prioritised from the advisory caseload as patients with predominantly palliative care needs, requiring regular consultant input.

Aims Prospective audit of SCU admissions during the initial nine-month period from opening in August 2019.

Results Over the initial nine-month period, a total of 85 patients were admitted to SCU with a mean length of stay of 10 days. Of these, 86% (n=72) had a primary cancer diagnosis, compared with 64% of patients under our advisory caseload. Age range was 37–98 years, with a mean age of 67 years. Mean waiting time once listed was 2 days (median 1 day, range 0–32 days). Mean time from referral to the advisory HSPCT to referral to SCU was 5 days (median 1 day, range 0–88 days). Length of stay reduced from a mean of 15 days in month one to 7 days in month six. Patients were most commonly admitted from medical wards (58%), followed by assessment areas (32%) and surgical wards (5%). Four patients were admitted electively; two for blood transfusion and two for paracentesis.

Conclusion Without any additional resource, we have successfully opened a small number of specialist palliative care beds. In September 2020, this increased to eight beds. Informal feedback is positive, and our next objective is to capture formal patient and family feedback. We will also develop processes to facilitate elective admissions for patients already known to palliative care services. It is interesting to note that the proportion of patients with a cancer diagnosis is higher on SCU compared with the advisory HSPCT. Prospective data collection is ongoing to see if this trend continues.

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IMPROVING USE OF CO-ORDINATE MY CARE ELECTRONIC PATIENT RECORD AT ST CHRISTOPHER'S HOSPICE – COMPLETING THE AUDIT CYCLE

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Introduction Co-ordinate my care(CMC) is the pan-london electronic patient record system for palliative care patients. It facilitates sharing urgent care records across settings, linking services which patients may access(GP, ambulance, district nurses, palliative care). By creating records and working with local services to update records, we aim to improve 'joined up working' for our patients.

Aims/objectives To audit use of CMC for patients under the hospice including numbers of patient consented/records created, congruence of information recorded with hospice electronic records and access of records by emergency services.

Methods We conducted snapshot audits of records in december 2018, subsequent QI initiatives including staff training and integration of CMC reviews into MDM meetings, with re-audit December 2019. Each audit examined 200 patient records, 100 indicated as 'CMC record created' on our hospice system and 100 indicated to have no record. Patients were randomly selected; 40 from each service:Bromley community, bromley care co-ordination, croydon community, Lambeth/southwark/lewisham community and sydenham outpatients. Information was cross-checked against the live CMC record. Standards included: 90% of patients should have a CMC record, 95% should have documentation of consideration of CMC, 95% of CMC records should have resuscitation and ceilings of

care decisions recorded with congruence between systems. We also recorded whether CMC records were accessed by OOH services.

Results Comparing data from our initial audit to the re-audit; 61% vs 73% of patients under our care were consented to have records created. Of these >95% had a live CMC record. For those not consented by us 220–40% had a live record across each of the 5 services. Between audits, numbers of patients with CMC records increased from 48–60% to 58–68%. Discussion of CMC with patients increased from 48–53% to 70–93%. Recording of DNAR status averaged >95%. Congruence of DNAR decisions was 82% with ceilings of care 61% congruent. Inclusion of hospice contact details varied across teams (30 to 74%). Records were accessed by out of hours services for 13 of these patients.

Conclusion Use of CMC is increasing with access to records by OOH services. Further QI initiatives to drive numbers and quality of records will be discussed with impact of OOH records accessed on patient outcome.

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'TO FEED OR NOT TO FEED': REVIEW OF PRACTICE IN AN ACUTE HOSPITAL TRUST AROUND INITIATION AND WITHDRAWAL OF PARENTERAL NUTRITION (PN) IN PALLIATIVE PATIENTS

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Background/Introduction National and European guidance around use of PN in palliative patients emphasises the need to consider risks, benefits, and impact on QOL with it unlikely to be appropriate in the last weeks of life. Starting PN can delay discharge from hospital to other settings and affect PPC/PPD.

Aims/Objectives To assess whether local processes around initiating and withdrawing PN for hospital inpatients with palliative care needs are in line with current guidance.

Methods Retrospective case review: All Patients prescribed PN feed over a 6-month period identified by pharmacy and known to the hospital supportive and palliative care team (SPCT) were recruited and their notes reviewed regarding indication for PN, evidence of discussions around initiation and withdrawal, date PN started and stopped, interventions planned/performed, details of SPCT involvement, and patient outcomes. Data analysed using descriptive statistics.

Results 183 patients received PN over 6-month period. 33 were known to SPCT. SPCT involvement began after PN initiation for 77% of patients. Wide range of indications for initiation, most common being oesophageal obstruction (16%). Most commonly withdrawn because patient approaching terminal phase (52%). Relevant documented discussions with patients/families recorded in 29% prior to initiating PN (none involved SPCT) and 26% prior to withdrawing PN (half involving SPCT). Nearly half (48%) of patients died within 2 weeks of starting PN (65% within 4 weeks). Importantly 26% died within 24 hrs of stopping PN. Over 2/3 died in hospital. 65% had no intervention planned to stop the need for ongoing PN at the time of initiation. Findings showed results were not in line with current national guidance

Conclusion/Discussion Decision for SPCT to be involved in all MDT discussions prior to PN initiation in palliative patients

incorporated into new hospital guidelines. Introduction of proforma planned to record initiation discussions in medical notes. Outcomes following changes will be reaudited.

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OUTCOMES FOR INPATIENTS WITH CHRONIC LIVER DISEASE, IS THERE A NEED FOR BETTER PALLIATIVE CARE PROVISION?

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Background Liver disease is the third largest cause of UK death in working age people and is prevalent locally. Early access to palliative care is associated with better quality of life and fewer hospital admissions. This study explores prognosis of inpatients with chronic liver disease (CLD) and their interaction with palliative care.

Methods New Cross Hospital inpatients with CLD, without malignancy, were discussed at the weekly liver Multidisciplinary Team (MDT) meeting (2014 to 2016) and followed up until 2020. Data were retrospectively collected using written and electronic records to determine baseline factors, liver disease severity, follow up and intervention, and analysed for timepoint analyses of death.

Results 112 patients data were analysed. The mean age was 55. 86% (96) had alcohol related liver disease. Other primary aetiologies included non-alcoholic fatty liver disease, cholestatic liver disease and drug-induced liver disease. 51% (57) died within a year of MDT, at least a further 21% (23) died during follow up. 58% (42) with Child-Pugh C grading died within a year of MDT, a further 18% (13) died during follow up. 3 patients went on to liver transplantation. Child-Pugh C grading was 74% sensitive for identifying those who will die within 1 year, but only 42% specific. Child-Pugh B or C was 100% sensitive for death within 1 year, but only 9% specific. 47% with Child-Pugh C, 37% of Child-Pugh B and 20% of Child-Pugh A were known to specialist palliative care team (SPCT). 56% of deceased patients were known to SPCT.

Conclusions This data confirms the poor prognosis of inpatients with CLD and demonstrates a need for greater integration of advance care planning principles and palliative care support. Further research is needed to assess which interventions would be beneficial and acceptable to these patients, or how we identify those who would most benefit.

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A KETAMINE PATHWAY: RESPONDING TO A NEED FOR QUALITY IMPROVEMENT IN KETAMINE BURST THERAPY

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Background Ketamine is an anaesthetic agent which can be used to treat pain that is unresponsive to standard treatments. Patients are admitted to the hospice inpatient unit to receive ketamine burst therapy over a five-day period. An audit was conducted to compare current practice against standards derived from regional guidelines.

Methods A retrospective case note audit was completed in July 2020 and using the controlled drugs register, 20 hospice inpatients were identified as having received ketamine burst

therapy over the prior three years. The electronic case notes were subsequently analysed.

Results Of the 20 patients who received ketamine, 17 (85%) completed the five-day regimen. Prior to commencing treatment, all patients had a clearly documented rationale and indication and 13 patients (65%) received counselling regarding the risks and benefits. Monitoring of respiratory rate and conscious level at baseline and during treatment was significantly below standard. Only a small proportion of patients (10%) had adequate monitoring of blood pressure and heart rate during treatment; with 4 patients (20%) having documented evidence of a significant rise in either heart rate or blood pressure. Of these, 3 received a ketamine dose alteration.

Conclusion The audit findings strongly suggested that monitoring during ketamine burst therapy was suboptimal and fell below regional standards. As this posed a potential patient safety issue, the findings were presented at a local audit meeting. In response, a Ketamine Pathway was developed to enhance and standardise patient care for those receiving ketamine burst therapy. The Ketamine Pathway outlines recommendations for counselling, opioid dose reduction prior to treatment and twice daily monitoring of vital signs during treatment. It also includes a pre-populated prescription and vital sign monitoring chart. Early evaluation of the use of the Ketamine Pathway in clinical practice is encouraging and re-audit is planned for 2021.

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DEMONSTRATING HOW BEING AVAILABLE FOR ADVICE ENHANCES PATIENT CARE

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10.1136/spcare-2021-PCC.120

Background The medical team are available for clinical advice 24 hours a day to Hospice staff, Hospital staff and HCP based in the community. They also advise patients, family or carers directly. Doctors may be asked for advice during any work activity even if it is unrelated to the enquiry. The role of advice is less visible than other patient contacts and therefore risks being undervalued.

Methodology The team recorded advice given over a 5 week period excluding whilst on call.

Results 151 pieces of advice given. Mean 6 pieces per day (range 0–21). 81% were dealt with within 30 minutes. The longest episode was 2.5 hours. This does not include the time taken if a home visit was needed. The episodes amounted to 77 hours 20 minutes. Mean 3 hours per day (range 0–11.5).

81% of advice is given to Hospice staff with Community CNS's being the largest single group. We took enquiries from a wide range of sources. 68% patients were already known to the hospice. Most advice given was around symptom control. Other advice included psychiatric symptoms, diagnosis/prognosis, bereavement, supporting families, genetic testing, making best interest decisions, ethical dilemmas, admissions, discharges, obtaining medications and completing death certificates.

No request was inappropriate. 6 hospital admissions were directly avoided. In 7 cases an urgent home visit was done by the medical team. The majority of patients remained in their care setting. Only one patient was admitted to hospital.

Conclusion Being available for advice has a direct impact on patient care and should be recognised as an efficient way of