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A CLEAR CALL FOR CONSISTENCY: CREATING A WORKING DOCUMENT FOR MANAGEMENT OF DIABETES IN PALLIATIVE CARE PATIENTS

Madeleine S Turley. *St Michael's Hospice, Hereford*

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Background Diabetes affects a significant proportion of our patients, with a higher prevalence than the UK population (6%) due to those with steroid induced and disease related diabetes. This can present both symptomatic challenges and regimen burden, which can require the patient to accept changes that may be at odds with their established management. In the hospice in patient setting a lack of consistency of clinical approach to diabetic patients was observed, due to part time working, a varied medical team and the perceived complexities of diabetic management in this patient group. Whilst a guideline existed, it was held away from the patients' bedside and not consistently reviewed. A new set of 'working documents' was created, based on the existing evidence, held at the patient's bedside. This 2 sided document contains detailed guidance on medical management dependent on prognosis, and incorporates monitoring charts for nursing staff; aiding consistency of approach and clarity of decision making. We audited the use of the form, both before and after education sessions to support its use, with an aim to make any necessary improvements.

Methods We audited 20 diabetes forms both pre and post education sessions. These involved staff confidence scores pre and post education, and then discussion around the use of the forms.

Results Following the education sessions, the number for forms correctly filled in increased from 5% to 30%. Confidence scores of staff users also increased significantly from 6.8/10 pre education, to 8.7/10 post education. General feedback was sought and incorporated where appropriate.

Conclusion A clear improvement was noted in the use of the forms following staff education sessions, which has positively impacted a new, cohesive MDT approach to improving diabetes management.

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HAS EMBEDDING SPECIALIST PALLIATIVE CARE IN AN INTERSTITIAL LUNG DISEASE CLINIC IMPACTED ON REFERRALS TO A LOCAL HOSPICE?

Kym Wakefield, Craig Gouldthorpe, Anne-Marie Bourke, Julie Harper. *Marie Curie*

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Introduction The British Lung Foundation states there should be a clear, standardised pathway to palliative care for patients with Interstitial Lung Disease (ILD). Our regional ILD clinic is based at the Royal Victoria Infirmary in Newcastle upon Tyne. In January 2016, specialist palliative care from the Marie Curie hospice Newcastle was embedded in this clinic. Patients can access same-day palliative care and respiratory reviews. The hospice has a 20-bedded inpatient unit (IPU) and a day therapy unit (DTU).

Aims To evaluate the effect of a collaborative ILD palliative care service on the number of referrals to the Marie Curie hospice, Newcastle.

Methods All patients referred to the hospice between November 2017 and May 2019 with a primary coded diagnosis of a

'non-malignant respiratory condition' were identified using SystmOne. Specific diagnosis, referrer and reason(s) for referral were also collected.

Results A total of 38 patients were identified. The majority of these had a diagnosis of ILD (n=26); the remainder had chronic obstructive pulmonary disease (n=11) or bronchiectasis (n=1). The 26 individuals with ILD accounted for 37 accepted referrals to the hospice (DTU=21, IPU=16); some patients were referred more than once. 90% (19/21) of these DTU referrals originated from the ILD clinic. A wider source of referrals was seen for IPU. The most frequently occurring reasons for referral were breathlessness and cough.

Discussion We are unable to compare current referrals with those prior to 2016 because a different record system was used. However, a search found only one patient with ILD admitted to IPU in 2015. We conclude that this increase is an outcome of our collaborative service. Anecdotal feedback suggests that patients who have met a member of the hospice team in clinic find it easier to accept hospice referral - further research is needed to explore this.

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WHAT ARE THE CURRENT TRENDS FOR PATIENTS WITH MOTOR NEURONE DISEASE (MND) ACCESSING HOSPICE INPATIENT UNIT (IPU) SERVICES? A RETROSPECTIVE REVIEW OF ADMISSIONS & CONSIDERATIONS FOR ONGOING DEVELOPMENT

Donna Wakefield, Sarah R Hanson, Anna Grundy. *Marie Curie Hospice Newcastle*

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Introduction MND is a progressive neurological disorder with an average prognosis of 2-3 years. NICE guidance recommends that Palliative Care specialists play an integral role in the MDT caring for patients with MND. We aim to examine how patients with MND are accessing the hospice IPU and to consider how we could support them further.

Method Retrospective review of the notes of all patients with MND admitted to hospice IPU over the past 2 years.

Results In the past 24 months, 16/861 (2%) of admissions to IPU had MND. However, 9/16 of these admissions were for planned carer respite (service no longer available). Excluding planned respite, all admissions (7 admissions, 5 different patients) were through urgent referrals. Three admissions were for social crisis, where one patient experienced problems with their care provider.

For the remaining admissions (n=4), the average age was 71 years, all admitted urgently from home with advanced disease (average 22 months from diagnosis) with rapidly progressive symptoms. Referrals were either from the MND team (50%) or the hospice Day Therapy Unit (50%). There were no referrals from other services such as hospital or GP. Half had some evidence of Advance Care Planning (ACP) documented prior to admission and all had ACP during admission. All patients died, 3 as inpatients and 1 discharged home for end of life care (EOLC). The time between admission to death ranged from 2-40 days. Two patients required withdrawal of life-prolonging treatment; one withdrawal of NIV and one withdrawal of PEG feeding.

Conclusion All patients admitted (excluding planned respite) were referred to hospice IPU urgently. For 80% this was late in disease and involved EOLC. A new outpatient MND group

has been developed to introduce patients with an early diagnosis of MND to the hospice. This may help patients access hospice services sooner.

160 'PALLIATIVE CRITICAL CARE': AN IMPORTANT AND TRANSFORMATIVE COLLABORATION BETWEEN PALLIATIVE CARE AND INTENSIVE CARE SERVICES AT A LARGE TEACHING HOSPITAL

J Westwood, H Crispin, K Haynes, E Gowling, R Chambers, C Davis. *University Hospital Southampton NHS FT*

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Introduction In 2013, the Hospital Specialist Palliative Care (HSPCT) and General Intensive Care Unit (GICU) Teams began a quality improvement initiative in response to the palliative care needs experienced by GICU patients. 'Palliative Critical Care' now involves seamless inter-disciplinary working on an almost daily basis, supported by one session each per week of dedicated Intensivist and Palliative Medicine Consultant time. Here, we detail the impact of this collaboration on HSPCT activity and patient outcomes.

Methods Retrospective review of HSPCT records between April 2013 and March 2019.

Results Over the last 5 years the HSPCT has received 588 referrals from adult intensive care services (General, Cardiac and Neurological). From a baseline of 6 referrals in 2013/14 we now receive over 130 new referrals per year. Over this time our caseload has evolved; 79% of referrals for non-malignant conditions in 2018/19, compared with 59% in 2014/15. In both years the in-hospital mortality rate of patients seen by the HSPCT was approximately 50%.

Key areas of impact include pain control, symptom control, family support in 66%, 81%, and 86% of interactions, respectively. Patients are given psychological support in 48% of interactions. The HSPCT also provide valued support to ICU staff in 32% of interactions and discharge advice in 19%.

HSPCT involvement now routinely continues throughout the patient's hospital stay. The average number of contacts per patient has increased from 4.3 to 7.5 (2014/15 vs 2018/19, respectively), each contact lasting 30–40 minutes. Thus, the average total duration of HSPCT time per patient has increased from 139 minutes (2014/15) to 287 minutes (2018/19).

Conclusion This Quality Improvement Initiative has enabled a flourishing collaboration between our HSPCT and GICU teams resulting in a sustained increase in referral numbers from all adult ICU areas with more time dedicated to support each patient in a continuously evolving cohort.

161 SETTING UP A HOSPICE BASED RENAL SUPPORTIVE CARE SERVICE: WHAT WE HAVE LEARNED OVER THE LAST 3 YEARS

Jane Whitehurst, Sue Goodall, Ellie Hayter, Kevin Blackett. *St Barnabas House*

10.1136/spcare-2020-PCC.181

Background St Barnabas House Renal Supportive Care (RSC) Service for patients with advanced renal disease (CKD <15)

launched in 2016. Model: RSC clinical nurse specialist (CNS) 32 hrs per week; palliative care consultant support within existing community sessions; hospice multidisciplinary team input. Intervention: domiciliary visits, hospice-based outpatient clinics, joint reviews in nurse-led hospital renal clinic, attendance at hospital renal service (HRS) complex patients MDM; symptom control including fluid management; advance care planning (ACP); decision making support regarding treatment modality; Psychosocial support; liaison with community services and HRS.

Methods Service evaluation using system 1 data for patients on RSC caseload April 2016 to August 2019. Identifying successes, challenges and future opportunities.

Results Strengths: Increased access from <1% to 3% of hospice annual referrals, 49% of patients accessed other hospice services; 87% of patients who died, died in a community setting; good feedback from patients; collaborative working with HRS.

Challenges Initial referral criteria included an eGFR <15 and patient's choice to pursue conservative management, both have limited value in predicting prognosis or specialist palliative care needs; Patients undergoing dialysis are underrepresented (17%); the traditional model of hospice care - acceptance onto caseload from referral until death, is less relevant in this group; unclear monitoring/prescribing responsibilities for renal specific symptoms - diuretics, anaemia and electrolytes; lack of a supportive care register or clinical lead for HRS.

Opportunities Modification of referral criteria - needs rather than diagnosis based; modification of service model to deliver care in episodes; further collaboration with HRS - shared symptom scale, clearer shared care responsibilities.

Conclusions The RSC service at StBH has increased access to specialist palliative care for people with advanced renal disease. However the described challenges could negatively impact a sustainable and safe service as referral numbers increase. We have identified and are implementing solutions working collaboratively with the HRS.

162 EVALUATION OF SPECIALIST PALLIATIVE CARE SERVICES TO THE GYPSY AND TRAVELLER POPULATION IN THE LEEDS AREA

Hannah Wilson, Marianne Ralph, Melanie Clarkson. *Wheatfields Hospice, Sheffield Hallam University*

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Background The health of Gypsy and Traveller communities is significantly worse than the health of other minority ethnicities, experiencing premature mortality and greater risk of illness. The Leeds Community Health Needs Assessment in 2013 identified poor access to health services, especially within primary care. Recent evidence has highlighted that end of life care needs of Travellers and Gypsies must be recognised, understood, and supported by services both nationally and locally. In order to achieve this we needed to understand our current palliative care service provision and the barriers from both service users and professionals to achieving wider access to palliative services in this community

Methods A service evaluation was undertaken focussing on the care provided within an area served by Sue Ryder