143

DEVELOPMENT OF AN ACUTE INTERVENTION TEAM – AN INNOVATIVE SOLUTION TO PROVIDING ENHANCED 24/7 PALLIATIVE AND END OF LIFE SUPPORT IN ACUTE HOSPITALS

Lucy Nicholson, Lisa Ward, Richard Hixon. *County Durham and Darlington Foundation Trust (CDDFT)*

10.1136/spcare-2020-PCC.163

Background The 'Acute Intervention Team' (AIT) is the culmination of a multi-disciplinary drive to better support parent teams to actively manage deteriorating patients and recognise and care for the patients where palliation is the most appropriate course.

Methods The AIT consists of Nurse Practitioners and Senior Health Care Assistants who, as well as possessing the skills of a typical critical care outreach team, have also received additional dedicated training in palliative and end of life care. This includes a period shadowing the Specialist Palliative Care (SPC) Team and bespoke training on recognition of potential lack of reversibility, diagnosing dying, management of palliative emergencies, symptom control and end of life care.

Results The Team have reviewed over 6000 patients since commencing clinical practice in December 2016. Just under half died during their admission, demonstrating how important palliative care is within the role. Whilst most referrals were for patients with high NEWS, notably 241 were referred by SPC for enhanced palliative support to wards out-of-hours. The percentage of cases where a DNACPR should have been in place for patients suffering a cardiac arrest reduced from 41% to 30% in 2017/18, and in 2018/19 reduced further to 17%. This demonstrates the team have had a positive impact on appropriate escalation planning. Palliative care coding has also significantly increased over this time, from 20% to 40% of deaths, reflecting improved palliative decision making and quality of care.

Conclusion This innovative team are addressing the challenges of providing good 24/7 end-of-life care for the approximately 2000 patients who die each year within CDDFT, allowing us to better meet the challenges of modern day healthcare. Pro-active care for these patients now includes escalation to critical care or to palliative care. Replication of this model would be cost neutral for any trust with a critical care outreach team.

144

THE 'TECHNOLOGY IN PALLIATIVE CARE' (TIP) STUDY: A DELPHI STUDY TO DEFINE RESEARCH PRIORITIES FOR THE USE OF TECHNOLOGY FOR THE CLINICAL MANAGEMENT OF PEOPLE WITH SERIOUS ILLNESS

Amara C Nwosu, Tamsin McGlinchey, Stephen Mason. *Palliative Care Institute Liverpool, University of Liverpool, Marie Curie Hospice Liverpool*

10.1136/spcare-2020-PCC.164

Background The development of data-driven technology presents an opportunity to improve quality and efficiency of healthcare provision and patient experience. It is important to carefully evaluate current and planned future developments, to identify research priority areas and determine how resources should be best utilised. This project aimed to explore how digital technology can improve the care of people with

palliative care needs by setting 'priority areas' for further research and development.

Methods and objectives A scoping literature review was conducted. Two rounds of international Delphi questionnaires were completed, followed by a consensus meeting of experts and a public engagement event.

Results One hundred and eight experts (from healthcare, academic and technology) from 11 countries participated in round 1 Delphi. The second round Delphi questionnaire was completed by 55 (53% of 1st round) participants in nine countries. Eleven experts attended the final consensus meeting. A total of 12 priorities were selected (from a list of 33) which were summarised into eight themes. These themes were: Big Data; mobile devices; ehealth/telehealth; virtual reality; smart homes; biotechnology and digital legacy. A public engagement meeting of six lay representative was conducted to discuss each priority area in depth and identify future research questions.

Conclusion The identified priorities represent a wide range of important emerging areas in field of digital health, personalised medicine and data science. Collaborative studies are required to address these priority areas, which will aim to improve the care and experience for people with palliative care needs.

145

PALLIATIVE CARE OUTCOMES COLLABORATION ASSESSMENT TOOLS IN PRACTICE: A SET OF 4 AUDITS

Frances O'Mahony, Siobhan Coffey, Claire Kearns, John Sheridan, Sue Moran, Martina O'Reilly. *Milford Care Centre, Limerick*

10.1136/spcare-2020-PCC.165

Background PCOC uses a suite of clinical assessment tools to help identify and manage common symptoms and problems among palliative care patients. They may help patients, carers and families to communicate their experiences and preferences with clinicians and, importantly, to benchmark outcomes. PCOC assessment tools are being adopted widely in the Irish palliative care setting at the moment.

Methods PCOC assessments were introduced in the inpatient specialist palliative care unit at Milford Care Centre in December 2018. 4 separate audits were conducted during this initial period: Phase Definition, Phase Change, Phase Assessment, Problem Severity Score (PSS) Assessment.

Results Phase Definition and Phase Change: Of a total of 127 phases among 10 patients, 91 (71.65%) were correct, 21 (16.54%) were incorrect and 15 (11.81%) were missed. Most errors related to recognition of the terminal phase and recording of a change of phase outside of routine assessment times. Phase and PSS Assessment: These examined the consistency of scores applied by two different clinicians when assessing a patient within two hours. Initially, our compliance rates were approaching those published previously. Following full implementation of training for all clinical staff, a re-audit showed the rate of consistency matched the published rates for all domains except for assessment of 'other symptoms' (aside from pain) and 'family/carer problems.' The latter improved significantly in the period between data collection.

Conclusions Overall results are very positive and areas for improvement have been identified. Education and dissemination of results to clinical staff is continuing. A positive response to

these interventions has been demonstrated. These audits will continue on a regular basis to ensure maintenance of these standards, and improvement where necessary. A further audit of response to PCOC assessments will be conducted.

146

AUDIT OF PATIENT BLOOD MANAGEMENT AT A SPECIALIST PALLIATIVE CARE UNIT

Ed Duffy, Frances O'Mahony, Helen O'Connell, Aoibheann Na Chonfhaola, Colin Mortlock, Martina O'Reilly, Syed Qadri, Caroline Burke, Hilary O'Leary, Feargal Twomey. *Milford Care Centre, Limerick*

10.1136/spcare-2020-PCC.166

Background Blood transfusion is a common practice in palliative care despite a dearth of evidence supporting its routine use in this setting.

Objectives

1. To review patient blood management at Milford Hospice.
2. To explore potential for prospective research in this area.

Methods Data pertaining to a purposive sample of transfusion events at Milford Care Centre that occurred in 2016 and 2017 was collected retrospectively from patient records and laboratory results. Data included demographic information, primary diagnosis, cause of anaemia, indication for transfusion, performance status, investigations such as haemoglobin and iron studies, and outcomes including 30-day outcomes and length of stay.

Results Of these 52 transfusion episodes included, 29 were regarding female patients and 34 were over the age of 65. All patients had a diagnosis of malignancy, with bone metastases reported in 13 (25%). Average Haemoglobin pre-transfusion was 7.21 g/dl. Iron studies were checked in ten cases.

2 or more units were transfused in all but 1 instance.

A beneficial response to transfusion was documented in 15 cases.

3 patients had haemoglobin checks after individual units of blood. 18 patients had haemoglobin checks within a week of the transfusion episode.

30-Day Outcome Post Transfusion: 46% of patients had returned home; 33% of patients had died; 13% of patients remained in hospice; 8% other (long term care, missing data).

Conclusions The lack of full investigation prior to transfusion demonstrates non-compliance with NICE standards and allows for potential overuse of blood products. Routine prescription of two units of blood without interval symptom reassessment or haemoglobin measurement may also contribute. These results were disseminated among clinical staff and an action plan was developed. An algorithm was developed for use in the inpatient palliative care setting and this is being implemented currently. Accompanying guideline development is also underway.

147

PEACE PLAN: THE FUTURE OF ADVANCE CARE PLANNING IN THE ELDERLY

N Palipane, KL Bettany, S Roy, S Gupta. *Mid Essex Hospital Service NHS Trust, Farleigh Hospice*

10.1136/spcare-2020-PCC.167

Background The PEACE (Proactive Elderly Advance Care) plan supports proactive planning of community care escalation

through documenting patient wishes and communicating these with care stakeholders in primary and secondary care. It has been shown to reduce inappropriate re-admissions to hospitals at the end of life. Since September 2018, Broomfield Hospital has been promoting the use of the PEACE plan for elderly patients at the end of life being transferred to care homes. During rollout, it became apparent that there was a need to improve understanding amongst doctors about the indications for the document and their competence in its completion as well as related communication with patients and carers.

Aims To assess local impact of using the PEACE plan and competency in completion, derive relevant training needs, and coordinate the provision of multimodal education interventions.

Method A 1-year pilot study of PEACE plan completion and patient outcomes was implemented across two elderly care wards with Gold Standards Framework accreditation. An online confidence and knowledge questionnaire was completed by junior medical doctors and the results were used to model a training programme.

Results The majority of patients died within the year. Only 8% were readmitted, most were turned around within hours. The questionnaire indicates that, although most junior doctors were aware of the plan, only half had completed the form at the trust. Overall confidence in completing the plan was below expected and discussing artificial nutrition and hydration was a particular area of concern.

Conclusions The PEACE plan reduced inappropriate re-admissions to Broomfield hospital at the end of life. Specific training is required to improve knowledge and confidence of junior doctors before its introduction to all medical wards. This will be delivered as presentations, simulation workshops with a focus on communication skills, and multimedia instructional aids.

148

HOSPICE AT HOME

R Richardson, K Maw, D Willis. *Severn Hospice*

10.1136/spcare-2020-PCC.168

Introduction Initially the 'Severn Hospice at Home Day Care Service' was created to provide specialist support and care to patients who were experiencing a crisis in their illness where additional nursing care could prevent hospital/hospice admission. The service needed a review to see if what it provided was what was needed by our local community.

Method Band 3 Healthcare Assistants were deployed to supplement other community teams supporting the assessment of that patient for a defined period of 72 hours. Evaluation of the service identified that most of these patients were in the last few weeks of life, requiring continual nursing care support. Subsequently the Hospice approached Complex Care (Continuing Health Care funding service) to become the palliative care provider of choice for Fast Track clients in the last 6 weeks of life.

Results End of life care is provided to all patients over the age of 18 regardless of diagnosis. The service provides one point of contact for all referrers seven days a week. Service quality standards already identified:

- Links to access to specialist advice – Outreach team, GP
- Prescribing and monitoring of medications
- Decrease in complaints received by complex care