

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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**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

in place of the old medical outpatient system. Where medical input was required, advice could be sought from the hub doctor and patients could be seen in the new ambulatory clinic or at home as needed. Of 21 patients were referred for hospice inpatient admission, 18 were admitted within 1 day, an improvement on the 2019–2020 average time from referral to admission of 3 working days. Of 26 patients triaged for medical outpatient review 23 were reviewed within 24 hours (8 same day) – the previous average was 15 working days from referral to appointment.

**Conclusions** The switch to a daily ambulatory clinic has improved timeliness of medical assessment and domiciliary visits have been completed in a more timely manner due to freeing up medical availability. Co-location of team members has enhanced information sharing and transfer of care between settings. Patients, carers and staff have reported the benefits of reduced waiting times for specialist input across the services.

106 **QUALITATIVE ANALYSIS OF RECOMMENDED SUMMARY PLAN FOR EMERGENCY CARE AND TREATMENT (RESPECT) WITHIN THE MEDICINE OF THE ELDERLY (MOE) DIRECTORATE AT THE WESTERN GENERAL HOSPITAL**

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**Background** There has been increasing awareness of the value of high-quality anticipatory care planning (ACP) in the frail, elderly population. ACP offers patients with chronic conditions the opportunity to plan their future care and treatment, while they have capacity to do so. This personalised approach improves patient outcomes, particularly towards the end of life. In NHS Lothian there is an opportunity to create a standardised tool to record a patient's ACP decisions. ReSPECT is in use as an ACP form across England and Scotland. ReSPECT focuses on patient wishes and realistic treatment goals prior to an emergency situation when they cannot make or express choices. This project aimed to ascertain whether ReSPECT is a suitable ACP form for a frail, elderly inpatient population in NHS Lothian.

**Methods** Ten medically stable MOE inpatients were approached for a discussion about their health and future wishes using the ReSPECT form. A questionnaire was created to facilitate this discussion and record responses.

**Results** Eight of ten participants were happy to discuss future wishes. Four participants found the discussion useful. Two participants found it distressing. Only two participants found the form easy to use.

**Conclusions** While some participants did find ACP discussions useful, the ReSPECT form was not well received amongst this inpatient sample. Barriers included difficulty understanding the form, concern that wishes were documented irreversibly, and a desire to avoid difficult topics while recovering from acute illness.

In view of the barriers identified, it is clear that we must factor in both sufficient time and support to facilitate patient-centred ACP discussion. In line with patient feedback, it is likely that the best time to initiate this process is not following an acute illness, but when the person is in a period of stability. ReSPECT may be more well received if initiated in primary care.

107 **A SERVICE EVALUATION OF A NEW POLICY TO SUPPORT CARERS GIVING SUBCUTANEOUS ANTICIPATORY MEDICATIONS AT HOME AT END OF LIFE WITHIN SOUTHERN DERBYSHIRE, POPULATION OF 607,000**

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**Background** The Derbyshire Policy for Informal Carers Administration of as required Subcutaneous Injections in Community Palliative Care was developed by Specialist Palliative Care Services, in conjunction with multiple agencies across Derbyshire. During policy development, for governance and learning, it was agreed that a rolling service evaluation would be undertaken and learning fed back to community partners annually.

**Methods** A qualitative acceptability question was posed to the caregiver after the relative had died. 'Was the process acceptable and beneficial?'

Demographic and quantitative data was collected at time of death.

- Number of injections of each drug given was collated from stock balance charts in the patient's home and correlated with the call log.
- Number of days carer enabled to give anticipatory drugs.

All carers were trained by the same palliative care consultant and supported by a designated community palliative care nurse. To support carers, a telephone call to specialist palliative care was mandated prior to each injection being given by the carer.

**Results** Six carers were trained between March and September 2020. Five have a health professional background. Four were trained at home and two in the Specialist Palliative Care Unit. Qualitative data is available for four patients who have died. The number of injections of anticipatory medications given by carers varies.

Patient 1: 109 injections over a 137 day period of care  
 Patient 2: 9 injections over a 7 day period of care  
 Patient 3: 2 injections over a 6 day period of care  
 Patient 4: 41 injections over a 16 day period of care

The breakdown of which drugs were given is available. All 4 relatives of deceased patients felt that the training was acceptable.

**Conclusions** Training carers to give subcutaneous anticipatory medications at home is acceptable and enables drug administration. The policy is available at <https://derbyshire.eolcare.uk/content/documents/uploads/tollkit-docs/POLICY-FOR-SC-ADMINISTRATION.pdf>

108 **A STUDY TO EXPLORE HOSPICE CATERING STAFF'S EXPERIENCES WITH PALLIATIVE AND DYING PATIENTS**

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**Background** It is recognised that clinical staff in various specialities engage with the ideas of death and dying. Less recognition is given to the experiences of non-clinical staff in contact with palliative patients. We identified Jors (2017)