

118 IN LIGHT OF THE GOSPORT REVIEW, HOW TRANSPARENT IS OPIOID PRESCRIBING WITHIN HOSPICES?

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Background With recent attention looking at opioid prescribing, the potential dangers with use in non-malignant pain conditions, increasing scrutiny on their indication, use and monitoring is now required. As supportive and palliative care veer into the earlier trajectories with conditions other than cancer, the traditional approach to escalating doses of strong opioids to manage mainly pain and breathlessness is being challenged emerging research.

Aim To explore the use of strong opioids within a hospice setting and to scrutinise the supporting documentation.

Methods Retrospective case-note review of patients within an inpatient and community hospice setting over a 3 month period.

Results 64 inpatient and 67 community case-notes were reviewed; 77% and 46% of patients having strong opioids when first reviewed by the hospice teams respectively. The most common opioids were morphine sulphate (26% vs. 16%), diamorphine (20% vs. 4%) and oxycodone (20% vs. 4%) with most inpatients (91%) having had clear documentation to support the indication, use, dose changes and opioid rotation rationale. The proportion of patients that subsequently died (51/64) within the inpatient unit, nearly all (50/51=98%) had some form of subcutaneous opioid prescribed regularly at their time of death. The comparison within the community was possible given the multiple health providers involved in prescribing of end of life medications.

Conclusions The findings from this piece of work provide reassurance that strong opioids when used within an inpatient hospice setting are used proportionally, with clear indication and rationale for their use. The community based practice supported by hospices identifies key concerns in terms of clarity and consistency in the prescribing of strong opioids in the last days of life. Given the multiple provider partners within the ever merging health landscape, clear and shared protocols identifying the responsible organisation to lead on opioid prescribing and their clear rationale will be key.

119 CORNEA DONATION – OUR 2020 VISION

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Introduction There is a shortage of over 500 corneas for transplant each year in the UK. Most people up to age 85 are eligible to donate, even those with metastatic cancer. From March 2018, following a period of staff education, all eligible patients admitted to Martlets Hospice were asked routinely about cornea donation and offered an information leaflet to enable informed decision-making. Prior to this period, only one inpatient per year on average donated their corneas.

Method Evaluation of the project had two components:

1) Audit - the electronic records of all inpatient admissions from March to May 2018 were analysed to identify:

- eligibility for donation and the proportion of patients approached about this

- factors that may have hindered eligible and willing patients successfully donating corneas

2) Staff Opinion Survey - all staff working on the inpatient unit were emailed with an online questionnaire asking about their experiences and suggestions for improvement

Results Audit:

- 27 of the 56 eligible patients were asked
- 14 wanted to donate
- 6 went on to donate

Not informing next of kin and not adequately recording suitable alerts in the notes led to some missed donations

Staff opinion survey:

- 55 responses
- 34 respondents felt able to initiate conversations about cornea donation

Factors that would improve staff confidence were identified as: further training and more time for discussion with patients and families

Conclusions

1. Staff education in and engagement with cornea donation in the hospice setting can empower patients to make informed decisions
2. Sensitive conversations regarding the option of cornea donation are integral to advance care planning
3. Simple changes in practice and culture in our unit led to an increase in donated corneas in just 3 months.
4. Further improvements to the process are planned with a re-audit next year.

120 NURSE-LED HOSPICE CLINIC. A CURATE'S EGG?

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Severn Hospice comprises two separate units and notably different geographical areas, each with a team of community-based 'outreach nurses' (linked to GP practices). Population totals 500,000 people, roughly equal per area. Telford & Wrekin has a population density of 584/km², Shropshire 136/km².

We aim to fulfil the national 'Ambitions' for palliative care and adopted a 'Living Well' strategy in 2017.

We offer nurse-led clinics within both hospices, an option given to all patients at initial triage. This initiative began in our Telford base and was evaluated positively by nursing staff. Shropshire clinics began in February 2019. We have evaluated these by reviewing everyone referred to the team from June - September 2019 to establish if clinic appointments may have been suitable.

The results revealed a total of 186 patients accepted our nurse outreach service over the four months; 181 patients were visited in their own homes. Of these only 16 were identified by the assessing nurse as being able to attend a clinic appointment: the main themes suggesting inappropriateness: end of life care, too unwell to attend a clinic or transport, travel & distance difficulties.

We also sent out clinic questionnaires in July 2019 to all twelve hospice outreach nurses, across both bases. Our questionnaires demonstrate significant differences by area: the more rural nurses noting difficulties with travel, including comments about cancelled and missed clinic appointments.

Both areas were concerned about missed 'clues' from the home environment. Interestingly the nurses within the more urban, generally lower socioeconomic class area, within the Telford team, repeatedly mentioned easier, 'less distracted' reviews in a clinic environment.

In Conclusion nurse-led clinics may be a useful adjunct for hospices and the option does fit with individualised care. However we encountered significant difficulties with patient demographics and nurse-assessed suitability for this service.

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ACUTE PALLIATIVE INTERVENTION (API): FACILITATING ENHANCED WORKING BETWEEN THE CRITICAL CARE OUTREACH TEAM (CCOT) AND THE HOSPITAL SPECIALIST PALLIATIVE CARE TEAM (SPCT) TO ENSURE APPROPRIATE COMFORT CARE FOR THE ACUTELY ILL

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Background Patients with life limiting illnesses commonly present to hospital acutely and are referred to the Critical Care Outreach Team (CCOT). It is frequently concluded that escalation of care is inappropriate due to the partially or completely irreversible nature of deterioration. In such cases escalation of palliative care is fundamental. We performed a retrospective service evaluation of patient outcome following critical care outreach review in patients deemed unsuitable for critical care admission and evaluated appropriateness of referral to the Specialist Palliative Care Team (SPCT).

Methods This was a two-centre study. Paper medical notes from a were reviewed. SPCT involvement was assessed for appropriateness using a conceptual framework.

Results 50 patients' (evaluated by CCOT but unsuitable for a higher level of care between October and December 2018) notes were reviewed. 34 (68%) died and 16 (32%) were discharged. Of those who died, the median time from initial CCOT review to death was 4.5 days. 6 (12%) of patients were referred to the SPCT. A further 7 (14%) were reviewed by the SPCT who proactively identified patients as end of life care through the discontinuation of physiological observations. However, 45 (90%) should have been referred.

Conclusions CCOTs identify patients who are inappropriate for higher-level care. Most of these patients are unlikely to survive their hospital admission and the vast majority would benefit from SPCT review for appropriate symptom management and Advanced Care Planning (ACP). The term Acute Palliative Intervention (API) could be utilised to change the language and culture of care decisions.

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THE PREVALENCE OF FRAILTY AMONGST HOSPICE IN-PATIENT POPULATIONS: WHAT DOES THIS MEAN FOR OUR PATIENTS AND THE CARE WE DO AND DO NOT PROVIDE?

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Background Improved understanding of how to provide palliative care to the growing number of people living and dying with frailty is an international priority. Appropriate models of care may have similarities and differences to existing specialist palliative care (SPC) provision. Patients who currently access SPC may subjectively be described as frail; however, there is limited data on actual frailty prevalence and how frailty is associated with demographics, diagnoses and outcomes.

Methods Specific measures of frailty are not routinely recorded in SPC; therefore, measures of performance that are consistently collected were mapped to frailty level. Hospices North East (a collaborative of independent hospices) have an established dataset detailing the care they provide for whom. Analysis of this dataset established levels of frailty and its relationships.

Results The Australia-Modified Karnofsky Performance Status (AKPS) can be mapped to Rockwood's Clinical Frailty Scale to provide a proxy measure of frailty. 520 discharges or deaths (from 455 patients) occurred in three independent hospices in the Northeast of England from April 1st 2017 to March 31st 2018. Admission AKPS was available on 420 discharges or deaths (from 407 patients). On admission to the hospice the prevalence of very severe frailty (AKPS 10–20) was 26.4%; severe frailty (AKPS 30) was 11.4%; moderate frailty (AKPS 40–50) was 35.5% and mild frailty (AKPS 60) was 17.6%. One-off high levels of frailty and progressively increasing frailty are detrimentally related to prognosis and length of stay.

Conclusions There is a significant burden of frailty in the current hospice in-patient population. Therefore, much may be learned from contemporary service provision when considering applicable future palliative care models for those with frailty. As with current patients a two-tier in-patient model comprising of both intensive medically led short stay units and nurse led longer stay units or community beds may be useful.

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IS THERE A ROLE FOR CARDIOPULMONARY RESUSCITATION IN PALLIATIVE CARE? DEVELOPING A HOSPICE APPROPRIATE SERVICE IN RESPONSE TO A PATIENT CASE

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Background Attempting cardiopulmonary resuscitation (CPR) in the hospice setting can be a divisive issue, with some arguing it should not be attempted. Within St Michael's Hospice, we are managing an increasing number of patients earlier in their illness, when CPR may remain appropriate. Following a patient case, we reviewed our CPR service to ensure it was still meeting the needs of our patients.

Method Following the successful resuscitation of a 42-year-old patient with locally advanced pancreatic cancer after an in hospice cardiac arrest, using basic life support with automatic external defibrillation (AED), the case was brought to the monthly Significant Event Meeting (SEM). This proved a controversial case, although overall we agreed CPR was appropriate for this patient.

Results In response to the SEM, several changes were made. As part of this, a multi-professional educational