P-86 DEVELOPING AND IMPLEMENTING A COMMUNITY CARE PATHWAY FOR THE MANAGEMENT OF CHRONIC OEDEMA

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Background Chronic oedema has a profound impact on quality of life. It may originate from primary anatomical reasons (primary lymphoedema), be secondary to cardio-vascular dysfunction, be related to cancer or cancer treatments and is increasingly a result of obesity. The numbers of patients with chronic oedema are increasing and both specialist lymphoedema and community nursing teams are over-stretched.

Many community nurses lack evidence-based knowledge and skills in the management of chronic oedema and specialist services therefore often provide care for both complex and straightforward management.

Aims To develop and pilot an integrated community pathway for the management of chronic oedema.

Method A Knowledge Transfer Partnership project was developed by 3M (Industry) with University of Nottingham. Clinical services in Leicester were engaged and an expert advisory group formed.

A clinical care pathway was devised through Nominal Group technique. Data from a point prevalence study, across Leicester City was used to operationally define a feasibility assessment of the pathway.

Implementation was supported by a competency framework and bespoke training programme. The pathway was piloted with 30 patients receiving care from three community nursing teams.

Data collection: Quantitative and qualitative data has been collected via one-to-one interviews with the community nurses following appointments with pathway inducted patients. Such data includes; a consideration of the symptoms of oedema, a record of resource use, and questions pertaining to levels of patient and nurse knowledge.

Results to date The pilot has been underway for three months and initial results reveal an improvement in symptoms supported by an immediate reduction in nurse visits and product use; alongside greater patient concordance.

P-87 LYMPHOEDEMA – EXPANDED PARTNERSHIPS ACROSS CARE SETTINGS CREATING BETTER PATHWAYS OF CARE

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Background Our comprehensive lymphoedema service supports primary, secondary and palliative lymphoedema, recognising long-term management striving to deliver seamless care between the primary and secondary settings.

Treatment incorporates a combination of elements, and while we carry out these specialist forms of treatment within our service, we understand that this is not achievable or sustainable in the wider community. Need is growing but the workforce is not.

Aims Through increased and innovative work with primary care the service aims to reduce the impact of lymphoedema and support management in community settings through a variety of partnership approaches, including:

- Staff rotational opportunities
- Early detection and prophylactic treatment.

Methods Recognising the demands on teams we have developed partnerships with acute and primary care settings and lead ongoing education of health care professionals to consolidate their knowledge and skill base.

Two developing elements include:

A rotational post with the community allowing a nurse to spend time within our service developing lymphoedema management skills. There is potential to expand this further. Through securing substantive rotational posts within the community setting, we can consolidate their skill base and promote partnership and ongoing support for the long term care of patients.

Research indicates that within breast related lymphoedema, early detection can minimise the risk of long term complications and in some cases can reverse the clinical signs. Through close working with the local breast team detecting the presence of oedema before clinical signs are apparent, a reduction in patients developing symptomatic lymphoedema can be achieved.

Outcomes

- Improved outcomes for patients through sharing and developing skills across services
- Positive evaluation of prophylactic monitoring has the potential to be used with other diagnosed malignancies to reduce the incidence of long-term complications
- New ways of working with greater potential to develop optimal patient care through collaboration.

P-88 MANAGEMENT OF HOSPICE PATIENTS WHO USE PRESCRIBED INTRAVENOUS DIAMORPHINE FOR OPIOID ADDICTION

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Background Whilst methadone and buprenorphine are the mainstay treatments for opioid addition in the UK, rarely patients are maintained on prescribed intravenous diamorphine. Misuse of Drugs (Supply to Addicts) Regulations 1997 restrict prescription of diamorphine for addiction to medical practitioners with a license issued by the Home Secretary. Managing hospice inpatients with existing diamorphine maintenance prescriptions raises important practical and legal issues.

Aims and methods We aimed to highlight key issues identified when caring for two such patients at our institution. We searched for literature concerning hospice management of cancer patients with existing prescriptions for diamorphine for opioid addiction.

Results Patient 1 was admitted with a long-term prescription for drug addiction (80 mg daily intravenous diamorphine, 300mg oral morphine) dating back 20 years. His cancer pain required additional high-dose fentanyl and oxycodone due to morphine tolerance before discharge. Diamorphine prescribed for addiction should be collected daily from a designated pharmacy under normal circumstances. The Substance Misuse Team continued to prescribe the opioids for addiction, and agreed to arrange weekly collections by a relative with the patient's written permission.

Patient 2 was admitted for terminal care, with a similarly long-standing prescription (60 mg daily intravenous diamorphine, 300 mg oral morphine). Legal and practical issues made organising