effects/complications, observations or bloods and collated case vignettes.

Results Between April 2020-Feb 2021, 28 patients were assessed, median age 87.5(43-97) years, 20(71%) female. Place of care: 13(46%) own home, the remaining 15 (54%) resided in care homes/extra care housing. Diagnoses: 19 dementia; 6 cancer, 2 heart failure, 1 Motor Neurone Disease. Frailty scores (Rockwood): median 7(6-9).

17(61%) received SCF. Equipment was sourced equally from hospice and local pharmacy. Four had clear benefit, symptom relief, admission avoidance, alive >1mth post-intervention. Six cases demonstrated psychological benefit for patient/family with no harm/side-effects (all died 4-17 days post-intervention). Two had possible benefit but diuretics were withheld/reduced concurrently (1 alive >1mth post intervention, 1 died 3wks).

Five had no clear benefit, but no harm. 6/11 cases where SCF were not given, died within a week (2-8 days). Five with dementia in care home/extra-care housing were managed with mouthcare/encouraging oral fluids (3 alive >1month post-assessment).

Fluids were stopped due to side effects in three patients: none experienced ongoing harm. Volumes of fluid given varied. Feedback from clinicians and families suggested the tool facilitated discussion/understanding of rationale for giving/withholding.

Conclusion SCF was of clinical benefit for some patients, with minimal harm. The tool increased clinicians' confidence to assess benefits/harms of SCF and address family concerns in a structured way. Further robust data collection is needed to monitor use/outcomes of SCF in a community setting and to better identify patients who may benefit.

P-133 SUBCUTANEOUS FUROSEMIDE USE IN THE COMMUNITY SETTING: CLINICAL BENEFIT AND HOSPITAL AVOIDANCE

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10.1136/spcare-2021-Hospice.150

Background There is little evidence on the use of subcutaneous furosemide infusions in heart failure patients, especially in the community setting (Beattie & Johnson, 2012). Integrated working is key to smooth the transition from management in the hospital to community settings, particularly for patients who are increasingly fatigued with short prognoses but who may still benefit from parenteral therapy.

Aim To retrospectively evaluate clinical effectiveness of subcutaneous furosemide used in the community setting at end-of-life.

Method We reviewed case notes of patients treated with continuous subcutaneous furosemide by the community palliative care team (2019–2021). A standardised proforma was used to assess patient demographics, indications, clinical outcomes and barriers/facilitators to the process.

Results 16 patients received a total 22 interventions. Median age 77(50-94), 11(69%) male, primary HF (Heart failure) diagnosis 6 HFrEF, 5 HFpEF,2 RHF, 2 Valvular, 1 unknown aetiology.

Phase of Illness, 13 unstable and 9 deteriorating with AKPS 30-60%. Oral diuretics included loop diuretics (furosemide 15/22 and bumetanide 6/22), aldosterone receptor antagonists (spironolactone 4/22), mineralocorticoid receptor antagonists (eplerenone 11/22) and thiazides (indapamide 1/22). Majority of interventions had stage 3 renal function (16/22 episodes). Patients were discussed with cardiology or palliative care consultant. Median dose given was 160mg (range 80-240mg) for 11(1-33) days.

Outcomes 15/22 showed symptomatic improvement, 6/22 had side-effects including worsening renal function, hypotension, hypokalaemia and site reaction needing antibiotics. 21/22 interventions avoided a hospital admission; 12/16 patients achieved preferred place of death (1 was admitted to hospital; 3 alive). Barriers to community administration included: challenges obtaining medications, burden of a continuous sub cutaneous infusion [CSCI].

Conclusion There is a clear benefit for individual patients, allowing those in last year of life to spend as much time as possible at home. We plan to develop a decision support tool to aid wider community decision making, facilitating timely use of subcutaneous furosemide, therefore maintaining effective symptom control in community settings.

P-134 SYMPTOMS MATTER; AN AUDIT OF SYMPTOMATIC MANAGEMENT OF MALIGNANT BOWEL OBSTRUCTION

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10.1136/spcare-2021-Hospice.151

Background The diagnosis, assessment and management of malignant bowel obstruction (MBO) varies across organisations. Different levels of emphasis are placed on resolution of the obstruction or symptomatic management. Yet there is currently a lack of comprehensive guidance or clinical pathways to ensure an equivalent high-standard level of care is offered to all patients.

Aims

- To determine current practice in the management of MBO.
- To inform future guidance and direct the emphasis placed on specific management strategies.
- To improve future patient care and experience through more effective symptomatic management.

Methods Patients with an inpatient diagnosis of MBO were identified from the specialist palliative care (SPC) multi-disciplinary [MDT] lists from March 2019-January 2020. Data collected included: demographics, admission length/outcome, diagnosis, symptomatic reviews and treatment methods. Data was tabulated and analysed in Microsoft Excel.

Results Fifteen inpatients were identified. Seven patients (47%) died in hospital on average 22 days after admission. Nine (60%) had known colorectal malignancies. Fifteen (100%) had nausea and vomiting or colic on admission. Of the nine (60%) who had colic on admission five (34%) still had colic on day 4.

Only five (45%) had a daily review of symptoms. By day four, 10(67%) had PRN anti-emetics prescribed and 5(34%) had regular anti-emetics prescribed. The most commonly used agents were cyclizine (PO/IM/IV) and ondansetron (PO/IM/IV). Ten (77%) had naso-gastric [NG] tubes inserted and none underwent surgical procedures. All were reviewed by the inpatient SPC team at least once during their admission.

Conclusions Surgical management of MBO is uncommon and so emphasis should be placed on symptomatic relief and conservative therapy options. This would enable greater patient autonomy to decide preferred place of death. Assessment of symptoms of MBO should be clearly documented on