7th & 8th March 2025

Academic General Practice Ireland, ASM

"Renewing Vision"

5D Poster – Theme: Variety is the spice

Chair: Prof Maureen Kelly

Irish College of GPs

AGPI Academic General Practice Ireland

QUEEN'S UNIVERSITY BELFAST

The Burden of Rheumatic Heart Disease and Issues Affecting the Provision of Care in Malawi: A Scoping Review

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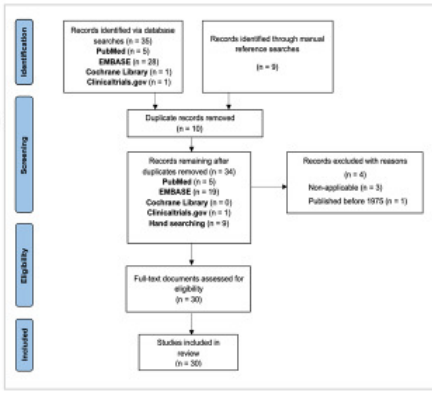
Background:

- Rheumatic heart disease (RHD) is a severe complication of untreated Group A Streptococcal (GAS) infection.
- Now rare in high-income countries, RHD remains a public health challenge in Malawi.
- This scoping review examines the burden of RHD & preceding infections in Malawi and the challenges in care provision.

Methods:

- Arksey & O'Malley framework employed.
- *PubMed, EMBASE, Cochrane Library, ClinicalTrials.gov* searches (1995–2024).
- Data extracted from 30 studies.
- Reported per the PRISMA-ScR checklist.



Results:

- Prevalence of RHD in Malawian children: **3.4% – 5.3%.**
- **62% – 82.5%** present late with severe disease.
- Key challenges:
  - Limited healthcare infrastructure
  - Inconsistent supply of benzathine penicillin G
  - Rural areas underserved – 84% of population
- Potential solutions:
  - Task-shifting to non-physician healthcare workers.
  - Increased primary care resourcing & education initiatives.
- Gaps: limited research on ARF and GAS infections in Malawi.

Conclusion:

- RHD remains a significant cause of morbidity and mortality in Malawi.
- Strengthening primary healthcare, improving workforce training, and ensuring consistent antibiotic supply are key priorities.
- Future research should focus on ARF & GAS infection burden to guide early intervention strategies.

An analysis of primary care utilisation and multi-morbidity in a Ukrainian Refugee population accessing primary care in Ireland

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2. Health Research Institute, University of Limerick
3. Mel Enid Zuckerman College of Public Health, Comprehensive Center for Pain & Addiction, University of Arizona

INSIGHT: **I**nquiry i**N**to **S**erv**I**ce usage, **G**erontological **H**ealth and Mul**T**i-Morbidity in **GP**

Introduction

Access to healthcare is a fundamental right but there are challenges for Ukrainian citizens and the teams of healthcare professionals in host countries supporting them.

These include access to healthcare records, interpreting for patient encounters, and cross-cultural issues.

The aim of this study was to gain insight into the healthcare utilisation and morbidity patterns of those ≥70 years attending a sample of general practices in Ireland and to compare this with a general practice cohort of Ukrainian citizens also aged ≥70 years fleeing war.

Methods

Four general practices across Ireland were selected for the study.

One practice comprised of Ukrainian nationals only and the three others were Irish general practices.

Electronic healthcare records of patients in these practices covering a one-year period were analysed for this study.
Participants needed to be ≥70 years of age to be included in the analysis and had to have an active healthcare file within the previous year at the practice.

HEALTH STATUS INDICATOR	N	MEAN (SD)	UNIT
Body Mass Index	**32**	**31.1 (13.4)**	**kg/m^3**
Total Cholesterol	**102**	**5.4 (1.1)**	**mg/dL**
Systolic/Diastolic Blood Pressure	**131**	**145.7 (17.9)/81.1 (10.7)**	**mm Hg**
Estimated Glomerular Filtration Rate	**56**	**66.3 (15.2)**	**mL/min/ 1.73m^2**

Figure 1: Morbidities and Health Status

Results

The Ukrainian sample included 191 patients >70 years, predominantly women (72%) with a mean age of 74.9 years.

The Irish sample had 1,546 patients, with a more balanced gender distribution (48% male, p-value < 0.0001) and a significantly higher average age of 78.1 years (p < 0.0001)

Primary care interaction rates were significantly lower among the Ukrainian patients, with 75.9% having at least one visit compared to 99.4% in the Irish cohort (p < 0.0001).

Ukrainian patients also had fewer outpatient, inpatient, and day-case visits, with notably fewer polypharmacy patients (39.3% vs. 69.1%, p < 0.0001) and a lower prevalence of multi-morbidity (72.7% vs. 85.4%, p < 0.0001).

Data in focus

- Of the Ukrainian sample, **77.1%** had at least one primary care interaction in the past 12 months.
- The median **number of prescribed medications was 4**, with a maximum of 13.
- The **median number of primary care interactions was 9**, with a **maximum of 79**.

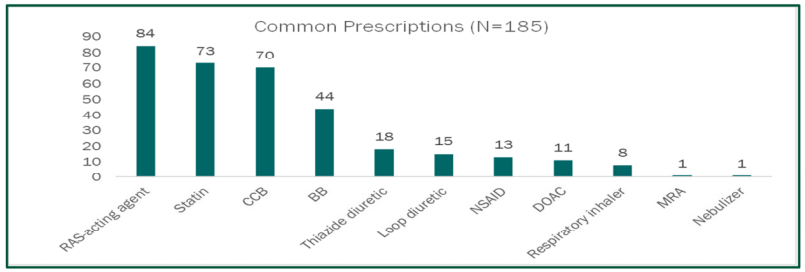

Figure 2: Most frequently prescribed prescriptions

Discussion

Despite eligibility, no Ukrainians were enrolled in chronic disease management (CDM) programmes.

Morbidity and prescription data for Ukrainians may be underreported.

Policy changes should be considered to allow Ukrainians to enrol in CDM programmes to receive comprehensive care.

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Lower physical activity levels are associated with poorer chronic disease management outcomes and may serve as a marker for identifying patients needing higher-intensity personalised interventions.

A multi-practice longitudinal study is required to examine how changes in physical activity influence outcomes.

Physical Activity Levels Recorded in Chronic Disease Management Consultations in General Practice

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Fellowship in Physical Activity for Chronic Disease, University of Limerick
Ray O'Connor
Associate Clinical Professor of General Practice, University of Limerick
Ailish Hannigan
Professor, Health Research Institute, University of Limerick
Catherine Woods
Chair of Physical Activity and Health, University of Limerick
Andrew O'Regan
Associate Professor, Health Research Institute ,School of Medicine, University of Limerick

"Acknowledgement: This research is funded by the HSE Aspire Fellowship in General Practice (Aspire Post-CSCST Fellowship)"

UNIVERSITY OF LIMERICK
OLLSCOIL LUIMNIGH

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

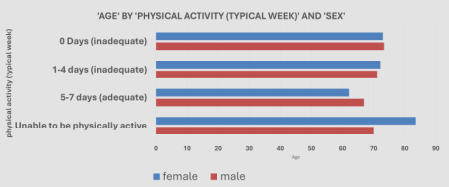
Introduction

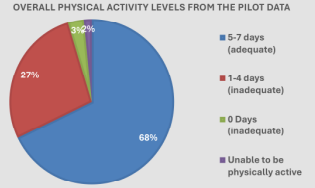
- Chronic diseases such as diabetes, cardiovascular disease, and chronic obstructive pulmonary disease are leading causes of illness and healthcare burden.
- Physical inactivity worsens health outcomes but is often overlooked in routine care.
- The World Health Organisation advocates for integrating physical activity into healthcare, yet real-world data on its role in chronic disease management remain limited.
- Ireland's Chronic Disease Management programme, introduced in 2020, systematically records physical activity levels, providing a unique opportunity to study its impact.
- This study explores the association between **physical activity levels** recorded in **chronic disease management consultations** and **chronic disease markers** in **Irish general practice**.

Methods

- **Retrospective cross-sectional study** using pseudonymised chronic disease management data
- Sample from **10 general practices** affiliated with the University of Limerick Education and Research Network for General Practices.
- **Study population**: Adults with at least one registered chronic disease. Data extracted from **Health One software**, including:
  - Physical activity levels (adequate versus inadequate)
  - Disease markers (glycated haemoglobin, body mass index, cholesterol, blood pressure, estimated glomerular filtration rate)
- Ethical approval pending; data collection to commence.

Results





Key Findings **(Pilot Data, N=324)**

•Inadequate Physical activity was linked to poorer disease control:

- **Higher** HbA1c (7.2% vs. 6.1%)
- **Elevated** BMI (31.2 vs. 28.3 kg/m²)
- **Worse** blood pressure control (Mean systolic BP: 142 mmHg vs. 128 mmHg)

Why do Patients Seek Emergency Care for Problems that could be managed in Primary Care? A Scoping Review

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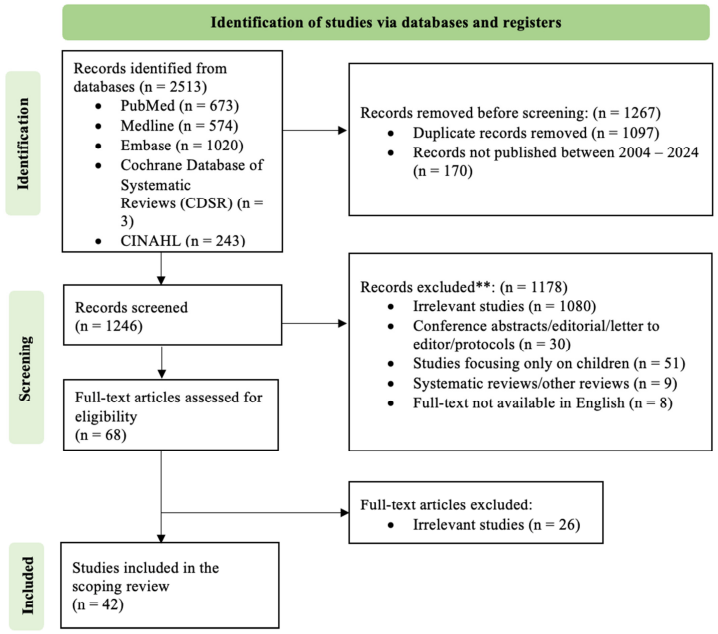
INTRODUCTION

Emergency Departments (ED) are hospital-based emergency medical care settings intended to manage a wide range of unpredicted, emergent and time critical medical problems requiring immediate care and attention. They ensure patients receive prompt and appropriate treatment, offering continuous access to unscheduled care for various urgent medical complaints (1). However, a significant number of individuals are utilising emergency care services, including ambulance services and EDs, for conditions that could be managed in primary care. Research has found that the use of ED is increasing at a faster rate than that of population growth, and there may be many underlying reasons contributing to this trend (2). This global phenomenon can create unnecessary strains on emergency care systems, leading to overcrowding, inefficient use of healthcare resources, and inadequate access to emergency care for those in need. Research conducted in Australia indicated that as high as 48% of all ED attendances were classified as "GP-type visits" based on previously defined criteria (3). This scoping review aimed to explore existing international evidence considering the multifaceted factors contributing to patients' decisions to seek emergency care for conditions that could be managed in primary care.

METHODS

A comprehensive search of 'PubMed', 'Embase', 'MEDLINE', 'CINAHL' and the 'Cochrane Library' was conducted for this review, including research published from 2004 to 2024, to provide an updated and comprehensive map of the literature. Search terms were broadly categorised into emergency care, primary care, and terms looking into patients' care-seeking behaviour. This review was guided by the six-stage methodological framework developed by Arksey and O'Malley (4).

Figure 1. The PRISMA Extension for Scoping Reviews Flowchart Illustrating Study Selection



RESULTS

42 studies across 20 countries were included in the review. Most collected information from participants in all age groups (children, adults and older adults), with three studies focused specifically on older adults, and 21 studies focusing on adults only. Regarding participant perspectives, three studies included responses from staff or health professionals, while all other studies included responses from patients only.

Table 1. Most Frequently Reported Reasons for attending EDs

Top 5 reported reasons	No. of articles identified
Unable to secure appointment due to GP related reasons	23
Perceived urgency/severity/emergency	21
More accessible or more convenient location of EDs	18
Immediate attention given by EDs	14
Advice or referral by GP or other healthcare professionals	14

Figure 2. Geographic Representation of Studies Included

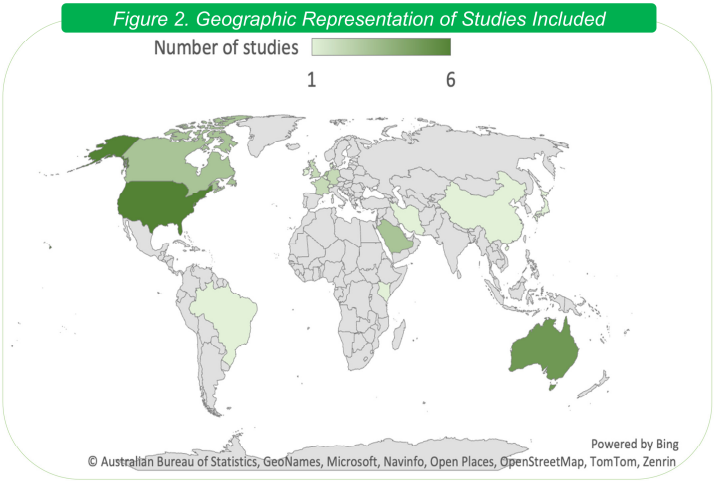
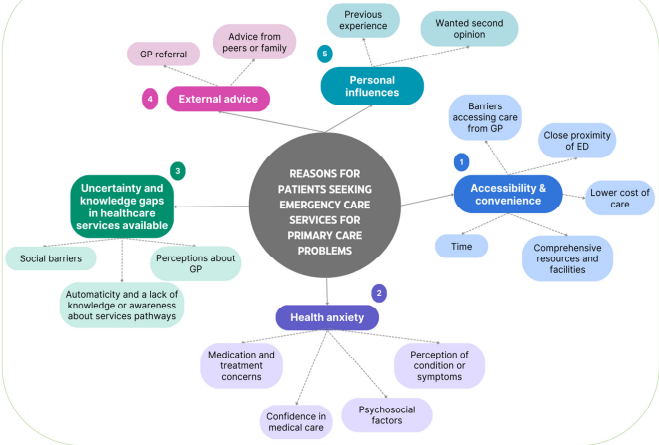


Figure 3. Thematic Map



CONCLUSION

Our findings demonstrate the complex and multifaceted nature of patients' decisions to visit the ED, which are influenced by a combination of practical considerations, psychological factors and knowledge gaps related to primary care service access. This thematic map (**Figure 4**) serves as a foundation from which to develop comprehensive strategies to address patient behaviors and service organization. Our study has the potential to act as an initial starting point for innovation and policy development. Research targeting the themes identified should develop and test measures to reduce the unnecessary use of emergency medical services.

References:
1. Beache SK, Guell C. Non-urgent accident and emergency department use as a socially shared custom: A qualitative study. Emergency Medicine Journal. 2016;33(1):47-51.
2. Northington WE, Brice JH, Zou B. Use of an emergency department by nonurgent patients. American Journal of Emergency Medicine. 2005;23(2):131-7.
3. Fatima Y, Hays R, Knight S, Neilson A, Fleming R, Panaretto K, et al. Drivers of general practice–type presentations to the emergency department in a remote outback community. Australian Journal of Rural Health. 2021;29(3):391-8.
4. Arksey H, O'Malley L. Scoping studies: towards a methodological framework. International Journal of Social Research Methodology. 2005;8(1):19-32.

GP Awareness of the Dementia Adviser Service in Cork and Kerry

Amara Singh, Prof. Tony Foley
Department of General Practice, School of Medicine, UCC

Introduction

Dementia

- Progressive cognitive decline, significant impact on patients and caregivers,[1] expected to double in Europe by 2050[2]

The Dementia Adviser Service (DAS)

- Established by The Alzheimer Society of Ireland, funded by the HSE[3]
- Support to patients and carers, collaboration with existing services[3-5]

Research Gap

- Limited GP input in 2018 service evaluation[6]
- Few studies regarding healthcare workers' perspectives on similar international programs[6-9]

Role of the GP

"The GP is **the first point of contact** and their intervention is crucial to the **long term outcome** for an individual".[6]

Aims

Awareness
GP awareness of the DAS

Understanding
GP perception of DAS roles

Use
How the DAS is used by GPs

Integration
How to better integrate the DAS with GP

Methods

Study: cross-sectional study, postal survey
Ethics approval: granted by SREC, UCC
Survey: Adapted from Coffey et. al 2018[7] with permission, developed with GP piloters and feedback*, open and closed questions
Survey dissemination: Random distribution to 500 GPs in Cork and Kerry
Statistical analysis: Descriptive statistics, inductive thematic analysis

References:

1. Cunningham EL, McGuinness B, Herron B, Passmore AP. Dementia. Ulster Med J. 2015;84(2):79-87. https://www.ncbi.nlm.nih.gov/pubmed/25844007
2. Alzheimer Europe. Dementia in Europe Yearbook 2019: Estimating the prevalence of dementia in Europe. Luxembourg: Alzheimer Europe; 2019. https://www.alzheimer-europe.org/sites/default/files/alzheimer_europe_dementia_in_europe_yearbook_2019.pdf
3. Department of Health. The Irish National Dementia Strategy: Report. 2019 May 27. https://www.gov.ie/en/publication/82d8ay-national-dementia-strategy/
4. The Alzheimer Society of Ireland. Dementia Adviser. Webpage. https://alzheimer.ie/service/dementia-adviser/
5. De Siún A. Briefing paper on dementia advisers. Report. 2013 Sep 1. http://hdl.handle.net/10147/612431
6. Coffey A, Connally N, Hegarty J, et al. Evaluation of The Alzheimer Society of Ireland Dementia Adviser Service Report. Report. 2018 Sep 26.
7. Dayson, C., & Bennett, E. Evaluation of the Rotherham Carers Resilience Service: Final Report. Report. 2016 August.
8. Goeman D, King J, Koch S. Development of a model of dementia support and pathway for culturally and linguistically diverse communities using co-creation and participatory action research. BMJ Open 2016;6(12):e013084. https://bmjopen.bmj.com/content/bmjopen/6/12/e013084.full.pdf
9. La Fontaine J, Brooker D, Bray J, & Milosevic SK. A Local Evaluation of Dementia Advisers (National Demonstrator Site) Worcestershire: Report for Dementia Adviser Service Implementation Team. Report. October 2011. https://www.worcester.ac.uk/documents/Dementia-Adviser-Service-Final-Report.pdf
10. Clarke CL, Keyes SE, Wilkinson H, et al. Organisational space for partnership and sustainability: lessons from the implementation of the National Dementia Strategy for England. Health & Social Care in the Community 2014;22(6):634-45. https://pubmed.ncbi.nlm.nih.gov/25243927/
11. Daniel K, Welzer D, Tooke J. Dementia Adviser service: Results of an evaluation of the Alzheimer Society Pathfinder sites. Report. 2011.

Results

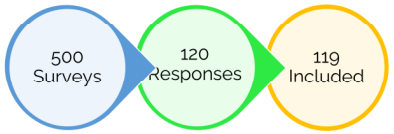


Figure 1: Participant and inclusion numbers

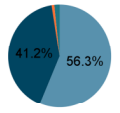


Figure 2: Gender of participants (n=119)

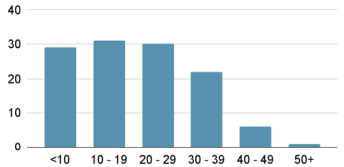


Figure 3: Number of years as a GP (n=119)

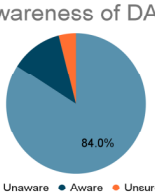


Figure 4: GP awareness of the DAS (n=119)

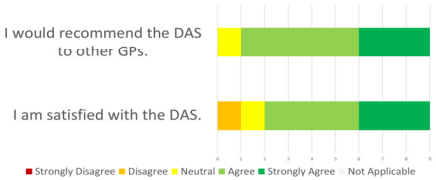


Figure 4: Likert scale of GP's opinions of the DAS (n=9)

How might the Dementia Adviser Service's quality, and integration with General Practice be improved?

"General practice needs to be made aware of [the] service."
Theme: Improved Communication
"Healthlink referrals are always beneficial."
Theme: Ease of Access

Discussion & Conclusions

Relevance

First study to evaluate GPs' perspectives of the DAS in Ireland.

Adds to limited literature on DAS in Ireland, and healthcare workers' perspectives.[6-9]

Advocacy

Importance of spreading awareness of the DAS among GPs.

Importance

May inform National Dementia Office policy.

Future Directions

Nationwide comparison of trends
Awareness campaign, Forum.

Acknowledgements: GP Piloters, GP Participants, Prof. Alice Coffey, *Kate Brennan (National Dementia Office), *Laura O' Philbin (The Alzheimer Society of Ireland), Cathal Doherty, Aoife O'Neill

An Investigation into Patient Understanding of Atrial Fibrillation and Awareness of Associated Modifiable Risk Factors for Stroke

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Introduction

Atrial Fibrillation (AF) is a major risk factor for stroke. Recent research shows that there is suboptimal knowledge amongst AF patients regarding AF and its implications. Research also demonstrates patient knowledge as a predictor of patient outcomes.

This study aimed to assess patient understanding of AF, its management, and other major risk factors for stroke, thereby shedding light on any existing knowledge gaps.

Methods

This was a single-site, cross-sectional study conducted in the General Practice (GP) setting. A two-section 25-item questionnaire was used to assess patient knowledge.

AF knowledge was assessed using the Jessa Atrial Fibrillation Knowledge Questionnaire (JAKQ), a 16-item validated questionnaire. Stroke risk factor knowledge was assessed using the NHS $ABCD_2$ risk questionnaire, a nine-item questionnaire, adapted for this study population.

Participants were patients with a confirmed diagnosis of AF on the Chronic Disease Management programme, invited to participate using convenience sampling. Questionnaires were verbally administered by the CDM nurse during appointments.

Results

Demographics:

- A total of 78 patients participated.
- 24 females (30.8%).
- 54 males (69.2%).
- Mean age: 75 years ± 7 SD.
- Direct Oral Anticoagulant (DOAC) users: 68 (87.2%).
- Vitamin K Antagonist (VKA) users: 10 (12.8%).

Questionnaire Findings:

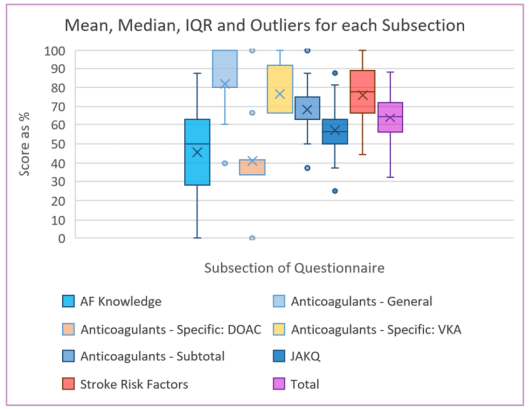
Seven questions had a low correct-response rate of <50%.

Mean JAKQ score: 56.97% ± 12.78% [95% CI 54.13, 59.81]

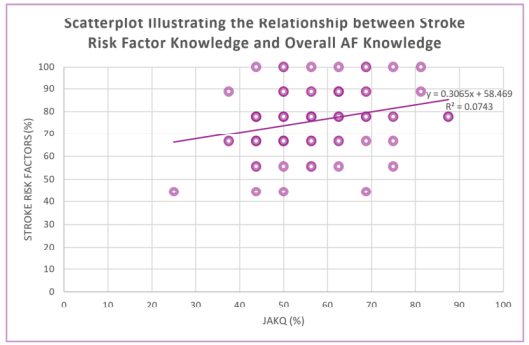
Mean $ABCD_2$ score: 75.73% ± 14.37% [95% CI 72.74, 79.12]

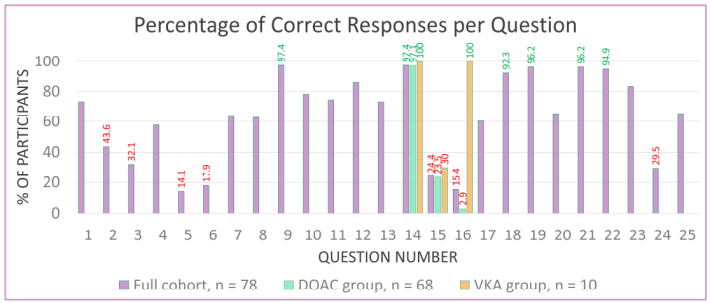
Mean Total score: 63.79% ± 10.80% [95% CI 61.40, 66.18]

Results



Knowledge levels differed significantly between DOAC and VKA users in many areas, with VKA users tending to score higher overall (p=0.008), as well as in the JAKQ (p=.016), the specific anticoagulant (p=<.001) and overall anticoagulant (p=.002) sections. A weak association of statistical significance was found between scores across the two sections of the questionnaire (p=.016).





Q	Topics of questions with a low correct-response rate (<50%)	n (%)
2	AF is not always accompanied by symptoms.	34 (43.6)
3	Patients can detect AF by taking their pulse regularly.	25 (32.1)
5	Medication cannot prevent atrial fibrillation permanently, as the arrhythmia will increasingly occur with ageing, even when taking medication.	11 (14.1)
6	An AF patient should not go to the general practitioner or emergency department each time they feel AF.	14 (17.9)
15	When AF patients taking a DOAC have forgotten to take their blood thinner, they can still take that dose, unless the time till the next dose is less than the time after the missed dose.	16 (23.5)
	When AF patients taking a VKA have forgotten to take their blood thinner, they should still take their forgotten pill (immediately or at the next dose).	3 (30)
16	DOACs come with a card, which AF patients have to show to their general practitioner and specialist.	2 (2.9)
24	HDL refers to 'good' cholesterol, and LDL refers to 'bad' cholesterol.	23 (29.5)

Conclusions

Our results provide new insight into key knowledge gaps amongst patients with AF in Ireland. The study also highlights an association between AF knowledge and stroke risk factor knowledge levels amongst participants, as well as a significantly lower knowledge level in DOAC users compared to VKA users. These findings may serve to guide the focus of targeted patient education initiatives in the future.

references:

1. Desteghe L, Engelhard L, Raymaekers Z, Kluts K, Vijgen J, Dilling-Boer D, Koopman P, Schurmans J, Dendale P, Heidbuchel H. Knowledge gaps in patients with atrial fibrillation revealed by a new validated knowledge questionnaire. Int J Cardiol [Internet]. 2016 Aug 21 [cited 2025 Mar 03];223:906–14. Available from: https://doi.org/10.1016/j.ijcard.2016.08.303
2. National Institute for Health and Care Excellence. Atrial fibrillation: diagnosis and management [Internet]. London: NICE; 2021 Apr 27 [updated 2021 Jun 30; cited 2025 Mar 03]. (NICE guideline [NG196]). Available from: https://www.nice.org.uk/guidance/ng196/chapter/Recommendations#rate-and-rhythm-control

GP and patient physical activity: Irish physician's physical activity experiences about motivating themselves and moving patients 'a step up the ladder'.

Vikram Niranjan[1], Ibak Baky[1], Conor Byrne[1], Alison Bourke[1], Joe MacDonagh[2], Amanda M Clifford[3], Tracey Barnes[4], Finola O'Neill[3], Matthew Cullen[3], Ray O'Connor[5], Andrew O'Regan[5]

1. School of Medicine, University of Limerick, Ireland. 2. Technological University, Dublin 3. School of Allied Health, University of Limerick, Ireland

Background & Objective

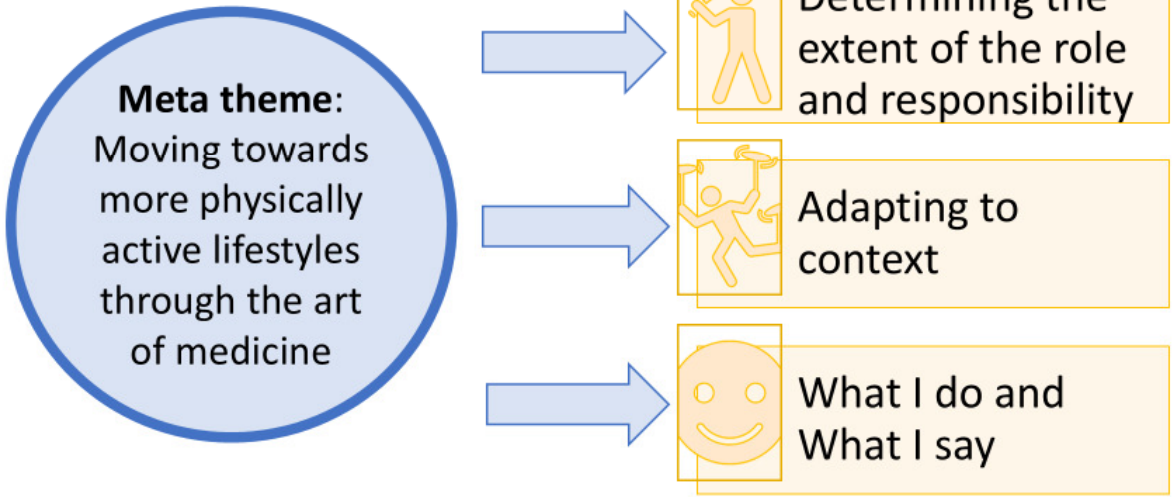
With rising physical inactivity levels and chronic conditions, general practitioners (GP) may have a critical role in promoting physical activity [PA]. With their own physically inactive nature of work and the workload capacity challenges, the experiences of GPs in relation to recommending PA is an important consideration.

This study explored general practitioners' (GPs) understanding of physical activity advocacy to patients and their own self-care, how GPs perceive their own physical activity behaviours, how their personal experience of physical activity affects how they promote it in practice and how they define the limitations of their role in this.

Methods

A qualitative study design was used, with semi-structured online one-on-one individual interviews (n=21 GPs) in Ireland. Participants were recruited from the University of Limerick Education and Research Network of General Practitioners (ULEARN-GP). Braun and Clarke's reflexive thematic analysis was used for data analysis.

Results



Key messages

- **Facilitators and Barriers** – GPs are in unique position in their own personal and private lives to promote PA for their health and their patient's as well.
- **Social prescribing** – Support in the form of community-based resources and programmes as well as brief intervention skills could enhance GP ability to further promote physical activity.