

aim of this study is to explore the role of CNS's in supporting patients with palliative care needs, using a case study of mesothelioma clinical nurse specialists (MCNSs).

Methods The study used a mixed methods design involving: (i) secondary analysis of existing research data from the National Mesothelioma Outcomes, Research and Experience (MORE) Survey in 2019, completed by 510 patients; (ii) an on-line survey of 23 MCNSs exploring delivery of palliative care and; (iii) focus groups and individual interviews with 16 MCNSs to explore their role in palliative care provision.

Findings Five key findings were generated from the research: (1) MCNS's are highly skilled at providing palliative care, the majority have received training or education in palliative care; (2) there is an important distinction between 'specialist' palliative care and 'generalist' palliative care in mesothelioma; (3) all MCNS's provide generalist palliative care and some also provide specialist palliative care, potentially reducing/delaying the need for additional specialist palliative care provision (4) good partnership working between MCNSs and specialist palliative care is crucial to ensure patients receive seamless care; (5) a co-ordinated approach to a patients care is crucial.

Conclusion MCNS's are skilled providers of palliative care, there is some evidence that the MCNS role may mitigate the need for specialist palliative care in mesothelioma. Further research is required to explore whether these findings can be replicated in other health conditions requiring palliative care. However, this study illustrates the significant potential for CNSs to support provision of both specialist and generalist palliative care in life limiting conditions.

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COMPLETION OF AN ADVANCE CARE PLAN (ACP) WITH PATIENTS WITH ADVANCED NEUROLOGICAL CONDITIONS, THE EVIDENCE

Hannah Fox, Julia Head, Eleanor Hendicott, Derek Willis. *Severn Hospice*

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Background As a result of service development through COVID-19, a community based Speciality Doctor was recruited to write ACPs for patients with progressive advanced neurological conditions through domiciliary visits. This study seeks to understand how their ACP may benefit patients and their primary health care providers (PHCP).

Methods

1. Retrospective cohort study, examining electronic hospital records 3 months pre-ACP/3 months post-ACP of 36 patients
2. Online survey of patient's named PHCP

Results 36 patients were reviewed, diagnoses included advanced Parkinson's disease/Parkinson's plus, secondary multiple sclerosis, NF1 and superficial siderosis. 2 of these patients were known to hospice services before ACP commencement.

5 patients died since their ACP was made, all in their preferred place of care (home), with anticipatory medications, and without hospital or hospice input at end of life. Comparing 3 months pre to 3 months post ACP, ED attendances reduced from 35 to 9, and acute hospital inpatient stays reduced from 16 to 5 (136 to 21 bed days). 9 of 26 PHCPs surveyed replied. 89% (8) knew about the ACP but

none had used it so far to make a clinical decision. 89% (8) felt confident of what an ACP is (8+/10 self scoring) with 33% (3) very confident to complete/review themselves. All responders felt happy for an ACP to be completed on behalf of them, concluding that it should be done by the 'most appropriate' 'experienced clinician' who 'knows the patient best'.

Conclusions This study demonstrates the benefit from ACP in terms of achieving PPOC and avoiding hospital admissions. For these 36 patients, there were potentially 11 acute hospital admissions avoided, with a reduction in 115 bed days.

Data will be extended by a further 3 months by the time of the PCC. Future work gauging patient's and carer's opinion of ACP is planned.

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ARE WE RESPECTING CARE HOME RESIDENTS? THE USE OF DO NOT ATTEMPT RESUSCITATION (DNAR) AND RECOMMENDED SUMMARY PLAN FOR EMERGENCY CARE AND TREATMENT (RESPECT) DOCUMENTS FOR CARE HOME RESIDENTS ATTENDING THE EMERGENCY DEPARTMENT (ED)

Eleanor Hendicott, Alice Holt. *University Hospitals of North Midlands NHS Trust*

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Background Average life expectancy for UK care home residents is 24 months, or 12 for those with nursing care. This population have higher ED attendance than the general population of the same age. DNAR and ReSPECT documents allow communication of plans for future emergencies, with ReSPECT incorporating both personal preference and professional judgement. This study explores the use of these documents in a single ED.

Methods Residents attending UHNM ED in a week in October 2020 or February 2021 were followed up for 2 months. UHNM discontinued DNAR with preference for ReSPECT documents between these timepoints. Data was retrospectively collected from electronic records regarding demographics; prior establishment, acknowledgement or implementation of either document on attending ED; attendances either side of the event and; death, if applicable.

Results Data of 74 patients from October and 51 patients from February were analysed with mean age of 85.6 and 86 years respectively. Residents of both cohorts averaged 2.2 ED attendances during the year prior to the event.

In October 64% (47) of residents had DNAR and 6.8% (5) ReSPECT documents with further implementation of ReSPECT in 2.9% (2). Of those with a ReSPECT 71% (5) were admitted, compared to 63% (42) of those without. 28% (21) of patients died during follow-up.

In February 69% (35) of patients had DNAR and 17.6% (9) ReSPECT documents with further implementation of ReSPECT in 7.1% (3). Of those with a ReSPECT 42% (5) were admitted, compared to 72% (28) of those without. 14% (7) of patients died during follow-up.

Conclusion The data demonstrates that greater uptake of ReSPECT documents for care home residents could lead to reduced hospital admissions for those attending ED. Further consideration is required to understand how to improve implementation, in order to be able to respect patient's wishes in an emergency.