

mortality burden. Inpatient palliative patients often have increased risk factors (cancer, reduced mobility). NICE guidelines identify specific measures to reduce VTE risk. This closed loop audit aims to assess practice against NICE standards in an inpatient hospice setting with comparison before and after interventions.

Methods Standards (based on NICE guidelines) included admission VTE assessment, consultant review, daily VTE review and stopping VTE prophylaxis when a patient enters the dying phase. All adult inpatient admissions to the hospice over a one-month period were audited, initially in March 2021 and repeated in February 2022. Two authors collected and analysed the data from electronic patient records (EPR) and drug charts using excel. Interventions between audit cycles included the introduction of a consultant review and daily board round templates to the EPR and education sessions for junior doctors on the inpatient unit.

Results 35 patients were audited in March 2021, 15 in February 2022. All patients had an admission VTE assessment. There was significant improvement in consultant review of VTE assessment between cycles (9% to 100%), and a marked improvement in documented daily review of VTE assessment (0% to 80%). There remains need for improvement in stopping VTE prophylaxis when a patient enters the dying phase (57% to 66%). Limitations of this audit include the small number of participants, with confounding factors including time of hospice admission, patient age, phase of illness and performance status on admission.

Conclusion This closed loop audit of inpatient hospice VTE assessment identifies areas of good practice and impact of implementing EPR templates as prompts. We plan to add electronic prompts for daily VTE assessment, including review when a patient enters the dying phase to further improve practice.

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ENHANCED COMMUNITY END-OF-LIFE CARE PROVISION IN FIFE, SCOTLAND, DURING THE COVID-19 PANDEMIC

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Background During the COVID-19 pandemic, there have been significant efforts to support more people to remain at home at the end of life. In Fife, Scotland, at the beginning of the pandemic, a significant proportion of NHS Fife Specialist Palliative Care Service (FSPCS) resource was diverted towards community care. This study examined trends in place of death prior to, and during, the pandemic and described patterns of unscheduled care use over the last months of life.

Methods A retrospective cohort study was undertaken, involving data linkage of routine administrative and healthcare data for all Fife decedents between April 2016 and March 2021.

Results Over the four years prior to the pandemic, place of death remained relatively stable across Fife with 53–56% of deaths in hospital, 23–25% at home and the rest in care/nursing homes. Compared with the preceding 12 months, between April 2020 and March 2021, there was a 6% reduction in the number of people dying in hospital (111 fewer deaths) and a 40% increase in the number dying at home (383 more deaths). Of patients known to FSPCS, there was a 26%

reduction in the number dying in hospital (170 fewer deaths) and a 57% increase in the number dying at home (158 more deaths). FSPCS patients spent 3297 fewer days in hospital (35% reduction) in their last 100 days of life and 1293 fewer days (30% reduction) in their last 30 days.

Conclusion Since the beginning of the pandemic, a far greater proportion of deaths in Fife have been at home and particularly when FSPCS has been involved in care. Enhanced provision of community palliative care delivers value at an individual and population level by supporting people to die in their preferred place while reducing acute hospitalisation in the last months of life.

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ON-DEMAND PALLIATIVE CARE FOR LUNG CANCER PATIENTS: A MULTI-DISCIPLINARY OUT-PATIENT CLINIC

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Background The Rapid access lung cancer clinic incorporates a multi-disciplinary team approach including surgeons, respiratory physicians, oncologists, radiologists, specialist nurses and specialist palliative care. We have developed a unique approach which combines medical and therapy palliative care assessments in a single out-patient appointment. Evidence suggests that taking a multi-disciplinary approach can improve patient care^{1,2}.

Methods Patients attending the out-patient clinic are referred to the Specialist Palliative Care Team (SPCT) and Occupational Therapist (OT) at diagnosis or at any point of their disease trajectory. A joint approach to the assessment incorporates psychological and spiritual needs, social needs, family support needs and activities of daily living as well as establishing what is important to the patient. If it is identified that a community visit would be helpful, this is implemented by the OT without the need to duplicate an initial assessment. Further needs highlighted at home are addressed by the OT with onward referral to the appropriate service as required. This joint clinic also enables pharmacological and non-pharmacological dyspnoea management which has been evidenced as the optimal approach³.

Results Results are positive with patients and families reporting that they feel well supported both in clinic and at home. Feedback suggests that patients feel comfortable and confident in contacting the team for follow up as required. The physician and OT provide a unique 'on-demand' service which allows patients to return to clinic or request further OT home visits as required.

Conclusions This unique approach to providing palliative care for lung cancer patients has proven beneficial for a number of reasons. Symptoms such as pain, nausea and psychological distress are addressed alongside functional needs such as mobility issues, social isolation and activities of daily living. Our work demonstrates how combining medical and therapy assessments can help to provide holistic care to patients with lung cancer.

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