British Geriatrics Society
Improving healthcare for older people

BGS Cymru

Wales Spring Meeting 2020

19th- 20th March 2020

Location

Wrexham Medical Institute

Contents

The British Geriatrics Society acknowledges with grateful thanks, the support given through sponsorship from:

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@GeriSoc #BGS Conf

Welcome from the organising committee

On behalf of the organising committee, we offer you a very warm welcome here in Wrexham for the 2020 BGS Wales Spring meeting.

We aim to offer you a varied and clinically relevant programme and are immensely grateful to those speakers who are coming to share their expertise. Whatever your professional background, area of special interest and expertise or level of experience, we hope you will find something to inform and stimulate further discussion because we believe this is the way we will continue to improve care for our ageing population.

Please join us for the social part of the programme: we are honoured to welcome Prof Tahir Masud, BGS President to speak, we will have memories from a Bollywood Movie Maker from Mr Nikhil Kaushik and music and dancing from Dr Lister's band. We hope you leave us remembering that strangers are just friends we haven't yet met.

Update and Welcome from Sandip

Welcome to Wrexham BGS (Wales). There are few firsts in this spring meeting for Wales. Most of the credit goes to organisers (Walee & Sam) as well as our efficient Secretary Karl.

We have for the first time as far as I remember in BGS (Wales) abstract book for the conference. This certainly gives added dimension to all those SpR and trainees displaying posters and platform presentations. It also gives members an opportunity to reference their work before and after the conference. Credit goes to Karl for compiling it.

We also have for the first time annual general meeting for BGS (Wales), which is a requirement for BGS as a charity and although our previous business (council) meeting served this purpose as a surrogate, this time agenda and minutes have been circulated and items for discussion agreed formally.

I must also point out that there is an important discussion about Glyn Penrhyn Jones fund and we are hoping to use part of this fund towards promoting positive image of ageing in Wales through high quality art competition and prizes every year. Credit for this goes to Susan.

As a chair into my second year I have been to three trustees meeting in London and gained valuable insight into working and planning of BGS as well as strategic plan for 2020-25. I have monthly telephone chat with our very able CEO Sarah at Central BGS and like to see her again possibly in our autumn meeting in Wales.

I would like to request our members to encourage and motivate all our trainees to become BGS members and allied health professionals they are in contact with, to boost our Welsh contingent and meetings.

Wish you all a good and enjoyable conference.

Dymunwm gynhadledd dda a difyr i chi i gyd.

Sandip Raha

Chair BGS (Wales)

BGS Wales Council Committee Meeting

Thursday March 19th 2.30 – 4.00 p.m. at Wrexham Medical Institute

1. Welcome and Apologies
2. Minutes of previous meeting at Oxwich Bay Hotel, 5 September 2019:
    - 2.1 Matters arising from minutes
3. Chair's report from BGS (Central)
    - 3.1 Chair's Update
    - 3.2 MSc grant for SpR's
    - 3.3 Nomination for Marjorie Warren Life-time Achievement Award
4. Report from Central BGS
5. Reports from BGS subcommittees:
    - 5.1 Education and Training Committee: Dr Biju Mohamed
    - 5.2 Specialist Training (College Advisors and Trainee Rep): Dr Indarjit/Dr TBA/Dr James
    - 5.3 Academic and Research Committee: Dr Hewitt
    - 5.4 Policy and Communications Committee: Dr James
6. NSAG update: Dr Hewitt
7. Reports on Special Interest Groups
    - 7.1 Stroke: Dr Phil Jones
    - 7.2 Movement Disorders: Dr Sion Jones/Dr Sally Jones/Dr Biju Mohammed
    - 7.3 Falls/Ortho-geriatrics: Dr Swapna Alexander/Dr Karl Davis
    - 7.4 Frailty and Delirium: Dr Shahul Sheriff/Dr James White
8. New consultant appointments, workforce & membership: Drs Morse & Butler
9. SAS doctors: Dr Amer Jafar
10. Arts and Geriatrics prize – the Silver Prize: Dr Susan White
11. Dr Glyn Penryhn Jones Fund: Dr Karl Davis/Dr Graham Boswell
12. BGS Local Funds
13. Cardiff University and MSc in Health Ageing & Disease: Dr Jonathan Hewitt
14. BGS Prize Winners
15. Council succession planning:
16. AOB
17. Future Meetings
    - Autumn: 17-18 Sep 2020: Abergavenny/Newport
    - Spring 2021- TBC – Aberystwyth

Welsh BGS AGM

Notice is hereby given that the 2020 Annual General Meeting of the Welsh Branch of the British Geriatrics Society will take place on Thursday 19 March at Wrexham Medical Institute 62 Croesnewydd Rodd, Wrexham LL13 7YX, commencing at 16.00 (until 16.30) for the purpose of conducting the following ordinary business:

1. To receive apologies for absence.

2. To approve the Minutes of the 2019 Business Meeting held on 5 September 2019 (see paper).

3. To note the BGS Memorandum and Articles of Association (see paper).

4. To approve the BGS Wales Terms of Reference (see paper).

5. To approve arrangements for the Dr Glyn Penrhyn Jones Trust (see paper).

6. To approve arrangements for locally held funds (see paper)

7. To approve the Treasurers Report (see paper).

8. To approve that future AGMs will take place annually at the Spring meeting.

9. To note demitting officers:

Dr Chris James is stepping down as Treasurer. Nominations are invited.

The current Council Committee composition is attached for reference.

10. AOB

11. The 2021 Annual General Meeting will be at the BGS Wales meeting in Aberystwyth (date TBC).

Dr Sandip Raha
Chair BGS Wales
March 2020

Welsh **BGS AGM Agenda and Linked Papers** (Including Proxy Voting Instructions) are available at:

https://www.bgs.org.uk/resources/bgs-wales-agm-2020-papers

Meeting at:	Dinner Reception at:
Wrexham Medical Institute, Croesnewydd Road, Technology Park Wrexham Betsi Cadwaladr University **LL13 7YP**	**Ramada Plaza Wrexham** Ellice Way, Wrexham, **LL13 7YH**

Dr Karl Davis is standing down as Chair of Falls/Fractures SIG.

If you are interested in taking on the role, please contact Dr Davis

<table>
<tr><th colspan="4">Programme Thursday 19 March 2020 – Wrexham Medical Institute</th></tr>
<tr><td>10.30-
12.30</td><td>Stroke Research Meeting
Room: Seminar 3</td><td>9.30 -
12.45</td><td>Trainee’s Meeting
Room: Lecture Theatre

09:30 Psych geriatrics
Dr Sandeep Rao, Consultant Psychiatrist, Betsi Cadwaladr University Health Board</td></tr>
<tr><td colspan="2" rowspan="2"></td><td colspan="2">10:30 Coffee</td></tr>
<tr><td></td><td>10:45 Nutrition
Dr T Mathialahan, Consultant gastroenterologist, Wrexham Maelor Hospital

11:45 Continence management
Mr C Seipp, Consultant Urologist, Wrexham Maelor Hospital</td></tr>
<tr><td colspan="2">13.30 Lunch – Atrium</td><td colspan="2">12.45 Lunch – Atrium</td></tr>
<tr><td>14.30</td><td>BGS Council Committee Meeting

Room: Seminar 4</td><td>13.30–
15.30</td><td>Trainee’s Meeting continues)

Room: Lecture Theatre

13:30 Tissue viability
Dr Lister, Consultant Dermatologist, Wrexham Maelor Hospital

14:30 Palliative Care: case studies with ethical/legal challenges at end of life care
Dr A Shuler, Consultant in palliative care medicine, Glan Clwyd Hospital

At the end of the training session, please attend BGS council meeting in Seminar room 4. Welsh BGS is at 16.00 after the council meeting, please attend.</td></tr>
<tr><td colspan="4">16.00 Annual General Meeting</td></tr>
<tr><td colspan="4">16.30 Coffee – Atrium</td></tr>
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Special Interest Groups: parallel sessions	
17.15 – 19.00 **Joint Falls & Bone Health and Parkinson's Groups** Room: Lecture Theatre	17.30 – 18.45 **Stroke** Room: Seminar 4
17.15 Update from Movement Disorders Excellence Network Dr Sion Jones, Consultant Geriatrician, Betsi Cadwaladr University Health Board **17.25 Parkinson's disease Education and its Value** Ms Pauline Sloan, Senior Physiotherapist, Cwm Taf Morgannwg University Health Board **18.00 Update on the National Hip Fracture Database / National Audit of In-Patient Falls** Dr Antony Johansen, Clinical lead for the National Hip Fracture Database, Consultant Orthogeriatrician, University Hospital of Wales **18.15 Embedding frailty and sarcopenia into falls and bone health services** Prof Tahir Masud, President of the BGS, Professor Nottingham Universities NHS Trust 18.50 Minutes of last meeting & AOB Election of New Chair and Secretary	Chaired By Dr Tom Hughes **Stroke research in Wales** Speaker Jonathan Hewitt Agenda for Discussion: 1. Thrombectomy in Wales 2. Stroke Training in Wales 3. 5-10 Vision for Stroke services in Wales
Dinner and Drinks Reception Ramada Plaza by Wyndham Wrexham	
19:00 Drinks reception 19:30 Speech by Professor Tahir Masud, Consultant Physician at Nottingham University Hospitals NHS Trust (NUH) and President of the British Geriatrics Society (BGS) 20:00 Dinner followed by after dinner speech by Mr Nikhil Kaushik Consultant Ophtolmologist, Wrexham Maelor Hospital	

Programme Friday 20 March 2020 – Wrexham Medical Institute Lecture Theatre	
9.00	Registration
9.15	Chair's Welcome & Wales Council update
9.30	**Session 1** Chaired by Dr Prof A D White **Seniors & Sex** Dr Olwen Williams OBE, Consultant physician in genitourinary/HIV medicine, RCP vice president for Wales and President of BASHH (British Association for Sexual Health & HIV)
10.15	Coffee Break & Poster Viewing Room 4/5
10.45 11.30	**Session 2** Chaired by Dr Sam Abraham **The patient is old, is there any point in calling a nephrologists?** Dr Stuart Robertson, Consultant Nephrologist, Wrexham Hospital **How to deal with impaired capacity** Prof Peter Lepping, Consultant Liaison Psychiatrist, Wrexham Maelor Hospital
12.15	Lunch & Poster Room 4/5
13.15 14.00	**Session 3** Chaired by Dr Sara Gerrie and Dr Salah Elghenzai **Diabetes in Elderly** Dr Anthony Dixon, Consultant Physician endocrine and Diabetes **Platform presentations**
15.00	Coffee Break and poster Judging Room 4/5
15.30	Prize presentation and Training

CPD Accreditation: This meeting has applied for 1 CPD credit for Thursday 19th March and 5 CPD credits for Friday 20 March 2020

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Speaker's biographies

Prof Tahir Masud

Professor Masud trained at University of Oxford and St Bartholomew's Hospital, London. After postgraduate training in London and Newcastle-Upon-Tyne and a Research Fellow post in St Thomas' Hospital, London he took up a position of Consultant Physician in General and Geriatric Medicine at Nottingham in 1994. He has a research and clinical interest in osteoporosis, falls and syncope and has published widely in these areas. He heads the Clinical Gerontology Research Unit at Nottingham University Hospitals NHS Trust. He has previously been a scientific advisor to the National Osteoporosis Society and is the main organiser of the annual International Conference on Falls and Postural Stability. He has also served as the Clinical Sub-Dean at the University of Nottingham Medical School. He also has Honorary/Visiting Professorships at the Universities of Nottingham, Derby and Southern Denmark. He is the former President of the European Union of Medical Specialists-Geriatric Medicine Section and is the current President of the British Geriatrics society.

Mr Nikhil Kaushik

Mr Nikhil Kaushik is a Consultant Ophthalmologist based at the Wrexham Maelor Hospital, since 1987. He is a general Ophthalmologist with interest in Cataract and External Eye Disease. Passionate about medical education for the undergraduates, he has produced several teaching aids for Junior Doctors and medical students. He has mentored several junior Doctors and offered junior trainee posts to beginners in Ophthalmology.

Besides medicine he has interest in arts, is a poet, writes regularly on social and medical issues. He has produced several documentaries and also a Feature film "Bhavishya- The Future", that explores the issue of medical migration.

I was the future once!

In this talk Mr Kaushik will reflect on the virtues of the NHS. He believes that the NHS gets an unfair criticism and would like the young doctors of today to extol the virtues of the NHS and feel proud of its achievements. He will include some aspects of the feature film that he directed and produced, the film explores professional migration particularly in respect of Global health.

Dr Stuart Robertson

Dr Robertson graduated from the University of Edinburgh before undertaking further training in GIM & Nephrology in Wales. He has a special interest in immunology and transplantation and completed a 3-year research fellowship in Children's Hospital and Harvard University, Boston in 2005. He was appointed as a consultant nephrologist in Wrexham in 2007.

The Patient is Old - Is There Any Point in Calling a Nephrologist

What nephrology should and should not offer the older, frail patient

Prof Peter Lepping

He is a clinical psychiatrist and researcher who was appointed as Consultant Psychiatrist in Wrexham Maelor Hospital in 2004 where he still works. He is Honorary Professor at Bangor University, North Wales, and Mysore Medical College and Research Institute, India. Since 2009 he has worked closely with Professor Rob Poole and Professor Catherine Robinson in the Centre for Mental Health and Society.

He went to University in Münster (Westphalia). He moved to Britain in 1995 and did his postgraduate psychiatric education in and around Liverpool. He has always had an interest in the interface between psychiatry and medicine and obtained accreditation as an adult and a liaison psychiatrist. He received a Master's in Medical Ethics from Liverpool University in 2003 and won several research prizes. He worked as an Associate Medical Director for clinical ethics in North Wales for several years. He has contributed to a number of books and published 160 research articles.

How to deal with impaired capacity

Overview of capacity, prevalence of impaired capacity, legislative frameworks and management strategies

Dr Anthony Dixon

Anthony qualified from the University of Southampton in 1994 and after house jobs moved to Chester to do SHO training. He completed Specialist Registrar training in the West Midlands and during this time achieved an MD in Type 2 Diabetes in Individuals of South Asian Origin. Anthony has been a Consultant Physician at the Wrexham Maelor Hospital since 2007 and has been College Tutor there since 2018.

Dr Olwen Williams

During Olwen's tenure as Betsi Cadwaladr University Health Board's chief of staff, she obtained an in-depth understanding of the complexities and challenges of delivering whole-system change across planned, unplanned and community care within the context of targets and financial constraints. As clinical lead for the RCP's Future Hospital development site project, she supported the introduction of telemedicine virtual clinics.

In her clinical work, Olwen has striven to ensure the vulnerable have access to high-quality healthcare, establishing services for sexual assault referrals, prison sexual health and virtual outpatients. She has worked closely with the Welsh government throughout her career and advised on development of the Welsh sexual health strategy, HIV delivery and issues regarding sexual assault and domestic violence. Physicians working with the socially excluded need a voice on Council, she believes, especially at times when some services are under local authority control.

She is currently president of the British Association for Sexual Health and HIV and a member of the RCP Joint Specialist Committee for Genitourinary Medicine (GUM), co-writing the specialty's chapter in Medical Care. Olwen is also a member of the RCP Wales strategic committee and the RCP Quality Improvement Faculty.

In 2005 Olwen received an OBE for services to medicine.

Seniors & Sex

Aging is not a reason for becoming sexually inactive, but often it's an area that is ignored & avoided as a topic for discussion by clinicians. My talk will cover aspect of sexual health including STIs & HIV, highlighting some of the pitfalls and empowering the clinician to address sensitive topics.

Abstracts

CQ - Clinical Quality - CQ - Patient Safety [ ]

A VTE risk assessment compliance audit on Morris Ward, Wrexham Maelor Hospital, BCUHB

Reshma Maraj

Wrexham Maelor Hospital, BCUHB East

Introduction

VTE is an important but preventable cause of death and morbidity in hospitalised patients in the UK. It is associated with considerable cost to the NHS. In 2008-2009 there were 176 reported cases of VTE in hospital inpatients in East BCUHB.

Method

A retrospective study was used to perform this audit on Morris Ward in Wrexham Maelor Hospital between 16/12/2019 and 20/12/2019. All inpatients during this period were included. However, patients currently on Acute Coronary Syndrome treatment, on palliation or without all available patient notes or drug charts from admission were excluded. The drug charts, patient notes, and nurse handover sheets for each patient were reviewed. A data collection proforma was used to collect information on each patient including: weight, platelet count, renal function, mobility status, documentation of assessments, date, type of and appropriateness of VTE pharmacological prophylaxis prescribed.

NICE guideline NG89 was the standard used for this Audit.

Results

The audit included 29 patients and showed that 86% were appropriately prescribed or not prescribed VTE pharmacological prophylaxis on the date of the audit. However, 10% of the patients were not prescribed VTE prophylaxis when they needed it and a further 4% were prescribed the wrong dose. This audit also showed that only 7% of the patients had VTE and Bleeding risk assessments documented. Furthermore, only 48% of the patients had their VTE prophylaxis prescribed within the first 24 hours after admission. It was shown that up to the time of the audit, only 27.6% of the patients were weighed.

Conclusion

While there is inadequate documentation of VTE risk assessment on the medical ward, there is better compliance with the prescribing of VTE prophylaxis.

CQ - Clinical Quality - CQ - Clinical Effectiveness

Evaluating the use of Parkinson's Kinetigraphs in patients with Parkinson's and frailty

L Evans 1, M Shukir 2, A Abdullah 2

1. Movement Disorder Service, University Hospital of Wales
2. Cardiff University

Introduction

Our Geriatrician-led Movement Disorder clinic has over 18 months experience in using the Parkinson's Kinetigraph (PKG). This wrist worn device collects data on the motor signs in Parkinson's Disease (PD) generating metrics in an online report, bradykinesia score (BKS) is one example. Studies suggest use of the PKG can improve patient outcomes; one recommendation is increasing treatments to achieve a target BKS of 18.6 (Farzenehfar P, NPJ Parkinsons Dis 2018). Our clinic cohort has a higher prevalence of frailty than a Neurologist-led clinic, such as that in the study. This service evaluation looks at our use of the PKG, specifically in frailty.

Methods

60 patients had recent PKGs as part of routine clinical care. The results and demographics were recorded. Rockwood clinical frailty scale (CFS) and Charleston co-morbidity index (CCI) were calculated using clinic letters.

Results

Of the 60 patients, 5 had a CFS ≥ 5 and are thus considered frail. Mean age was similar in both groups, 72 in the frail and 71 in the non-frail. Mean BKS was higher in the frail group, 36.7 and 31.7 respectively (p=0.329). Of the 60 patients, 19 had a CCI ≥4. Those with more co-morbidities had a significantly higher BKS than those with CCI of less than 4 (35.8 compared to 30.5, p= 0.016).

Conclusions

Frailty is not a barrier to our patients having access to a PKG. There is a suggestion that patients who are frail have higher bradykinesia scores. Using cumulative co-morbidities as a surrogate marker for frailty, we have shown that those with more co-morbidities have higher bradykinesia scores. If being frail in itself can increase the BKS independently of the PD motor symptom control, then the "treat to target" method may not be as beneficial to people with frailty.

1 Farzanehfar P, Woodrow H, Braybrook M, McGregor S, Evans A, Nicklason F, Horne M. Objective measurement in routine care of people with Parkinson's disease improves outcomes. NPJ Parkinsons Dis. 2018; 3;10

https://www.ncbi.nlm.nih.gov/pubmed/29644334

CQ - Clinical Quality

Recording of Weight in Hospital Inpatients

Matthew Howard. Princess of Wales Hospital, Cwm Taf Morgannwg University Health Board

Background

Weight is a key parameter in the care of hospital inpatients, with a number of uses including drug dosages, ascites, heart failure and nutrition monitoring.

An initial audit was performed on 05/10/2019, including 47 patients across two wards including medical, surgical and gynaecology patients at Princess of Wales Hospital, Bridgend. All documentation was checked for an up to date weight.

Of the 47 patients, only 27 (43%) had an accurate weight recorded. Medical patients yielded the worst results, with only 4 out of 21 patients having an up to date weight recorded. Only 20 patients had a weight recorded on the drug chart.

Table 1: Results of initial audit

Speciality	Number	Drug chart	Health Board nursing documents	Weight chart	% without weight recorded
Medical	21	4	0	0	17(81%)
Surgical	23	14	0	14	9 (39%)
Gynaecology	3	2	0	0	1 (33%)
Total	47	20	0	14	27(57%)

Following the initial results, two suggestions were made to ensure patients were being weighed. The first was a dedicated weight round to be undertaken on a regular basis. The patient information board was also altered to incorporate a weekly weight column. In order to monitor response to these suggestions, a second audit was undertaken including 47 patients across the same wards.

Table 2: Results of second audit

Speciality	Number	Drug chart	Health Board nursing documents	Weight chart	% without weight recorded
Medical	20	2	0	14	4(20%)
Surgical	23	19	0	19	4(17%)
Gynaecology	4	2	0	0	2(50%)
Total	47	23	0	33	7 (15%)

However, this still falls short of the target expected. Some reasons for this include:

- Some drug charts had been re-written, and the accurate weight had not been transferred across
- 3 patients were new admissions
- 2 could not be weighed for medical reasons, such as patients on bed rest for fractured neck of femur

This still does not meet the standards set at the start of the audit, but improvements have been made. If these improvements are maintained, it will have a range of benefits, including accurate doses of medications. Not only will this positively benefit the patient, but make it easier for staff as well.

References

Lees, L, Allen-Mills G (2009) Auditing the nursing standard for weighing patients on an acute medical unit. *Nursing Times*; 105: 27, 12-13

National Institute for Health and Care Excellence (2006) *Nutrition Support in Adults: Oral Nutrition Support, Enteral Tube Feeding and Parenteral Nutrition*. London: NICE.

A QIP ON IMPROVING MANAGEMENT OF INTRACEREBRAL HAEMMORHAGE AT A LOCAL DGH

Ysanne Clark, Christopher Jones, Jason Ray, Nibu Thomas, Rhian Owen, Linda Rowlands, Laura Roberts and Salah Elghenzai.

Department of Geriatric Medicine and Stroke Medicine, Ysbyty Gwynedd, BCUHB

Introduction

NICE guidance is clear about recommendations on patients presenting with acute intracerebral haemorrhage (ICH). Target systolic blood pressure (SBP) of 130 to 140 mmHg should be achieved within 1 hour of starting treatment for 7 days. Anticoagulation should be reversed. Local guidelines recommend that patients should be discussed with the local neurosurgery centre if modified Rankin Scale (mRS) <3, hydrocephalus, Glasgow Coma Scale (GCS) <9 or presence of posterior haemorrhage. We performed an audit to assess how compliant our district general hospital (DGH) was with these guidelines.

Method

Information was obtained from case notes of 18 patients admitted to the acute stroke unit with ICH from 4th October 2019 to 16th February 2020. Data was entered into a proforma and analysed using statistical software.

Results

1 patient with insufficient data was excluded. Data from the remaining 17 patients were analysed. Of 12 patients (70.6%) who had elevated SBP on admission, 4 (33.3%) were treated, 1 (25%) achieved SBP < 140 mmHg within 1 hour and 3 (75%) achieved this within 6 hours. 1 patient was on warfarin which was reversed. 2 patients on NOACs were not treated with reversal agents. 13 patients (76.5%) were discussed with neurosurgical tertiary centre, only 5 of which (38.4%) met criteria for discussion. Of 4 patients not discussed, 1 met criteria for discussion but not done as patient was palliated. 8 patients died.

Conclusions

We missed the opportunity to correct blood pressure in 66.6% patients presenting with ICH who met criteria. Of 4 treated, SBP was corrected to below 140mmHg, although 3 out of 4 were outside of the 1 hour recommended by NICE. Anticoagulation reversal decisions were appropriate. Most patients discussed with neurosurgery did not meet the local criteria for discussion. In future, we intend to design a proforma, update the local guidance and publicise it. This will focus on achieving target blood pressure and ensuring patients are not unnecessarily discussed with the neurosurgical centre resulting in huge loss of time with increased workload.

CQ - Clinical Quality - CQ - Clinical Effectiveness

Assessing the use of Urinary Catheters in patients presenting with fracture Neck of Femur

Dr Susan Tucker Geriatrics SpR
Dr A. Johansen, Orthogeriatrics Consultant

University Hospital of Wales, Cardiff

Introduction

Urinary catheters are frequently used in the care of patients presenting with Hip Fractures but are associated with adverse outcomes such as UTI, Delirium and longer length of stay. Current guidance recommends that catheters be inserted for precise urine output measurement, wound management, and urinary retention. Catheters should be reviewed daily and removed as soon as no longer indicated. I undertook an audit to ascertain if we were appropriately inserting urinary catheters and if we were removing them promptly.

Method

Spot audit on patients admitted with a Fracture Neck of Femur on the T&O wards in University Hospital of Wales and University Hospital Llandough

Results

55 patients had a diagnosis of fracture Neck of Femur, 12 were catheterised. 42 % for urinary retention, 17% long term catheters, 8% haematuria and 8% Acute Kidney Injury. 25% No documented reason

Average duration 9.6 days (range 2-17) 3 Patients had not had a TWOC at the time of audit. The majority of patients who were suitable for a TWOC, underwent one (78%), average time to TWOC was 8.8 days (Median 10.5)

Conclusion

The Audit shows that our reasons for insertion are not always in accordance with current guidance and our documentation is poor. It also shows that there is scope for earlier removal of catheters.

To take this forward, catheter insertion and removal has now been included in the Patients admitted with suspected Hip Fracture Admission and Pre-Operative Care Clerking Proforma which also includes a Day 1 Post-op check list, and it is also being incorporated into an ongoing project to create and implement a Day 3 Post-Op checklist (in Hip Fracture patients) to improve care.

SP - Scientific Presentation

Muscle matters: current knowledge and clinical practice of sarcopenia diagnosis in physiotherapists in Ireland and Wales.

K Thomas, C Hayes, I Jameson, I Alghamdi

Cardiff University

Introduction

Sarcopenia is “an age-associated loss of skeletal muscle function and muscle mass, common in older adults”. An estimated 5-20% of people aged 65 and older have sarcopenia. The International Clinical Practice Guidelines for Sarcopenia (ICFSR) have published recommendations on detecting, diagnosing and treating sarcopenia. However implementation of the existing recommendations is poor. This study aims to explore the current knowledge, clinical practice and barriers to sarcopenia diagnosis among physiotherapists in Ireland and Wales.

Methods

Physiotherapists in Ireland and Wales were asked to complete a survey. A 10-point questionnaire was disseminated through the Irish Society of Chartered Physiotherapists (ICSP)(n= 265) and the NHS Welsh Physiotherapy Leaders Advisory Group (WPhLAG) (n= 375). Data were analysed by Microsoft Excel and Stata Statistical Software.

Results

The survey response rate was 17% (n= 111). Reassuringly 78% (n= 86) of physiotherapists reported that understanding sarcopenia was relevant to their practice. Yet, 33% (n= 37) rated their knowledge of sarcopenia competent. Additionally, only 16% (n=17) were aware of the ICFSR guidelines. Routine screening/diagnosing of sarcopenia took place by 11% (n=12) respondents. The most reported measures to diagnose sarcopenia were clinical impression 38% (n=42), timed get up and go 36% (n=40), 5 x sit to stand test 32% (n=35) and handgrip dynamometer 24% (n=26). Barriers to screening/diagnosing sarcopenia were lack of confidence 39% (n=42), and lack of awareness among other healthcare professionals 32% (n=35).

Conclusions

Whilst Physiotherapists have an awareness of sarcopenia, evidence based practice is limited. Barriers need to be addressed to improve diagnosis and treatment.

CQ - Clinical Quality - CQ - Clinical Effectiveness

Barriers to Mobilisation Day One post Hip Fracture: A Welsh Perspective

Denise Thomas; Edel McDaid; Shannon Costello; Pattamawan Janon, Lynwen Williams

Glangwili Hospital, Hywel Dda University Health Board, Carmarthen

Introduction

Performance indicator 4 on the National Hip Fracture Database (NHFD) is mobilisation day one post-surgery. Early mobilisation leads to better outcomes (Dubljanin-Raspopovi et al., 2013; Hirose et al., 2010). Nationally 80.5% of patients are mobilised the day after surgery compared to 77% in Ireland and 72.1% in Wales (NHFD Report 2019, IHFD 2019). Barriers to mobilisation have not been widely recorded to date. NHFD 2018 reported that 9.4% of patients were unable to mobilise day one due to pain or low blood pressure. Fatigue and hip fracture-related pain have also been cited (Munter et. al 2017). Of note, one quarter of hip fracture patients experience post-operative delirium (NHFD Report 2019) impacting mobilisation.

Method

1. To compare rate of mobilisation day one in Glangwili Hospital (GGH) with national average

2. To identify barriers to day one mobilisation in GGH

A retrospective review was completed on the hip fracture database for GGH patients. Data was anonymous and maintained for service evaluation and contribution to National databases. This database also cites reasons for not mobilising. Barriers were analysed using Microsoft Excel.

Results

In 2018, 70.8% of patients were mobilised on the first post-operative day in GGH. The main reasons for not mobilising were Low Blood pressure and Haemoglobin (31.8%) and Pain (20.9%). Delirium was the primary reported barrier in 3% of cases.

Conclusion

Glangwili Hospital is below national average for day one mobilisation post hip fracture surgery. Low Blood pressure, low haemoglobin and pain are the primary reported reasons. Further exploration of the impact of these factors on mobilisation rates and overall patient outcome is needed. The limitation of this study was that only primary cause was recorded and secondary co-existing factors were not accounted for. An enhanced recording system may provide a more comprehensive understanding of the early mobilisation barriers.

SP - Scientific Presentation - SP - Education / Training

Improving the quality of electronic discharges from medical wards: A quality improvement project

G Davies, S Kean, I Chatterjee

Glan Clwyd Hospital
Contact; gdav19@doctors.org.uk

Introduction
Electronic discharges (E-discharges) can often be incomplete or inaccurate, particularly for frail, older people with complex medical and social issues. Following a hospital admission, the E-discharge is the main communication between secondary and primary care and can also be the only source of information available immediately when patients re-present. Junior doctors writing E-discharges have little training in this key skill and rarely receive feedback or supervision.

Method
We conducted a retrospective audit assessing the quality of E-discharges from all medical wards. Local GPs were involved in identifying areas for improvement. A series of E-discharge workshops were then conducted which involved a teaching session followed by a practical session. Crib sheets were emailed to all junior staff and posted on all medical wards. The PDSA cycle was subsequently completed.

Results
Audit 1 demonstrated adequate quality in all areas in only 21% of E-discharges. There were major inadequacies in test results, diagnosis and 'progress in hospital' sections. 35 junior doctors attended the three one-hour workshops, with 97% stating their practice would change following the workshops. Audit 2 demonstrated improvements in most areas, with 35% adequate quality in all sections, however this improved to 55% in those who had attended the workshops. There was also a significant decrease in the number of job requests for GPs.

Conclusions
E-discharge workshops are effective in improving the quality of discharge summaries. However, there are challenges in rolling out the workshops, including the practicalities of reaching all professionals who are involved in writing E-discharges (including ANPs, PAs and non-training grade doctors). Introduction of mandatory sessions during hospital induction and junior doctor inductions would be beneficial to teach this important yet challenging skill.

CQ - Clinical Quality - CQ - Clinical Effectiveness [ ]

The New Mobility Score as a Predictor of Post-acute Rehabilitation Outcome

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Introduction:

High New Mobility Score (NMS) is associated with return to mobility and discharge home from acute care post hip fracture (Kristensen et al 2010). A Cumulated Ambulation (CAS) score of 6 is indicative of successful return to mobility and function. The Irish Hip Fracture Database report NMS and CAS scores from acute care. However little is known about the application of these measures in an Irish post-acute rehabilitation setting. This study aimed to identify the NMS and CAS scores of patients admitted to offsite post-acute rehabilitation and determine if these measures were associated with discharge mobility status and destination.

Methods:

A retrospective data review was completed for patients admitted post hip fracture in 2019. Data was anonymized and collected as part of service evaluation. CAS was recorded on admission, at day 30 and at discharge as well as NMS. Data was analysed using Microsoft Excel.

Results:

72(49 female; mean age; 82.3 years) participants were used in this study. 93% (n=68) of participants (93.1%, n=68) were discharged home. 61.1% (n=44) had a high pre-fracture mobility status (NMS >6). A high NMS was associated with return to independent mobility (CAS=6) upon discharge. CAS on admission to rehab was significantly correlated with length of rehab stay (R2=0.99). Reduced time to transfer to rehabilitation was significantly correlated with regaining independence with mobility on discharge (R2=0.98).

Conclusion:

Most participants requiring offsite rehabilitation had a high NMS which was associated with independent mobility on discharge. Reduction in the time to transfer from acute care to post-acute care may result in improvements in discharge mobility status. Further research is needed to identify the early indicators of need to transfer to offsite rehabilitation to ensure optimal use of this intervention post hip fracture.

QIP using the Modified Short Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE) in improving quality of collateral history-taking for new admissions

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Introduction

Collateral history taking is often required as part of the medical clerking especially in older adults or confused patients who may not be able to provide accurate information on their baseline cognition, mobility status and social support status. Currently, there is no standardised proforma used to gather this information. This delays planning for patient's care and discharge. We hope to come up with a standardised, user friendly and accessible proforma that can be used to collect collateral history regarding patients' baseline.

Method

We modified the IQCODE to include more information not just on patient's cognition, but also on patient's mobility and social support. The proforma is not meant to replace cognitive assessment tools used by a clinician to assess patients.

Over the period of 3 months from October 2019 to December 2019, we distributed the proforma to patients' relatives to collect collateral history regarding patients. We also compared the new information that was gathered by using this questionnaire with information that was already available from clerking.

Results

Information on cognitive decline improved from 10% to 100%. Information on mobility status improved from 90% to 100%. Information obtained about social support status improved from 35% to 100%.

Conclusion

We noticed that there is a sizeable information gap between the traditional method and our standardised approach. This gap may be due to many reasons like time constraints of the healthcare professional, knowledge gap about questions to be asked or the lack of a reliable informant. The advantage of using this questionnaire is that it can be filled up by the next of kin without taking up more of the clinician's time and the information will be readily accessible at different points of patient care (such as prompting delirium pathway, assisting therapists and organising discharge).

We hope that the use of this questionnaire may also aid in improving patient care, patient flow and preventing unnecessary readmissions.

Directions

Wrexham Medical Institute

Technology Park Centre

Croesnewydd Road

Wrexham

LL13 7YP

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DRIVING DIRECTIONS

- North
  Leave M6 at Junction 20 & Join M56 direction of Runcorn/Chester North Wales. Leave M56 at Junction 11 & join M53 direction Chester/Wrexham. Leave M53 at Junction 12 & straight ahead on A55, off A55 exit for A483 Wrexham taking the first exit at the roundabout. Continue on A483 over the roundabout sign posted Wrexham. Come off at Junction 5 sign posted A541 Wrexham/Mold & take the first exit at the roundabout. Take the third exit off next roundabout onto the Berse Road. B&Q on the right and then 350 yards take the first exit off roundabout into Rhyd Broughton Lane. The Ramada Plaza Hotel is on the left hand side. At the next mini roundabout, take the second exit off and follow the road round the corner and the Medical Institute is on the right-hand side.

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  Leave M6 at Junction 10a & straight ahead on to M54 direction North & Mid Wales Wolverhampton & Telford. Leave M54 at Junction 3 and straight ahead onto A41 direction Weston & Whitchurch, continue straight & take 1st exit off roundabout onto A534 St Georges Crescent turn right onto A541 Regent Street. 1st exit off roundabout B5101 Berse Road B&Q on right and then after 350 yards take first exit off roundabout into Rhyd Broughton Lane. The Ramada Plaza Hotel is on the left hand side. At the next mini roundabout, take the second exit off and follow the road round the corner and the Medical Institute is on the right-hand side.

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  Take A547 Conway road, second exit off roundabout A55, continue straight until next roundabout & take third exit off A483 over the next roundabout sign posted Wrexham. Come off at Junction 5 sign posted A541 Mold/Wrexham& take the first exit at the roundabout. Take the third exit off next roundabout B5101 Berse Road B&Q on right and then after 350 yards take the first exit off roundabout into Rhyl Broughton Lane. The Ramada Plaza Hotel is on the left hand side. At the next mini roundabout, take the second exit off and follow the road round the corner and the Medical Institute is on the right-hand side.

- West
  Take M53 which leads onto the A55, off A55 exit A483 Wrexham taking the first

exit at the roundabout. Continue on the A483 over the next roundabout signposted Wrexham. Come off at Junction 5 signposted A541 Wrexham/Mold & take first exit at the roundabout. Take Third exit off next roundabout onto B5101 Berse road B&Q on right and then after 350 yards take first exit off roundabout into Rhyd Broughton Lane. The Ramada Plaza Hotel is on the left hand side. At the next mini roundabout, take the second exit off and follow the road round the corner and the Medical Institute is on the right-hand side

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