emergency and urgent care, between 2001 and October 2015. Markers of feasibility included the time taken to complete an assessment; acceptability to clinicians; and completion rates of tools.

Results: 1754 titles and abstracts were identified and reviewed by two researchers. 47 full papers were reviewed with nine included in the final critical review. Median CASP score was 75%, interquartile range = 69–81. Eight of the nine papers included information on how long an assessment took to carry out; three assessed completion rates; and one investigated the acceptability of tool domains to clinicians.

Conclusion: There is a paucity of evidence of the practical application of frailty tools and their feasibility. The most commonly assessed feasibility marker is time taken to complete an assessment. Further work is required to better understand the acceptability of frailty identification to ED staff.

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Assessing the feasibility of implementing frailty identification tools in the Emergency Department

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Introduction: Identifying frailty in older people in the Emergency Department (ED) is important as ED assessment and initial management substantially affect outcomes. Screening tools can be used for identification but there is relatively little evidence of their practical application.

Methods: A convenience sample of ED clinicians in a large teaching hospital, employing 179 nursing and 104 medical staff, assessed four frailty tools: clinical frailty scale (CFS), ISAR, PRISMA-7 and the Silver Code (SC) against patient vignettes, developed from focus groups. Assessments were timed and participants were asked about: their opinion on the tools; whether they would use them in practice; and how easy they were to use on a scale of 1–5.

Results: 121 staff members were recruited, representing 36% of nursing staff (n = 65), 53% of doctors (n = 55) and one manager. 75% (95% CI 68–80%) of participants would use a frailty tool in future. Proportions who would use each tool again were: • CFS = 75% (61–85) • ISAR = 85% (72–93) • PRISMA-7 = 79% (65–89) • SC = 62% (48–75) Median and interquartile ranges in seconds to carry out the assessment were: • CFS = 41 (28–57.5) • ISAR = 66 (52–93) • PRISMA-7 = 52 (40–77) • SC = 54 (36–86) The silver code's median ease of use score was five out of five, with the rest scoring four out of five.

Conclusion: Implementing frailty tools in the Emergency Department is quick, simple and acceptable. There are no significant differences between the four tools but the silver code appears to be less acceptable with the lowest proportion of people willing to use it and the second longest median time to use.

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Falling of eldery living in the community

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Objectives: The research was aimed to investigate falling prevalance and associated factors among elders who was evaluated in Fatih district geriatric study.

Material and methods: Age range of 60–101 were taken into the study. Falling has been evaluated as an existence of falling within a year. The fragility screened with FRAIL-questionnaire, functional capacity measurement with KATZ-Activities-of-Daily-Living-Scale (ADL) and LAWTON-BRODY-Instrumental Activities-of-Daily Living Scale (IADL), quality of life measurement with EQ5D-questionnaire, cognitive status with Mini–Cog-test, depression with GDS-SF, malnutrition with MNA-SF, balance and gait with Romberg-test and postural-instability-test, were evaluated accordingly.

Findings: 204 cases (94 male–110 female) were recruited in this research. Average age is 75.4 ± 7.3. Case of falling rate is %28.1 in all

cases(M: %25.5, F: %30.3). There was a significant difference among falling and number of disease (p < 0.001)-number-of-drug (p = 0.003)-fragility-score (p = 0.001), IADL (p = 0.019), EQ-5D score (p = 0.010), depression score (p = 0.023) but there wasn't any significant finding among falling and age (p = 0.97), BMI (0.56), afraid of falling (p = 0.16), VAS score (p = 0.98), power of muscle (p = 0.053), diameter of forelegg (p = 0.60), TUG test (p = 0.96), UGS (p = 0.91), ADL score (p = 0.065, BIA parameters (body fat, visceral tallowing, bone), CDT score (p = 0.08), MNA score (p = 0.065, point of subjective health condition (p = 0.16)). Among the group of falling, dementia (p = 0.003), chronic pain (p = 0.028), dynapenia (p = 0.028), level of ambulation (p = 0.036), fragility (p = 0.013) had a significant difference, however; gender (p = 0.47), obesity-DSO(p = 0.69), level of education (p = 0.50), HL (p = 0.63), existence of MN (p = 0.09), existence of DM (p = 0.07), existence of HT (p = 0.54), UI (p = 0.48), finding of Romberg (p = 0.51), postural instability (p = 0.38), low UGS (p = 0.84), cognitive defect (p = 0.47, existance of depresion (p = 0.35)) didnot have a significant difference. Falling non-releated factors in regretion analysis in last 1 year scores were; (depending variablitiy: falling/non-depending variability: disease/number of drug/fragility/IADL/GDS-SF/Eq-5d score/demantia/chronic pain/ existence of dynapenia): Existance of demantia (OR = 0.29, p = 0.012) and fragility score (OR = 1.43, p = 0.031).

Result: Many falling related factors were taken into account. As a result, we think that cognitive defect and fragility are major factors which are the related factor of falling.

Keywords: Falling; Geriatric, Fragility; Cognitive defect.

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Sarcopenia and nutritional status in elderly patients with fragility hip fracture

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Objectives: To describe the prevalence and main characteristics of sarcopenia and malnutrition in hip fracture elderly patients.

Methods: Observational study. Patients aged ≥65 admitted with hip fracture (September 2015–February 2016) were included. Variables: sociodemographic, clinical, functional assessment (Barthel index-BI-, FAC), Comorbidity (Charlson's index-CCI-), nutritional status (BMI, biochemical parameters, MNA), body composition by bioimpedance analysis-BIA-, (MMI, phase angle-PA-), and muscular strength (grip strength). EWGSOP criteria. Statistical analysis: SPSS.

Results: 74 patients were included (mean age 85.2 ± 8, women 76.7%, lived at home 95.9%). BI 85.1 ± 13, CCI 6.71 ± 1.5. 38.4% had a pertrochanteric fracture. Preoperative stay was 4.4 days ± 2.31, length of stay 11 days (IQR 9–15), in-hospital mortality 6.8%. Preoperative measures: serum albumin 3.3 mg/dL ± 0.2, IL-6 47.0 pg/mL ± 45.8, Vit D 15.7 ng/mL ± 8.1. According to MNA score 50.7% were at risk of malnutrition and 4.1% were undernourished. BMI 26.5 Kg/m^2±4.5. 9.45% had sarcopenia (men 29.4%, women 3.6%), MMI 9.53 ± 2.49. Low grip strength: men 88.2%, women 82.1%. There was association between: severe sarcopenia and BI at discharge (β = −0.299, p = 0.019), PA and BI at discharge (β = 0.0256, p = 0.029). There was no association with mortality, co-morbidity, nutritional status, discharge destination. There was association between: discharge destination and BI at discharge (OR = 1.051, p = 0.002), length of stay and CCI (β = 0.098, p = 0.004). There was no association with nutritional status, albumin, MMI, age, gender or grip strength.

Conclusions: Sarcopenia was more prevalent in men than in women with hip fracture. Severe sarcopenia was associated with the degree of functional decline at discharge. More than half of patients were at risk of malnutrition or undernourished.

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Frailty and malnutrition

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