autobiographic data were analyzed from the eight randomly selected student hospice immersion journals (approx. 200 pages) who participated during academic year 2017-18. Pre-fieldwork, fieldwork, post-fieldwork journals were reviewed and analyzed using manual content analysis followed by NVivo 12+ analysis. Thematic coding resulted in representative quotes, key words, and native concepts. Inter-rater reliability was established with the use of a codebook and agreed upon thematic definitions. Four key themes included: Subversion of End of life (EOL) Expectations; Character Development/Introspection; Exposure to Diverse Cultural/Spiritual Perspectives; and Skills to Bring into Future Practice. Proximity to death/dying resulted in reflections on values and priorities, and a renewed sense for compassionate patient care. Students developed skills for future practice, including competency in EOL and post-mortem care, navigating difficult, emotionally laden family dynamics, and contributing to an interprofessional staff team even in uncomfortable situations. This immersion positively affected student perspectives about death and end-of-life care; creating life-altering experiences in patient-centered-care. Students stated significant impacts to employ as a physician.

AN INNOVATIVE APPROACH TO ENHANCING COPD CARE AND MANAGEMENT IN A RURAL NORTHERN COMMUNITY
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Background: COPD is the third leading cause of death worldwide. Rural communities often face challenges to provide high quality chronic disease care for aging populations. Despite these longstanding challenges, there was an intention to improve the care setting by developing and fostering a shared vision for quality care, as evidenced by enhancing COPD screening and care. To ensure consistent and longitudinal patient access to high quality of care as well and ongoing physician recruitment and retention a new rural program was developed. Objective-In this presentation we will describe a new rural community based COPD program from conceptualization and development through to current functioning highlighting areas of innovation. Methods-A process evaluation guided by Moore et al.’s framework to assess program implementation, mechanisms of impact, and context was conducted. Qualitative thematic analysis was undertaken of stakeholder interviews conducted in 2021 (n=11) and document review (n=60;~500 pages) of key clinic documents dated back to pre-program development.

Results: We describe five phases of program development: Survive; Reorganize and Stabilize; Assess and Respond; Build and Refine; and Sustain and Share. Outreach and localizing resources improved access to the program. Acquiring secured physician compensation, capturing quality data, and improving patient and provider self-efficacy built the capacity of the system and stakeholders within it. Finally, relationships were forged through building an integrated facility, collaborative networking, and patient engagement. The key elements of program implementation were the resources required to ensure its operation, categorized as hardware, software, organizational, and human.

EVALUATING IMPLEMENTATION FIDELITY TO A NURSE-LED CARE MODEL IN NURSING HOMES: A MIXED-METHODS STUDY
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Implementation fidelity assesses the degree to which an intervention is delivered as intended. Little is known about how it acts as a moderator between an intervention and its intended outcome(s) and which factors affect the fidelity trajectory over time. We exemplify implementation fidelity in INTERCARE, a nurse-led care model implemented in eleven Swiss nursing homes (NH) successfully decreasing unplanned hospital transfers. A mixed-methods design was used, guided by the Conceptual Framework for Implementation Fidelity. Fidelity to INTERCARE’s core components was measured with 44 self-developed items at 4-time points (baseline, 6, 12 months after intervention start, 9 months post-intervention; fidelity scores were calculated for each component and overall. Structured notes from NH meetings were used to identify moderators affecting the fidelity trajectory over time. Generalized linear mixed models were computed to analyze the quantitative data. Deductive thematic analysis was used for the qualitative analysis. The quantitative and qualitative findings were integrated using triangulation. A higher overall fidelity score showed a decreasing rate of unplanned hospital transfers (OR: 0.65 (CI=0.43-0.99), p=0.047). Higher fidelity score to advance care planning was associated with lower unplanned transfers (OR= 0.24 (CI 0.13-0.44), p= < 0.001) and a lower fidelity score for communication tools (e.g., ISBAR) to higher rates in unplanned transfers (OR= 1.69 (CI 1.30-2.19), p= < 0.003). High implementation fidelity to INTERCARE was necessary to achieve a reduction in unplanned transfers. In-house physicians with a collaborative approach and staff’s perceived need for nurses working in extended roles were important factors for high fidelity.

AN INTERPROFESSIONAL APPROACH TO DEPRESCRIBING: A CURRICULAR FRAMEWORK
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Deprescribing is an important approach for managing polypharmacy and reducing harm from potentially inappropriate medications. Healthcare professionals identify barriers to deprescribing, including lack of knowledge and skill. This is not surprising as pre-licensure education does not consistently incorporate components of deprescribing into curricula. As such, there is a clear need to consider how to promote deprescribing competencies, teach related
knowledge and skills and assess learning outcomes. The Canadian Deprescribing Network (CaDeN) Health Care Professional Committee undertook a consensus process to develop a proposed competency framework that describes essential knowledge, teaching strategies, and assessment protocols to promote deprescribing skills and advocate for consistent education about deprescribing principles and practices. The framework is informed by the deprescribing process, which includes gathering and interpreting patients’ medication history and clinical information within their context, using tools that help identify potentially inappropriate medications, weighing potential benefit and harm of continuing or deprescribing medications, using shared decision-making to make decisions about deprescribing, communicating deprescribing and monitoring plans, and monitoring progress and outcomes. The competency framework considers interprofessional learning and how to involve patients and care partners in deprescribing decisions. Integrating deprescribing competencies in healthcare curricula requires an intentional and structured approach across all years of the program, focusing on interprofessional collaboration. Learning activities should be active and practical, progressing from early to advanced learner skills and include integration of deprescribing during experiential education. This framework includes a review of the competencies, learning outcomes, and assessment strategies, with a discussion of strategies to incorporate interprofessional learning activities.

CONSIDERATIONS OF AGE-FRIENDLY 4M PRINCIPLES IN DEPRESCRIBING INTERVENTIONS: A SCOPING REVIEW

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The 4Ms – Medication, Mentation, Mobility, and What Matters - represent the key components in the Age-Friendly Health Systems initiative and provide a conceptual framework for research in the older adult population. Over 40% of older adults experience polypharmacy, which can be addressed by deprescribing unnecessary medications. This review aimed to assess the degree to which the 4Ms were considered in intervention design, sample selection, and outcome assessment in deprescribing trials by keyword search in six databases and snowballing. Thirty-seven of the 564 trials identified met the review eligibility criteria. Imbalanced consideration of 4Ms in the deprescribing trials was observed. Intervention design: “Medication” was considered in all trials; “Mentation” was considered in 8 trials; “Mobility” (n=2) and “What Matters” (n=6) was less often considered. By targeting providers, most of the trials lacked consideration of patient-centeredness - aligning what matters most to older adults and their families with deprescribing decision making and implementation. Sample selection: “Medication” was considered in 15 trials (e.g., samples including patients taking ≥ 5 medications or specific types of medications), whereas “Mentation” (n=6), “Mobility” (n=6) and “What Matters” (n=0) were less often considered. Outcome assessment: “Medication” was the most commonly assessed outcomes (n=33), followed by “Mobility” (n=13) and “Mentation” (n=10) outcomes, with no study examining “What Matters” outcomes. 4Ms were not purposefully considered in the intervention design, sample selection, and outcome measurement of existing deprescribing trials. Future deprescribing trials need a more balanced and complete consideration of the 4Ms in the trial design and implementation.

HIGH-RISK ELDERLY SCREENING IN MEDICAL INTENSIVE CARE UNIT

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Geriatrics care in medical intensive care units (MICU) establishes a unique opportunity in early screening of High Risk Elderly (HRE) patients admitted for critical care. Many MICUs do not have a standard protocol to screen for HRE patients as part of their daily huddle. Our program is a quality improvement initiative to identify early identification of HRE patients in the MICU. HRE patients were identified based on nursing specific screening triggers at one of the Regional Hospitals of a large teaching hospital in Northeast Ohio. The program was designed as a part of geriatrics care expansion at regional hospital sites. Identified patients were discussed in daily huddles to determine unique geriatric needs in caring for these patients. A geriatrics co-management team was engaged in comprehensive geriatric assessments and care transition when it was needed. Geriatrics care in MICU demonstrates a unique opportunity in early identification of HRE patients. This helps to support a patient–centered approach in caring for critically ill elderly patients. The program would lay foundations in early screening for risk factors and optimizing elderly care in MICU.

RESULTS OF A PILOT IMPLEMENTATION OF AN ADL GUIDELINE FOR NURSING PROFESSIONALS IN THE NETHERLANDS

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Nursing care in activities of daily living (ADL), such as washing, dressing, or eating is frequently provided while being poorly informed by scientific evidence. To address nursing professionals’ need for guidance we developed a practice guideline on ADL-care. This guideline comprises eleven core recommendations on involving care receivers and informal caregivers in ADL-care, identifying ADL-care needs, and effective ADL-interventions. Since the success of this guideline hinges on its actual use by nursing professionals, we assessed the use and determined influencing factors to guide targeted strategies for future implementation in different nursing care settings. In a mixed-method study, nursing professionals documented the number of core operations of this guideline hinges on its actual use by nursing professionals. The program was designed as a part of geriatrics care expansion at regional hospital sites. Identified patients were discussed in daily huddles to determine unique geriatric needs in caring for these patients. A geriatrics co-management team was engaged in comprehensive geriatric assessments and care transition when it was needed. Geriatrics care in MICU demonstrates a unique opportunity in early identification of HRE patients. This helps to support a patient-centered approach in caring for critically ill elderly patients. The program would lay foundations in early screening for risk factors and optimizing elderly care in MICU.