A SYSTEMATIC REVIEW EXPLORING FACTORS ASSOCIATED WITH PALLIATIVE CARE UTILISATION IN PATIENTS WITH IDIOPATHIC PULMONARY FIBROSIS

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10.1136/spcare-2023-PCC.131

Background Palliative care is being underutilised in patients with idiopathic pulmonary fibrosis (IPF). Barriers to accessing palliative care (PC) included prognostic uncertainty in IPF, lack of clarity regarding the role of PC and patients fear regarding the future. The aim of this review is to explain how PC is currently being utilised in IPF patients.

Methods Medline and CINAHL were searched following a sensitive search strategy developed with a faculty librarian. Inclusion criteria included reporting PC utilisation in a health care setting as defined by WHO.2

Results From 245 search results, we included 12 articles. At a national and institutional level we found a PC utilisation of 0%-62% and 13.5%-36% respectively, with PC commencing 1 day – 1 month before death. PC was associated with in home and hospice death. PC utilisation did improve over time. Factors influencing PC utilisation include being older at the time of diagnosis with more severe comorbidities and residing closer to the institution. One cohort study highlighted patients receiving PC had more severe baseline disease which coincided with the centres focus on these measures. Many Cohort studies focused on the idea of a PC referral. Novel Education programmes, MDT approaches and decision aid tools all increased PC utilisation.

Conclusion PC utilisation has shown high variability, with onset of care too late to derive maximal benefit, however utilisation has been improving over time. Structured approaches taken by individual centres did improve PC utilisation, however, more research is needed to understand the upward trend in PC utilisation. While some studies focused on the idea of a PC referral, centres should be aware that PC can be delivered by a range of healthcare professionals. Novel models of PC delivery have paved the way forward in increasing PC utilisation, therefore, more research should focus on developing these approaches.

REFERENCES

WHAT DOES AN OUT OF HOURS CONSULTANT LED PALLIATIVE CARE ADVISORY SERVICE LOOK LIKE?

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10.1136/spcare-2023-PCC.132

Background Supportive Care UK provides a nationwide remote palliative consultant led service to support medical professionals. This study aimed to characterise the nature of calls made to their out of hours (OOH) helpline.

Methods Retrospective review of 126 anonymised call logs, documenting second on call phone advice given across 19 sites during OOH periods between January and September 2021. Data was collected on demographics of the call, the patient and the nature and complexity of advice.

Results 68% (86) calls were made on Saturdays and Sundays.

- Peak call times were 11–12 am and 5–6pm.
- The most common caller was a junior doctor (32%), followed by staff grade doctors (19%), 73% of callers were doctors (92), 13% (7) were clinical nurse specialists/advance nurse practitioners and 10% (12) were registered nurses.

- Patients were most frequently aged between 60 and 89 (61%).
- 78% (98) of patients had a malignant diagnosis, most commonly colorectal, urological and lung cancer.
- The commonest reason for calling was for advice regarding symptom control (58% – 73 calls). 18% (23) were regarding medical emergencies, 16% (20) about medication advice, 3% (4) about non-symptom control end of life care issues, 1.5% (2) regarding ethical advice.

14 calls (11%) were simple not requiring specialist palliative care knowledge. 96 calls (76%) were more complex including advice on symptom control and syringe driver adjustments. The remaining 16 calls (13%) were particularly complex requiring experienced specialist input, such as advice on Methadone, Ketamine, Phenobarbital and complex ethical discussions or decision making.

Conclusions This project demonstrates a pattern of usage of a second on call advice line across multiple sites nationwide. The most common usage of the service were training grade or staff grade doctors doctors calling predominantly for symptom advice, in the weekend day period about patients with a malignant diagnosis. Further analysis is ongoing.

RETURNING HOME: EXPEDITING DISCHARGE INFORMATION TO COMMUNITY SERVICES

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10.1136/spcare-2023-PCC.133

Introduction Effective and efficient co-ordination between healthcare professionals across settings is vital to ensure the continuity and quality of patient care. Particularly in the palliative care population who often have complex and rapidly changing needs. This includes communication of admission information, medication changes, advanced care plans and follow up information. A key method of communication is the discharge letter. Whilst working in Woodlands Hospice, we became aware that there were a notable number of calls including from GP pharmacies, Community Palliative Care Team and GPs to clarify discharge information and I felt there was an opportunity to improve the discharge communication process. This project explored a range of interventions to expedite the flow of discharge information. We focused on the completion and dispatching of letters from the medical team. The aim was to increase the percentage of discharge letters being sent from Woodlands Hospice to community services (GRCPSCT, etc.), within or at 24 hours of discharge to 100% at 4 months.

Methods Data was analysed from 07/06/21–15/10/21. We compared the time frame in days from a patients’ discharge, to the sent date printed on discharge letters. Prior to any intervention, the percentage of letters meeting the target was 47%. We planned to accomplish the aim through 3 interventions; 1.
Making a common ‘Discharge Letter Preparation Table’ Template, 2.‘UP-TO-DATE’ Whiteboard, 3. Changing to an electronic system for discharge letters.

Results After the first and second interventions the percentage of discharge letters meeting the target was 28% and 69% respectively. By the end of the 3rd intervention, this had increased to 78%.

Conclusion There has been a significant improvement in the percentage of discharge letters being sent to community teams within or at 24hrs of discharge, hence improving patient continuity of care. These changes are relevant to and could be replicated across clinical settings.

114 WHAT’S THE DEMAND? DEVELOPING PALLIATIVE CARE RAPID RESPONSE SERVICE

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Background Coventry and Warwickshire Partnership Trust Community Nursing had manned an urgent access phone to respond to people requiring just in case medication or have a syringe driver. The Integrated Palliative Care Team, following investment, took ownership daily between 8am-8pm. The use of this phone had not been monitored previously.

Method We created a proforma to document the calls being received detailing date, time, patient demographic details, caller details, reason for call, response needed and whether the call was appropriate. The data for September 2022 were analysed on excel.

Results There were 130 calls to the phone in the month, between 8am and 8pm 7 days per week. 117 (90%) were deemed appropriate. The most frequent callers were family members, 66 (51%), the next most common group was health and social care professionals, 48 (37%). The phone was busiest between 4pm and 8pm with this accounting for 56 calls (43%), the quietest time was between 12–4pm accounting for 28 (22%) of calls. 69 (53%) of appropriate calls were related to symptom needs, the second most common reason for call was for palliative support care, 13 (11%). 96 (82%) required a 2-hour response, 3 (3%) a 24-hour response and 18 (15%) advice was given.

Conclusion This review shows there is a demand for this service, and it is on the whole used appropriately by service users and professionals. The data has supported the team arranging planned work between 12–4pm as this is the quieter time. The majority require a 2-hour response but there is also an element of supporting people and professionals with advice. Anecdotally, this service been manned by the team has been positive for patients and professionals.

115 VIRTUAL CONSULTATIONS: THE EXPERIENCE OF ONCOLOGY AND PALLIATIVE CARE HEALTHCARE PROFESSIONALS ‘ONE SIZE DOESN’T FIT ALL’

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Introduction To maintain continuity of care during the Covid-19 pandemic, virtual consultations (VC) became the mainstay of patient practitioner interactions. Prior to this, little was understood regarding healthcare professionals’ (HCP) experiences in translating their care to this modality.

Aim Exploration of oncology and palliative care HCP perspectives on VC, the role of VC in varying stages of the treatment and management of patient care, and the future role of VC in patient care.

Method A cross-sectional mixed methodology observational study of oncology and palliative care HCPs, analysed via an inductive thematic approach.

Results 87 surveys completed within a one-month period. Three master themes were identified. Personal, professional, and familial factors included factors of patient age, illness and VC skill in influencing HCPs’ experience of VC. Relationships and connection highlighted the influence of VC in empowering patients, the importance of a therapeutic relationship. Here, there was a perceived loss in these domains with VC. Significant challenges were felt in sharing bad news and having challenging conversations. Many survey respondents emphasized that they preferred to have first time consultations face-to-face, and not virtually. Within the domain of logistical and practical implications reduced travel and increased accessibility were seen as a benefit of VC. The inability to examine patients and concerns regarding missing clinical signs was emphasised as a significant barrier, alongside the challenges faced with sometimes failing technology.

Conclusion VC have a stronger role for those patients who are already known to professionals, when prior relationships have already been developed, and here they are perceived as practical and beneficial. VC for difficult discussions and for unstable patients were felt to be inadequate. Triaging patients with regard to suitability prior to offering VCs, with emphasis on the importance of patient choice, were seen as priority areas in this new era of VCs.

116 IMPROVING VTE RISK ASSESSMENT FOR HOSPICE INPATIENTS

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Background & Aims Hospice inpatients are often at higher risk of developing venous thromboembolic (VTE) events, but also often have various contra-indications to VTE prophylaxis. Careful assessment based on a risk-benefit balance is important to ensure that decisions are made that support patients’ quality of life and symptom control. A project was carried out to review the local hospice’s practices on VTE risk assessment and management with primary prophylaxis, and documentation of this.

Methods An audit was conducted in February 2021, prompted by participation in the data collection for the national UK Palliative care Research Collaborative (UKPRC) VTE audit. A local VTE assessment tool was then developed based on NICE guidance and practices from hospices in other regions of England.1,2 The tool was then embedded into the electronic SystmOne software used by the inpatient hospice team. A re-audit of local practice was then performed in May 2022 to assess the impact of this intervention.

Findings and Discussion The electronic VTE assessment tool led to greater percentage of patients having a documented VTE risk assessment (87.5% vs 62.5%), and better