

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

100 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.

101 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.

102 DEMONSTRATING HOW BEING AVAILABLE FOR ADVICE ENHANCES PATIENT CARE

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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