple and validated prognostic tool to predict in-hospital mortality in patients with AECOPD. However, its application has not been previously studied in Latin American geriatric populations, where demographic, clinical, and healthcare system differences may impact outcomes.

Method: A retrospective observational cohort study was conducted using clinical records from patients aged 65 years or older admitted for AECOPD to a high-complexity hospital in Colombia between 2016 and 2020. DECAF scores were calculated based on admission data. Demographic characteristics, comorbidities, laboratory values, and radiologic findings were recorded. The primary outcome was in-hospital mortality. Descriptive statistics, logistic regression, and ROC curve analyses were used to assess the relationship between DECAF score and mortality.

Results: A total of 130 patients were included, with a mean age of 82 years (SD ±7.9), and 53.8% were male. Overall, in-hospital mortality was 15.4%. A stepwise increase in mortality was observed with higher DECAF scores: 0% in the low-risk group (0–1 points), 11.9% in the intermediate-risk group (2 points), and 54.2% in the high-risk group (≥3 points). The DECAF score showed strong discriminative ability with an area under the ROC curve (AUC) of 0.84 (95% CI: 0.76–0.91). At a threshold of ≥3, sensitivity was 90% and specificity was 72.5%.

Conclusion(s): The DECAF score demonstrated robust predictive performance in this Latin American geriatric cohort, confirming its utility as a practical and reliable tool for risk stratification in hospitalised AECOPD patients. Its implementation could aid clinical decision-making and optimize resource allocation in similar healthcare settings.

POSTER

Scientific Presentation - Respiratory

3804. REDUCED HOSPITAL-ASSOCIATED HARMS IN OLDER ADULTS TREATED WITH IV ANTIBIOTICS VIA HOSPITAL AT HOME: A RETROSPECTIVE COHORT STUDY

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Introduction: Hospital at Home (HAH) is an admission avoidance service where patients receive hospital-level care in their own homes. We conducted a retrospective cohort study to compare patient outcomes in older adults with community-acquired pneumonia (CAP) treated through HAH versus an acute frailty ward in hospital. HAH patients received once daily IV ceftriaxone whereas hospital inpatients were prescribed IV antibiotics as per hospital guidelines.

Method: All patients diagnosed with CAP requiring IV antibiotics under HAH and on an acute frailty ward were identified between January and December 2024. 52 patients discharged from hospital to HAH for continuing treatment of CAP were excluded from analysis. 12 HAH patients admitted to hospital during their HAH admission were also excluded from analysis.

Results: 64 HAH patients (mean age 85 years, average clinical frailty score of 7) and 108 hospital inpatients (mean age of 85 years, average frailty score of 5) were treated for CAP during the study period. Mean National Early Warning Score (NEWS) on admission was 4 for HAH patients compared to 3 for patients presenting to hospital. Average length of IV antibiotic treatment was 4 days under HAH and 5.5 days in hospital. Average length of stay for patients treated under HAH was 4 versus 14 days in hospital. 17% HAH patients developed an AKI compared to 25% of hospital inpatients. 9% HAH patients developed delirium whilst under HAH compared to 37% inpatients during their hospital stay. 33% HAH were palliative compared to 12% inpatients. 12-month mortality rate of HAH patients was 59% compared to 34% inpatients.

Key Conclusion: HAH offers an effective alternative to inpatient care for older adults with CAP, with shorter treatment duration, fewer complications, and reduced hospital stay. Higher mortality likely reflects greater frailty and palliative focus in the HAH cohort, as opposed to reduced care quality.

AUTHORS' INDEX