less than 35 mmHg, or if there was presence of venous incompressibility in lower limb ultrasonography or if tricuspid annular plane systolic excursion (TAPSE) in transthoracic echocardiography was less than 1.6cm. All patients were diagnosed using computed tomography pulmonary angiography (CTPA). Data obtained was analyzed to determine if a negative CUEPED would be able to conclusively rule out a pulmonary embolism. All patients received a CTPA for confirmation of diagnosis.

RESULTS

30 patients (mean age 48 years) were included with an equal distribution between genders. The incidence of PE was 56.7%. CUEPED had a sensitivity of 100% (95% CI 80.3% to 100%) for PE. Negative CUEPED ruled out PE (P=0.001) with a negative predictive value of 100% (95% CI, 58.9% to 100%). Positive CUEPED ruled in PE with a low specificity (53.8%, 95% CI 25.2% to 80.6%) and moderate positive predictive value (73.9%, 95% CI 51.5% to 89.7%).

DISCUSSION

This prospective diagnostic study showed conclusively that a negative CUEPED proved reliable in ruling out pulmonary embolism.

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DEVELOPING A SYSTEMATIC SCORING FOR THE EVALUATION OF MUSLIM ORTHOPAEDIC AND TRAUMA PATIENTS' ABILITY TO PERFORM RELIGIOUS PHYSICAL CLEANSING AND PRAYER

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INTRODUCTION

For Muslim patients, illness does not alleviate the obligation to perform religious duties such as prayer. The need for a systematic evaluation of patients' ability to perform such duties should be highlighted and anticipated. This study aims to develop an objective evaluation scoring system to recognize disability levels of Muslim patients in performing religious physical cleansing and prayer during their illness and improve the deliverance of assistance they need.

MATERIALS & METHODS

Based on observation and critical survey among patients and health care personnel in orthopaedic wards of a tertiary hospital, we identified problems contributing towards patients' inability to perform religious practices during hospitalization. They can be grouped into five main disabilities, which formed the basis of the scoring system: pain, mobility, extremity involvement, bandage/ cast application, and toileting. The scale ranged from score of 1 (no disability) to 5 (worst ability to perform specific task). Panels of experts involved in face and content validations, as well as pilot testing of the scoring system.

RESULTS

100 patients participated in the study. We evaluated the inter- and intra-observer reliability using intraclass correlation coefficient and Spearman correlation coefficient, respectively. Our analysis provided good results for inter-

observer agreement and reliability, and internal consistency for most disabilities. At the end of the study, two major outcomes produced; a disability score to categorize trauma patients according to their needs, and a coding system to assist health care personnel in scrutinizing the types of assistance required by patients.

CONCLUSION

The proposed system provides a new practical measure to evaluate disability among Muslim patients in performing their religious duties. It will provide a balance approach in trauma patients' care and deliverance of assistance wherever required. It has potential of becoming a standard of practice in a holistic patient care in accordance to the much-anticipated ibadah-friendly hospital.

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UTILISING FRAILTY SCORING IN THE ACUTE HOSPITAL SETTING TO IDENTIFY FRAIL AND VULNERABLE PATIENTS

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ABSTRACT CATEGORY
Research

TITLE

Utilising frailty scoring in the acute hospital setting to identify frail and vulnerable patients

AIM

Our objective is to operationalize a clinically usable tool, frailty early warning score (FEWS), which will identify frailty and help predict significant outcomes, including readmission, length of stay (LOS) transfer to higher level of care and mortality.

METHODS

FEWS is based on a frailty model described by Soong et al (2015) with four specific domains (physical, mental, social and environmental, as illustrated in figure 1). Between 03 June 2015 and 27 August 2015, 700 acutely admitted patients over the age of 65 were reviewed. Data were collected from clinical notes taken routinely as part of the emergency admission process. No new data were collected. All data were collected electronically through bespoke software by Thinkshield and innate hospital programs. The national early warning scores (NEWS) were simultaneously collected for comparison.

OUTCOMES/RESULTS

700 patients were included (52.6% female) with an average age of 81 years. 94% were medical admissions (including orthogeriatric patients). 30 day mortality was 3.0%, 30 day readmission rate was 16.1% and the average length of stay (LOS) was 12.3 days (Table 1). 280/700 (40.0%) patients aged > 80 had >3frailty score, whereas ages 65-80; 96/700 (13.7%) had a frailty score of 0. Table 1 provides additional patient demographics. NEWS and FEWS were cross-tabulated: 246 admissions scored < 3 on NEWS (i.e. this would not trigger escalation), of which 206 scored ≥1 on the frailty tool. This could indicate a potential threshold for frailty escalation.

CONCLUSION

This study describes FEWS as a novel way of predicting a frail