

BGS Wales 2020 Autumn Meeting

ABSTRACTS

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CQ - Clinical Quality - CQ - Patient Centredness

Telecommunication simulation training for junior doctors during the SARS-CoV-2 Pandemic - Dr Julia Scaife
Dr Julia Scaife; Dr Angela Puffett

Withybush General Hospital

Introduction

The current pandemic of SARS-CoV-2 has meant even with acutely deteriorating patients, hospital visitors have been extremely limited. Subsequently, the thrust of medical undergraduate and postgraduate training on breaking bad news face to face, although still carrying appropriate principles, needed revisiting to include practice with telecommunication.

Method

Foundation, IMT, and clinical fellows from medicine and surgery were invited to attend small group, facilitated sessions focused on communicating with relatives over the phone. A willing lay person was sourced from a local palliative care charity who has wide experience in advanced care planning; she became the 'acting relative' who was contacted during the sessions. Clinical vignettes were created that would provide the basis for the junior doctors' consultation by telephone over loudspeaker. Following the consultation, the actor was called a second time so that feedback could be given and received. Additionally, the facilitator utilised the small group sessions to allow the workforce, if desired, to share anxieties and concerns and thus provide some wellbeing support.

Result

These sessions of up to 4 doctors were sought after and well attended. They were organised week by week to fit around the actors' availability. This was advantageous, making the sessions more inclusive for the changing shift patterns and new rotas. Qualitative data show doctors benefitted from these 'realistic', 'well organised', 'helpful' sessions. Many attendees mentioned outworking the principles and conversations in ongoing clinical practice, some of whom had never broached escalation of care conversations before.

Conclusion

Responsive clinically relevant teaching and communication sessions remain important to support the medical workforce and equip them for communicating with patients and relatives at a distance. Incorporating peer support and wellbeing strategies into everyday clinical practice should be considered, particularly when facing novel situations and quickly changing local, national and global circumstances.

Training in practice

Communication skills amongst junior doctors within the SARS-CoV-2 Pandemic



J Scaife, A Puffett

Background

The current pandemic of SARS-CoV-2 has meant that even with acutely deteriorating patients, hospital visitors have been extremely limited. Subsequently, the thrust of medical undergraduate and postgraduate training on breaking bad news face to face, although still exhibiting appropriate principles, needed expanding to include practice with telecommunication.

Method

Medical students, foundation doctors, internal medicine trainees and clinical fellows from medicine and surgery were invited to attend small group, facilitated sessions focussed on communicating with relatives over the phone.

A willing lay person was sourced from a local palliative care charity who has wide experience in advanced care planning; she became the 'acting relative' who was contacted during the sessions.

Clinical vignettes were created that would provide the basis for the junior doctors' consultation by telephone over loudspeaker. Scenarios always included a patient with suspected or confirmed SARS-CoV-2 infection and either their clinical deterioration, potential need for ventilatory support, or the patients' escalation and resuscitation status.

After each consultation there was a facilitated debrief with personal, peer and 'actor' feedback. Additionally, the facilitator utilised the small group session to allow the workforce, if desired, to share anxieties and concerns and thus provide some opportunistic wellbeing support.

'The session was well organised with clear objectives'. 'Small group sessions led by SpR's would benefit all trainees.'

'The actor gave a brilliant opportunity to work through scenarios and discuss some of the salient issues arising from breaking bad news over the phone.'

Results

These small group sessions of up to 4 doctors were well attended. They were organised week by week to fit around the volunteer actor's availability. This was advantageous, making the sessions more inclusive for changing shift patterns and new rotas.

Qualitative data shows many of the doctors benefitted from these 'realistic', 'well organised', 'helpful' sessions. 100% 'strongly agree' that the session better prepared them for breaking bad news in the future.

Many attendees mentioned outworking the principles and conversations in ongoing clinical practice, some of whom had never broached escalation of care decisions before.

'A prescient issue. Sensitively and effectively gave us an opportunity to practice and reflect on breaking bad news'

'I have already had to put into practice what I've learnt in this session'

'Realistic simulation session'

Discussion

Responsive, clinically relevant teaching sessions remain important to support the medical workforce and equip them for communicating with patients and relatives at a distance. Simulation training has a growing recognition within the medical curriculum and facilitators can maximise its utility not only in introducing themes and practicing processes and procedure but also in mitigating some of the anxiety junior doctors face when responding to new scenarios. Incorporating peer support and wellbeing strategies into everyday clinical practice should be considered, particularly when facing novel situations and quickly changing local, national and global circumstances.

CQ - Clinical Quality - CQ - Patient Safety

TRIPPER: Trying to Reduce Inappropriate Prescribing in Patients who are Elderly and at Risk of falls - Aedin O'Kane

Aedin O'Kane; Niamh McGarry; Jonny Baillie; Rick Plumb
Care of the Elderly, Belfast City Hospital

Background: Falls in older adults are common, and a major cause of mortality and morbidity. Polypharmacy is associated with a greater number of falls and is prevalent but preventable. The American Geriatrics Society Beers Criteria for Potentially Inappropriate Medication (PIM) Use in Older Adults are used worldwide. This project focused on Table 3 of the 2019 Beers Criteria which recommends an explicit list of PIMs to be avoided in older adults with a history of falls.

Aims: To increase documented discussion about PIMs on discharge letters for elderly patients at risk of falls over a 6-week period.

Method: A retrospective review was undertaken to define baseline data on falls, PIMs and documented discussion of PIMs on discharge letters.

Stickers for Kardexes were introduced to highlight PIMs for review. A table documenting discussion of PIMs was incorporated to discharge letter templates. Data was then collected on falls, PIMs and documented discussion of PIMs on discharge letters over a 6-week period.

Results: Of patients discharged over 10 weeks, 44% had a history of falls. Of patients with a history of falls, 73% were taking at least one PIM pre-admission. Following intervention, the median percentage of discharge letters with documented discussion of PIMs increased from 4% to 30%. Following intervention, there was a greater average reduction in prescribed PIMs on discharge in patients with a history of falls.

Discussion: We confirmed a significant burden of falls and PIMs in our patient population. QIP intervention increased documentation of PIM discussion and reduced the volume of PIMs prescribed on discharge. Communicating PIM discussion on discharge letters encourages deprescribing; informs primary care and future admissions; and promotes patient centred decision-making in this important risk area. Further work includes collecting feedback from primary care and introducing a PIMs review table to discharge letter templates throughout the hospital.

TRIPPER QI Project: Trying to Reduce Inappropriate Prescribing in Patients who are Elderly at Risk of falls



Aedín O’Kane, Niamh McGarry, Jonny Baillie, Rick Plumb
Belfast City Hospital April 2020



Introduction

Falls in older adults are common, and a major cause of morbidity and mortality. Polypharmacy is associated with a greater number of falls. The American Geriatrics Society Beers Criteria for Potentially Inappropriate Medication (PIM) Use in Older Adults recommend medications to be avoided by older adults under specific situations. This project focused on Table 3 of the 2019 Beers Criteria which recommends a list of PIMs to be avoided in older adults with a history of falls.

Aims

To increase documented discussion about PIMs on discharge letters for elderly patients at risk of falls over a 6-week period.

Method

A 4 week retrospective review was undertaken to define baseline data on falls, PIMs and documented discussion of PIMs on discharge letters in a Care of the Elderly ward in Belfast City Hospital. Stickers for Kardexes were introduced to highlight PIMs for review. A table documenting discussion of PIMs was incorporated to discharge letter templates. Data was then collected on falls, PIMs and documented discussion of PIMs on discharge letters over a 6 week period.

Results

Of 172 patients discharged over 10 weeks, 56% had a history of falls. Of patients with a history of falls, 73% were taking at least one PIM pre-admission. Following intervention, the median percentage of discharge letters with documented discussion of PIMs increased from 4% to 30%. Following intervention, there was a 29% average reduction in prescribed PIMs on discharge in patients with a history of falls. This was compared with an 18% average reduction in prescribed PIMs on discharge prior to intervention.

Discussion

We confirmed a significant burden of falls and PIMs in our patient population. Our intervention increased documentation of PIM discussion and reduced the volume of PIMs prescribed on discharge. Communicating PIM discussion on discharge letters encourages deprescribing; informs primary care and future admissions; and promotes patient centred decision-making in this important risk area. Further work includes collecting feedback from primary care and introducing a PIMs review table to discharge letter templates throughout the hospital.

Disease or Syndrome	Drug(s)	Recommendation
History of falls or fractures	Antiepileptics	Avoid unless safer alternatives are not available; avoid antiepileptics except for seizure and mood disorders Opioids: avoid except for pain management in the setting of severe acute pain (eg, recent fractures or joint replacement)
	Antipsychotics ^b	
	Benzodiazepines	
	Nonbenzodiazepine, benzodiazepine receptor agonist hypnotics	
	Eszopiclone	
	Zaleplon	
	Zolpidem	
	Antidepressants	
	TCAs	
	SSRIs	
SNRIs		
Opioids		

American Geriatrics Society Beers Criteria 2019 Table 3: potentially inappropriate medications (PIMs) in patients with a history of falls

Falls and medication review

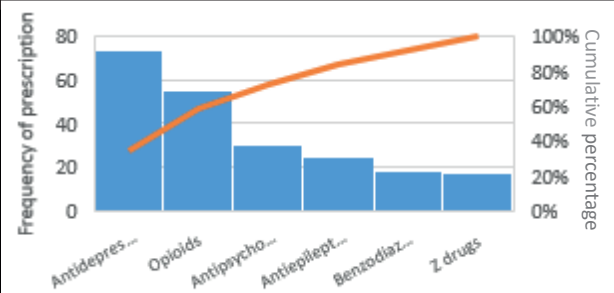
Medicines linked with falls were discussed with the patient/carer and the outcome listed below.

Medication	Outcome*/comment

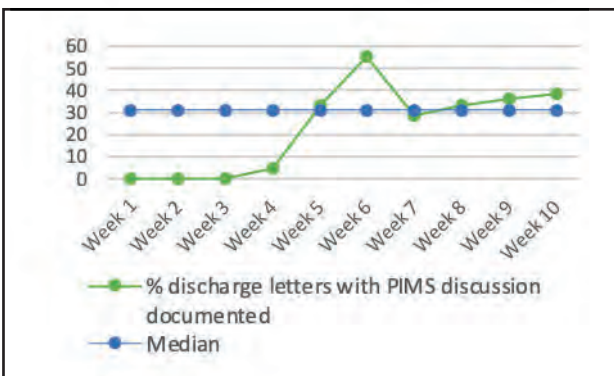
Key*

- The patient acknowledged the risk of falls and wishes to remain on this medicine.
- We have made a change to the medicine, in agreement with the patient.
- We have stopped this medicine, in agreement with the patient.
- Not discussed during admission

PIMs discussion table for discharge letter template



Pareto chart: Total PIMs by class pre-admission



% discharge letters with PIM discussion documented

CQ - Clinical Quality - CQ - Patient Centredness

Virtual Visiting: a tool to tackle loneliness and social isolation for patients in Hospital during the SARS-CoV-2 Pandemic. -Alex Elliott-Green

Alex Elliott-Green; Nicola Pagett;
Aneurin Bevan University Health Board

Introduction:

Aneurin Bevan University Health Board like others in Wales during the COVID-19 pandemic halted visits to prevent transmission of infection. This Quality Improvement (QI) project sought to explore the impact of 'Virtual Visiting' to remotely connect older patients with their families and friends, exploring whether such technology can reduce isolation.

Methods

This QI project involved the evaluation of the uptake of and feedback from a 'Virtual Visiting' programme using smartphones on COTE wards in Nevill Hall Hospital three PDSA cycles in a 3-month period.

Results

During the first PDSA cycle 2 phones were obtained for one ward (4.3). Initial uptake showed a mean of 3.2 calls per day comprising mobile and video calls. Bed occupancy during this period was around 20 beds.

In the second PDSA cycle 'Virtual Visiting Champion' and staff education sessions were introduced; mean calls rose to 13.03 per day with similar occupancy levels, broadly comprising mobile calls.

Patient and staff feedback of Virtual Visiting was positive and during our third PDSA cycle we obtained further phones for ward 4.3 and a further COTE and stroke rehabilitation ward (1.2). Mean calls for ward 4.3 were 6.57 per day (all mobile) while for ward 1.2 mean calls were 7.5 per day, predominantly video-based. Though these rates were lower than cycle two, this likely reflected staff turnover and the arrival of younger surgical outliers.

Conclusion

Virtual Visiting appears effective in connecting patients with their loved ones during a period of increased isolation during the COVID-19 pandemic. The programme was widely utilised with positive comments from patient, staff and relatives. Virtual Visiting appears optimised when each setting has a champion who can design a structure ensuring equal access to devices among patients. Clinical settings should explore the use of such technology, both presently and potentially post-COVID.

Virtual Visiting: to tackle loneliness and social isolation for patients in Hospital during the SARS-CoV-2 Pandemic.

Virtual Visiting: to tackle loneliness and social isolation for patients in Hospital during the SARS-CoV-2 Pandemic.

Alex Elliott-Green and Nicola Pagett
Nevill Hall Hospital

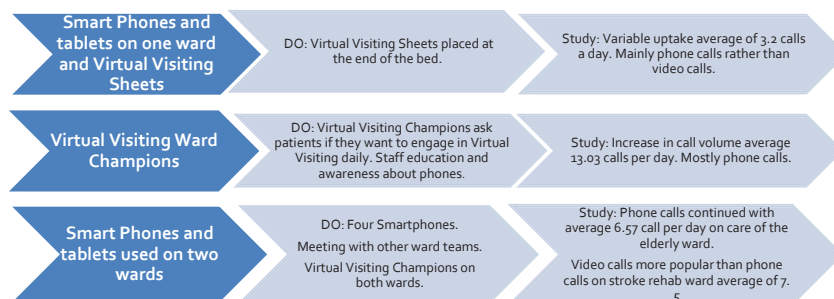
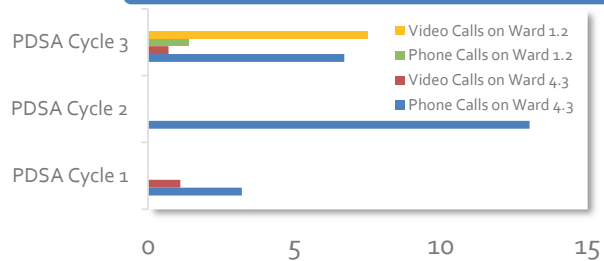
Background

- **SARS-CoV-2** has forced older people into a position of loneliness
- Loneliness increases older peoples risk of: frailty progression (1) and admission to care homes (2)
- Digital technology offers a bridging solution to allow patients to communicate with their families.

Method

- Introduction of smartphones and tablets for virtual visiting
- Three PDSA cycle (highlighted below).
- Evaluation from 22/4/20 – 27/7/20 on uptake of demand and feedback of use of digital device to communicate with friends and family

Virtual Visiting Call Volume



Results: Patient Feedback

"Talking to my daughter has kept me going"

"I couldn't believe it I got to see my grandson's face it was marvellous"

"Being able to speak to my wife has got me through, I've been in and out of hospital and it can be scary you feel alone"



"It's not the same as seeing them, but it's something and better than nothing."

"It's the first time in 54 years we've been apart and I am worried about her, hearing her voice and that she was ok... well I need that."

Discussion

- **SARS-CoV-2** has had massive ramifications impacting on older peoples' emotional and social well-being.
- Virtual Visiting using digital technology can offer some support to patient in hospital.
- Nominating a Virtual Visiting Champion inviting patients to engage with the digital technology on a daily basis increases participation.
- Ward demographics and personal access to devices affects patient engagement with ward based digital devices.
- Demographics and co-morbidities impact on which device and mode patients opt to communicate with loved ones.
- It is important that patient have regular and designated access to digital technology to allow them to communicate with loved ones.

Conclusion

- Virtual visiting is an effective way of connecting patients with their friends and family.
- The intervention was widely utilised by patients
- Feed back was positive
- Clinical setting should explore the use of such technologies.

Reference:

- 1) Social isolation and loneliness as risk factors for the progression of frailty: the English Longitudinal Study of Ageing. Gale C, Westbury L, Cooper C, the English Longitudinal Study of Ageing, Age and Ageing, Volume 47, Issue 3, 1
- 2) Loneliness as a risk factor for care home admission. English Longitudinal Study of Ageing, Age and Ageing 2018; 27:896-900

CQ - Clinical Quality - CQ - Patient Centredness

Does a Documented Frailty Score Improve the Completion Rate of Resuscitation Decisions: a Quality-Improvement Project - Harri Foster-Davies

Morrison Hospital, Heol Maes Eglwys, Cwmrhydyceirw, Swansea. SA6 6NL

Introduction

The NCEPOD 2012 Report analysed 552 CPR attempts in a multi-centre study. Key antecedent factors included physiological instability, fatal outcome as per the McCabe Classification, advanced age, and advanced frailty as per the Rockwood Frailty Score. Despite these prompts, they also found that 77.9% of CPR attempts had no prior documentation of resuscitation decision. The authors highlighted the need for discussions with patients about resuscitation status at an early stage. This Quality Improvement Project aimed to assess if documentation of the Rockwood Frailty Score helped to prompt discussions and decisions about resuscitation status in a large district general hospital during the coronavirus pandemic.

Methods

For 4 weeks in November 2019 and again in April 2020, all patients arriving onto an acute medical ward at Morrison Hospital were screened. Patients with Frailty Scores ≥ 6 , age ≥ 70 , and admitted for ≥ 48 hours were included. I recorded the number of documented frailty scores, resuscitation decisions, and DNACPR decisions. Interventions conducted in early April included education sessions on the Rockwood Frailty Score to all medical junior doctors and the addition of a Frailty Score subsection in the Rapid Assessment Unit proforma.

Results

In the November cohort (213 screened, 47 included), 48.9% of admissions had a documented resuscitation decision. For the April cohort (104 screened, 20 included), this increased to 80.0%. Sub-analysis of the entire screened April cohort revealed that of the 23.2% of patients with a documented frailty score, 95.5% had a documented resuscitation decision whereas for the 76.8% of patients without a documented frailty score, the rate of resuscitation decision documentation was 57.5%.

Conclusions

Education sessions and proforma subsections for the Rockwood Frailty Score help to increase the rate of resuscitation decisions in acute patients. Further study of the role of prompting and human factors engineering in hospital clerking proformas is required.

Completion Rate of Resuscitation Decisions

A QI Project During The COVID-19 Pandemic

1. The Problem

NCEPOD "Time to Intervene" 2012 Report^[1]:

Of 552 CPR attempts in this study, 430 (77.9%) had no documentation of resuscitation status.

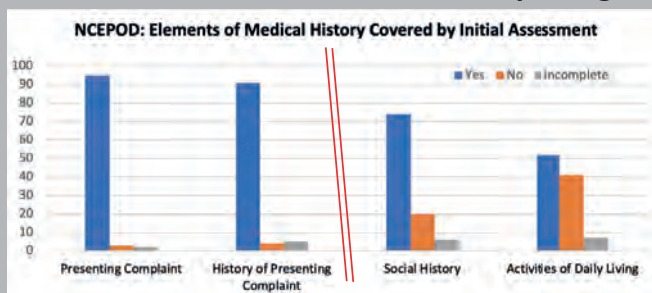
Why?



Issues?

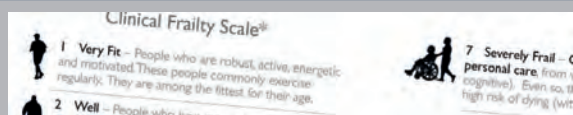


Poor Documentation of Activities of Daily Living^[1]:



When considering human factors engineering^[2], could a quantitative frailty score act as a useful prompt?

2. The Question



In a suitable cohort, does a prompted and documented Clinical Frailty Score improve Resuscitation Decision Completion Rates during the COVID-19 pandemic?

3. Interventions

- Education session on the Rockwood Frailty Score for all junior medical doctors.
- Frailty Score subsection on the RAU proforma.
- Posters in A&E and the RAU illustrating the Rockwood Frailty Score.

4. Analysis

Completion of Resuscitation Status:

	AMAU W (Nov 2019) [4 weeks]	Ward G (Apr 2020) [4 weeks]
Patients screened	213	104
Patients included	47	20
Completed resuscitation decisions	23/47 (48.9%)	16/20 (80%)
Completed on this admission	16/23 (69.6%)	14/16 (87.5%)
DNACPR decisions	22/23 (95.7%)	16/16 (100.0%)
Calculated frailty score	0 (0%)	3 (15.0%)

Sub-Analysis:

(Of all patients screened in April)



i.e. Which factors drive this change?

Does a documented frailty score make a difference?

- 23.2% of patients had a documented frailty score
 - ▶ Of these, 95.5% had a documented resuscitation decision
- 76.8% of patients had no documented frailty score
 - ▶ Of these, 57.5% had a documented resuscitation decision

Does the proforma make a difference?

Clerking Proforma	Frailty Score Documentation	Resus Decision Documentation
RAU	18/21 (85.7%)	19/21 (90.5%)
Medical	4/43 (9.3%)	31/43 (72.1%)
Surgical	0/27 (0.0%)	10/27 (37.0%)

5. Recommendations

- Education sessions for all teams (Medical + Surgical) regarding the use of the Rockwood Frailty Score and the use of Resuscitation Decisions.
- Subsection for Frailty Scoring on the Medical and Surgical proformas.
- Further study of the role of prompting and human factors engineering in hospital clerking proformas.

References

1. Time to intervene: Lessons from the NCEPOD report. Perkins et al. (2012) Resuscitation (83;11:1305-1306)
2. Implementing Human Factors in Healthcare. Carthey and Clarke (2009). Patient Safety First (Version 1).

CQ - Clinical Quality - CQ - Improved Access to Service

Improving Hearing Awareness within the Department of Elderly Medicine - Dr Catherine Rawes

Dr Catherine Rawes; Dr Fiona Thomson

Hull Royal Infirmary

Introduction

Hearing loss is one of the biggest modifiable risk factors contributing to deterioration of dementia. When patients lose their hearing, it creates a communication barrier between patient and staff which can frustrate patients and lead to agitation and aggression. Within the Department of Elderly Medicine, a large proportion of patients have dementia and also struggle with hearing loss. This population struggle to remember to bring their hearing aids to hospital, many actively do not bring their hearing aids into hospital for fear of losing them and often forget to wear their hearing aids or switch them on.

Method

An audit on 2 elderly medicine wards at Hull Royal Infirmary over a one week period assessing patients hearing concerns and comparing them to those of staff. After the first audit a sticker was designed and placed in the medical notes to remind staff to assess hearing and thus improve hearing awareness. A further audit was completed to close the loop and assess for improvement.

Results

Many patients in the first audit reported struggling with their hearing when asked directly but had not been assessed on admission. Staff seemed to have developed compensatory behaviours and were unaware of patient's hearing difficulties. Following the introduction of the hearing awareness sticker although staff were aware of hearing concerns disappointingly no actions were taken as there was no pathway within the hospital to help patients who require hearing tests or repair broken hearing aids.

Conclusion.

The first audit showed that hearing was not being assessed and although in the follow up audit it was being assessed, nothing was being actioned due to a lack of pathway.

A new pathway has been developed between ENT/Audiology and the Department of elderly medicine to address this and the success of this will need re auditing.

Improving Hearing Awareness within the Department of Elderly Medicine.

C. Rawes & F. Thomson

Department of Elderly Medicine, Hull Royal Infirmary.

AIM: A quality improvement project to evaluate hearing awareness within the Department of Elderly Medicine at Hull Royal Infirmary. We aimed to identify deficiencies in routine assessment of hearing for older in-patients with a view to improve patient care.

INTRODUCTION:

Hearing loss is one of the biggest modifiable risk factors contributing to deterioration of dementia. It creates a communication barrier between patient and staff which can frustrate patients and lead to agitation and aggression. Within the Department of Elderly Medicine, a large proportion of patients have dementia and also struggle with hearing loss. This population to forget to bring their hearing aids to hospital, many deliberately do not bring their hearing aids into hospital for fear of losing them and often forget to wear their hearing aids or switch them on.

STUDY DESIGN AND METHODS.

INITIAL AUDIT:

102 patients admitted to ward 9 and 90 over a 1 week period were included.

Staff and patient questionnaires were used to identify:

- . Patient self-reported hearing concerns
- . Staff reported hearing concerns
- . Patients with hearing aids
- . When did they last have a hearing test?
- . Has anyone examined their ears for wax?

For Patients with hearing aids we then identified:

- . Were they wearing it?
- . If not why not ?
- . Was it working/batteries charged?



FOLLOWING THE INITIAL AUDIT:

We Implemented a hearing awareness record sticker.

RE-AUDIT:

This audit included 29 patients admitted to ward 9 over a one week period.

Staff and patient questionnaires asked the same questions as the initial audit, but we also examined the patients medical notes to identify.

- . If the hearing awareness record sticker had been completed?
- . If the hearing awareness record sticker had been actioned ?

RESULTS OF INITIAL AUDIT.

55% of patients reported hearing concerns

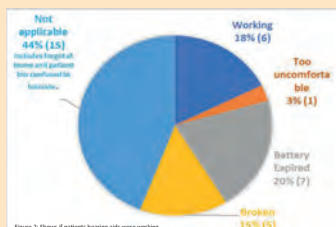
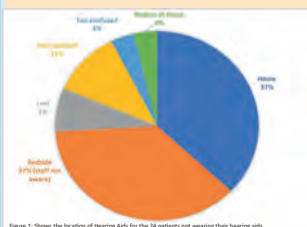
Staff only reported hearing concerns in 19% of patients.

Staff and self reported hearing concerns were only concordant for 60% of patients.

3 patients (4%) had been told they needed hearing aids but had never received them

31 patients (37%) had hearing aids.

Of those patients with hearing aids 24/31 were not wearing them.



30% of patients reported never having had their hearing tested
33% had never had their ears examined for wax.

CONCLUSION OF INITIAL AUDIT.

- . 55% of patients reported hearing problems, not all of those had hearing aids and no action was taken by the department during admission
- . The majority of patients requiring hearing aids were not wearing them
- . A significant proportion of patients left their hearing aid at home
- . Staff perception of hearing problems is low– likely due to compensatory behaviours and good communications skills developed working on the wards.
- . 20% of patients reported expired batteries as the reason for not wearing their hearing aids. When staff were informed the batteries were replaced.

ACTION

Introduction of the hearing awareness record sticker as a prompt for medical staff. (Shown to the right)

HEARING ASSESSMENT RECORD

Do have any concerns about your hearing? YES NO
Do you have a hearing aid? YES NO
Is patient wearing hearing aid? YES NO
Is it working? YES NO
Inform patients that we can replace batteries if theirs run out of charge? YES NO
Do you feel you need your hearing testing? YES NO
Would you like an NHS hearing test YES NO
Has anyone looked in your ears for wax? YES NO
Would you like your ears examining? YES NO
Management Plan:

RESULTS OF RE-AUDIT.

- . 29 patients were admitted to ward 9, 5 patients were excluded as they were unresponsive.
- . 31% of patients reported hearing concerns, staff reported hearing concerns in 14% of patients.
- . 5 patients (26%) of patients required hearing aids. Only one patient brought it to hospital. 2 patients forgot their hearing aid at home and 2 patients left it at home as it was broken.
- . The one patient who brought his hearing aid to hospital was wearing the hearing aid, and had the batteries replaced by staff however it was broken. No further actions were made.
- . 58% of patients reported never having had their hearing tested. 42% felt they would benefit from a hearing test. Many had concerns over the cost of hearing aids. No actions were made as the department didn't have a pathway to organise hearing test.
- . 36% of patients reported having had a doctor examine their ears for wax. 47% of patient felt they would like someone to examine their ears during admission.
- . The hearing assessment record stickers were completed in only 38% of patients medical records (11 patients).
- . 36% of patients with completed stickers required actions which included :
 1. Ears examining for wax
 2. Hearing tests
- . No actions were taken as the department did not have a working Auroscope, they did not know the procedure to organise hearing tests and patients had been discharged before audiology replied to our phone calls and emails.

CONCLUSION

Even with increased focus on hearing awareness, the ward staff did not accurately identify patients with hearing concerns.

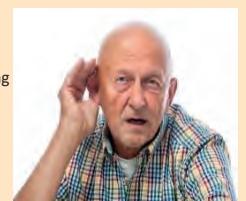
Sticker completion improved awareness of hearing concerns, however a significant number of patients did not have a sticker completed in their records.

When stickers were completed they were not actioned for 2 key reasons

- 1) They did not have access to a working Auroscope
- 2) They were unable to organise hearing tests

ACTION

We have liaised with ENT to establish pathways for booking hearing tests, ear syringing and fixing broken hearing aids. We aim to re-audit to demonstrate continued benefit for our patients. Auroscopes have been purchased by the department.



CQ - Clinical Quality - CQ - Clinical Effectiveness

Improving Urine Sampling in Elderly Medical Inpatients - Sarishka Singh

Sarishka Singh; Zaira Abbas; Quratulain Yousuf

Walsall Manor Hospital (Walsall Healthcare NHS Trust)

Introduction

The National Institute for Health Research reported in 2012 that urinary tract infections are a significant cause of mortality especially among the elderly population with 4835 deaths in England and Wales. During an elderly care placement, we noted that a number of elderly inpatients were being treated for UTIs without urine sampling. They were treated with antibiotics largely on the basis of positive urine dipsticks and/or clinical signs and symptoms. Despite local policy reflecting current national guidance on the diagnosis of UTIs in the elderly population, compliance remained poor.

Method

A quality improvement project using both quantitative and qualitative methodology was designed to improve the rate of urine sampling in elderly medical inpatients by addressing limiting factors which proved a hindrance to urine sampling in this age cohort. We collected run-through data and suitable patients were identified on medical wards.

Results

The data was analysed in a statistical process control tool (SPC). Urine sampling improved from 43.5% in the initial audit in February 2020 to 89.7% in July 2020.

Conclusion

It was identified that lack of awareness and communication from both sides of the medical and care teams contributed to untimely urine sampling at our hospital. Education and personal discussion represents a sustainable intervention which could easily be replicated in other Trusts. Further work is underway with the development of a teaching session to support nurses and clinical support workers obtaining urine samples from incontinent patients undertaken by one of our community continence clinical nurse specialists.

IMPROVING URINE CULTURING RATES IN ELDERLY MEDICAL INPATIENTS

Sarishka Singh, Zaira Abbas, Quratulain Yousuf

Your Key To Success: Urine Sampling in the Elderly

Aim

The aim of the project was to improve urine culturing rates in elderly medical inpatients that were treated for a urinary tract infection. The project was initiated after noticing that a few elderly inpatients were being treated for UTIs without urine sampling being done

Why is this important to service users and carers?

Carers were vital in this project and their guidance helped shape the project and streamline interventions. Service users benefit by reducing rates of misdiagnosis and inappropriate antimicrobial use

Intervention

Posters displayed in staff toilets and on the urine dipstick store cupboard, Trust wide emails, oral presentations and a feature in the Trust's daily newsletter proved effective

Does your patient have a UTI?

DON'T DIP IT, it's not accurate!
If your patient is ≥ 65
Send a urine culture
instead!

Having difficulties with your patient being incontinent or confused?

Why not try a Newcastle pad or condom catheter?

Are you sampling correctly?
Take a midstream sample using the aseptic technique



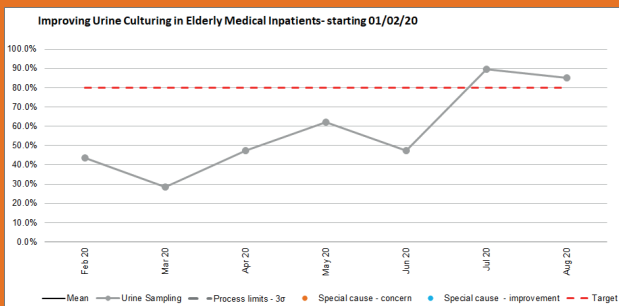
Got the sample?
Send within 4 hours of collection
Label sample immediately



No time to take the sample? **PLEASE HANDOVER!**

Improvement Tools Used

NHS Improvement Statistical Process Control (XmR) Tool



Data

Urine sampling with culture improved from 43.5% after initial audit to 85.19% over the 7 month project period. The project team persevered through COVID-19 challenges in order to complete this piece of work

Learning and what next?



A lack of awareness and communication from both sides of the medical and care teams contributed to untimely urine culturing at our Trust and this has been addressed by demonstrable improvement in urine culture rates. An impediment to timely urine sampling, incontinence, has been identified and is being addressed by a teaching session aimed at care staff led by our community continence clinical nurse specialist

CQ - Clinical Quality - CQ - Patient Centredness

Stay Home, Stay Safe? The impact of lockdown and social isolation on frail community-dwelling adults. - Sara Long

Sara Long, Karl Davis, Sian Cook

University Hospital of Wales, Cardiff

Introduction

There is limited understanding of how public health measures to reduce SARS-CoV-2 spread have impacted the frail and vulnerable population. This observational study seeks to describe the population at risk due to lockdown and social isolation, and explores themes surrounding admission to hospital.

Methods

Patients admitted to older adult medicine between April and July 2020 were included. Data from patient notes on home circumstances, formal/informal care provision and demographics were recorded. Baseline Clinical Frailty Score (CFS) was assigned. The likelihood of admission being related to lockdown measures was marked on a continuous scale and converted to a percentage for analysis. A threshold $\geq 75\%$ identified a 'lockdown-influenced' admission. Reasons for likelihood rating were recorded and categorised for thematic analysis.

Results

Data were collected for 94 patients. 2 were not frail, 11 were from care homes. 81 were included in analysis. 54 patients (64.1%) were female, median CFS was 6 ± 1.03 . 66.7% of patients had no formal care provision. 80.7% of those with no formal care received informal care input.

Odds ratio (OR) of lockdown-influenced admission for those with no formal package of care was 3.88 (95% CI 1.51-9.98, $P = 0.004$) compared to those in receipt of any formal care. This increased to an OR of 4.96 (CI 1.59 - 15.44 $P = 0.039$) if the patient also had a CFS ≥ 6 .

Lockdown-influenced admissions showed recurring themes: loss of informal care, carer strain, mental health deterioration, delayed presentation due to fear of coronavirus and physical deconditioning.

Discussion

Informal care networks enabling frail and vulnerable people to live independently were negatively impacted by public health measures to control SARS-CoV-2. This effect was amplified if the person was severely frail. Physical deconditioning and late presentation to healthcare services were also identified as contributing to lockdown-influenced hospital admissions.

Stay Home, Stay Safe?

The impact of lockdown and social isolation on frail community-dwelling adults

Dr Sara Long*, Dr Karl Davis, Dr Sian Cook
University Hospital of Wales, Cardiff

Background

There is limited understanding of how public health measures to reduce SARS-CoV-2 spread have impacted the frail and vulnerable population.

This observational study seeks to describe the population at risk due to lockdown and social isolation, and explores themes surrounding admission to hospital.

Methods

Frail and pre-frail patients (CFS ≥ 4) admitted to older adult medicine between April and July 2020 were included. Data from patient notes on home circumstances, formal/informal care provision and demographics were recorded. The likelihood of admission being related to lockdown measures was marked on a continuous scale and converted to a percentage for analysis. A threshold of $\geq 75\%$ identified a 'lockdown-influenced' admission. Reasons for likelihood rating were recorded and categorised for thematic analysis.

94 records reviewed, 81 included in analysis. 46% identified as related to lockdown

Excluded 2 CFS < 4 , 11 from care homes. 64% female, median CFS 6 ± 1.03

None of the patients included had a diagnosis of coronavirus during the reviewed admission.



67% had no formal package of care input at time of admission.



80% of those with no formal care received informal care input from family or friends.

Lockdown-associated admissions were **nearly four times more likely** if there was no formal care package in place, regardless of call frequency

Odds Ratio (OR) 3.88, 95% CI 1.51-9.98

This increased to **nearly five times as likely** in the severely frail

OR 4.96, 95% CI 1.59 - 15.44

Themes identified in lockdown-associated admissions included:



Loss of care

More common in informal care situations. Some carers advised to shield due to own health conditions.



Deteriorating mental health

Some cases of substance misuse. Loneliness and isolation heightened. Loss of activities.



Carer strain

Loss of carer support networks. Intense home environments. 'Feels like there's no respite'.



Fear of contracting coronavirus

Assumption GP surgeries closed. Late presentations to hospital. People 'struggling on' at home.



Physical deconditioning

Shielding advised for over 70s in March; many have not left the house since. Limited scope for physical exercise at home.



Deconditioning influenced **1 in 4** lockdown-associated admissions, and was **increasing** as a causative factor throughout the months.

5% of admissions in April vs. 33% in June

Discussion

Informal care networks enabling frail and vulnerable people to live independently were negatively impacted by public health measures to control SARS-CoV-2. This effect was amplified if the person was severely frail. Physical deconditioning, deteriorating mental health and late presentation to healthcare services were also identified as contributing to lockdown-influenced hospital admissions.

Older adult teams, especially those working in the community, should be aware of the negative effects associated with social isolation. Efforts should be made to identify those at risk, to put in place strategies to support informal carers, and to avoid hospital admission where possible.

CQ - Clinical Quality - CQ - Patient Safety

Starting a service on a shoestring – Is there any point? Can patients benefit? -
Karina James

Karina James; Angela Nelmes; Ketan Vegad; Raja Biswas

Royal Glamorgan Hospital, South Wales

A good Orthogeriatric service is undoubtedly beneficial (1), but this doesn't come for free. With no extra staff available, we wanted to see if it was possible to initiate a worthwhile service.

The Royal Glamorgan is a DGH treating about 250 NOFs annually. There is no structured, acute orthogeriatric service currently offered, medical input given on an ad-hoc basis.

We piloted a service using our 3 registrar level doctors (2.6 FTE) with consultant support in order to improve NOF care and provide support for orthopaedic colleagues.

A contact book was placed on the ward for the orthopaedic teams to list all acute #NOFs with our registrars as a point of contact. Between the registrars we tried to check the book daily and see as many NOFs as possible around our other current workload and on call duties. We reviewed falls/bone health/medical morbidity for all patients and followed up where needed.

During the pilot period 1/12/19-20/1/20 we saw 93% of #NOF admissions to the RGH compared to 3% previously (2). 51% were seen within the first 72 hours.

Despite having no extra resources it is clearly possible to initiate a new service. The drawbacks however are that it relies on an element of good will and can't be run as rigidly as a dedicated service. We managed to see the majority of NOF admissions despite the Christmas/New year bank holidays however some were not as timely as hoped. We showed a definite improvement in the numbers of patients receiving orthogeriatric input and were a point of contact for our orthopaedic colleagues. Clearly this is an extremely valuable service to patients but in order for it to be safe and sustainable in the long run it will require a dedicated time slot within the current registrars weekly timetable.

Starting a service on a shoestring – Is there any point? Can patients benefit?

Dr K James, Dr R Biswas, Dr A Nelmes, Dr K Vegad
Royal Glamorgan Hospital, Cwmtaf Healthboard

Introduction

The Royal Glamorgan is a DGH treating about 250 NOFs annually. There is no structured, acute orthogeriatric service currently offered. Any medical input is dependent on queries raised by the orthopaedic team on an ad-hoc basis.

A good Orthogeriatric service is undoubtedly beneficial but this doesn't come for free. Orthogeriatric review is shown to:

- Decrease operation delay
- Decreased delirium post-op
- Decrease mobilisation delay (1)

Hip fracture mortality is greater in Wales than England and only 4 trusts have an established fracture liaison service. We wanted to know if there is any scope to improve things without extra staff or funding.

Methods

Our pilot commenced on 1st December 2019 with 3 registrar level doctors (working 2.6 FTE) and a supervising consultant.

We placed a contact book on the orthopaedic ward and asked for the nurse practitioners and orthopaedic juniors to put patient details inside for any admitted NOF's.

We aimed to check this daily and our bleep numbers were made available to the orthopaedic juniors for advice.

As we were fitting this around our normal day jobs and on call commitments we advised them to contact us if they had concerns or needed a more pressing review, with the medical registrar on call contactable out of hours as usual.

We met with the orthopaedic teams to inform them of the service starting, and also the audit department who enter all the NHFD information to ensure they looked for our reviews when pulling the notes.

We also collected our own data for a 6 week period looking at the type of patients we saw, the timeliness of the review and general data such as fall type and bone health.

All patients received a review in line with the Blue book recommendations including falls history, bone health and medication review, assessment of cognition and any acute medical issues. We saw all patients once but would review further if needed.

Aim

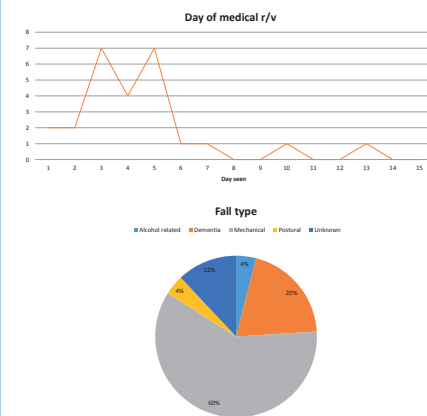
Our aim was to introduce a medical liaison service for all fracture neck of femur patients as per the Blue book.

We wanted to see all patients within a timely manner, offering a falls and bone health assessment, along with reviewing any acute medical issues. We wanted to show an improvement from the 1.7% who received a perioperative medical assessment in 2019. (2)

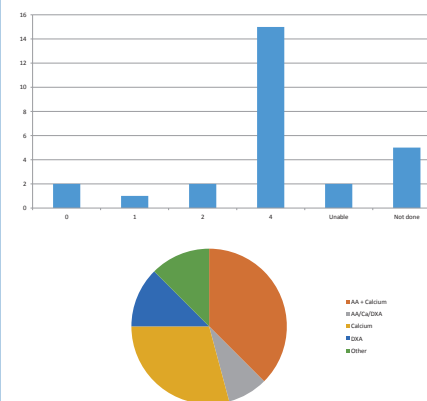
We had no capacity for extra staff members so wanted to see if this service could not only be run but run to a good level with our current staffing.

Results

The pilot ran between 1/12/19 and 20/1/20, during which time there were 29 patients admitted with fracture NOFs. They were aged between 65 and 97 with a split of 48% male, 52% female. Some of our data collected is shown below



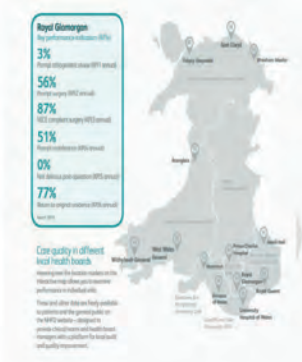
Admission AMT (done either by clerking team or ourselves)



This final graph shows our recommendation and action for the patients bone health

Care of people with a broken hip in Wales – figures from the National Hip Fracture Database

The National Hip Fracture Database (NHFD) is the largest national database of hip fracture patients in the UK. It provides a centralised source of information on hip fracture patients, allowing for the collection of data on a national scale. The NHFD is a key resource for researchers, clinicians and policy makers. It provides a centralised source of information on hip fracture patients, allowing for the collection of data on a national scale. The NHFD is a key resource for researchers, clinicians and policy makers.



Discussion

93% of the 29 patients over a 6 week period had a medical review, 51% were considered 'prompt' (within 72hours) as per the Blue book. In 2019 this number was 3% (as above).

There was a wide variety in the time it took for patients to be seen which reflects several things:

- The pilot was rolled out in December encompassing a number of bank holidays
- Patients were seen around our normal commitments therefore when team members are on call or leave there is very little stretch to allow for an extra service.

Many patients were admitted following a previous fracture often with no bone protection; following this service they all had a bone health review and the majority were commenced on treatment.

We also put in place a number of treatment ceilings of care and DNARs along with giving advice on things such as hyponatraemia and infections.

Despite the many patients being accredited with a 'dementia related fall' the most common AMT4 score was 4. This perhaps suggests the ones which weren't done would have been low and this is valuable information that is being missed or recorded incorrectly.

Following the pilot we met with the orthopaedic teams who felt there had been a real benefit to the service and it was continued in the same manner until the COVID pandemic made things too difficult.

Conclusions

We all learnt some really important lessons from this project. Whilst it is possible to run a service such as this it relies on a lot of good will from team members in terms of picking up extra work.

It is difficult to run a timely service due to on calls etc. and the service quickly became impossible to provide during the pandemic. We showed an excellent improvement from 3% to 97% in terms of medical reviews and should the service continue over time there would hopefully be a place for a more permanent system.

Contact

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References

1. British Orthopaedic Association. The Care of Patients with Fragility Fractures. London: British Orthopaedic Association; 2007
2. State of the Nation - Wales Report, Falls and Fragility Fracture Audit Programme

CQ - Clinical Quality - CQ - Patient Centredness

Communication issues during COVID - a Quality improvement project- Karina James

Karina James; Raja Biwas Royal Glamorgan Hospital

During the pandemic a huge problem we noted on our COVID wards was communication for a number of reasons. All staff are wearing the same scrubs, PPE is distressing for patients to see and makes hearing and vision difficult. Many non-verbal cues are lost due to visors and masks.

We did a simple quality improvement project introducing large wipeable photo ID badges worn over our PPE when on the ward. We also ensured every ward had a set of amplifying headphones.

We did a staff survey looking at whether they had a positive impact along with recording patient comments.

Although the thought was that patients would benefit, the results actually showed that the badges were useful for both patients and other staff members to identify each other whilst in PPE. Staff also thought it was comforting for patients and that it should be rolled out universally on the ward.

Patient comments included 'That's nice doctor, we can see what you look like' and 'Great idea, nice to make care feel more personal and less scary for patients'

As our initial pilot had such good feedback the badges were made available to any staff who wanted one from our medical photography department.

In a time when communication and care was very difficult and yet so vital we think these little changes made a significant difference. I think as time goes on it will serve to remind us that we should make every effort to communicate effectively and potentially badges like these could be used in dementia and delirium wards to good effect.

Improving communication during a pandemic

#covid19



Dr K James, Dr R Biswas, ANP T Pooley
Royal Glamorgan Hospital, Cwmtaf Healthboard



Introduction

The COVID pandemic presented many challenges and potentially changed the way we work forever.

Whilst many of these were due to capacity, work force and logistical issues some were more specific to our geriatric patients especially those with delirium and cognitive impairment. As some of the first clinicians looking after the COVID patients in the Royal Glamorgan a number of issues came to light

One huge stumbling block within the COVID wards was communication for a number of reasons.

- All staff were wearing the same scrubs
- Visors and masks prevented patients hearing and seeing you clearly
- Many non-verbal cues were lost due to body language and eye contact being difficult
- Patients with delirium and cognitive impairment were distressed by PPE

Methods

A quality improvement project was formulated where by team members had a wipeable A5 badge with their name, job and photo printed that they could wear over their PPE. They were provided by medical photography and could be cleaned as with visors for infection control purposes.

Amplifying headphones were also proved for each ward which could be cleaned between patients.

Following these changes we did a survey of staff members on the COVID wards to gauge a response, along with noting any feedback (positive or negative from patients).

We did not undertake a formal survey of he patients as many were too unwell or confused to take part.



Aim

We wanted to try and improve things as day to day communication was becoming a big issue. It was key that any changes were within the limits of safe working and infection control.

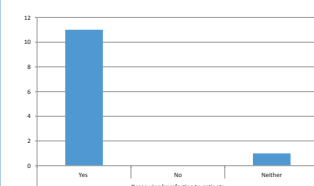
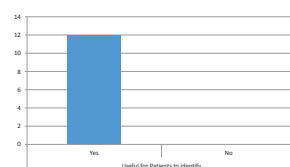
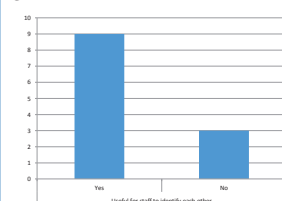
Due to the nature of staff from a variety of departments working within each ward team it was vital that any changes were easy to do and didn't require specific geriatric skills.

In an ideal world we wanted to make any changes beneficial and easy to use for all members of the ward team – doctors, nurses and allied health professionals.

Results

We surveyed a mix of allied health professionals including doctors, nurses and HCSWs during a shift on the COVID ward using a brief questionnaire as seen above.

Our results were as follows



The questionnaire showed staff felt it was beneficial both for staff and patients in terms of identification and also comforting.

>80% of staff felt that the badges should be made available to everyone working on the COVID wards who wished to wear one.

Along with this we received the following comments from patients and staff :

'Great idea, nice to make care feel more personal and less scary for patients'

'That's nice doctor, we can see what you look like'

'It's nice to see what you look like in real life'

COVID Photo badge QIP

Would you mind completing a brief survey about our use of large photo badge while wearing PPE, we would be grateful for any feedback!

Do you think wearing the badges is useful for STAFF to identify who team members are?

Yes No

Do you think they are useful for patients to IDENTIFY who staff members are i.e. doctor, nurse?

Yes No

Do you think they are useful in REASSURING/COMFORTING patients when you are wearing PPE?

Yes No

Do you think it would be good for all staff members to wear them while using PPE?

Yes No

Any comments including ideas as to how we could improve

Thank You!

Discussion

The rapidly developing nature of an unknown pandemic means everyone is learning and things are changing day to day. Daily and weekly new guidance and advice is being released from various sources. Skills we previously took for granted such as communication became significantly more challenging.

Whilst it sometimes felt like there was very little in the way of positive outcomes during COVID this showed simple things like wearing a photo had a really positive outcome both with patients and staff. This is not necessarily something which should be confined to COVID wards.

We are currently wearing masks on our ward rounds when social distancing is not possible and communication continues to be an issue.

In order to make this more beneficial I would encourage all staff to wear a photographic badge on the ward and make them easier for all staff to access.

Conclusions

COVID 19 taught everyone a number of lessons not least myself. A simple skill such as communication suddenly became more challenging.

Simple photographic badges made a big difference to both staff and patients

I feel this is definitely something we could consider as a permanent change in practice where PPE is being used as this is likely to continue for some time

Contact

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CQ - Clinical Quality - CQ - Improved Access to Service

Assessment and documentation of bone health plans for patients admitted with fragility neck of femur fractures - Francesca Loro

Bristol Royal Infirmary

Introduction

Osteoporosis is very common. With an ageing population and the number of fragility fractures estimated to increase, focus on preventative management is now be a priority. The aims of this audit were to investigate the in-patient assessment of bone health plans for patients admitted with neck of femur (NOF) fractures, and to evaluate the documentation of such plans on discharge letters. The target aims were 100% for both, based on national guidance.

Methods:

Patients admitted with a fragility NOF fracture at the Bristol Royal Infirmary were included. The online systems, clinical notes and discharge summaries were reviewed. Quality improvement tools such as brain storming and fish bone diagrams were used to design the changes. Two Plan-Do-Study-Act cycles were carried out.

Change 1: A tick-box checklist was implemented on the ward team's online system available to the wide multi-disciplinary team.

Change 2: The NOF proforma was updated and re-printed with a specific section on bone health plans.

Results:

100% of patients had a documented in-patient bone health assessment and management plan by an orthogeriatric consultant. Documentation of bone health plans on discharge letters doubled and reached the set target of 100% after the first change. This suffered a slight decrease to 93% after the second change.

Conclusion:

This audit demonstrates that the two changes, combined, have resulted in a great improvement in documentation in discharge letters and that this improvement has lasted over time and throughout ward staff changes. This is important as the discharge letter is the main tool used for arranging follow-up of bone health plans. Going forward, these changes are being considered to include all other sites of fragility fractures.

Prevention is better than cure

'An audit looking at the assessment and documentation of bone health plan in patients admitted with fragility neck of femur fractures'

F Loro, A Berry

Background

In the UK over 500,000 people are admitted to hospital with a fragility fracture each year. This carries an extremely high morbidity, mortality and financial burden. With an ageing population and the number of fragility fractures estimated to increase, focus on preventative management is now a priority.

NICE approved osteoporosis treatments have demonstrated a 20-70% reduction in the future fracture risk (1). However, adherence to bone health therapy is recognized as very poor and is estimated to be as low as 14% at one year (2). Currently, in the Bristol Royal Infirmary (BRI), the responsibility for bone health follow-up primarily falls on general practitioners for first line treatments, and on hospital based orthogeriatricians and/or on Fracture Liaison Service (FLS) nurses for second line treatments..

Aims and Standards

This audit has two main aims:

- 1) To look at the in-patient assessment of secondary bone health plans for patients admitted with fragility neck of femur (NOF) fractures at the BRI
- 2) To investigate whether at the point of discharge, out-patient follow-up arrangements were organized appropriately for the bone health plans, either via discharge summaries or via out-patient Fracture Liaison Service (FLS) referrals

Standards	Target	Source of Evidence
All patients admitted with a fragility NOF fracture, should be assessed for risk of osteoporosis	100%	NICE Quality Standard (QS149) NOGG 2017: Clinical guideline for the prevention and treatment of osteoporosis Best Practice Tariffs
All patients admitted with a fragility NOF fracture, have an appropriate follow-up arranged for their bone health plan	100 %	NOGG 2017: Clinical guideline for the prevention and treatment of osteoporosis The Department of Health 2009

Methods

All patients aged over 60 admitted with a fragility NOF fracture at the BRI were included in this audit. The online systems (ICE, Medway) and the clinical notes were reviewed. Two Plan-Do-Study-Act (PDSA) cycles were carried out. The FLS service was not re-audited in PDSA Cycle 2 as the process unfortunately changed due to funding.

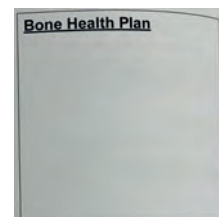
Change 1

Situation	Background	Assessment	Recommendation
Left IC NOF # hemi 13/04/20	T2DM IHD	post op x-ray: satisfactory Bloods: CTH: NAD	<input checked="" type="checkbox"/> OP Bloods <input checked="" type="checkbox"/> D1POXR <input type="checkbox"/> Post-op 4AT/AMT <input type="checkbox"/> Bone health plan in TTA <input checked="" type="checkbox"/> FLS ref if needed Chase MC&S

A tick-box checklist system was implemented on Careflow (the ward's online handover system) to all the fragility NOF fractures from April 2020. This system is available to a wide range of multidisciplinary teams, provides repeated daily reminders, and is free to implement.

Change 2

The NOF proforma was updated and re-printed with a specific section for bone health plans. This change was brainstormed during one of the departmental meetings. It provides more formal and long term documentation compared to Change 1.

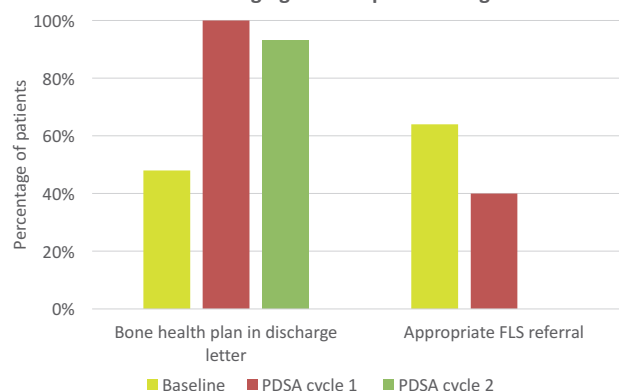


Results

Patient sample: Thirty-one, thirteen and twenty eight patients were included in each data collection cycle, respectively.

Aim 1: **100% of patients** had their bone health assessment as an in-patient. This was documented in all cases in the clinical notes by an orthogeriatric consultant.

Aim 2: Arranging follow-up at discharge



Conclusion and Going Forward

This audit showed that in-patient assessment of bone health is excellent and achieved the 100% target throughout both cycles. This is important as it is a Best Practice Tariff for which the Trust receives financial compensation.

This audit showed a real improvement in the documentation of bone health plans on discharge letters. The first change reminds doctors on a daily basis to organize bone health plans, whilst the second change makes it easier to find and highlights its importance in the clinical notes. Follow-up of first line osteoporosis treatments is currently the responsibility of general practitioners. Therefore, documentation in discharge letters is essential in order to increase compliance with treatment and maximize its benefits.

Unfortunately, there was no improvement in the FLS referrals in the first PDSA cycle and this could not be followed through with the second cycle as the referral process is undergoing changes. Once the new FLS system is in place, this can be re-audited. Two of the main reasons for the low referral rates were thought to be lack of knowledge regarding the FLS system and the complexity of the referral system itself. Education regarding the new system is currently being organized for rotating junior doctors.

Going forward, the simple to implement tick-box system could be considered for all sites of fragility fractures and its contents can be edited over time to target other areas needing improvement.

References

1. NICE- Bisphosphonates for treating osteoporosis - Technology appraisal guidance [TA464]
2. Fracture Liaison Service Database (FLS-DB) clinical audit FLS forward: Identifying high-quality care in the NHS for secondary fracture prevention April 2017
3. 2020/21 National Tariff Payment System – a consultation notice Annex DTD: Guidance on best practice tariffs. December 2019
4. NOGG 2017: Clinical guideline for the prevention and treatment of osteoporosis

CQ - Clinical Quality - CQ - Patient Centredness

["Did I see the doctor?" – Implementing a patient information leaflet to aid patient recall in intermediate care - Lauren Evans](#)

University Hospital Llandough

Introduction

The Vale Elderly Care Assessment Service provides urgent outpatient assessments and MDT input for frail older adults. Patients interact with a minimum of 3 different professionals, with the outcomes of various assessments and recommendations recorded electronically. Verbal feedback is given to patients and relatives on the day, however the setting and amount of information may make recall difficult.

Method

Telephone contact was made with patients or carers who had attended the service within the last month. After giving permission, they were asked about recall of key outcomes from their visit, which was then compared to the notes for accuracy. This data and MDT discussion was used to inform the design of a patient held leaflet, with a plan to repeat data collection after implementation.

Results

15 telephone calls were successfully completed, on average 15 days after the visit. One third of the patients had cognitive impairment, one of whom attended unaccompanied. 27% of respondents correctly recalled which professionals they had seen, with 20% recalling the main recommendations. 47% could not correctly recall if any changes were made to medication, and 40% had incorrect recall of whether any follow up was arranged. All respondents commented that they would have found a leaflet helpful, and some made suggestions of what to include, which was paired with MDT input to design a leaflet. Unfortunately, due to the COVID-19 pandemic, a second cycle of data collection has not yet been possible, however staff feedback was positive.

Conclusion

Patients visiting "one-stop" frailty clinics can potentially be overwhelmed with the intensity and professionals should be aware that they may not recall everything that is discussed. Patient-held information is a useful and potentially vital tool that should be incorporated into the service, ideally with input from all members of the MDT, to improve patient experience.

“Did I see the doctor?”

Implementing a patient information leaflet to aid patient recall in intermediate care

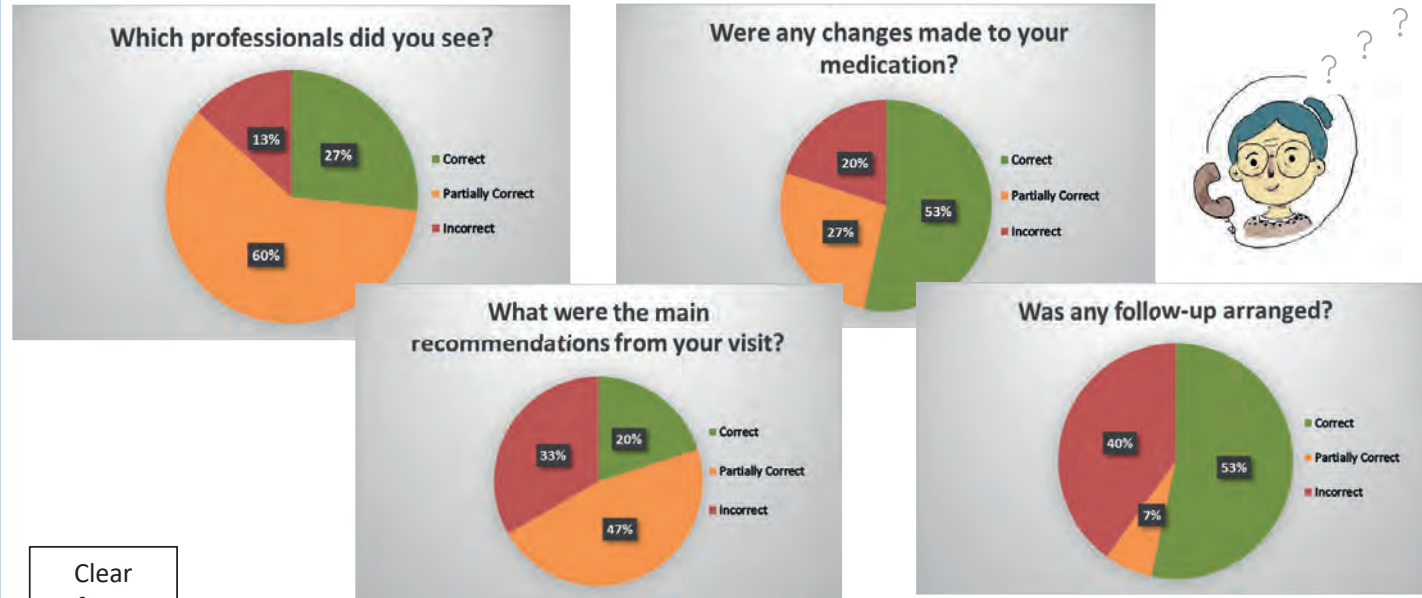
Deborah Allen, Lauren Evans
University Hospital Llandough



The Vale Elderly Care Assessment Service provides urgent outpatient assessments and MDT input for frail older adults. Patients interact with a minimum of 3 different professionals, with the outcomes of various assessments and recommendations recorded electronically. Verbal feedback is given to patients and relatives on the day, however the setting and amount of information may make recall difficult.

Telephone contact was made with 15 patients or carers who had attended the service within the last month, on average 15 days after their visit. After giving permission, they were asked about recall of key outcomes from their visit, which was then compared to the notes for accuracy. All respondents felt that they would have found a leaflet helpful, and some made suggestions of what to include. This data and MDT discussion was used to inform the design of a patient held leaflet, with a plan to repeat data collection after implementation, which unfortunately hasn't yet been possible due to COVID-19. Staff feedback on the leaflet was positive.

Patients visiting “one-stop” frailty clinics can potentially be overwhelmed with the intensity and professionals should be aware that they may not recall everything that is discussed. Patient-held information is a useful and potentially vital tool that should be incorporated into the service, ideally with input from all members of the MDT, to improve patient experience.



Clear font, personal to patient

Vale ECAS is an Intermediate Care Service based at Llandough Hospital

We work as a multidisciplinary team and aim to provide rapid access assessment for people who are at risk of deteriorating and for whom early multidisciplinary input is likely to prevent hospital admission

Name: _____

Date seen: _____

Your named Consultant is
The doctor you saw today was

Diagnosis:

Medication changes:

Referrals made (if required):

Follow up (if required):

The physiotherapist you saw today was

The following recommendations were made:

Walking aid:

Home exercise program:

Further rehab:

Signposting:

The nurse you saw today was

Routine observations completed

Any other information:

The occupational therapist (OT) you saw today was

Recommendations:

Any other information:

Handy phone numbers

Useful Contact Numbers

VECAS co-ordinator (Maria Griffiths): 01446 729558

Day Hospital, Llandough: 02020 715425

Age Connects: 01443 490650

Care and Repair: 02920 473337

Adult Social services, Vale (C1V): 01446 700111
*For support with home care, community alarm, attendance allowance etc

The Vale Third Sector Broker Service, Community Liaison Officer: 01446 729558
*One stop shop that enables access to third sector services in the community (including advocacy, welfare benefits, carer support, loneliness, shopping, transport etc)

Sections to be completed by each MDT member to maximise efficiency

Printed on yellow paper for memorability

CQ - Clinical Quality - CQ - Patient Centredness

[OUH Active Hospital Pilot: The impact of Advanced Rehabilitation Support Workers on a Complex Medical Unit - Christopher Speers](#)

Christopher Speers; Tracy Barnett; Rebecca Gould; Natasha Jones

Oxford University Hospitals Foundation Trust, Sports and Exercise Medicine, Oxford, United Kingdom

Introduction

Physical inactivity during hospitalisation is an independent predictor of negative outcomes. In older patients, typical of those admitted to complex medical units (CMUs), it leads to longer stays and reduced functional ability on discharge. This project aims to reduce the impact of hospital-associated deconditioning (HAD) by improving physical activity (PA) levels.

Methods

In January 2020, Advanced Rehabilitation Support Workers (ARSWs) were appointed to work across 2 (out of 4) CMUs. Their role was to promote PA and support patients to be as functionally independent as possible through delivery of exercise-based interventions, motivational interviewing and bedside mobility assessments. The ARSWs were supported with a range of evidenced-based tools and a governance framework developed by the Active Hospital team.

Results

170 patients were seen from January to July 2020. 52% were seen within 24 hours of admission to the ward. 40% had a documented mobility assessment, 65% had at least one exercise session, 51% participated in other activities including games, music, or video calls to relatives (particularly valuable during the Covid-19 pandemic).

96% would recommend input from the ARSW to other patients and 100% enjoyed the experience. All staff felt that the ARSWs had benefited the ward with over 80% strongly agreeing.

There was a trend that CMUs with ARSWs may have reduced adverse events, but this was uncertain.

Length of stay was reduced across all wards, compared to the same period the previous year, however it is unclear what impact the Covid-19 pandemic had on this data.

Conclusion

The introduction of ARSWs to deliver PA interventions to this frail, elderly cohort was extremely well received with benefits felt by both patients and staff. Embedding a PA culture within an inpatient environment could unlock the wide-ranging benefits of preventing HAD. Further analysis of performance through the winter is required.

Oxford University Hospitals Active Hospital pilot: The impact of Advanced Rehabilitation Support Workers on a Complex Medical Unit

C. Speers¹, T. Barnett², R. Gould¹, N. Jones¹

1. Department of Sport and Exercise Medicine, Nuffield Orthopaedic Centre, Oxford University Hospitals NHS Trust, Oxford, United Kingdom
2. Active Hospitals Project, Oxford University Hospitals NHS Foundation Trust, Oxford, United Kingdom

Introduction: Physical inactivity (PA) during hospitalisation is an independent predictor of negative outcomes. In older patients, typical of those admitted to complex medical units (CMUs), physical inactivity leads to longer stays and reduced functional ability on discharge.

Aims: To assess the feasibility and acceptability to both staff and patients of using Advanced rehabilitation support workers (ARSW's) on CMU's to promote physical activity

Methods: In January 2020, Four ARSWs were appointed to work across 2 (out of 4) CMUs. Their role was to promote PA and support patients to be as functionally independent as possible through delivery of exercise-based interventions, motivational interviewing and bedside mobility assessments. The ARSWs were trained in motivational interviewing techniques and supported by a range of tools such as the BMAT, bed, chair and standing exercise leaflets and a video, and an 'I can' tool. The programme was supported by a governance framework. The programme was led by the Moving Medicine/OUHFT [Active Hospital](#) team. Patient and staff acceptability was assessed by patient and staff surveys.

Results:

170 patients were seen by ARSWs, from January to July 2020, across two wards (CMU A + B). 52% of patients were seen within 24 hours of admission to the ward (Figure 1). 40% had a documented mobility assessment, 65% had at least one chair or standing exercise session, 51% participated in other activities including games, music, or video calls to relatives (particularly valuable during the Covid-19 pandemic)(Figure 2.).

A patient survey found 96% would recommend input from the ARSW to other patients and 100% enjoyed the experience. A selection of comments are in Figure 3. A staff survey (30 responses) found all staff felt that the ARSWs had benefited the ward with over 80% strongly agreeing. Key themes from comments to questions regarding changes on the ward since the ARSW role was started are summarised in Figure 4.

In CMUs with ARSWs there was a trend towards reduction in adverse events compared to wards without but there is insufficient evidence to draw firm conclusions (Falls RR 0.53 95% CI 0.24 to 1.18; VTE RR 0.43 95% CI 0.135 to 1.36).

Length of stay was reduced across all wards, compared to the same period the previous year, however it is unclear what impact the Covid-19 pandemic had on this data.

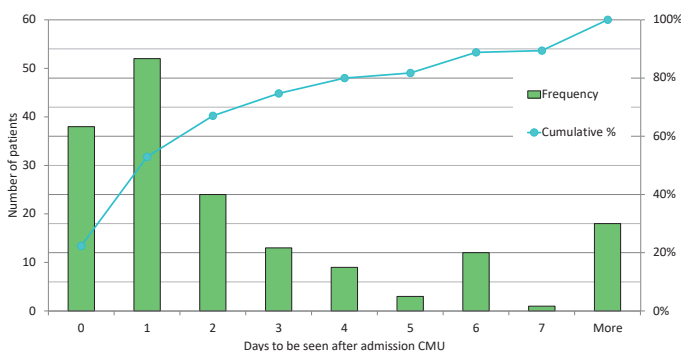


Figure 1. Number of days between admission to CMU and first seen by ARSW.

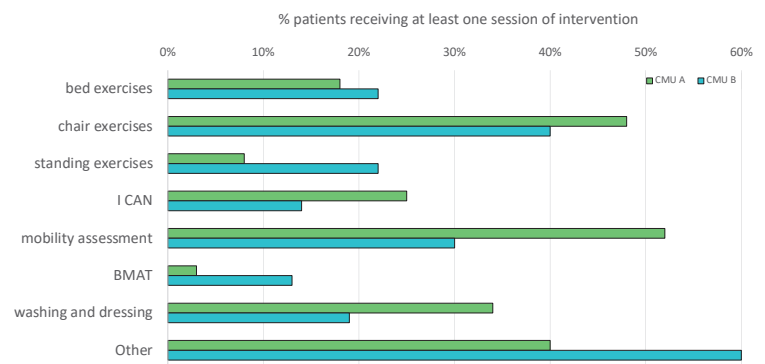


Figure 2. Proportion of patients receiving at least one session of intervention



Figure 3: Feedback from patients on wards with ARSWs

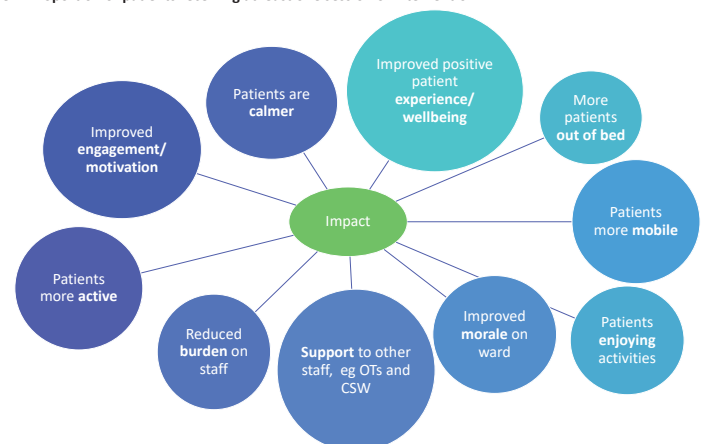


Figure 4: Summary of key themes from comments made by staff

Conclusions:

The introduction of ARSWs to deliver PA interventions to this frail, elderly cohort was extremely well received with benefits felt by both patients and staff. Embedding a PA culture within an inpatient environment could unlock the wide-ranging benefits of preventing HAD. Further analysis of performance through the winter is required.



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#movingmedicine

contactus@movingmedicine.ac.uk

CQ - Clinical Quality - CQ - Patient Centredness

[Frailty in the Field Hospital - Dafydd Brooks](#)

Dafydd Brooks; Laura Rozier; Ceri Hathway; Cherry Shute; Debbie Allen

University Hospital of Wales, Cardiff

Background

The Dragon's Heart Hospital (DHH) was built as a COVID-19 Field Hospital for Cardiff and Vale UHB inside the Principality stadium. It had a capacity of 1500 beds, and was the first in Wales to admit patients. We collected snapshot data to characterize the patient cohort and present a description of our unique experience.

Staffing

Teams of 3 doctors worked in shifts, led by Geriatrics trainees, with consultant oversight from medical sub-specialties. Nurses were from various areas of the UHB, supported by students and St John's volunteers. There was comprehensive 7 day cover from therapy teams.

Environment

The initial ward was a 27 bed mixed gender ward inside a hospitality area of the stadium. Issues such as a lack of natural light and inadequate patient screens presented challenges. After 23 days patients were moved to a marquee-type area on the pitch, which was more spacious and allowed access to outside areas.

Patient Cohort

50 patients were admitted to DHH over 37 days of operation. The average age was 84 (range 43 – 99). 68% of patients developed COVID-19 while inpatients in other UHB settings and the majority were post-14 days on transfer. The average LOS before transfer was 33 days. Delirium was common (54% of patients) and 44% of patients had a pre-existing diagnosis of dementia. Polypharmacy was nearly universal, and 48% of patients were prescribed strong opioids.

Outcomes

32 patients were discharged to a community dwelling, 3 patients died and 15 patients were transferred back to other hospitals when DHH was placed on standby. Some of the issues raised by staff were addressed and resolved, and many lessons can be learned from caring for a cohort of complex frail patients in a field hospital setting.



Frailty in the Field Hospital



*Dafydd Brooks, Laura Rozier, Ceri Hathway, Cherry Shute, Debbie Allen
University Hospital of Wales*

Background

The Dragon's Heart Hospital (DHH) was built as a COVID-19 Field Hospital for Cardiff and Vale UHB inside the Principality stadium. It had a capacity of 1500 beds and was the first in Wales to admit patients. We collected snapshot data to characterize the patient cohort and present a description of our unique experience.

Staffing

Teams of 3 doctors worked in shifts, led by Geriatrics trainees, with consultant oversight from medical sub-specialties. Nurses volunteered from a variety of settings in the UHB including Geriatrics wards, outpatients and midwifery. They were supported by nursing students and St John's volunteers. There was comprehensive 7-day cover from therapy teams with daily presence of physiotherapists, occupational therapists, speech and language therapists, and dietetics assistants and dietitians.

Patient Cohort

50 patients were admitted to DHH over 37 days of operation. The average age was 84. The majority of patients developed COVID-19 while inpatients in other UHB settings. Patients had been in hospital for a month on average before being transferred to DHH. Delirium was common and nearly half of patients had a pre-existing diagnosis of dementia. Polypharmacy was nearly universal, and despite guidance issued during the pandemic, only half were prescribed Vitamin D.

Table: Snapshot data of 25 patients

Average age	84 (43-99)
Diagnosis of dementia	44%
Delirium during admission	54%
Number of medications	12.3 (6-19)
Vitamin D Prescribed	48%
Strong opioids prescribed	48%
Admitted with COVID or diagnosed within 24 hours	32%
Diagnosed more than 24 hours after admission	68%
Average time between admission and COVID diagnosis	14.7 days (-12 to 74)
Average time between admission and transfer to DHH	33.3 days (7 to 100)

Environment



27 Bed mixed gender ward inside hospitality area of the stadium. Issues identified included lack of natural light, lack of bed sides, inadequate seating and multiple trip hazards. Advantages were frequent Geriatrician review and controlled numbers which allowed for almost daily communication with family.



After 23 days patients were moved to a marquee-type area on the pitch.



The pitch level was more spacious, allowed male and female wards, had better lighting and allowed access to outside areas. There was also space for a day room where patients could be entertained and eat together

Outcomes

32 patients were discharged to a community dwelling, 3 patients died and 15 patients were transferred back to other hospitals when DHH was placed on standby. Some of the issues raised by staff were addressed and resolved, and many lessons can be learned from caring for a cohort of complex frail patients in a field hospital setting.

CQ - Clinical Quality - CQ - Clinical Effectiveness

[Capacity Assessment - A Crisis of Confidence? A Survey of Junior Doctors - Caoimhe Mcmanus](#)

Caoimhe Mcmanus; Alanna Keena; Lisa Murphy; Kevin Bates; Shane Kelly; Carmel Curren

Beaumont Hospital, Dublin

Background

Patient capacity assessment is an essential skill in clinical practice. To make a decision, a person must understand and retain information relevant to the decision, use that information to come to a decision and then communicate that decision. Capacity assessment issues often arise in the context of procedural consent and in the discharge planning process. The aim of this study is to ascertain the confidence level of Junior Doctors (JD) in assessing capacity.

Method

A survey was distributed to a convenience sample of 212 Medical and Surgical JD in Ireland using an online survey tool. Respondents were asked about their training and to rate their confidence level in capacity assessment across a variety of scenarios on a 5 point Likert scale. The survey also explored their knowledge of who can legally consent to a procedure on a patient's behalf.

Results

The response rate to the survey was 80.18% (170/212). 32 Interns (18.82%), 80 Senior House Officers (47.06%), and 58 Registrars (34.12%) responded. 20% (31/170) were not confident, or not at all confident, in carrying out capacity assessments for procedural consent, with 30.32% (47/170) being confident. 29.68% (46/170) were not confident, or not at all confident, in carrying out capacity assessments pertaining to discharge planning, with only 17.42% (27/170) stating that they were confident. 51.77% of participants incorrectly reported that Next-of-Kin could consent for a procedure when a patient was deemed not to have capacity. 75.88% of participants reported that they did not receive formal post-graduate training on capacity assessment.

Conclusion

While capacity issues arise on a regular basis in the clinical setting, less than one third of Junior Doctors feel confident in assessing capacity within the context of procedural consent or discharge planning. These results emphasise that further capacity assessment education is needed for Junior Doctors.



Capacity Assessment – A Crisis of Confidence? A survey of Junior Doctors

Caoimhe McManus, Alanna Keena, Lisa Murphy, Kevin Bates, Shane Kelly, Carmel Curran



Background

Patient capacity assessment is an essential skill in clinical practice. To make a decision, a person must understand and retain information relevant to the decision, use that information to come to a decision and then communicate that decision. Capacity assessment issues often arise in the context of procedural consent and in the discharge planning process. The aim of this study is to ascertain the confidence level of Junior Doctors (JD) in assessing capacity.

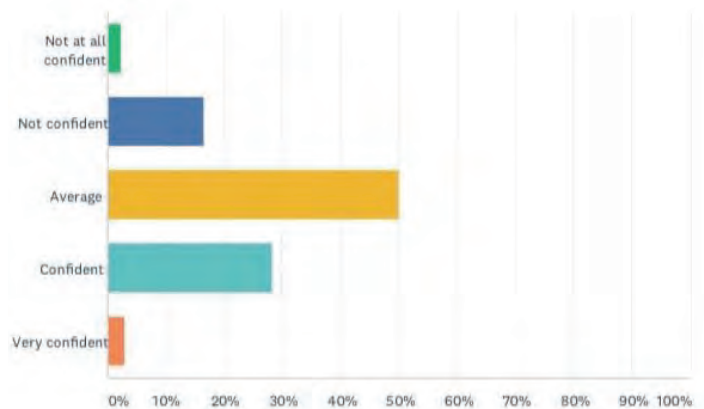
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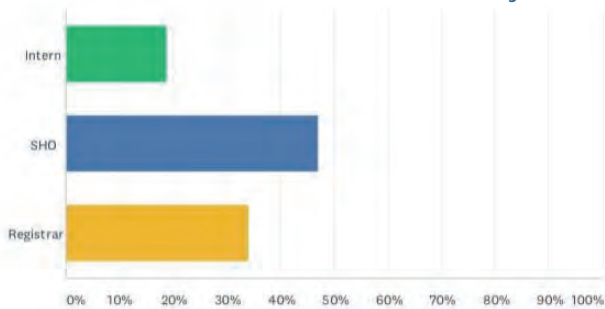
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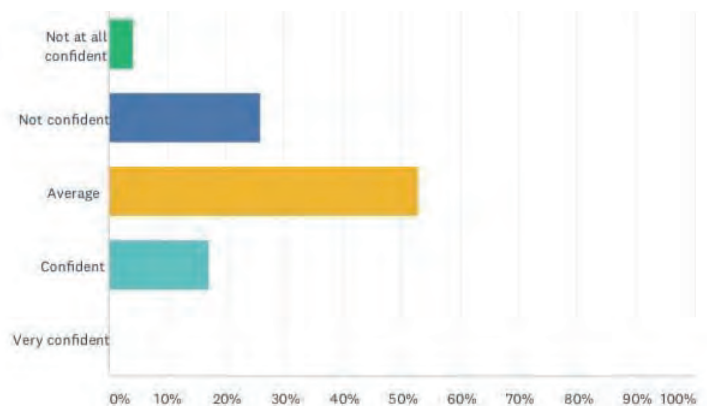
How confident are you at assessing capacity in the context of consenting for a procedure/operation?



What level of Junior Doctor are you?



How confident are you at assessing capacity for discharge decisions/planning?



Have you received formal post graduate teaching on capacity?

Yes	25.16%
No	74.84%

Conclusion

While capacity issues arise on a regular basis in the clinical setting, less than one third of Junior Doctors feel confident in assessing capacity within the context of procedural consent or discharge planning. These results emphasise that further capacity assessment education is needed for Junior Doctors.

CQ - Clinical Quality - CQ - Patient Safety

[A checklist improves clinical decision making in assessing nasogastric tube placement on chest x-rays - Manveer Rahi](#)

Dr Manveer Rahi; Dr Aoife Duignan; Dr Susan Kerr

NHS Borders; University of Edinburgh

Introduction: Oropharyngeal dysphagia is common following stroke. NG feeding can reduce adverse effects associated with dysphagia. However, NG tube misplacement can result in a Never Event- feeding into the lung. We piloted a checklist to aid clinical decision making and reduce the likelihood of systematic errors associated with misplaced NG tubes.

Method: National Patient Safety Guidelines were incorporated with local policy to create a checklist for the placement of NG tubes. Clinician accuracy and confidence for assessing chest x-rays for NG tube placement was assessed pre- and post-checklist.

Results: Doctors-in-training (n=24) were surveyed. 67% of clinicians thought that FY2s and above were responsible for interpreting chest x-rays for NG tube placement. Confidence in interpreting chest x-rays was lower during the out of hours period compared to during working hours across grades. There was a statistically significant increase in confidence levels across grades following use of a formal checklist (p-value: 2.489×10^{-5}). The increase in confidence following introduction of the checklist: Foundation Year doctors (FYs) 9.7%; GP speciality trainees & core trainees (GPST/CT) 11.1%; ST3+ 5.6%. Following introduction of the checklist accuracy was improved in FYs and showed no change in GPST/CT and ST3+ doctors.

Conclusion: Doctors-in-training are frequently tasked with interpreting chest x-rays following NG tube insertion. Confidence in interpreting these investigations is lower among FY doctors and during out of hours periods, when senior cover is reduced. A formal decision aid for interpreting tests following NG tube insertion was created using existing local and national guidelines. A decision aid can improve accuracy and confidence in decision making for interpreting chest x-rays for NG tube placement to reduce systematic errors.

BACKGROUND

Dysphagia following stroke: 80% of patients with stroke are reported to have impairment of swallow with increased mortality from aspiration and increased morbidity from malnutrition. (1)

Feed or ordinary diet (FOOD) trial showed that NG feeding reduced mortality by 5.8% following stroke and improved nutritional state. (2)

NG tube misplacement occurs between 2% and 5% of cases of stroke with dysphagia and up to 50% of cases in patients suffering severe stroke. (3)

Never Events: Feeding into the Lung was designated as a 'Never Event' in 2009 by the (NPSA).

Checklists and decision aids have been shown to improve clinical decision making and can be used to reduce the likelihood of systematic errors such as use of misplaced NG tubes.

OBJECTIVES

1. Explore which clinicians are assessing chest x-rays following NG tube insertion
2. Determine baseline clinician confidence and accuracy in assessing chest x-rays following NG tube insertion
3. Introduce a formal checklist for assessing NG tube placement
4. Examine clinician confidence and accuracy following introduction of a formal checklist

METHODS

The Borders General Hospital is a 328-bedded district general hospital in the Scottish Borders.

Doctors in training (n=24) were surveyed regarding NG tube placement on chest x-rays.

Outcome Measures:

Accuracy: A test comprised of four chest x-rays with participants asked to determine whether the NG tube was correctly sited

Confidence: Participants asked to indicate their level of confidence in their decision regarding NG tube positioning by marking a 10cm line

NG Tube checklist

Figure 1. The NPSA guidelines were incorporated into pre-existing hospital ITU-based guidelines to create a formal decision aid and checklist for the placement of NG tubes.

RESULTS

Which clinicians are assessing chest x-rays following NG tube insertion?

Clinician grade	Number of participants
Foundation Year (FY)	13
GP Speciality Trainee (GPST) or Core Trainee (CT)	7
Speciality registrar (ST3+)	4

Table 1: Demographics of study with number of participants of each clinical grade

- 67% of clinicians thought that FY2s and above were responsible for interpreting chest x-rays for NG tube placement.

RESULTS

Pre-intervention results

	Levels	FY	GPST/CT	ST3+
Confidence during working hours (%)	Mean (SD)	62.8 (23.5)	65.1 (31.0)	84.2 (3.9)
Confidence during out of hours (%)	Mean (SD)	44.3 (23.9)	55.0 (27.1)	77.8 (6.6)
Any formal criteria used	No	9 (69.2)	2 (28.6)	
	Yes	4 (30.8)	5 (71.4)	4 (100.0)

Table 2 – Overall characteristics of confidence of clinicians in interpreting chest x-rays for NG tube placement across grades

Post-intervention results

- The increase in clinician confidence on assessing NG tube placement on chest x-rays after introduction of checklist was statistically significant on Wilcoxon signed rank test (p-value: 2.489x10⁻⁵).
- Accuracy was improved by the use of formal checklist in FY doctors in 30.8% of cases.

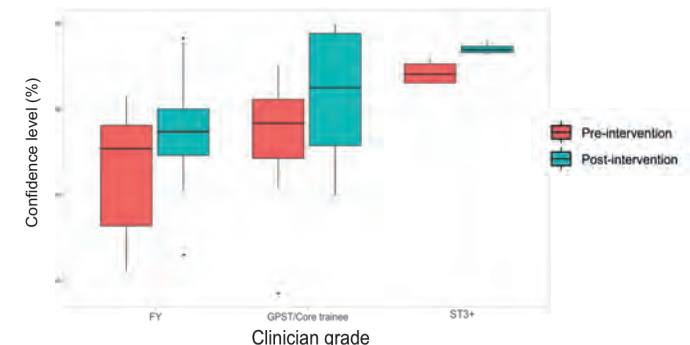


Figure 2. Confidence levels of clinicians assessing chest x-rays for NG tube placement before and after introduction of formal checklist

CONCLUSIONS

Confidence in interpreting NG tube placement is lower among FY doctors and during out of hours periods. A checklist for interpreting tests following NG tube insertion was created using existing local and national guidelines. A decision aid can improve accuracy and confidence in decision making for interpreting chest x-rays for NG tube placement to reduce systematic errors.

CQ - Clinical Quality - CQ - Patient Centredness

Get up and go: Improving patient independence and mobility during the COVID-19 pandemic - Sophie Constantinou

Sophie Constantinou, Katherine Carnegie, Sian Cook, Karl Davis

University Hospital of Wales, Heath Park Way, Cardiff CF14 4XW

Introduction:

During the COVID-19 pandemic we observed that older inpatients were spending much of the day in bed. This project aimed to establish whether the positive impact of the #EndPJPParalysis campaign had been lost and, if so, whether a simple intervention could help improve care quality and prevent further deconditioning.

Methods:

Across ward A (General Medicine) and ward B (Gerontology), four PDSA cycles were undertaken, aiming to increase the proportion of patients out of bed by 10:00am by $\geq 10\%$ during the COVID-19 pandemic. Demographic data and total patient number were collected pre- and post-intervention. Interventions included: highlighting the initiative at 'Board Round,' helping patients to get out of bed during ward rounds and certificates for staff to recognise achievement.

Results:

On Ward B (n=63), more patients were out of bed at 10:00am post-intervention (71% versus 60%; $p=0.05$, $p=0.33$). Barriers preventing patients from getting out of bed were also identified.

Conclusions:

Following the peak of the COVID-19 pandemic, the quality of care as measured by the proportion of patients out of bed by 10am, had diminished. A set of simple interventions were identified, resulting in an increase in the proportion of patients out of bed by 10:00am on ward B. Interestingly, the same interventions did not lead to a significant improvement on ward A, which may be due to smaller sample size or issues arising from redeployment (e.g. staff familiarity with team members and specific needs of older inpatients). Going forward, additional interventions such as staff champions and posters, may provide additional impetus to continue to improve care quality.

Background

During the COVID-19 pandemic we observed that older inpatients were spending much of the day in bed. Lockdown, social isolation and reduced physical activity is likely to lead to widespread deconditioning, particularly for the elderly,¹ which is known to result in frailty, falls, complex hospital-to-home transitions, and even death.² The #EndPJPParalysis³ campaign was a nationwide project, also carried out at the University Hospital of Wales in 2018. The campaign aimed to increase the numbers of inpatients out of bed and dressed to encourage mobility and prevent harm from deconditioning. This project aimed to establish whether the positive impact of the #EndPJPParalysis campaign had been lost and, if so, whether some simple interventions could help improve care quality and prevent further deconditioning.

Methods

Aim

- To improve patient independence and mobility on inpatient geriatric wards during the Covid-19 pandemic, by increasing the proportion of patients out of bed by 10:00 by $\geq 10\%$.

Analysis

- Survey patient preferences and identify barriers to getting out of bed.
- Collect and compare demographic data between wards A (general medicine) and ward B (geriatrics).
- Compare 'spot-check' analyses of patients out of bed at 10:00 pre- and post-intervention on wards A and B.

Interventions

- Highlighting our initiative on daily MDT 'board rounds.'
- Helping patients out of bed during consultant ward rounds.
- Awarding certificates to staff to recognise achievement.



Cycle 1: Considering the #EndPJPParalysis campaign in the context of the Covid-19 pandemic

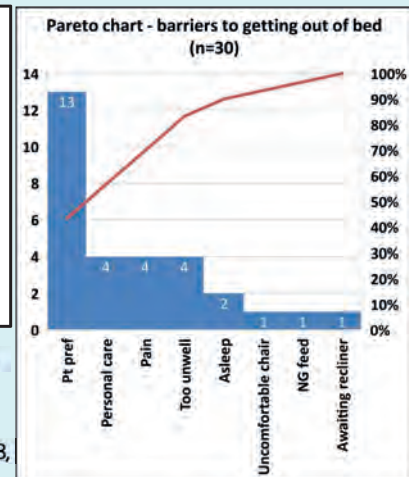
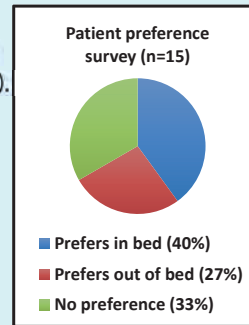
Cycle 2: Identifying barriers to inpatient mobility and independence

Cycle 3: Staff redeployment to Geriatrics ward from general medical ward.

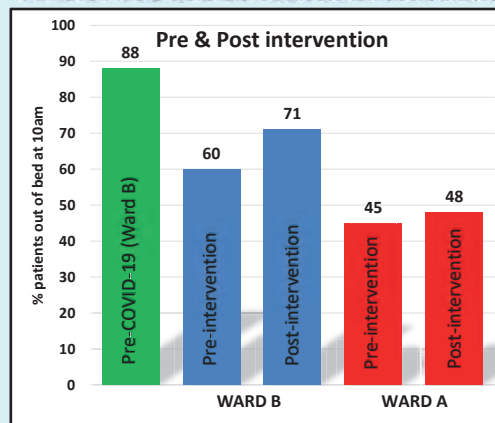
Cycle 4: Embedding lessons learned.

Results

- Of patients surveyed, most preferred to be in bed (40%).
- Patient preference was the most common reason given for patients not being out of bed (34%).
- Additional barriers such as receiving or waiting for personal care, being in pain or being too unwell were also identified.



- Demographic data was similar between Wards A and B, with 56.5% females on Ward A and 63.5% on Ward B ($p=0.56$).
- The median age on Ward A ($n=23$) was 81 (IQR 15.0 pre-intervention, 13.0 post intervention).
- The median age on Ward B ($n=64$) was 84 (IQR 15.5 pre-intervention, 16.8 post-intervention).
- There was no significant difference in patient residence, mobility / use of walking aids, Waterlow or Clinical Frailty Score on admission between the wards.
- However: there were more wheelchair users on Ward A than Ward B (17.4%, vs 1.6%, $p=0.006$).



- On Ward B more patients were out of bed at 10:00am post-intervention (71% versus 60%; $p<0.05$, $p=0.03$).
- However, this was less than the 88% achieved on Ward B during the #EndPJPParalysis campaign (dressed and out of bed).
- On Ward A, there was no difference between the proportion of patients out of bed pre- (45%) or post- (48%) intervention ($p>0.05$, $p=0.33$).

Discussion

Following the peak of the COVID-19 pandemic, the quality of care, as measured by the proportion of patients out of bed by 10am, had diminished, and may reflect the wider negative health effects of the pandemic response. Interventions identified were simple, cost-effective & morale-boosting, and resulted in an increase in the proportion of patients out of bed by 10:00am on Ward B. These interventions can help to prevent serious negative consequences for older hospitalised inpatients and could be rapidly adopted amidst similarly challenging working conditions in future.

However, the same interventions did not lead to a significant improvement on Ward A, which may be due to a smaller sample size or issues arising from redeployment, such as staff familiarity with team members, or the subspecialty they were working in. This may account for the results obtained on Ward B, a geriatrics ward, where nursing staff were working within their own speciality and were more familiar with the specific needs of older inpatients. This observation not only highlights the need for geriatric patients to be cared for in the right environment but should also serve as a reminder to avoid staff redeployment as this may lead to poorer team working and health outcomes for patients.

Going forward, barriers to patient mobility on Ward A should be studied in greater depth to allow interventions to be better tailored. On Ward B, staff champions and visual reminders such as posters may provide additional impetus to continue to improve care quality during these challenging times.

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CQ - Clinical Quality - CQ - Patient Centredness

COVID-19 and the impact on hip fracture patients within Cardiff & Vales
University Health Board. Nedaa Haddad

Nedaa Haddad
University Hospital of Llandough, Cardiff, Wales

Introduction

Covid-19 resulted in huge disruptions within the NHS. During the pandemic, acute hip fracture patients were still admitted within Cardiff and Vale University Health Board and surgeries performed. Though it was obvious how elective work was being impacted, the focus was on how the pandemic was impacting the management and outcomes of hip fracture patients.

Method

Data was collected using the IMPACT audit spreadsheet (an international multicentre audit of COVID-19 in T&O). All hip fracture patients between March 2020 – May 2020 were identified. Some of the data was obtained from the National Hip Fracture Database (NHFD). Whilst the rest collected from patient records on hospital software. It was then analysed using Microsoft Excel.

Results

A total of 132 hip fracture patients were admitted to Cardiff and Vale between March – May 2020. Some entries were excluded due to incomplete data. The average patient age was 81.4 years with 28.8% male patients, and 71.2% female. The average length of stay for patients during the three-month period was 18.2 days, with an average of 85.2% of patients returning to their original residence, the majority being own home/sheltered accommodation. There were 14 patients who swabbed positive for covid-19 post-operatively. Negative swabs contributed to 67 of the patients, with 47 not having a covid swab during admission. Inpatient mortality was 11% (15/130) with 6 patients being covid-19 positive post-operatively and 6 having a negative result.

Conclusion

The length of stay in comparison to the same period in 2019 was the most significant finding (15.56 days less). In addition, more patients returned to their original residence compared to the previous year. These were unexpected figures, especially during this time. We need to examine what service changes contributed to this difference, and whether it can be replicated for the future of hip fracture patients.

COVID-19 and the impact on hip fracture patients within Cardiff & Vale University Health Board

Nedaa Haddad - University Hospital Llandough, Cardiff

Introduction

COVID-19 resulted in huge disruptions within the NHS. During the pandemic, Cardiff and Vale University Health Board continued to admit and operate on hip fracture patients. The pandemic was impacting both elective and emergency services. The question was how and if the pandemic was affecting the management and outcomes of hip fracture patients.

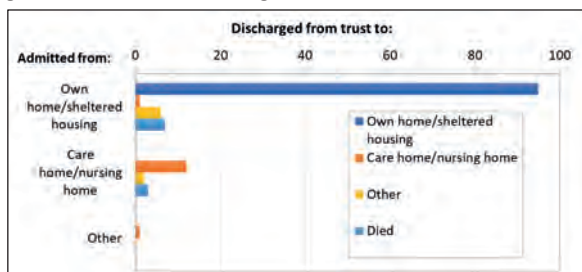
Method

- Data was collected using the IMPACT audit spreadsheet (an international multicentre collaborative audit of COVID-19 in T&O).
- All hip fracture patients between March 2020 – May 2020 were identified.
- Data was obtained using the National Hip Fracture Database (NHFD) and accessing patient results/discharge summaries.
- It was then analysed using Microsoft Excel.

Results

- A total of 132 hip fracture patients were admitted to Cardiff and Vale between March – May 2020. Five entries were excluded due to incomplete data.
- The average patient age was 81.4 years with 29% male, and 71% female.
- 85.8% patients were admitted from their own home/sheltered housing¹.
- 83.5% of patients returned to their original residence¹.
- The average length of stay for patients during the three month period was 18.3 days².
- 13 patients swabbed positive for COVID-19 post-operatively. Negative swabs contributed to 66 of the patients, with 47 not having a COVID-19 swab during admission³.
- Inpatient mortality was 9.4% (12/127) - 4 patients COVID-19 positive post-operatively, 1 patient COVID-19 positive on admission. Though these numbers are too small to interpret, the all Wales figures shows higher risk of inpatient death with a positive COVID-19 swab⁴.

Fig. 1. Admission vs. discharge residence



Results

Fig.2. Average length of stay – acute admission (days)



Fig.3. COVID-19 Status during admission

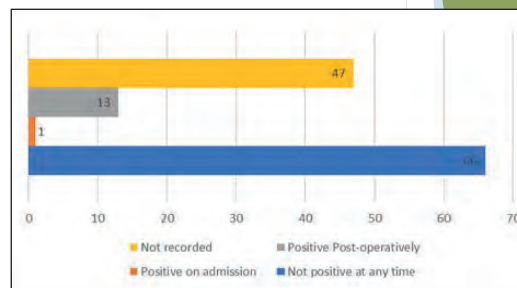
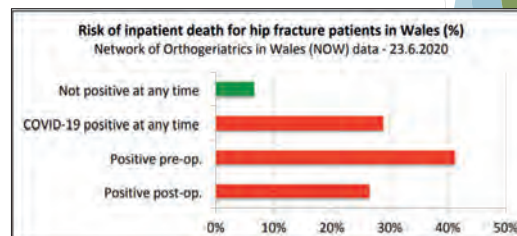


Fig.4. Network of Orthogeriatrics – COVID status & risk of inpatient death [Source: Network of Orthogeriatrics in Wales.]



Conclusion

- Reduction in length of stay in comparison to the same period in 2019 from NHFD data was the most significant finding.
- More patients returned to their original residence compared to the previous year. The impact on discharge is likely to be multi-factorial (more intensive therapy with the goal of discharge, more discharge driven actions of social services/families etc).
- These were unexpected figures, especially during this time. However, the increase in mortality with positive COVID-19 status was not so unexpected.
- We need to examine what service changes contributed to this difference, and whether it can be replicated for the future of hip fracture patients.

Acknowledgements

This poster was possible because of the work of the IMPACT hip fracture audit, Dr Lucy Jawad and Mr Scott Mercer for their help with data collection and Dr Antony Johansen for his guidance with the presentation.

References

- IMPACT collaborative research - <https://www.trauma.co.uk/impact>
- The National Hip Fracture Database - <https://www.nhfd.co.uk/20/hipfractureR.nsf/vwContent/about?opendocument>

CQ - Clinical Quality - CQ - Patient Centredness

Forward Thinking in Idiopathic Parkinson's Disease - Catherine Grose

Catherine Grose; Chris Thomas; Biju Mohamed; Rosemary Patten

Cardiff and Vale University Health Board; Velindre NHS Trust

Introduction

The unpredictable and highly variable disease trajectory that exists within Idiopathic Parkinson's Disease creates great challenge in identifying the optimum time in which to undertake Advance Care Planning (ACP).

The aim of the study was to determine the current utilisation of Advance Care Plans in people with Idiopathic Parkinson's Disease (IPD).

Method

We conducted a retrospective case note analysis of all patients with IPD who were known to the Movement Disorder Service in Cardiff & Vale UHB and who died between January 2016 and December 2019.

Results

Of 85 deaths, 59 patients had a diagnosis of IPD. 8.5% (n5) of patients were known to specialist palliative care teams due to IPD however only 2.8% (n1.7) had a documented ACP. The mean time from diagnosis to death in IPD was 8.4 years (range 2-23 years). 59% (n34.8) of deaths occurred in a hospital setting, of which 68% (n23.7) were due to pneumonia or pneumonitis. 4.2% (n2.5) of patients were documented as being in a palliative phase however none of these patients were known to specialist palliative care teams. 16.9% (n10) of patients were referred to the specialist palliative care team during their last admission. 81% (n47.8) of patients had a last recorded Hoehn and Yahr score of ≥ 4 .

Conclusion

There are currently no widely accepted or published prognostic indicators in Parkinson's Disease. Despite the high proportion of frail patients in IPD the occurrence of Advance Care Planning was low. We are involving palliative care teams late on in the disease course, most frequently during patients last admission, which misses a significant opportunity to prevent unwanted treatment or adhere to patient's wishes with regards to preferred place of care and death.

Forward Thinking in Idiopathic Parkinson's Disease

Catherine Grose¹, Rosemary Patten², Biju Mohamed¹, Chris Thomas¹
Department of Geriatrics, University Hospital of Wales, Cardiff¹, Velindre NHS Trust²



Introduction

Background

The benefits of supporting patients in making decisions about their future care are well recognised.

The unpredictable and highly variable disease trajectory that exists within Idiopathic Parkinson's Disease creates great challenges in identifying the optimum time in which to undertake Advance Care Planning (ACP).

Aims

The primary aim of the study was to determine the current utilisation of Advance Care Plans in people with Idiopathic Parkinson's Disease (IPD) and Atypical Parkinsonism (AP) who are known to the Movement Disorder Service within the Cardiff and Vale University Health Board.

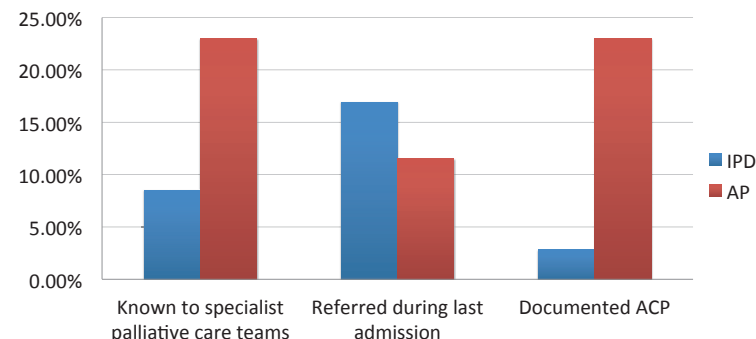
The secondary aim was to identify factors which predict morbidity and mortality in increasingly complex Parkinson's Disease, enabling instigation of ACP discussions at the most appropriate time.

Method

We conducted a retrospective case-notes analysis of all patients with IPD and AP who were known to the Movement Disorder Service and who died between January 2016 and December 2019.

Results

- Of 85 deaths, 59 patients had a diagnosis of IPD and 26 had a diagnosis of AP.
- 8.5% (n5) of patients were known to specialist palliative care teams due to IPD however only 2.8% (n1.7) had a documented ACP.
- The mean time from diagnosis to death in IPD was 8.4 years (range 2-23 years).
- 59% (n34.8) of deaths occurred in a hospital setting, of which 68% (n23.7) were due to pneumonia or pneumonitis.
- 59% (n14) of those who died from pneumonia/pneumonitis had a previously documented impairment of speech/swallow.
- 4.2% (n2.5) of patients were documented as being in a palliative phase however none of these patients were known to specialist palliative care teams.
- 16.9% (n10) of patients were referred to the specialist palliative care team during their last admission. 81% (n47.8) of patients had a last recorded Hoehn and Yahr score of ≥ 4 indicating significant disease burden and frailty
- 23% (n6) of the 26 patients with AP were known to specialist palliative care teams and an additional 11.5% (n3) of patients were referred during their last admission.
- 23% (n6) of patients had an ACP. The mean time from diagnosis to death was 2.7 years (range 0.3-7).



Conclusion

There are currently no widely accepted or published prognostic indicators in Parkinson's Disease. Despite the relatively short disease trajectory particularly in Atypical Parkinsonism and high incidence of frailty in IPD, the occurrence of Advance Care Planning was surprisingly low. We are involving palliative care teams late on in the disease course, most frequently during patients' final admissions. This exposes them to potentially unwanted and futile treatments, and misses a significant opportunity to adhere to patient's wishes with regards to preferred place of care and death.

It is imperative to identify the prognostic factors that could determine the optimal timing and patient subset in which to undertake Advance Care Planning.

CQ - Clinical Quality - CQ - Improved Access to Service

Assessing a Newly Established COVID-19 Safe Parkinson's Service - Catherine Grose

Catherine Grose, Jyothi Adenwalla, Biju Mohamed, Chris Thomas
Cardiff and Vale University Health Board

Introduction

The COVID-19 pandemic has created significant challenges with regard to outpatient services. The significant reduction in available clinic time, backlog of outpatient appointments, recommencement of new referrals and infection control considerations all need to be taken into account when reconfiguring outpatient services.

Aims;

- The development of COVID-19 safe virtual (VC) & face-to-face (F2F) model for Parkinson's clinics
- Measurement of patient acceptability and satisfaction

Method

All patients who were due or overdue a follow up consultation that had either had a F2F or VC between March and July 2020 were contacted by telephone to request their feedback via a short questionnaire. AccuRX software was used to conduct all virtual appointments.

Results

Feedback was obtained from 66 patients.

Post F2F Appointment:

There were 51 respondents. 98% (n50) were satisfied by their F2F appointment. 100% were reassured by pre-clinic preparation and the infection control measures taken by staff. 78.4% (n40) would prefer a F2F appointment in the future. Of the 51 patients who attended a F2F appointment only 21.6% (n11) would prefer a subsequent VC appointment.

Post VC Appointment:

14 patients were contacted for a VC appointment. Of these 35.7% (n5) were changed to a phone consultation due to difficulties with technology. 88.9% (n8) did not feel anxious at the prospect of a virtual appointment. 88.8% (n8) felt their concerns were able to be addressed. 22.2% (n2) would prefer a F2F appointment in the future.

Conclusion

Consultations have traditionally been F2F and there is still a preference to maintain this appointment type in those who have not experienced a virtual appointment or in those who had an unsuccessful virtual appointment. The use of technology appears to be a primary consideration when planning future appointments.

Assessing a Newly Established COVID-Safe Parkinson's Service

Catherine Grose, Jyothi Adenwalla, Biju Mohamed, Chris Thomas
Department of Geriatrics, University Hospital of Wales, Cardiff



Introduction

Background

The COVID-19 pandemic has created significant challenges with regard to the provision of routine and urgent outpatient care. The significant reduction in available clinic time, backlog of outpatient appointments, recommencement of new referrals and infection-control considerations all need to be taken into account when reconfiguring outpatient services.

Aims

1. The development of COVID-19 safe and effective virtual (VC) & face-to-face (F2F) model for Parkinson's clinics
2. Measurement of patient acceptability and satisfaction

Method

All patients who were due or overdue a follow-up consultation that had received a F2F or VC between March and July 2020 were contacted by telephone to request their feedback via a short questionnaire. AccuRX software was used to conduct all virtual appointments.

Questionnaire – Post VC

1. Would you prefer a phone consultation/ virtual consultation /F2F appointment in the future?
2. Do you have access to smart phone /tablet/laptop?
3. If so do you use it for browsing the internet regularly?
4. Do you have a problem with network connection or internet coverage in your house?
5. Would you know your telephone number if asked?
6. Do you struggle with technology in general?
7. Did you find the technology easy to operate?
8. Did you require assistance to undertake the appointment? If so why?

Questionnaire – Post F2F

1. Were you satisfied by your F2F clinic apt?
2. Were you reassured by pre-clinic preparation and clinical staff/PPE in clinic?
3. Would you prefer a VC or F2F clinic in the future?

Post Face-to-Face Appointment

- There were a total of 51 respondents. Of those 98% (n50) were satisfied by their face-to-face appointment with 2% (n1) feeling dissatisfied.
- 100% of patients were reassured by pre-clinic preparation and the infection control measures taken by staff.
- 78.4% (n40) would prefer a face-to-face appointment in the future with 37.5% of these patients (n15) happy to accept a virtual or telephone appointment if necessary.
- Of the 51 patients who attended a face-to-face appointment only 21.6% (n11) would prefer a subsequent virtual clinic appointment.

Post Virtual Clinic Appointment

- 14 patients were contacted for a virtual clinic appointment.
- Of these 35.7% (n5) were changed to a phone consultation due to difficulties with technology: one had no access to the internet, one patient was abroad, one patient was unable to access the camera on their smartphone, the volume controls presented a problem in one case and the fifth patient had access to the internet but didn't use it.
- We were able to obtain feedback from 64.3% (n9) of those who completed a virtual appointment.
- 88.9% (n8) did not feel anxious at the prospect of a virtual appointment. 88.8% (n8) felt their concerns were able to be addressed with a virtual appointment. 22.2% (n2) would prefer a face to face appointment in the future.
- All patients had access to a smartphone or tablet and had no problem with network coverage/internet connection in their home. 66.6% used their phone/tablet regularly for internet access. 88.8% (n8) knew their phone number. 55.6% (n5) usually struggled with technology whilst the same percentage found the technology easy to operate at the time of the appointment.
- 88.8 (n8) needed assistance to undertake the appointment – to facilitate use of the technology and due to loss of dexterity.

Discussion

Consultations have traditionally been face to face and there is still a preference to maintain this appointment type in those who have not experienced a virtual appointment. However virtual clinics were received well by those who undertook them successfully and it was this patient group who were predominantly more willing have a subsequent virtual appointment. The use of technology appears to be a primary consideration with a high proportion of patients requiring assistance to undertake the appointment. Further work is planned looking into patient selection according to appointment type.

CQ - Clinical Quality - CQ - Patient Centredness

Older people's deaths are 'more run of the mill': an Interpretive Phenomenological Analysis - Denise Shanahan

Cardiff and Vale UHB, Cardiff University

Introduction

The largest numbers of people dying in the UK are over 85. They are more likely to have multi-morbidity and frailty contributing to vulnerability at end-of life.

Method

Interpretative Phenomenological Analysis was used to 'give voice' to the concerns of seven RN's by exploring their understanding and sense making of their experiences. They were enrolled at Cardiff University who granted Ethical Approval for the study.

Data was generated using minimally structured interviews for which the RN's were asked to describe a memorable clinical experience(s) of end-of-life care involving older vulnerable adult(s) with frailty. This provided focus to elicit experiences grounded in clinical practice.

Results

One of the original contributions of this study includes the shining gem "older people's deaths are more run of the mill". Older people's deaths were more difficult to remember; The RN's did not necessarily describe their experiences of caring for older adults. Older people's deaths were not particularly memorable. Of the 18 patient deaths discussed only 1 was an older adult with high levels of frailty. Most were condition specific i.e. cancer rather than frailty.

Conclusion

A Healthier Wales proposes those with frailty or at the end of their lives should be treated with dignity, in the most appropriate setting. The shining gem (Smith, 2009) "older people's deaths are more run of the mill" (participant 5, line 10) 'run of the mill' particularly with older adults with frailty creates a sense of invisibility for this particularly vulnerable group which needs further consideration particularly given older peoples' reported experiences during the current Covid-19 pandemic.

"older people's deaths are more run of the mill"

Dr Denise Shanahan, Consultant Nurse Older Vulnerable Adults

The largest numbers of people dying in the UK are over 85 (ONS, 2017, 2020). They are more likely to have multi-morbidity and frailty contributing to vulnerability at end-of-life.

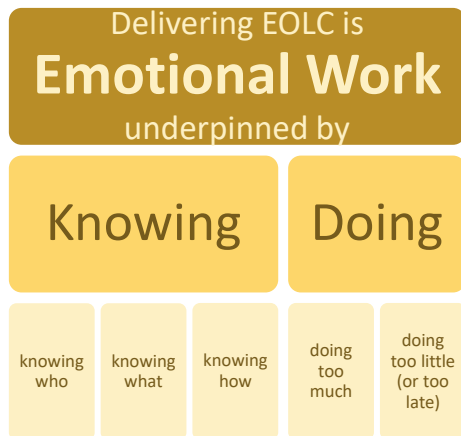
Aim

The aim of the study was to critically explore registered nurses (RN's) professional experience of delivering end-of-life care (EOLC) for older vulnerable adults (with frailty). It involved a critical exploration of the nurses understanding and meaning of the good *enough* death, and aimed to make explicit the similarities and differences of their experiences.

Method

Interpretative Phenomenological Analysis was used to 'give voice' to the concerns of seven RN's by exploring their understanding and sense making of their experiences. They were enrolled at Cardiff University who granted Ethical Approval for the study. Data was generated using minimally structured interviews for which the RN's were asked to describe a memorable clinical experience(s) of end-of-life care involving older vulnerable adult(s) with frailty. This provided focus to elicit experiences grounded in clinical practice.

Findings: the RN's shared experiences



The determinants that facilitated the good enough death involved:

- ✓ recognition of imminent dying
- ✓ being able to provide comfort to the patient and their loved ones
- ✓ awareness of dying

Barriers to the delivery of the good enough death involved:

- × futile treatments
- × staff and family's unpreparedness
- × inability to provide sustained comfort for the patient and their loved ones

The RN's did not necessarily describe their experiences of caring for older adults. Older people's deaths were not particularly memorable.

Of the 18 patient deaths discussed only 1 was an older adult with high levels of frailty. Most were condition specific i.e. cancer rather than frailty.

The shining gem (Smith, 2011)

"*older people's deaths are more run of the mill*" ('Elsa' participant 5, Line 10).

These findings created a sense of invisibility of older people's dying and deaths which is particularly relevant given older peoples' reported experiences during the current Covid-19 pandemic.

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Implications for practice

This study considered a number of associated topics which may have implications for practice:

- ✓ understanding frailty, particularly at end-of-life (WG, 2018: p.23)
- ✓ the RN's role in patient advocacy
- ✓ familiarisation with older adults' values and wishes; particularly within and between different settings of care
- ✓ the concept of the 'good enough death for whom?' <https://caringpractitioner.co.uk/index.php/2019/death-for-whom/>
- ✓ reflective accounts shared for revalidation purposes

CQ - Clinical Quality - CQ - Clinical Effectiveness

Emergency Admissions to Hospital from Nursing Homes: an audit of appropriateness of admission and discharge - Kate Moffat

Kate Moffat; Jane Noble
Department of Older People's Medicine, Newcastle Upon Tyne Hospitals Trust (NUTH)

Introduction:

Nursing Home residents suffer high levels of morbidity and mortality when admitted to hospital. The NHS Long Term Plan recommends a reduction in avoidable emergency hospital admissions from nursing homes and prompt discharge, with personalised care plans to reduce re-admission[1]. This audit aimed to examine the appropriateness of admission and discharge pathways for residents admitted to hospital from nursing homes in Newcastle.

Method:

Information on admissions from nursing homes is routinely collected in NUTH. The electronic records of all emergency admissions from nursing homes in January and February 2020 were reviewed. Data were collected on demographics, frailty score, and discharge implementation. Following review of records, admissions were defined as unavoidable or avoidable; and discharges as appropriate, delayed or premature. The audit was registered on the Trust Clinical Effectiveness database.

Results:

42 nursing home residents (median Clinical Frailty Scale 7 range 5-8) were admitted. 81% of the admissions audited were judged to be unavoidable. Of the 19% in whom admission might have been avoided, half were due to absence or confusion about implementation of Emergency Health Care Plans (EHCP), and half were due to constipation, reduced oral intake, or pre-existing conditions which could have been addressed in the community. On review of case notes of patients deemed to have had appropriate hospital admission, 1 patient had premature and 2 patients had delayed discharge. The latter were related to weekends.

Conclusion:

This audit demonstrates that the majority of patients within this cohort were admitted appropriately to hospital. It identifies three potential areas for improvement: communication and documentation regarding EHCPs; management of pre-existing conditions in community settings; and facilitation of weekend discharge. The Specialist Care Home Support Nursing Team, in conjunction with local geriatricians, is addressing these areas.

References:

[1] NHS England(2019). The NHS Long Term Plan. [PDF]. Available at: <https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf> [Accessed: 28/04/2020]

Emergency Admissions to Hospital from Nursing Homes

An Audit of Appropriateness of Admission and Discharge

Kate Moffat, Jane Noble

Department of Older People's Medicine, Newcastle Upon Tyne Hospitals Trust (NUTH)

Introduction

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Of the 19% in whom admission might have been avoided, half were due to absence or confusion about implementation of Emergency Health Care Plans (EHCP), and half were due to constipation, reduced oral intake, or pre-existing conditions which could have been addressed in the community.

On review of case notes of patients deemed to have had appropriate hospital admission, 1 patient had premature and 2 patients had delayed discharge. The latter were related to weekends.

Conclusion

This audit demonstrates that the majority of patients within this cohort were admitted appropriately to hospital. It identifies three potential areas for improvement: communication and documentation regarding EHCPs; management of pre-existing conditions in community settings; and facilitation of weekend discharge. The Specialist Care Home Support Nursing Team, in conjunction with local geriatricians, is addressing these areas.

References

[1] NHS England(2019). *The NHS Long Term Plan*. [PDF]. Available at: <https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf> [Accessed:28/04/2020]

CQ - Clinical Quality CQ - Patient Centredness

Recording of Weight in Hospital Inpatients - Matthew Howard

POW Hospital, Cwm Taf Morgannwg University Health Board

Introduction

Weight is a key parameter when it comes to the care of hospital inpatients, with a number of uses including drug dosages.

Methods for recording weight include drug charts, as well as nursing documentation and weight charts. Despite the indications for regular weight recording, many hospital inpatients do not have up to date weights recorded. Time restraints, bedbound patients, faulty equipment and increased demand on nursing staff are potential reasons for this. The reason for performing this audit was to determine whether patients are weighed at least once monthly according to NICE guidelines. This audit will focus on a cohort of patients across two wards at Princess of Wales Hospital, Bridgend.

Methods

An initial audit was performed on 05/10/2019, including 47 patients across 2 wards including medical, surgical and gynaecology patients. All documentation was checked for an up to date weight. Following the initial results, two suggestions were made to staff nurses to ensure that 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 new weekly weight column. In order to monitor response to these suggestions, a second audit was undertaken 2 weeks later on 19/10/2019, including 47 patients across the same 2 wards.

Results

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. After the suggestions were implemented, the results improved compared to the initial audit 2 weeks earlier. The number of patients without a weight recorded dropped to 7(15%), with 33 weigh

Recording of Weight in Hospital Inpatients

Matthew Howard
F2, Morrision Hospital, Swansea

Introduction and Reasons for Audit

Recording of weight is key in hospital inpatients and has a number of potential uses:

Selection Criteria

- NICE have published guidance on the recording of weight
- This should be done weekly initially, and then monthly once stable

Data Collection (Cycle 1)

- This audit was initially performed on 5/10/2019 at Princess of Wales Hospital, Bridgend
- This included 47 patients from Obstetrics and Gynaecology, Medical and Surgical specialties across 3 wards
- Patient documentation was analysed to determine whether an up to date weight had been recorded. This included nursing documentation, medication charts and weight charts

Results

- The results of the first audit showed that only 20 patients (43%) had a weight recorded
- Medical patients yielded the worst results, with only 4 patients with a documented weight
- In total, only 4 patients had a weight recorded on the drug chart (see table 1)

Table 1: Results of Initial Audit

Speciality	Number of Patients	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%)
Gynae	3	2	0	0	1(33%)
Total	47	20	0	14	27(57%)

Implementing change

- Following the first audit cycle, a discussion took place with the nurses on the wards. We discussed the importance of recording weight and the recent NICE guidance for recording of weight.
- A weekly weight round was discussed with the nurses to ensure patients were weighed according to guidance. In addition, a new column was added to the patient information board to ensure patients were weighed weekly.

Re-Audit

- A second audit was performed on 19/10/19 across the three same wards at Princess of Wales Hospital
- This included 47 patients from the same specialties
- Results improved significantly, with 85% of patients having an up to date weight, with only 7 without a weigh recorded.
- However, no weights were recorded on nursing documentation

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%)

Discussion

- The results of the re-audit were much improved. However, this still fell short of the NICE guidance
- The 7 patients without a weight recorded were discussed with the nurses, and the following reasons were given:
 - Medication charts had been rewritten and the weight was not written on the new chart
 - 3 patients were new patients on the ward following discharges of patients involved in the initial audit
 - 2 patients could not be weighed for medical reasons (e.g. fractured neck of femur)

Conclusion

- Recording of weight significantly improved following the changes implemented. A vast improvement was seen between both audit cycles.
- These interventions will not only benefit member of staff, but also improve patient care
- The audit itself involved some relatively simple, effective and cheap interventions that made a big difference to patient care
- This goes to show that simple interventions can make a big difference

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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.

Abstract: A VTE Risk Assessment Compliance Audit

Reshma Maraj - Morris Ward, Wrexham Maelor Hospital, BCUHB

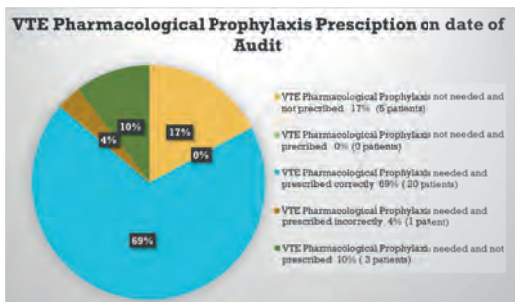
Background:

- In 2005, a UK Health Committee report estimated that ≈ 25,000 deaths from Venous Thromboembolism (VTE) occur each year in hospitalized patients in England alone.
- VTE is the immediate cause of 10% of hospital deaths.
- A 2010 survey into the Prevention and Management of VTE in Hospitalized Patients showed that between 2006 and 2009, 526 patients suffered from a VTE whilst a hospital inpatient in East BCUHB, North Wales.

Methods:

- The audit standard used was NICE guidelines [NG89], Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism. NICE; 2018.
- This retrospective study included inpatients on Morris ward between 16/12/2019 to 20/12/2019.
- After the implementation of the action plan, a reaudit was done on inpatients on Morris ward between 10/02/2020 & 14/02/2020.

Results:



Timing of VTE Prophylaxis Prescription



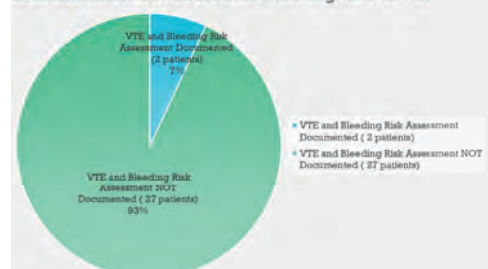
Early, Appropriate VTE Prophylaxis is essential in reducing a preventable cause of morbidity and mortality amongst patients.

Acknowledgements – This audit could not be completed without the advice and assistance from Dr S Abraham, Dr R Mammachan and Dr C Proctor.

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Documentation of VTE Risk/Bleeding Risk Assessment



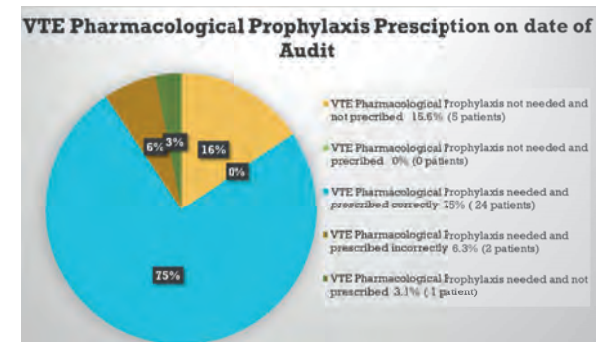
Summary:

- There is a clear need to improve VTE Risk Assessment, Documentation and Compliance with NICE guidelines.

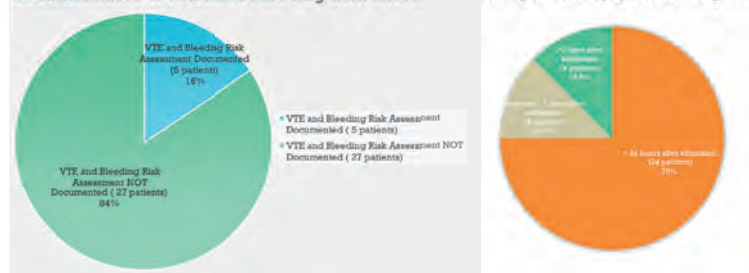
Action plan:

- Labels were made and distributed to junior doctors to reiterate the need for timely VTE Risk Assessment and VTE Prophylaxis Prescribing when clerking patients.
- New Continuation sheets were distributed with tick boxes to be completed which reminded doctors of the need for VTE Prophylaxis.
- The Ward Manager was asked to disseminate the need for early weighing of patients on admission.
- Re-audit in February 2020

Results of Reaudit:



Documentation of VTE Risk/Bleeding Risk Assessment Timing of VTE Prophylaxis Prescription



Summary of Re-audit:

- The simple measures implemented after the initial audit had a positive impact on VTE Risk Assessment, Documentation and Compliance with NICE guidelines.

References:

- Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism. NICE guideline [NG89] Published date: March 2018 Last updated: August 2019 <https://www.nice.org.uk/guidance/ng89>
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CQ - Clinical Quality CQ - Clinical Effectiveness

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

The Royal Hospital Donnybrook, Dublin

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 ($R^2=0.99$). Reduced time to transfer to rehabilitation was significantly correlated with regaining independence with mobility on discharge ($R^2=0.98$).

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.



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

Edel McDaid¹, Elaine Ross¹, Dr. Lisa Cogan¹

1. The Royal Hospital, Donnybrook, Dublin.

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.

Figure 1: New Mobility Score

The New Mobility Score (0-9 points):

Mobility	No difficulty and no aid	With a walking aid	With help from another person	Not at all
Able to get about the house (indoor walking)	3	2	1	0
Able to get out of the house (outdoor walking)	3	2	1	0
Able to go shopping (walking during shopping)	3	2	1	0

Kristensen MT, Hvidovre Hospital. Updated from Parker & Palmer [17] following personal communication with Dr. Martyn Parker, Peterborough, England, December 2009.

Figure 2: Cumulated Ambulation Score

Activity	Not able to despite human assistance or cueing	Able to with human assistance or cueing	Able to with no human assistance or cueing (Can use gait aid)
Get in and out of bed	0	1	2
Sit -> stand -> sit from chair	0	1	2
Walking	0	1	2

Results

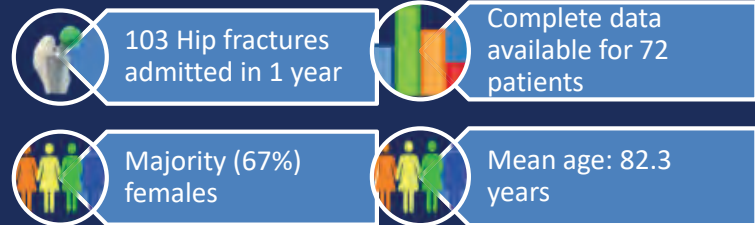
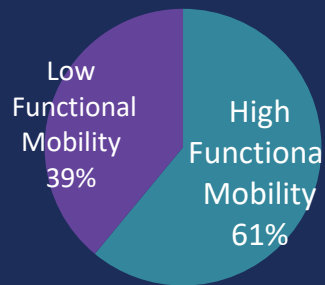
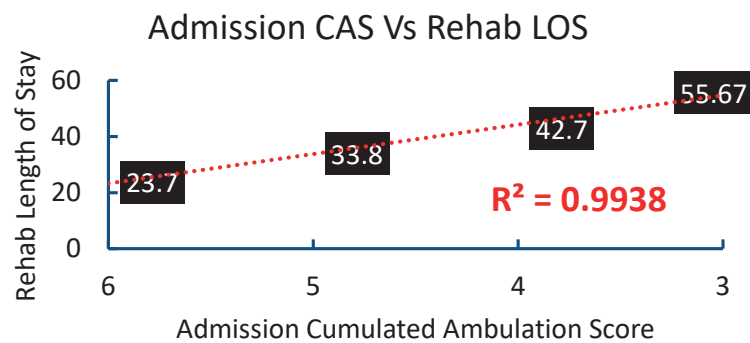


Figure 3: Pre-Fracture Mobility (NMS)



Key Findings

- ✓ **High NMS** was associated with return to independent mobility (CAS=6) on discharge.
- ✓ **CAS on admission** to rehab was significantly correlated with length of rehab stay ($R^2=0.99$).
- ✓ **Reduced time to transfer** was significantly correlated with regaining independence with mobility on discharge ($R^2=0.98$).



Conclusions

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.

References:

- Fitzgerald, M., Blake, C., Askin, D., Quinlan, J., Coughlan, T. and Cunningham, C. (2018). Mobility one week after a hip fracture – can it be predicted?. *International Journal of Orthopaedic and Trauma Nursing*, 29, pp.3-9.
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CQ - Clinical Quality CQ - Patient Centredness

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

Shakira Ramzah, Eint Thein and Nibu Thomas
Geriatric Medicine Department, YG,BCUHB

Collateral history taking is required part of 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.

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.

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%.

We noticed a sizeable information gap between the traditional method and our standardised approach. This gap may be due to many reasons; 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).

Use of questionnaire may also aid improving patient care, patient flow and preventing unnecessary readmissions.

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

Shakira Ramzah, Eint Thein and Nibu Thomas.
Geriatric Medicine Department, Ysbyty Gwynedd, BCUHB.

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 standardized proforma used to gather this information. This delays planning for patient's care and discharge. We hope to come up with a standardized, 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. 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.

References

Jorm, AF: Short Form of the Informant Questionnaire on Cognitive Decline in the Elderly (Short IQCODE)
Psychol Med 1994 ; 24:145-153

(<https://www.alz.org/media/documents/short-form-informant-questionnaire-decline.pdf>)

Modified IQCODE Proforma

Modified Short Form of the Informant Questionnaire on Cognitive Decline in the Elderly (Short IQCODE) for Collateral History Taking
Compared with 6 months ago how is your next of kin at:

1. Remembering things about family and friends e.g. occupations, birthdays, addresses	Much improved	A bit improved	Not much change	A bit worse	Much worse
2. Remembering things that have happened recently	Much improved	A bit improved	Not much change	A bit worse	Much worse
3. Recalling conversations a few days later	Much improved	A bit improved	Not much change	A bit worse	Much worse
4. Remembering his/her address and telephone number	Much improved	A bit improved	Not much change	A bit worse	Much worse
5. Remembering what day and month it is	Much improved	A bit improved	Not much change	A bit worse	Much worse
6. Remembering where things are usually kept	Much improved	A bit improved	Not much change	A bit worse	Much worse
7. Remembering where to find things which have been put in a different place from usual	Much improved	A bit improved	Not much change	A bit worse	Much worse
8. Knowing how to work familiar machines around the house	Much improved	A bit improved	Not much change	A bit worse	Much worse
9. Learning to use a new gadget or machine around the house	Much improved	A bit improved	Not much change	A bit worse	Much worse
10. Learning new things in general	Much improved	A bit improved	Not much change	A bit worse	Much worse
11. Following a story in a book or on TV	Much improved	A bit improved	Not much change	A bit worse	Much worse
12. Making decisions on everyday matters	Much improved	A bit improved	Not much change	A bit worse	Much worse
13. Handling money for shopping	Much improved	A bit improved	Not much change	A bit worse	Much worse
14. Handling financial matters e.g. the pension, dealing with the bank	Much improved	A bit improved	Not much change	A bit worse	Much worse
15. Handling other everyday arithmetic problems e.g. knowing how much food to buy, knowing how long between visits from family or friends	Much improved	A bit improved	Not much change	A bit worse	Much worse
16. Using his/her intelligence to understand what's going on and to reason things through	Much improved	A bit improved	Not much change	A bit worse	Much worse

Additional questions for Social History

Baseline mobility:

Before illness, how has your next-of-kin been mobilising? Circle the best option	Independent or stick	Frame	WheelChair	Housed out of bed	Immobile
How many assistants? Is this different to now and how so?	Independent Or stick	0	1	2	>2
How many assistants?		0	1	2	>2

Social support:

Number of carers a day? 1 2 3 4 Alternate days

Does your next-of-kin require help with:

Dressing Yes / No

Washing Yes / No

Meal preparation Yes / No

Feeding self Yes / No

Shopping Yes / No

Equipment available at home (Circle what is available):

Commode	Steady
Toilet aids (Frame/ different heights)	Hoist
Bed raise	Dressing aid
Bed frames	Washing stool
Kitchen trolley	Other kitchen aids

Home modifications:

Stair lift -Y/N

Hand rails -Y/N

Hospital bed -Y/N

Carpeting -Y/N

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 standardized 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.

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

Recommendations

We would recommend using the modified IQCODE proforma to gather information on cognitive decline, patients' mobility and social support at the point of admission OR during hospital stay if collateral history is required.

CQ - Clinical Quality CQ - Clinical Effectiveness

A QIP ON IMPROVING MANAGEMENT OF INTRACEREBRAL HAEMORRHAGE AT A LOCAL DGH – Dr Nibu Thomas

Ysanne Clark, Christopher Jones, Jason Ray, Nibu Thomas, Rhian Owen, Linda Rowlands, Laura Roberts and Salah Elghenzai
Department of Geriatric Medicine and Stroke Medicine, YG, 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 mRS <3, hydrocephalus, GCS <9 or presence of posterior haemorrhage. We assessed how compliant our 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 DOACs 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. Our new proforma 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.

A QIP ON IMPROVING MANAGEMENT OF INTRACEREBRAL HAEMMORHAGE AT A LOCAL

DGH Clark, Y.F., Jones, C., Ray, J., Thomas, N.P., Owen, R., Rowlands, L., Roberts, L., Elghenzai, S. *Department of Geriatric Medicine and Stroke Medicine, Ysbyty Gwynedd, BCUHB*

Please email ysanneclark@gmail.com with any questions

Background

NICE guidance is clear about recommendations on patients presenting with acute intracerebral haemorrhage (ICH). We performed an audit to assess how compliant our district general hospital (DGH) was with these guidelines.

Target systolic blood pressure (SBP) of 130 to 140 mmHg should be achieved within 1 hour of starting treatment.

Anticoagulation should be reversed if possible.

Follow local guidelines for discussion with neurosurgery centre

Local criteria
modified Rankin Scale (mRS) <3
hydrocephalus
GCS <9
presence of posterior haemorrhage.

Results

Descriptive Stats

- Age range: 57-103, median 81yo
- 10 male, 7 female
- Collapse most common presentation (47%)
- GCS on admission between 7-15, median 14
- NIHSS on admission between 6-33, median 11

Blood Pressure Control

- 4/12 patients (33%) who had elevated SBP on admission were treated
- 1 (25%) achieved SBP < 140 mmHg within 1 hour and 3 (75%) achieved this within 6 hours.

Anticoagulant Reversal

- 1 patient on warfarin had this reversed.
- 2 patients on NOACs were not treated with reversal agents.

Discussion with Neurosurgery

- 13 patients (76.5%) were discussed with neurosurgical tertiary centre
- 8 of these patients (61.4%) did not meet criteria for discussion.

Conclusions

We are missing the opportunity to correct blood pressure in 66.6% patients presenting with ICH

Anticoagulants were reversed appropriately, however it was only a factor in 17% of these ICHs

We are discussing too many patients with neurosurgery, and not using mRS enough. All of our patients were managed conservatively.

By creating a proforma for use in the ED we could improve blood pressure control in these patients and reduce workload by minimising neurosurgery referrals

Figure 1: "Reduce, Reverse, Refer" algorithm currently being introduced in Ysbyty Gwynedd

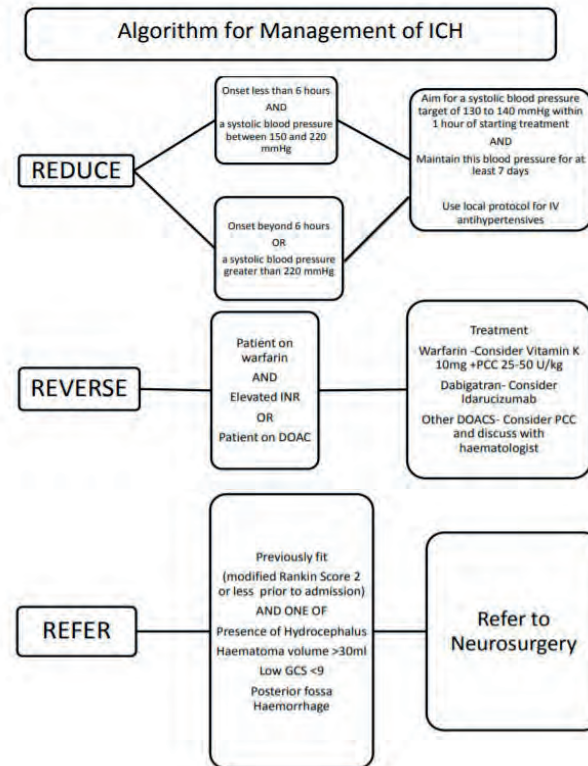


Table 1 showing modified Rankin Score

Patient's Baseline Activity	Modified Rankin Score
No symptoms	0
No disability despite symptoms, carry out all activities and ADLs	1
Slight Disability: unable to carry out all previous activities, able to look after own ADLs without assistance	2
Moderate Disability: Requires some help, able to walk without assistance	3
Moderately severe disability: assistance for all ADLs/walking	4
Severe Disability, bedbound, incontinent, constant nursing care	5
Dead	6

Methods

- 18 patients admitted to the acute stroke unit with ICH from 4th October 2019 to 16th February 2020. (About 1 patient/week)
- 1 excluded due to insufficient data
- 8 patients died

Information was obtained from case notes and entered into a proforma. Analysed using Microsoft Excel.

Patient Group

Data collection and analysis

SP - Scientific Presentation - SP - Other (Other medical condition)

[Chronic venous ulcers and plasma and wound iron levels - Amy Ferris](#)

Amy Ferris; Keith Harding

Cardiff and Vale University Health Board, Welsh Wound Innovation Centre

Background: Haemosiderin deposition is a recognised feature of chronic venous disease suggesting that localised iron metabolism may play a part in disease pathogenesis but the mechanism of this is not yet established.

Aim: In this novel pilot study we aim to demonstrate the relationship between plasma and wound fluid iron and healing in venous leg ulcers as well as the effect of anaemia on this relationship.

Design: 15 patients with established venous leg ulcers had wound fluid iron concentration measured from wound exudate, with a paired venous blood sample for analysis of haemoglobin and iron parameters. Their wound area was also measured at baseline and repeated at 4 weeks.

Results: Wound fluid and serum iron concentrations have a positive association (correlation coefficient=0.27) in patients with venous leg ulcers. Patients with systemic anaemia were also generally found to have lower levels of iron in wound fluid and 88% of patients who's wounds failed to show signs of healing were iron deficient or anaemic.

Discussion: The positive association between wound fluid and serum iron which is more prominent in patients with anaemia suggests that systemic iron levels are being depleted due to the presence of a chronic wound, the mechanism for which is currently unclear but may involve leaching of iron out of the body in wound exudate. This data also suggests that the prevalence of iron deficiency anaemia may be higher in this group of patients than the general population.

Conclusions: The prevalence of iron deficiency anaemia appears to be higher in patients with chronic venous disease and a larger population level study is required to fully quantify this issue. In addition to this, further data is required on the association between wound and systemic iron levels to fully characterise the mechanism of iron deficiency in this patient population.

Dr Amy Ferris, Cardiff and Vale University Health Board
Professor Keith Harding, Welsh Wound Innovation Centre

Background

- Haemosiderin staining in the limbs of patients with chronic venous disease is well recognised.¹
- Research has previously shown higher levels of iron and ferritin in wound fluid from chronic wounds compared to acute.^{2,3}
- Biopsies of chronic venous ulcers have shown higher levels of iron at the ulcer edge than elsewhere on the limb⁴
- Given the role of iron and haemoglobin in tissue oxygenation, it would seem logical to assume that anaemia would cause localized hypoxia impairing tissue viability however very little robust data are available in the conclusive link.⁵

Aim

Pilot study to establish the relationship between systemic and wound fluid iron levels and healing in venous leg ulcers.

Design

15 patients with established venous leg ulcers had wound fluid iron concentration measured from wound exudate, with a paired venous blood sample for analysis of haemoglobin and iron parameters. Their wound area was also measured at baseline and repeated at 4 weeks. This was approved by the South Central Research Ethics committee (17/SC/0521).

Results

- 15 patients studied, with ulcers present between 1-33 years.
- Figure 1: Wound fluid and serum iron concentrations have a weakly positive association (correlation co-efficient=0.27).
- There was no correlation between wound fluid iron levels and haemoglobin or ferritin, but the 2 patients with the lowest wound fluid iron level also met the diagnostic criteria for iron deficiency anaemia (figure 1, yellow dots)
- Figure 2: No correlation was identified between wound fluid iron level and percentage reduction in wound area at 4 weeks, however, all patients who's wound reduced in size had normal blood parameters (black points), whereas 88% of patients who's wounds did not reduce in size had either anaemia or iron deficiency (red dots)

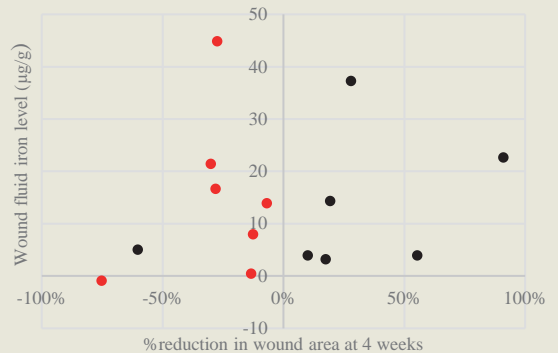


Figure 2: Graph showing the association between reduction in wound area at 4 weeks and wound fluid iron level. Red = meet definition of anaemic or iron deficient according to World Health Authority or British Society of Gastroenterology.

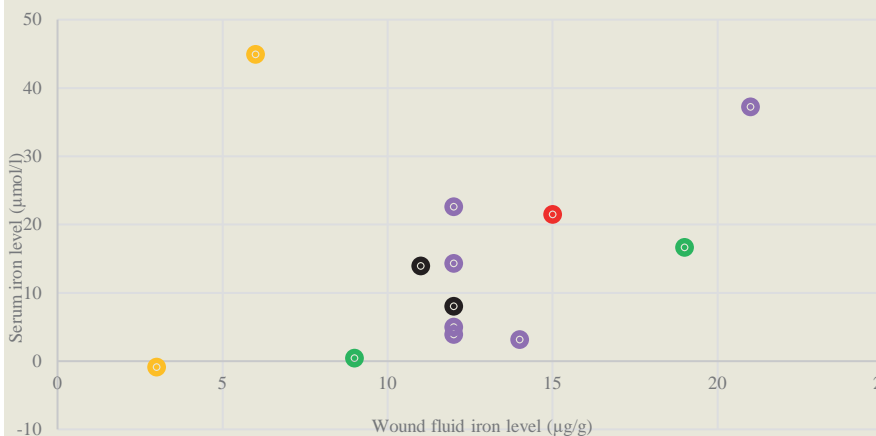


Figure 1: Graph showing association between wound fluid iron level and serum iron level. Key: Red = anaemic only. Yellow = anaemic and iron deficient according to WHO definition (10). Green = ferritin <50 suggesting iron deficiency in context of chronic inflammation, black = anaemic and ferritin <50 suggesting iron deficiency in context of chronic inflammation according to British Society of gastroenterology guidelines(11). Purple = no anaemia or iron deficiency by either definition

Conclusion

In this pilot study we have demonstrated a suitable method of evaluating the relationship between fluid and serum iron levels in patients with venous leg ulcers. We have demonstrated a potential association between wound fluid iron loss and systemic iron depletion which requires further research to characterise fully. Our data suggests there may be a higher prevalence of iron deficiency anaemia in patients with chronic venous disease and the diagnostic criteria for this needs careful consideration.

References

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Discussion

The positive association between wound fluid and serum iron which is more prominent in patients with anaemia suggests that systemic iron levels are being depleted due to the presence of a chronic wound, the mechanism for which is currently unclear. We hypothesise that iron may leach out of the body in wound exudate, depleting systemic stores. This data also suggests that the prevalence of iron deficiency anaemia may be higher in this patient group than the general population. We suggest that the presence of a chronic wound is itself an inflammatory state and as a result the diagnostic criteria of ferritin <15 for iron deficiency also needs to be reviewed in this patient group as ferritin is an acute phase protein, which could be falsely reassuring in this cohort.

SP - Scientific Presentation - SP - Epid (epidemiology)

[Outcomes of COVID-19 infection in Care Homes: Learning from Experience - Germain Lam](#)

Germain Lam; Angela Puffett

Withybush General Hospital

Introduction: In the early stages of the COVID-19 Pandemic, those aged over 70 were warned that infection with the virus could result in hospitalisation or death. This retrospective observational study examines the outcomes of those living in care homes who have tested positive for the virus.

Method: Three care homes in the Pembrokeshire County Area that reported outbreaks of COVID-19 between March and August 2020 were contacted. Gender, age, frailty score, and mortality and morbidity of those who had tested positive were recorded.

Results: The average age of patient in the study was 82, and the mean frailty score was 6.56. Of those who tested positive for COVID-19, 30% were asymptomatic, 30% recovered well, and 40% died. Frailty score was positively correlated with case fatality. Conversely age did not appear to be associated with case fatality; however, there was a trend towards an increased likelihood of displaying symptoms with age.

Conclusion: This small observational study describes the outcomes of COVID-19 infection in the elderly living in care homes. The data suggests that frailty rather than age is associated with higher mortality in COVID-19 infection; whereas, age may play a role in morbidity in COVID-19. Due to the small sample size, further research is needed for corroboration of these results.

Covid-19 infection in Care Homes: Learning from Experience

DR GERMAIN LAM, DR ANGELA PUFFETT

WITHYBUSH GENERAL HOSPITAL, PEMBROKESHIRE

Background: At the start of the COVID-19 Pandemic, those aged over 70 were warned that infection with the virus carried a high chance of hospitalisation or death¹. This retrospective observational study examines the outcomes of those living in care homes who have tested positive for the virus, and whether age or frailty carries a higher risk of morbidity or mortality in COVID-19 infection.

Method: Three care homes in the Pembrokeshire County Area that reported outbreaks of COVID-19 between March and August 2020 were contacted. Gender, age, frailty score, and mortality and morbidity of those who tested positive were recorded.

Results: 52 out of 121 residents tested positive for COVID-19. Of those with a positive test, average age was 84, and the mean frailty score was 6.4. Outcomes of those who tested positive in care homes is illustrated by the [chart](#).

The [table](#) summarizes the average age and frailty score of patients of each outcome.

Frailty score was positively correlated with case fatality and morbidity. Conversely age did not appear to be associated with case fatality.

Discussion: This small observational study defines the outcomes of COVID-19 infection in the elderly living in care homes. Most patients over the age of 70, with a mild to moderate frailty score, managed to make a full recovery (79%). The data suggests that frailty rather than age is associated with higher mortality and morbidity in COVID-19 infection; however younger patients were more likely to be asymptomatic. This study supports current evidence that frailty may have superiority over age in predicting for adverse outcomes in a multitude of presentations²⁻³. Limitations of the study include: small sample size, lack of data on patient's comorbidities, and the subjectivity in assessing patients frailty score. Further research with a bigger sample size, taking into account comorbidities is needed for corroboration of these results.

Chart: Outcomes of COVID-19 in Care homes

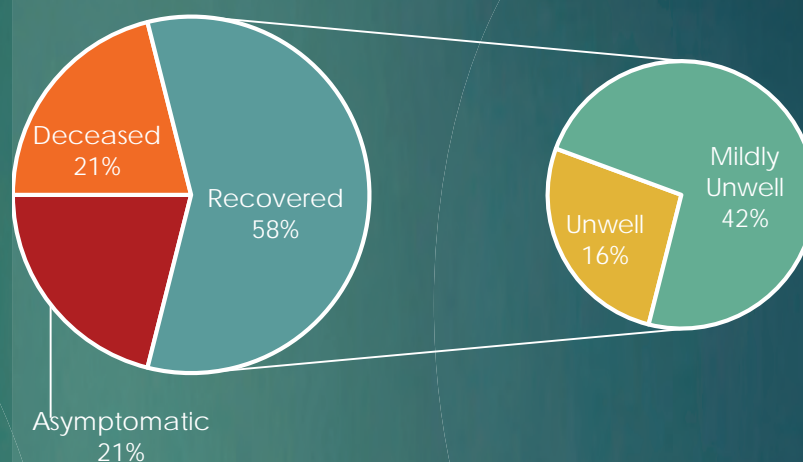


Table: Average Age and Frailty Score of Outcomes

	Average Age	Average Frailty Score
Died	83	6.6
Recovered	86.7	6.4
Mildly Unwell	87.5	6.4
Unwell/Required Hospitalisation	84.5	6.4
Asymptomatic	78.5	6.2

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SP - Scientific Presentation - SP - Other (Other medical condition)

Predictors of mortality in older patients with Covid-19: A ward-based cohort study - Stephanie Wells

Stephanie Wells (1), Andrew Forrester (2) and Sanjeev Vasishta (2)

(1) University Hospital of Wales, Cardiff and Vale University Health Board. (2) Royal Gwent Hospital, Aneurin Bevan University Health Board

Background: Routine frailty scoring for patients was introduced in Aneurin Bevan University Health Board during the Covid-19 pandemic. D4 West in the Royal Gwent Hospital (a Geriatric Medicine ward) was repurposed as a Covid-cohort ward in March 2020. Our aim was to examine the impact of frailty on patient outcomes in Covid-19. At the point of data collection, there were no large published data sets examining this.

Method: Demographic data including age, sex and ethnicity were collected for patients admitted to the ward with confirmed Covid-19. The Clinical Frailty Score (CFS), Charlson Co-morbidity index and length of stay were calculated. Discharge destination and Covid-19 associated mortality were also recorded. We re-visited the data of discharged patients to assess all-cause mortality at 30 and 100 days.

Results: 120 patients were admitted to the ward in this period. 7 patients were excluded from the analysis (age \leq 5). 30 day mortality was 44% (n= 50) rising to 50% (n=56) at 100 days. Age $>$ 80 and CFS $>$ 5 were significantly associated with increased mortality at both time points (p $<$ 0.05). 59% (n=40) patients with hospital acquired infection died.

Conclusions: Our findings are consistent with other published data sets demonstrating increasing age and frailty to be predictors of poor outcomes in Covid-19. Of concern in our data is the high mortality associated with hospital acquired Covid-19. Targeted reflection and quality improvement activities within the organisation will be critical for safeguarding vulnerable inpatient populations in the event of a resurgence of Covid-19 infection

Predictors of mortality in older patients with Covid-19: A ward based cohort study

Dr Stephanie Wells¹, Dr Andrew Forrester², Dr Sanjeev Vasishtha²

1. University Hospital of Wales, Cardiff and Vale University Health Board
2. Royal Gwent Hospital, Aneurin Bevan University Health Board

BACKGROUND

In March 2020, rapid guidance published by the National Institute for Health and Clinical Excellence (NICE) recommended the use of the Clinical Frailty Score to help guide decisions regarding escalation of care and ceilings of treatment for patients with Covid-19¹. Driven by anxieties surrounding organisational preparedness and critical care capacity, suddenly, issues surrounding frailty were launched to the forefront of the pandemic. However, whilst emerging data suggested that increasing age was associated with poor outcomes in the context of Covid-19 infection², at the time there was no published data examining the impact of frailty³.

SETTING

In response to the NICE Guidance¹, routine frailty scoring for patients was introduced in Aneurin Bevan University Health Board. The Clinical Frailty Score with descriptors was included on the medical clerking proforma and on the forms documenting patients' Treatment Escalation Plans. D4 West usually operates as a Geriatric Medicine ward in the Royal Gwent Hospital, Newport. However, in March-May 2020 it was temporarily re-purposed as a Covid-19 Cohort ward. The ward accepted admissions of Covid-19 confirmed patients direct from the Emergency Department or as transfers from other wards within the hospital. Patients were either discharged home, transferred to community rehabilitation hospitals or died.

STUDY AIMS

- Capture the demographics of our patient cohort
- Assess the prevalence of frailty
- Identify patient factors associated with adverse outcomes
 - Increased length of stay
 - Mortality



METHOD

Data were collected prospectively for all patients admitted to the ward with a PCR confirmed diagnosis of Covid-19 between 12th March and 23rd April 2020.

Data collected for each patient included:

- Demographic information (Age, sex and ethnicity)
- Clinical Frailty Score
- Community vs Hospital Acquired Infection
- Length of Stay
- Discharge destination
- Mortality (30 days and 100 days)



*Hospital acquired infection was defined as:

1. Patients who had developed the first symptoms of Covid-19 as an inpatient where they had not displayed symptoms of Covid-19 at the point of admission.
2. Patients who had a previous hospital admission with known close contact with a PCR confirmed case who were discharged to self-isolated but were subsequently readmitted with symptoms of Covid-19 within the incubation period.

RESULTS: COHORT CHARACTERISTICS

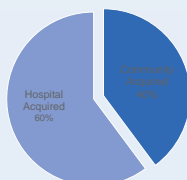
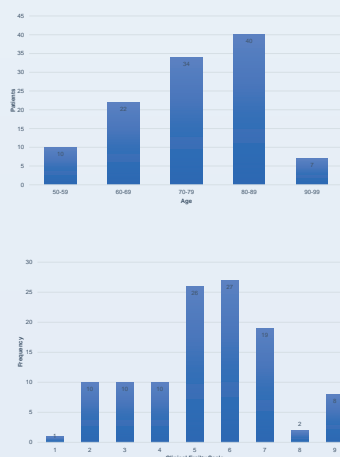
120 patients were admitted to the ward in this period. 7 patients were excluded from the analysis (age<50).

97% were white (n=110) and 56% (n=64) were male.

The average age was 76 years with 65% (n=74) aged 70-90.

Frailty was prevalent with 73% (n=82) of patients with CFS >5.

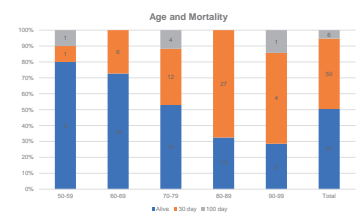
40% (n=45) were admitted with Covid-19 and 60% (n=68) acquired it in hospital.



RESULTS: OUTCOMES

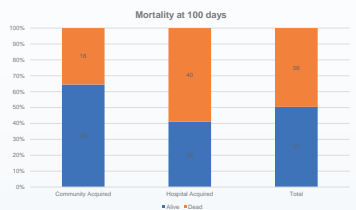
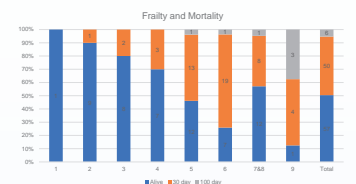
Length of Stay

- The mean length of stay was 23 days.
- Frailty scores ≥ 5 were associated with an increased length of stay (CFS ≤ 4 15.74 days, CFS ≥ 5 25.64 days $p=0.02$)
- Time from positive swab to hospital discharge was higher in patients with hospital acquired infection (Community acquired 10.42 days, Hospital acquired 18.35 days $p<0.01$)
- 23% (n=26) were discharged from D4 West to their original community dwelling, 34% (n=39) required transfer to a rehabilitation hospital and 42% (n=48) died before discharge from the ward.



Mortality

- 30 day mortality was 44% (n= 50) rising to 50% (n=56) at 100 days.
- Age >80 ($p<0.001$) and CFS >5 ($p<0.0001$) were associated with significantly increased mortality at both time points.
- 59% (n=40) patients with hospital acquired infection died. There were significant differences between mortality in the community and hospital acquired infection groups ($p<0.02$)



DISCUSSION

The strengths of our study include prospective data collection, 100 day follow up for mortality data and results that are in keeping with the findings of larger published data sets in the literature. The limitations include a relatively small data set, the examination of all cause mortality rather than Covid-19 specific mortality and the use of a definition of hospital acquired infection that may have resulted in an overestimation of case numbers.

Our findings are consistent with literature that has since been published demonstrating increasing age and frailty to be independent risk factors for adverse outcomes in Covid-19³⁻⁵. The proportion of patients with CFS >5 was higher in our cohort than other larger centre studies³, this may be a result of patients who were less frail being cared for in higher care settings within the hospital e.g. Respiratory Ward/Critical Care.

There was a high proportion of nosocomial infection and associated mortality in our cohort. Our results demonstrate a higher incidence of nosocomial infection (60%) than other estimates in the literature with studies in London⁵⁻⁷, Birmingham⁸ and Wuhan⁹ giving a lower estimates. The significant differences in mortality identified between mortality in community and nosocomial acquired Covid-19 has not been observed in other data sets^{5,10}. The higher mortality rates in our cohort may be explained by the higher prevalence of frailty and differences in the definition of nosocomial infection. Strategies that could be employed to reduced the rate of in-hospital transmission include the strict employment of basic hygiene measures for staff and patients, routine testing of healthcare workers to identify asymptomatic carriers, robust admission triage systems and local engagement with quality improvement activities.

CONCLUSIONS

Higher frailty score and increasing age are associated with worse outcomes for patients with Covid-19. A significant proportion of cases in our cohort acquired Covid-19 in hospital. Robust operational strategies within organisations are needed to safeguard vulnerable inpatient groups from nosocomial acquired infection in the face of a second wave.

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SP - Scientific Presentation - SP - Falls (Falls, fracture & trauma)

Inpatient Head Injury: A routine event or a clinical risk in our practice? - Jayashree Pathak

Jayashree Pathak, Mehnaj Noor Babui, Inder Singh

Ysbyty Ystrad Fawr, Aneurin Bevan UHB, Wales

Introduction: Inpatient falls (IF) are common in our hospitals but there is no national benchmark data for IHI rate, risk management or clinical outcomes. The purpose of this scoping exercise is to understand clinical risk and adverse outcomes to envisage the gaps in our care.

Methods: This is a retrospective analysis of the current service at Ysbyty Ystrad Fawr, Wales. All data for IF from 01/01/2017 to 30/04/2020 was retrieved. All IF with clinically suspected head injury and where CT scan was requested were included.

Results: Total number of IF falls during study period were 2635 from 227,927 occupied bed days (OBD), giving IF rate of 6.3/1000 OBD. Total number of IF with suspected HI and CT done was 365, therefore IHI rate was 1.6/1000 OBD. Mean age was 82.7 ± 7.7 (range 55–99) years, 53% were women. The incidence of dementia and delirium were 32.3% (n=118/365) and 37.8% (n=125/365) respectively. 64.6% (n=236/365) % on anticoagulation. CT request same day in 50% (n=184/365). Delay in requesting CT head was 1.4 ± 3.0 days. Delay in performing CT head was 0.08 ± 0.3 days. The five most common reasons for requesting CT were anticoagulation (24%, 83/365), External injury (23%, 78/365), new confusion (22%, 75/365), focal neurological deficit (18%, 61/365) and drop in conscious level (17%, 58/365). Mean hospital stay was 50.7 ± 44.2 days; admissions from own home were 94.2% (n=344/365) and discharges to own home was 50.4% (n=184/365); 97 patients required a new care home placement, inpatient mortality was 16.1% (n=59/365) and one-year mortality was 44.6% (n=129/289). Anticoagulant use associated in 59.3% inpatient death (n=35/59)

Conclusion: IHI have considerable poorer outcome and leads to serious harm in terms of mortality and a need for a new care home. We recommend further evaluation from other hospital sites to measure the impact of environmental and patient factors.

INPATIENT HEAD INJURY: A ROUTINE EVENT OR A CLINICAL RISK IN PRACTICE?



Jayashree Pathak; Mehnaj Noor Babui; Inderpal Singh

DEPARTMENT OF GERIATRIC MEDICINE, ANEURIN BEVAN UNIVERSITY HEALTH BOARD, WALES, UK

BACKGROUND

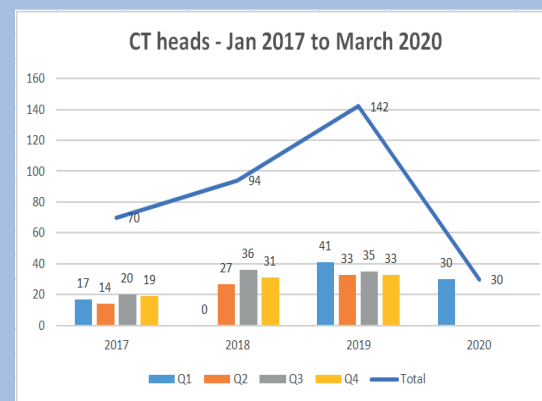
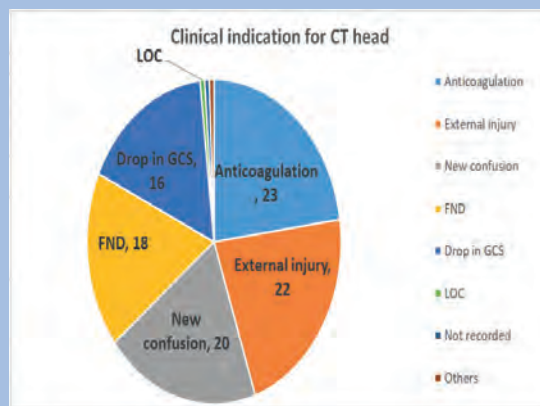
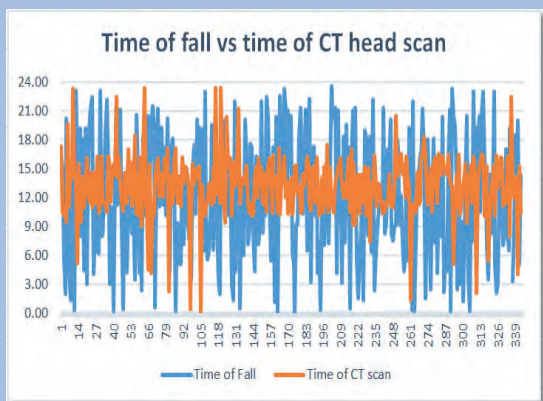
Inpatient falls (IF) are common in our hospitals but there is no national benchmark data for IHI rate, risk management or clinical outcomes. The purpose of this scoping exercise is to understand clinical risk and adverse outcomes to envisage the gaps in our care.

METHODS

This is a retrospective analysis of the current service at Ysbyty Ystrad Fawr, Wales. All data for IF from 01/01/2017 to 30/04/2020 was retrieved. All IF with clinically suspected head injury and where CT scan was requested were included.

RESULTS

- Total number of IF falls during study period were 2635 from 227,927 occupied bed days (OBD), giving IF rate of 11.5/1000 OBD.
- Total number of IF with suspected HI and CT done was 365, therefore IHI rate was 1.6/1000 OBD.
- Mean age was 82.7±7.7 (range 55–99) years, 53% were women.
- The incidence of dementia and delirium were 32.3% (n=118/365) and 37.8% (n=125/365) respectively.
- 64.6% (n=236/365) % on anticoagulation.
- CT request same day in 50% (n=184/365). Delay in requesting CT head was 1.4±3.0 days. Delay in performing CT head was 0.08±0.3 days.
- Mean hospital stay was 50.7±44.2 days, admissions from own home were 94.2% (n=344/365) and discharges to own home was 50.4% (n=184/365); 97 patients required a new care home placement.
- The five most common reasons for requesting CT were anticoagulation (24%, 83/365), External injury (23%, 78/365), new confusion (22%, 75/365), focal neurological deficit (18%, 61/365) and drop in conscious level (17%, 58/365).
- Inpatient mortality was 16.1% (n=59/365) and one-year mortality was 44.6% (n=129/289).
- Anticoagulant use associated in 59.3% inpatient death (n=35/59)



CONCLUSION

IHI have considerable poorer outcome and leads to serious harm in terms of mortality and a need for a new care home. We recommend further evaluation from other hospital sites to measure the impact of environmental and patient factors.

SP - Scientific Presentation - SP - Epid (epidemiology)

Trends in Mortality from Dementia in the European Union: An Observational Study of the WHO Mortality Database from 1985 – 2015- Emeka C. Okonji

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Introduction: Dementia is a global health priority for which trends in mortality are important to monitor the burden of the disease. We provide an up-to-date analysis of trends in dementia mortality across the European Union (EU).

Methods: Sex-specific, age-standardised death rates (ASDR) for all-cause dementia – as per the ninth and tenth revisions of the International Statistical Classification of Diseases – were collated from the World Health Organization Mortality Database, for twenty-five member states of the EU between 1985 and 2015. Joinpoint analysis was used to further assess overall trends in dementia-related mortality in each country stratified by sex. Joinpoint software computes an estimated annual percentage change (EAPC) for each trend to fit a regression line to the natural logarithm of the mortality rates.

Results: During the study period, there is an overall increase in dementia mortality for both sexes in EU countries, with the exception of Slovenia. There are significant disparities in dementia mortality between males and females. In 2013 – 2015, male and female ASDR from dementia were lowest in Bulgaria and Slovenia; and highest in Finland and the United Kingdom (UK). The sharpest rise in dementia mortality (EAPC) was demonstrated in Slovakia, Portugal and the UK. In the majority of countries with complete data at the start of the study period dementia mortality was higher in males such that the average difference between dementia ASDR for males and females was 0.23/100 000. However, by the end of the observation period, the polarity of this gender gap had reversed and was accompanied by a seven-fold increase in magnitude.

Conclusions: Mortality from dementia is rising in most EU countries, with substantial variation observed between countries and between genders.

Trends in Mortality from Dementia in the European Union: An Observational Study of the World Health Organization Mortality Database between 1985 – 2015

Emeka C. Okonji^{1*}, BM BCh; Charlie D. Zhou¹, BM BCh, Dominic C. Marshall², MBBS; Joseph Shalhoub³, PhD; Justin D Saliccioli⁴, MBBS

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HARVARD
T.H. CHAN
SCHOOL OF PUBLIC HEALTH

Introduction

Dementia is a global health priority for which trends in mortality are important to monitor the burden of the disease. To the best of our knowledge, no up-to-date analysis has described dementia-related mortality trends across member states of the European Union (EU). Our primary objective was to describe patterns of all-cause dementia mortality in Europe.

Methods

Data sources

Sex-specific and country-specific dementia-related mortality rates – as coded by the ICD-9 and ICD-10 systems – were extracted from the WHO Mortality Database for the years 1985 – 2015. Of the 28 EU member states, Cyprus, Luxembourg and Malta were excluded due to having populations of fewer than 1 million citizens.

Diagnostic categories

We chose *a priori* to include broadly all organic (non-toxic) dementias including Alzheimer's disease, vascular dementia, dementia with Lewy Bodies as well as fronto-temporal dementia. To this effect, we included the following diagnostic categories from ICD-9 and ICD-10 classifications, respectively: 290, 330 and F01 – F03, G30 – G31. We chose to exclude dementias secondary to toxic or metabolic disorders such as alcohol misuse or inborn autosomal disorders (331.3, 331.4, 331.5, 331.7, 331.81, G31.2, G31.81, G31.82, G31.9, G32), which represent pathophysiology distinct from those of dementias which typically occur later in life.

Data handling and statistical analysis

Mortality data are expressed as age-standardised death rates (ASDR) per 100,000 population using the WHO Standard Population. Three-year average ASDR were calculated for the start (1985 – 1987) and end (2013 – 2015) of the observation period to allow comparison of percentage change in mortality rates over the study period. Joinpoint analysis was used to further assess overall trends in dementia-related mortality in each country stratified by sex. Joinpoint software (Version 4.5.0.1) computes an estimated annual percentage change (EAPC) for each trend to fit a regression line to the natural logarithm of the mortality rates. Data handling was performed in SAS v9.4. Unless otherwise specified, all statistical tests of the data were two-tailed with an alpha of 0.05.

Results

Table 1. Change in dementia mortality rates in males over the 30-year study period

Country	Three-year average ASDR for dementia at start of study period (per 100 000)	Three-year average ASDR for dementia at end of study period (per 100 000)	Percentage change in three-year average ASDR between start and end of study period (%)	Observation Period
Austria	2.80	8.39	199.91	1985-2015
Belgium	11.16	20.31	82.04	1985-2014
Bulgaria	0.46	1.01	123.19	1985-2014
Croatia	1.66	6.70	304.29	1985-2015
Czech Republic	2.70	11.75	334.82	1986-2015
Denmark	6.40	21.93	242.79	1994-2015
Estonia	3.01	5.57	85.07	1994-2015
Finland	21.88	51.59	133.93	1987-2015
France	10.15	17.35	70.91	1985-2014
Germany	4.91	12.24	171.60	1990-2015
Greece	2.83	3.40	9.38	1985-2014
Hungary	2.73	15.44	454.01	1985-2015
Ireland	6.73	21.08	213.27	1985-2014
Italy	3.22	12.27	280.49	1985-2014
Latvia	1.65	5.13	211.15	1996-2015
Lithuania	1.87	4.75	153.76	1993-2015
Netherlands	5.06	29.03	473.78	1985-2015
Poland	1.51	2.84	54.11	1985-2015
Portugal	2.35	13.97	494.01	1985-2014
Romania	1.03	3.76	265.63	1985-2015
Slovakia	0.74	14.98	1939.95	1992-2014
Slovenia	10.76	2.44	-77.32	1985-2015
Spain	5.53	21.17	283.03	1985-2015
Sweden	9.06	35.55	181.99	1987-2015
United Kingdom	12.63	32.50	149.50	1985-2015

Table 2. Change in dementia mortality rates in females over the 30-year study period

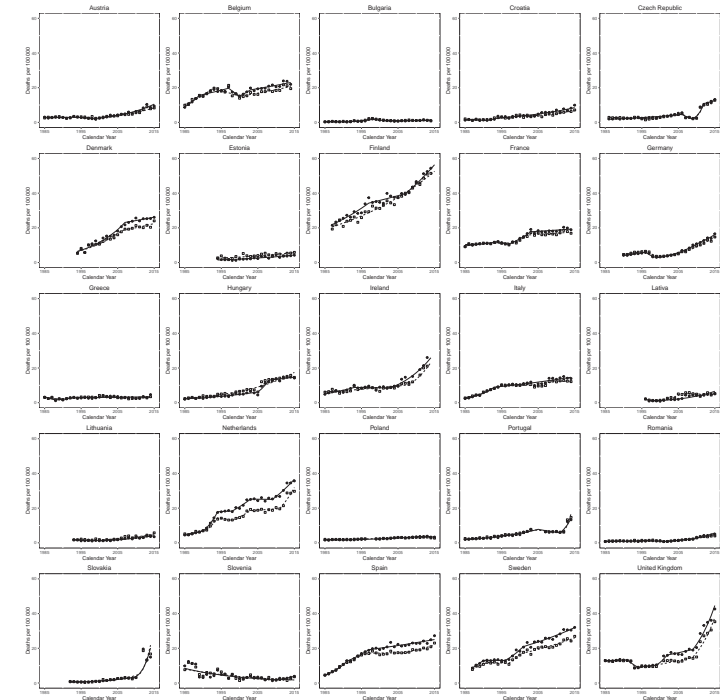
Country	Three-year average ASDR for dementia at start of study period (per 100 000)	Three-year average ASDR for dementia at end of study period (per 100 000)	Percentage change in three-year average ASDR between start and end of study period (%)	Observation Period
Austria	2.72	9.48	248.15	1985-2015
Belgium	10.41	22.82	119.27	1985-2014
Bulgaria	0.36	1.12	210.93	1985-2014
Croatia	1.29	8.36	546.37	1985-2015
Czech Republic	2.10	11.85	463.69	1986-2015
Denmark	6.34	25.57	303.62	1994-2015
Estonia	1.84	3.95	114.74	1994-2015
Finland	23.00	53.42	132.32	1987-2015
France	8.82	19.42	97.76	1985-2014
Germany	4.29	14.90	247.74	1990-2015
Greece	2.90	3.84	32.40	1985-2014
Hungary	2.41	14.52	502.26	1985-2015
Ireland	5.57	26.04	367.66	1985-2014
Italy	2.78	14.01	404.16	1985-2014
Latvia	1.39	4.89	252.39	1996-2015
Lithuania	1.52	3.68	142.40	1993-2015
Netherlands	4.72	34.91	639.59	1985-2015
Poland	1.61	3.48	116.71	1985-2015
Portugal	2.10	12.76	506.67	1985-2014
Romania	0.72	4.62	539.72	1985-2015
Slovakia	0.64	14.06	2109.21	1992-2014
Slovenia	11.15	3.30	-70.38	1985-2015
Spain	5.32	25.00	370.27	1985-2015
Sweden	10.08	31.05	207.92	1987-2015
United Kingdom	12.82	37.91	195.81	1985-2015

Three-year average age-standardized death rates (ASDR) per 100 000 for dementia in males and females at the start (1985 – 1987) and end of the study period (2013 – 2015) † Due to missing data at the start of the study period, the following countries have a three-year average ASDR calculated from the three earliest available years (shown below) and used in lieu of 1985 – 1987: Czech Republic; 1986 – 1989, Denmark; 1994 – 1997, Estonia; 1994 – 1997, Finland; 1987 – 1990, Germany; 1990 – 1993, Latvia; 1996 – 1999, Lithuania; 1993 – 1996, Slovakia; 1992 – 1995, Sweden; 1987 – 1990. ‡ For Belgium, Bulgaria, France, Greece, Ireland, Italy, Portugal and Slovakia there was no value for 2015, so a two-year average ASMR for 2013 – 2014 was used in lieu of 2013 – 2015.

During the study period, there is an overall increase in dementia mortality for both sexes in EU countries, with the exception of Slovenia. There are significant disparities in dementia mortality between males and females. In 2013 – 2015, male and female ASDR from dementia were lowest in Bulgaria and Slovenia; and highest in Finland and the United Kingdom (UK). The sharpest rise in dementia mortality in 2013 – 2015 was demonstrated in Slovakia, Portugal and the UK (**Fig 1**).

In the majority of countries with complete data at the start of the study period dementia mortality was higher in males such that the average difference between dementia ASDR for males and females was 0.23/100 000. However, by the end of the observation period, the polarity of this gender gap had reversed and was accompanied by a seven-fold increase in magnitude.

Figure 1. Trends in dementia mortality rates in member states of the European Union from 1985 to 2015



Age-standardized death rates per 100 000 for dementia in member states of the European Union between 1985 to 2015. Triangles indicate males. Circles indicate females. Joinpoint analysis was used to fit a regression line for each sex-specific trend.

Conclusions

Mortality from all-cause dementia between 1985 and 2015 has risen in most EU countries and is accentuated by significant geographic variation and inequality between the sexes. These findings emphasize the need for primary prevention policies and population-wide interventional studies to ensure that these unfavourable trends do not persist.

Funding: The authors declare no sources of funding for this study | **Conflicts of interest/Competing interests:** None

SP - Scientific Presentation - SP - Other (Other medical condition)

Age and frailty predict mortality in elderly patients with COVID-19 - Amer Jafar
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Aneurin Bevan University Health Board

Background:

Elderly citizens with high frailty scores are at greater risk of severe and fatal COVID disease. Reports from the UK have confirmed higher risk of mortality in the elderly population with advanced frailty and co-morbidities.

Objective:

To analyse the outcome of COVID-19 on hospitalized older persons in association with age and frailty score.

Methods:

This is an observational study conducted at 3 community hospitals in Aneurin Bevan University Health Board. All hospitalized adult patients with a Corona virus positive PCR test (COVID-19) were included, from March 1st, 2020 to April 30th, 2020. Demographic data was collected and frailty scores were assessed using the clinical frailty scale-9 (CFS). Two outcomes (recovery or death) were recorded at discharge.

Results:

A total of 74 hospitalized patients with COVID-19, included. Incidence proportion was 60.16% of total admissions. The average age was 77.2 years old (StEr 1.6 years). 38 were men with average age 73.2 years old (StEr 2.16 years) and 36 women with average age 81.4 years old (StEr 2.2 years). There was a 24.3% mortality rate among the study population from COVID-19. Age average in RIP group was 84.22 years old Vs 75.25 years old in control group. CRP and CFS were significantly higher ($P = 0.0003$, $P < 0.0001$. respectively) higher in RIP group compared to control group.

Conclusion:

There was a higher rate of mortality in the elderly patients compared to the national mortality rates. The average population age of COVID related deaths, was higher than the average age of control group. CFS and CRP were higher as well. There was no differences in mortality rate between both genders. In summary, Age, CRP and CFS were strong indicator for COVID-19 mortality rate in the elderly.

Age and frailty score predict COVID-19 mortality in the elderly

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Induction & Methods

Elderly patients with high clinical frailty scores (CSF) are at greater risk of severe and fatal COVID-19 disease. Reports from the UK and Europe have confirmed higher risk of mortality in the elderly population with advanced clinical frailty and co-morbidities. This study aim to collect and analyse the outcome of COVID-19 on hospitalized elderly patients in association with age, Gender, clinical frailty score (CFS) and laboratory inflammatory markers.

This is an observational study conducted at three community hospitals in Aneurin Bevan University Health Board (ABUHB) County, St Woolos and Chepstow Hospitals. All hospitalized adult patients with a Corona virus positive PCR test (COVID-19) were included. Two outcomes (recovery or death) were recorded.

Results

There were total 74 patients with a positive COVID-19 included in this study. 22 patients from County hospital (Rowan ward 14 patients, Phoenix/Usk ward 8 patients), 43 patients from St Woolos hospital (Ruperra ward 22 patients, Gwanwyn ward 21 patients) and finally 10 patients from Chepstow hospital. Half of study population are male patients (37 patients). Total population average age was 77.23 years old with standard error 1.6 years. Male patients' average age was 73.2 years old standard with error 2.16 years and female patients' average age was 81.39 years old with standard error 2.2 years.

There was a significant higher mortality COVID-19 outcome associated with increased age, advanced CFS and higher CRP measurements.

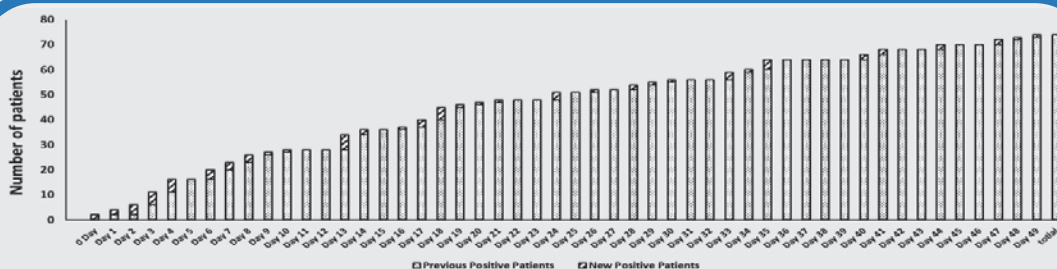
number of population	all wards	Rowan ward	Phoenix/Usk ward	Ruperra ward	Gwanwyn ward	Chepstow ward
Total	74	14	8	22	21	10
Age mean	77.23	77.23	74.5	76.14	75.905	84.6
StEr	1.6049	4.482	4.61	3.123	3.1281	1.8511

number of population	Male	Female
Number of Patients	38	36
Age (average)	73.2	81.39
StEr	2.163	2.2047

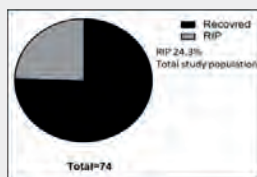
number of population	all wards	Rowan ward	Phoenix/Usk ward	Ruperra ward	Gwanwyn ward	Chepstow ward
Recovered	56	11	6	19	13	8
RIP	18	3	2	3	8	2
Mortality rate	24.3%	21.4%	25%	13.6%	38%	20%

Total number of patients involved in this study and average age for total population and within each ward (left table). Total number of pupation according to gender and average age (right table).

Distribution of COVID-19 outcome among the wards. Mortality differ from ward to another. Highest in Gwanwyn ward (38%) and lowest in Ruperra ward 13.6%.



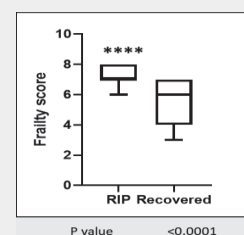
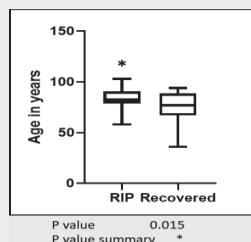
First 2 COVID-19 cases were reported 6th March 2020, then there was a gradual increase in COVID-19 cases over the next several days. Starting 6th March (day 0) Reaching 74 confirmed COVID-19 cases in 27th May 2020.



number of population	Male	Female
Recovered	26	30
RIP	11	7
Total	37	37

Distribution of COVID-19 outcome according of gender.

There was a 24.3% mortality rate among the positive COVID-19 patients

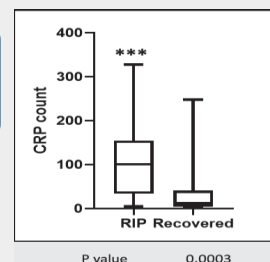


Significant difference between RIP and Recovered COVID-19 patients in age groups. there was a significant increase in CFS median in RIP compared to Recovered group. P value < 0.0001.

Discussion

In the elderly patients admitted to hospital, COVID-19 mortality was worse than the national rates in general population (24.3%, 8.4%. Respectively) and it was predicted by frailty, age and CRP. However, mortality in our data is in line with mortality rate globally in the elderly. For example, the COPE study mortality was 27.2%. (1). Our data showed that older age group, CFS of 7 and above and CRP of 100 and above are associated with higher mortality rate.

A significant increase in CRP measurement in RIP group when compared to control group. P value = 0.0003.



Conclusion

Our data support the use of CFS and Age as prediction factors for a medical specialist to use in escalation plans, resource allocations and shared decision making.

SP - Scientific Presentation - SP - N & N (Neurology & Neuroscience)

Experiences & Clinical Outcomes of Patients and Carers Accessing Acute Care in Patients With and Without a Diagnosis of Dementia - Dr Cherry Shute,

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University Hospital Wales, Cardiff

Introduction

Dementia poses major challenges to society and healthcare systems. Previous research has concluded that patients with dementia admitted to secondary care have worse clinical outcomes compared to those without cognitive impairment (CI). The aim of this study was to establish locally the differences in outcomes of patients admitted to hospital in those with and without dementia.

Method

A point prevalence analysis of patients admitted under medicine was performed (N= 367 patients). Patients were prospectively followed-up, with data retrieval via Welsh Clinical Portal, to determine length of stay (LOS), mortality, discharge destination and diagnoses. A smaller prospective analysis of 'patient journeys' reviewed quantitative data including LOS, falls, delirium, antipsychotic use, institutionalisation, readmission rates and mortality, and qualitative feedback from patients and relatives (N= 34). Outcomes for those living with dementia were compared to those without CI.

Results

The point prevalence of CI in UHW and UHL was 36.3% (28.1% dementia; 5.7% MCI; 2.5% referred for assessment). Prospective follow-up of patients highlighted increased LOS in those with dementia (71.4 versus 50.3 days), increased risk of institutionalisation (23.4% versus 8.6%) but lower mortality both as an in-patient and at 4 month follow-up (8.74%/ 14.6% versus 12%/ 22.5%). In the prospective analysis 47% had a diagnosis of dementia, 12% MCI and 41% did not have a diagnosis of CI. LOS was 68.3 (3-191) in those with CI compared with 39.9 days, new care home admission 21.4% versus 7.7% and in-patient mortality 12.5% versus 7.1%. Rates of falls, delirium, antipsychotic use and specialising were all higher in those with dementia.

Conclusion

Our data has confirmed that patients living with dementia have worse clinical outcomes when admitted to secondary care. A multilevel, multidisciplinary and multifactorial approach to improving the quality and safety of care for patients with dementia in the acute setting should be sought.

SP - Scientific Presentation - SP - Cardio (Cardiovascular)

The association between increasing frailty and greater co-morbidity and surviving cardio pulmonary resuscitation - Dr Elin Heledd Thomas

Dr Elin Heledd Thomas; Dr Aled Rhys Lloyd; Dr Nicky Leopold
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Introduction

Population ageing is a triumph of public health and medical advancement but it can equally lead to burdensome and futile interventions at the end of natural life. This is especially relevant when offering treatments such as cardiopulmonary resuscitation (CPR) that can carry a significant burden of harm. The aim of this study was to investigate the association between increasing frailty and greater co-morbidity and surviving CPR.

Method

A retrospective analysis of prospectively collected data from contemporaneous patient notes and electronic patient records of all patients that suffered an in-hospital cardiac arrest between 1st April 2017 and March 31st 2018 in a tertiary hospital (that includes tertiary cardiology) in South Wales was undertaken.

Results

A total of 113 patient records were assessed. Average patient age was 74. Patient frailty was assessed based on calculation of Rockwood score (RS) and co-morbidity assessment based on Charlson index (CI). We identified a strong linear correlation between increasing CI and poor survival and rates of ROSC. No patient with a Charlson index of above 6 survived one year. Similarly, patients with a RS between 1-3 had a survival to discharge, 30 day and 1 year survival rate of 45.7%. Only 10.3% of those with a RS between 5-9 survived 1 year post cardiac arrest. No patient with a RS above 6 survived one year. No association between duration of CPR and patient frailty was identified. Increasing age was also found to be linearly associated with reduced likelihood of survival. This association was much less significant than the association with increasing RS or CI.

Conclusion

It is clear from our findings that both increasing patient frailty and level of co-morbidity significantly adversely affect survival from CPR. Accurate individualised assessment of both of these factors is therefore imperative when assessing the appropriateness of undertaking CPR.

Frailty and Cardio Pulmonary Resuscitation : How frail is too frail?

Dr Elin Heledd Thomas¹, Dr Aled Lloyd¹, Dr Nicky Leopold¹

¹ = Swansea Bay University Health board

INTRODUCTION

- Cardiopulmonary resuscitation (CPR) often harmful with poor outcomes¹
- Little evidence to aid decision making about appropriateness of CPR in frail patients

METHODS

- Retrospective analysis of prospectively collected data from contemporaneous patient notes and electronic patient records
- Included all patients that suffered an in-hospital cardiac arrest between April the 1st 2017 and March 31st 2018 in a tertiary hospital in south Wales.
- Frailty assessed according to calculated Rockwood score (RS)
- Co-morbidity assessment based on Charlson Index (CI).

RESULTS

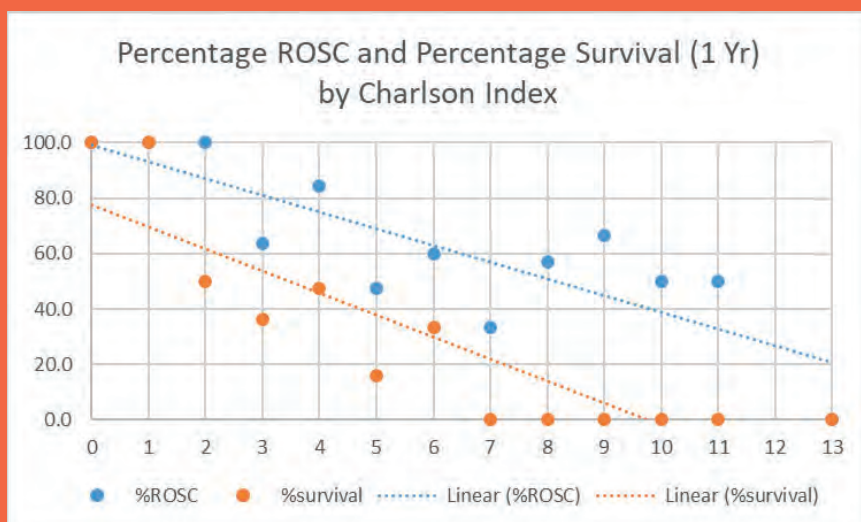
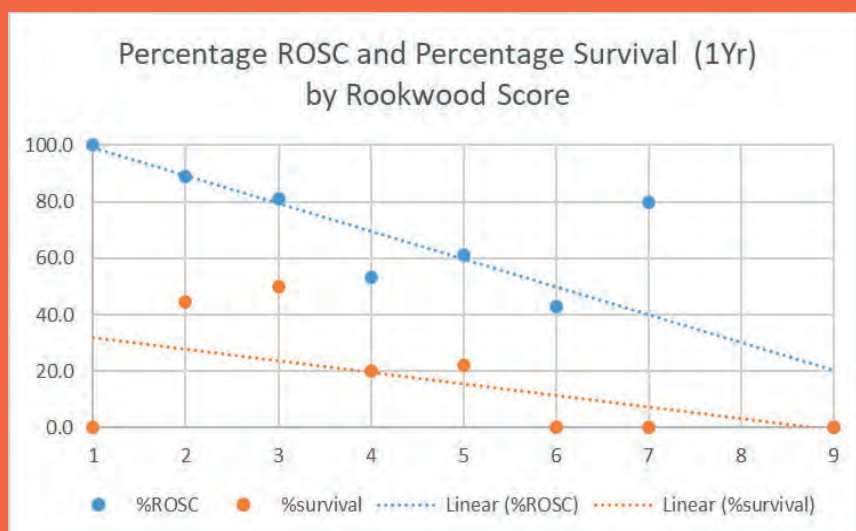
- 113 patient records assessed.
- Linear correlation between increasing CI and poor survival (ANOVA $p = <0.001$) and rates of ROSC (ANOVA $p = <0.001$)
- No patient with CI >6 survived one year.
- Similarly, linear correlation between increasing RS and poor survival (ANOVA $p = 0.001$) and rates of ROSC (ANOVA $p = 0.002$)
- No patient with a RS >6 survived one year.

DISCUSSION

- Frailty and co-morbidity imperative when assessing risk benefit balance.
- Importance of accurate social history taking
- Especially pertinent to consider appropriateness of such interventions in COVID era.

CONCLUSION

- Clear relationship between increasing frailty and multimorbidity with poorer CPR outcomes.
- More research required
- Importance of fundamentals to optimise patient care



References

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

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Glan Clwyd Hospital

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.

THE QUALITY OF ELECTRONIC DISCHARGE SUMMARIES FROM MEDICAL WARDS: A QUALITY IMPROVEMENT PROJECT

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Department of Geriatric Medicine, Glan Clwyd Hospital, Rhyl

Introduction

The electronic discharge (E-discharge) summary forms an essential component of communication between secondary and primary care following a patient's discharge from the hospital.

Yet the content and quality of these discharge communications can be sub-standard, particularly for frail, elderly patients with complex clinical problems and long hospital stays.

Method

We conducted a retrospective audit assessing the quality of E-discharges from all medical wards. The audit proforma consisted of seven questions relating to each E-discharge section with two additional questions on the inclusion of relevant past medical history and treatment escalation plans.

Local GPs were involved in identifying areas for improvement and a series of E-discharge workshops were conducted. The PDSA cycle was then completed.

Table 1 – Results of all sections	Audit 1	Audit 2		Workshop attendees	
NS = not significant	Proportion adequate (n = 66)	Proportion adequate (n = 66)	Change significance (p value)	Proportion adequate (n = 33)	Change significance with Audit 1 (p value)
Allergies recorded	86%	86%	NS	87.9%	NS
Allergy nature stated	4.76%	35%	0.016	50%	0.0027
Presenting complaint adequate	90.9%	92.4%	NS	97%	NS
Clinical findings adequate	90.9%	86.3%	NS	90.9%	NS
Test results adequate	54.5%	84.8%	< 0.001	90.9%	<0.001
Diagnosis adequate	74.2%	80.3%	NS	84.8%	NS
Progress and outcome adequate	48.5%	72.7%	<0.01	90.9%	<0.001
Advice & recommendations adequate	86.4%	83.3%	NS	84.8%	NS
All sections of adequate quality	21.2%	34.8%	NS	54.5%	<0.001

Results

Sixty-six case notes were audited for both audits 1 and 2 across eleven medical wards. A sub-group analysis of the E-discharges authored by those who had attended the workshop (33 E-discharges) was also undertaken.

The results (table 1) showed improvements in the quality of most sections, particularly in the sub-group of E-discharges authored by workshop attendees 'Test results' and 'progress and outcome' sections showed significant improvements. There was also a significant improvement in the number of E-discharges containing information regarding past medical history (Table 2).

Table 2 - Results of additional information	Audit 1 (n = 66)	Audit 2 (n = 66)	Change significance (p value)	Workshop attendees	Change significance with Audit 1 (p value)
Past Medical History documented	31.8%	53%	0.016	67%	<0.001
Resuscitation / escalation decision documented	11.76%	30%	NS	40%	NS

Table 3 – Examples of inappropriate requests made to GPs on E-discharges

Please chase anti-TTG antibodies
Review vitamin B12 bloods
Please re-check U&Es and Mg in 1 week
Please chase HIV results
Please arrange for ferrinject once antibiotics finished
GP kindly chase serum electrophoresis results
3/7 sando phos prescribed; please check bloods on completion of this course

Discussion

In addition to highlighting various inadequacies in documentation (table 1), audit 1 also highlighted instances in 29% of E-discharges where requests were made to the GPs when the onus of executing some of those actions should have been on the patient's own team (table 3).

The reasons for shortfalls in E-discharge standards were likely to be multiple including lack of knowledge on the expected standards, lack of skills, and inability to grasp the patient's clinical journey from the documented notes.

Those who attended the workshops did produce better quality E-discharges and none recommended unnecessary or inappropriate actions for the GPs.

Conclusions

E-discharge workshops with junior doctors are effective in improving the quality of discharge summaries from the medical wards, as well as reducing unnecessary requests for GPs to action after discharge.

Introduction of mandatory E-discharge training sessions during hospital induction and junior doctor rotations would be beneficial to teach this important yet challenging skill.