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

influencing the management of a large number of patients. It is an opportunity to support whoever is asking the advice. If advice was not sought the patient may have ended up in the acute hospital due to sub-optimal management.

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QIP: IMPLEMENTING A PALLIATIVE CARE ELECTRONIC PATIENT PROFILE TO IMPROVE MDT COMMUNICATION AND HANDOVER

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10.1136/spcare-2021-PCC.121

Background and Introduction Northumbria Healthcare Trust uses an electronic patient record called 'Nervecentre' to display admission information. This was often inaccurate and less palliative care focussed. A palliative care profile ('PCU Profile') was created within this software with the aim to improve information sharing and handover.

Methods Usage of 'Nervecentre' and the data within the current 'Medical Profile' were analysed in terms of accuracy and inclusion of palliative care specific outcome measures (phase of illness and Australia-modified Karnofsky Performance Status (AKPS)). Qualitative data was gathered on the current weekend handover process (junior doctors creating a document every Friday). The 'PCU Profile' included relevant information about the patient's admission with designated areas for weekend handover. The MDT completed and edited the profile during the hospital admission. After implementation, the accuracy of the data included was reviewed and feedback gained.

Results 45 'Medical profiles' were analysed which included 19 inpatients over 10 days. None of these profiles had phase of illness or AKPS documented. All included the correct resuscitation status. The diagnosis was accurate in 67% with an updated management plan in 29%. 58% had the correct past medical history. With regards to weekend handover, a move to using 'Nervecentre' was supported with current issues including reliability, clinical governance and efficiency. The 'PCU Profile' led to 91% of diagnoses being accurate, 100% of management plans updated, 82% of profiles stating AKPS and 91% including phase of illness. Quantitative feedback is ongoing but has been positive especially with regards to weekend handover.

Conclusions Initial data shows improved accuracy of inpatient information leading to more efficient, accurate and therefore safer verbal handovers thus improving patient care. Virtual handover to the on-call team improved ease of information sharing, confidentiality and patient safety. It is hoped more feedback will allow the profile to evolve in future.

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THE DEVELOPMENT OF A SUPPORTIVE AND PALLIATIVE CARE LIVER SERVICE WITHIN AN ACUTE HOSPITAL TRUST TO SUPPORT PATIENTS WITH ADVANCED LIVER DISEASE

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Patients with advanced liver disease have significant symptom and psychological burdens. Palliative care can

improve symptoms and quality of life. Timely advance care planning (ACP) allows patients to prepare for deterioration and facilitate patients dying in the place of their choice.

Method Collaborative working between the Macmillan Supportive and Palliative Care Team (SPCT) and Gastroenterology colleagues developed a Supportive and Palliative Care Liver Service (SPCLS) to meet the needs of patients with advanced liver disease. SPCT engaged with doctors and nursing staff; discussing the service and referral criteria. SPCT joined Gastroenterology ward rounds, alongside joint working between the Alcoholic Liver Disease Clinic and SPCT Clinic. A retrospective audit looked at inpatient referrals to the SPCT for 19 liver disease patients before and 22 patients after the SPCLS.

Results

- Prior to the SPCLS 68% of patients referred were in the last days of life at time of referral or had a poor prognosis, this reduced to 23% after the service started. As a consequence most patients (63%) were unable to discuss ACP whilst with the SPCLS 73% could discuss ACP.
- Prior to the SPCLS in only 21% of cases did the referring ward team recognise and refer their patients for symptom control, compared with 68% of patients referred for symptom control after the service started.
- Since the SPCLS started the percentage of patients who received psychological support increased from 53% to 73%.
- Since the SPCLS started the percentage of non-cancer patients referred to the SPCT dying in hospital reduced from 90% to 50%.

Conclusion SPCLS has facilitated patients being referred to SPCT earlier in their illness; there is an improved awareness of symptoms and the role of SPCT. Earlier referral enabled more patients to discuss ACP and receive psychological support. Since the development of the SPCLS fewer patients died in hospital.

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BREAKING BARRIERS AND BUILDING BRIDGES: A SYNERGISTIC FUTURE FOR PALLIATIVE CARE IN LIVERPOOL

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Background and Methods Professionals in Liverpool have designed the IMPaCT (Integrated Mersey Palliative Care Team) model of care to improve access for patients, their families and other professionals. The COVID-19 pandemic enabled implementation of this much more quickly than envisaged. The IMPaCT service in North Liverpool was piloted over July to September 2020 and went 'live' in October. The 'Hub' accepts calls and referrals from anyone and comprises coordinators from hospice outpatient, hospital and community palliative care specialist nursing teams. This single point of access allows for sharing of information, elimination of duplication, and reduces delays in care. Patients are no longer discharged when they move between settings; once they are referred to the IMPaCT service, they remain on the locality caseload until their death.

Results In North Liverpool 136 patients have been regularly reviewed under the newly formed nurse-led surveillance clinic